2012–2013 Child Health Plan *Plus* Technical Report

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

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Purpose of Report

The State of Colorado, in compliance with federal regulations, requires an annual external quality review (EQR) of each medical contractor with the Child Health Plan *Plus* (CHP+) insurance program to analyze and evaluate the quality and timeliness of, and access to, health care services furnished by the contractor to CHP+ beneficiaries.

CHP+ is Colorado's implementation of the Children's Health Insurance Program (CHIP), a health care program jointly financed by federal and state governments and administered by the states. Originally created in 1997, CHIP targets uninsured children in families with incomes too high to qualify for Medicaid programs, but often too low to afford private coverage.

The Balanced Budget Act of 1997 (BBA) and The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), require states to prepare an annual technical report that describes the manner in which data from EQR 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 the health plans addressed any previous recommendations. 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 EQR activities performed on the CHP+ contracted health maintenance organizations (HMOs).

Results are presented and assessed for the State Managed Care Network (SMCN) and the following HMOs:

- Colorado Access
- Colorado Choice Health Plan (Colorado Choice)
- Denver Health Medical Plan, Inc. (DHMP)
- Kaiser Permanente Colorado (Kaiser)
- Rocky Mountain Health Plans (RMHP)

Scope of EQR Activities

The HMOs and the SMCN were subject to three federally mandated BBA activities, with the exceptions that Colorado Choice was not required to submit HEDIS measures due to its small CHP+ population size and the SMCN was not required to complete a performance improvement project. As set forth in 42 CFR 438.352, these activities were:

- **Compliance monitoring evaluations.** These evaluations were designed to determine the health plans' compliance with their contract with the State and with federal managed care regulations. HSAG determined compliance through review of various compliance monitoring 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 the HMOs. The validation also determined the extent to which Medicaid-specific performance measures calculated by the HMOs followed specifications established by the Department.
- **Validation of performance improvement projects (PIPs).** HSAG reviewed PIPs to ensure that the projects were designed, conducted, and reported in a methodologically sound manner.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the HMOs in each of these domains.

Quality

CMS defines quality in the final rule at 42 CFR 438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which a managed care organization (MCO) or pre-paid inpatient health plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-1]

Timeliness

The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-2] NCQA further discusses that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO or PIHP, such as processing expedited appeals and providing timely follow-up care.

[1-1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*. *Code of Federal Regulations*. Title 42, Volume 3, October 1, 2005.
[1-2] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

Access

In the preamble to the BBA Rules and Regulations,[1-3] CMS discusses access and availability of services to enrollees as the degree to which MCOs implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO.

Overall Conclusions

To draw conclusions about the quality and timeliness of, and access to, care provided by the HMOs and SMCN, HSAG assigned each of the components reviewed for each activity (compliance monitoring, performance measure validation [PMV], and validation of performance improvement projects [PIPs]) to one or more of these three domains. This assignment to the domains is depicted in Table 1-1 and described throughout Section 3 of this report.

This section provides a high-level, statewide summary of the conclusions drawn from the findings of the activities regarding the plans' strengths with respect to quality, timeliness, and access. Section 3 describes in detail the plan-specific findings, strengths, and recommendations.

Table 1-1—Assignment of Activities to Performance Domains

	Quality	Timeliness	Access
Compliance Monitoring			
Standard III—Coordination and Continuity of Care	✓	✓	✓
Standard IV—Member Rights and Protections	✓		✓
Standard VIII—Credentialing and Recredentialing	✓		✓
Standard X—Quality Assessment and Performance Improvement	✓		
Performance Measures			
Childhood Immunization Status	✓	✓	
Well-Child Visits in the First 15 Months of Life	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Adolescent Well-Care Visits	✓		
Prenatal Care and Postpartum Care Note: Only applicable to the SMCN population		✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Ambulatory Care			✓
Performance Improvement Projects			
All performance improvement projects	✓		

[1-3] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Quality

The CHP+ plans performed very well in the quality domain. All five plans and SMCN had robust policies and practices to ensure the protection of member information and to ensure there was no discrimination against members. All plans credentialed and recredentialed providers using practices compatible with National Committee for Quality Assurance (NCQA) standards and guidelines. Most plans demonstrated comprehensive care coordination programs that ensured members received necessary services related to physical health and behavioral health, as well as nonmedical needs, and did a good job communicating the importance of care coordination to their providers.

With regard to the performance measures, statewide performance in the quality domain was mixed. While Colorado experienced significant increases in several of the *Childhood Immunization Status* and the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators, plans also experienced significant declines. However, HSAG stresses that caution when interpreting these results. Some of these rate fluctuations may be caused by a change in data collection methodology and/or a change in the dosing requirements for hepatitis A, and not necessarily a reflection on a plan's performance.

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. All five PIPs validated by HSAG earned a *Met* validation status. This demonstrates that each health plan exhibited a strong understanding and implementation of processes required to conduct a valid study for its PIPs.

Timeliness

Coordination and Continuity of Care was the only compliance monitoring standard that contained requirements pertaining to the timeliness domain. Overall, the health plans' performance was good. Most of the plans had processes in place to coordinate between providers for members with special health care needs and during transitions of care. These processes helped ensure members received essential services in a timely manner. The health plans also demonstrated processes for ensuring timely referrals to specialists and community-based providers.

As with the quality domain, statewide performance measure results in the timeliness domain were varied, most notably among the *Childhood Immunization Status* measures. These variations may be because the 2012 *Childhood Immunization Status* measures were reported using hybrid methodology, whereas the 2013 measures were reported using the administrative methodology. These instances are highlighted on the tables and, when available, HSAG provided hybrid rates in the footnotes of tables. Additionally, the dosing requirements for hepatitis A were different between 2012 and 2013. HSAG speculates that this, too, may have impacted the variation in rates.

Access

Overall performance in compliance monitoring, as it relates to the access domain, was moderate. All of the health plans performed some level of care coordination for members with special health care needs, including referrals to specialists and nonmedical services needed to ensure access to care or transition to a lower or higher level of care. All of the health plans also had credentialing programs that ensured access to a variety of qualified providers. HSAG made a significant number of recommendations to one of the health plans that, if implemented, could provide a positive impact on the quality of its services.

The SMCN was the only CHP+ plan that offered prenatal and postpartum care. Although this rate demonstrated a statistically significant increase of more than 6 percentage points, it still fell below the national HEDIS Medicaid 25th percentile. Likewise, although the statewide performance for the utilization-based performance measure indicator, *Ambulatory Care: Total—Emergency Department Visits Per 1,000 Member Months,* had a slight rate increase, it still fell below the national HEDIS Medicaid 10th percentile.

Activities

This EQR report includes a description of three performance activities for the CHP+ health plans: compliance monitoring evaluations, validation of performance measures, and validation of PIPs. HSAG conducted compliance monitoring site reviews, validated the performance measures, and validated the PIPs.

Appendices A, B, and D 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 includes a summary assessment of each health plan's strengths and opportunities for improvement derived from the results of the external quality review (EQR) activities conducted for each of the plans. Also included are HSAG's recommendations for improving performance for each health plan. In addition, this section includes, for each health plan, a summary assessment related to the quality, timeliness of, and access to, services furnished, as well as a summary of overall statewide performance related to the quality, timeliness, and access to services.

Compliance Monitoring Site Reviews

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with regulations and contractual requirements. The Colorado Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for the Colorado Child Health Plan *Plus* (CHP+) managed care health plans by contracting with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO).

This is the second annual EQR of compliance with federal managed care regulations that HSAG has performed for the CHP+ health plans. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing these four performance areas. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. For each standard, HSAG conducted a desk review of documents sent by the health plans prior to the on-site portion of the review, conducted interviews with key health plan staff members on site, and reviewed additional key documents on site.

The health plan's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal managed care regulations and contract requirements was evaluated through a review of the four standards. HSAG calculated a percentage of compliance score

for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also calculated an overall record review score separately.

Recognizing the interdependence of quality, timeliness, and access, HSAG determined which standards contained requirements that related to the domains of quality, timeliness, or access. Table 3–1 displays which standards contain requirements related to each of the domains. By making this determination, HSAG was able to draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the health plans. Following discussion of each health plan's strengths and recommendations, as identified during the compliance monitoring site reviews, HSAG evaluated and discussed the sufficiency of that health plan's performance related to the quality, timeliness, and access of services provided.

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

Table 3–1—Standards containing Requirements related to Performance Domains

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

Colorado Access

Findings

Table 3–2 and Table 3–3 present the number of elements for each of the four standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2012–2013.

Table 3–2—Summary of Scores for the Standards for FY 2012–2013 *for* Colorado Access

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard III—Coordination and Continuity of Care	9	9	9	0	0	0	100%
Standard IV—Member Rights and Protections	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	50	50	49	1	0	0	98%
Standard X—Quality Assessment and Performance Improvement	11	11	11	0	0	0	100%
Totals	**75**	**75**	**74**	**1**	**0**	**0**	**99%***

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

Table 3–3—Summary of Scores for Colorado Access' Record Review						
Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	80	79	79	0	1	100%
Recredentialing	80	76	76	0	4	100%
Total	**160**	**155**	**155**	**0**	**5**	**100%***

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

Strengths

Colorado Access had a well-defined care coordination program and processes that were applicable to all lines of business, including the HMO that served the CHP+ population. There was evidence that care coordination staff members provided frequent monitoring of members' needs and progress, and that they were actively involved in coordinating essential services with providers and agencies on behalf of members and families. Colorado Access had processes to ensure members and providers understood member rights and complied with member rights requirements. Colorado Access provided frequent training for its staff and had mechanisms to engage providers in partnership. Colorado Access' practitioner credentialing and recredentialing files were comprehensive and well-organized, as were its organizational provider records. Colorado Access had an experienced management staff to support the CHP+ line of business and the quality improvement (QI) programs, and it was invested in the development of a high-functioning health information system to integrate data and produce reports to support QI monitoring and activities.

Recommendations

Based on the findings from the site review activities, Colorado Access was required to submit a corrective action plan to address the following required actions:

Credentialing and Recredentialing

- While Colorado Access had numerous and appropriate methods to prevent discrimination during credentialing and recredentialing processes, there were no monitoring methods in place to ensure nondiscriminatory credentialing practices, as required by NCQA. Colorado Access must develop processes to monitor credentialing activities to ensure nondiscriminatory credentialing practices.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: Colorado Access performed well in the quality domain. It had processes in place to ensure that members had an ongoing source of primary care and had a mechanism to formally designate a person primarily responsible for coordinating members' care. Colorado Access had effective tools for assessment and care planning for members with special health care needs. Colorado Access

provided its staff, providers, and members with periodic reminders about member rights and the need to ensure member rights were taken into account. Colorado Access also had effective procedures to ensure the privacy and confidentiality of protected health information. The credentialing program at Colorado Access was NCQA-compliant and included ongoing monitoring of providers and monitoring for sanction activity. Colorado Access' Quality Assessment and Performance Improvement Program included clinical practice guidelines (CPGs), methods to detect over- and underutilization of services, and mechanisms to evaluate member perceptions of access to and adequacy of services.

Timeliness: Colorado Access conducted outreach calls to members following enrollment to perform health-risk assessments and identify members with special health care needs who were appropriate for a care coordination program. Early identification of these members ensured timely access to services and programs needed. Colorado Access also had processes in place to support PCPs in providing care coordination for members with complex needs. On-site presentation of two care coordination cases involving members with complex needs demonstrated that Colorado Access care coordinators worked as liaisons with members and providers and were able to ensure that members received timely access to services.

Access: Colorado Access demonstrated strong performance in the access domain. On-site presentation of care coordination records demonstrated how the care coordination program at Colorado Access assisted members with obtaining access to necessary services through referrals to specialists and community-based providers, and by providing coordination between providers. By sending periodic reminders of member rights to its staff, providers, and members, Colorado Access informed all parties of members' rights related to accessing services. The credentialing program at Colorado Access was NCQA-compliant, ensuring a robust network of qualified providers.

Colorado Choice Health Plan

Findings

Table 3–4 and Table 3–5 present the number of elements for each of the four standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2012–2013.

Table 3–4—Summary of Scores for the Standards for FY 2012–2013 *for* Colorado Choice

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard III—Coordination and Continuity of Care	9	9	3	4	2	0	33%
Standard IV—Member Rights and Protections	5	5	1	3	1	0	20%
Standard VIII—Credentialing and Recredentialing	50	49	19	17	13	1	39%
Standard X—Quality Assessment and Performance Improvement	11	11	2	4	5	0	18%
Totals	**75**	**74**	**25**	**28**	**21**	**1**	**34%***

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

Table 3–5—Summary of Scores for Colorado Choice's Record Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	80	77	75	0	0	97%
Recredentialing	80	80	73	7	0	91%
Total	**160**	**157**	**148**	**9**	**0**	**94%***

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

Strengths

Colorado Choice had care coordination policies that described a basic framework for care coordination processes, although these policies were not completely implemented. Colorado Choice had a health information system capable of identifying members appropriate for the care management program. At the time of the site review, Colorado Choice had other basic processes described in policy that, if properly used, could enhance the provision of care management services (e.g., risk stratification, member self-assessment). Rigorous implementation of specific processes already available to Colorado Choice will further its efforts to comply with federal health care regulations and the Colorado CHP+ managed care contract.

There was evidence that Colorado Choice notified both providers, via the provider contract, and members, via the member handbook, of member rights information. In addition, there were clear statements of nondiscrimination in both member and provider materials.

Colorado Choice's credentialing records were well-organized and demonstrated clear compliance with the requirements regarding provider application, primary source verification, and rigorous provider evaluation prior to a provider's acceptance into the network.

Because its CHP+ population was small, Colorado Choice integrated data and monitoring of CHP+ quality measures into the greater Colorado Choice population data and the overall QI program activities. Colorado Choice had an integrated health information system that had the capability to provide many routine and ad-hoc reports for QI monitoring and analysis activities.

Recommendations

Based on the findings from the site review activities, Colorado Choice was required to submit a corrective action plan to address the following required actions:

Coordination and Continuity of Care

- Colorado Choice must develop policies, procedures, and processes to designate the party responsible for the members' care coordination and provide clear expectations for providers.
- Colorado Choice must develop a comprehensive assessment tool and assess its members' health care needs on enrollment, provide comprehensive assessments of members with special health care needs, and share assessments with other health care providers, as appropriate.
- Colorado Choice must implement procedures to ensure that an individual care coordination plan is developed and that both this plan and the member's agreement with the plan are documented in the care management file.
- Colorado Choice must clarify in the provider manual that CHP+ members with special health care needs have direct access to specialists.

Member Rights and Protections

- Colorado Choice must develop written policies and procedures related to CHP+ member rights and responsibilities. The policies and procedures should address all of the components of rights as stated at 42CFR438.100 and in the Colorado CHP+ managed care contract. The policies and procedures should also address how members and providers are informed of member rights, how Colorado Choice monitors providers to ensure member rights are taken into account when furnishing services, and how Colorado Choice monitors its processes to ensure that members feel free to access rights processes without fear of retaliation.
- Colorado Choice must ensure that each of its applicable documents (policies, member materials, and provider materials) addresses each of the rights at 42CFR438.100 and in the Colorado CHP+ managed care contract, and that each document informs members of their right to exercise these rights (for example, grievance and appeal rights) without adverse effect on the member's treatment and without fear of retaliation. Colorado Choice must also develop a method to inform providers of the expectation to take member rights into consideration when furnishing services.

- Colorado Choice must revise the member handbook to remove the statement that members may be terminated from the CHP+ program. If the member handbook is used for multiple lines of business and the statement in question applies to other lines of business, then separating sections or informing members regarding what does and does not apply to CHP+ members would be acceptable.

Credentialing and Recredentialing

- Colorado Choice must revise and implement policies and procedures related to the credentialing and recredentialing of practitioners to address all NCQA-required elements. (Detailed corrective actions were identified in the 2012–2013 compliance review report.)
- Colorado Choice must develop a process to ensure that the offices of all practitioners meet its office-site standards.
- Colorado Choice must ensure that practitioners are recredentialed within 36 months of the initial credentialing date or the previous recredentialing date.
- Colorado Choice must develop and implement policies, procedures, and processes to assess and reassess organizational providers and that include all required elements. (Detailed corrective actions were identified in the 2012–2013 compliance review report.)
- Colorado Choice must amend the delegation agreements to include each of the required provisions.
- Colorado Choice must develop a process to ensure delegates' follow up on recommendations for improvement based on monitoring activities.

Quality Assessment and Performance Improvement

- Colorado Choice must designate a quality oversight committee within a defined accountability structure and ensure that the committee reviews the results of ongoing quality performance measures, member satisfaction survey results, grievance data, focused studies, utilization data, and other quality data, and produces an annual evaluation and impact report.
- Colorado Choice must develop a process/procedure to adopt clinical practice guidelines as specified in contract.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: Colorado Choice's performance in the quality domain, as it relates to the standards reviewed by HSAG, was mixed. In regard to the Coordination and Continuity of Care standard, Colorado Choice had not fully implemented the policies it had. Although Colorado Choice had certain topic-specific policies in place that related to member rights, HSAG recommended that Colorado Choice develop additional policies and procedures to ensure compliance with federal health care regulations and contract requirements related to member rights. Although Colorado Choice's credentialing policies and procedures were not NCQA-compliant, staff members performed essential credentialing functions, initial and ongoing monitoring for provider sanction activity, and primary source verification of licensure and qualifications, ensuring a network of qualified providers. HSAG also recommended that Colorado Choice enhance its quality program by

more effectively using its health information systems capabilities to monitor over- and underutilization, as well as analyze member perceptions of the access to and adequacy of services. Colorado Choice was also encouraged to develop clinical practice guidelines and develop more robust quality oversight processes. Although Colorado Choice had many required actions related to the quality domain, HSAG found that employees were open to all recommendations and willing to work with HSAG and the Department to achieve full compliance.

Timeliness: The Coordination and Continuity of Care standard is the only one reviewed that HSAG determined to have requirements that could impact the timeliness domain. Colorado Choice's performance in the timeliness domain was also mixed. It had processes in place to assess members following enrollment to identify those with special health care needs. HSAG encouraged Colorado Choice to enhance these processes. Colorado Choice also provided care coordination to members during transitions of care; however, its policies and procedures required revisions and clarifications. HSAG recommended that Colorado Choice develop more robust tools to document assessment and care planning for members with special health care needs, thereby ensuring member needs are met in a timely manner.

Access: Colorado Choice's performance in the access domain was also mixed. Colorado Choice was encouraged to develop mechanisms that more effectively identified members who were appropriate for the coordination of care program and to formalize needs assessment and care planning to ensure access to services and programs needed. For the Credentialing and Recredentialing standard, Colorado Choice staff members followed most NCQA requirements in practice; however, the policies and procedures needed revision to reflect procedures in place, and to ensure compliance with NCQA standards and guidelines.

Denver Health Medical Plan, Inc.

Findings

Table 3–6 and Table 3–7 present the number of elements for each of the four standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2012–2013.

Table 3–6—Summary of Scores for the Standards for FY 2012–2013 *for* DHMP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard III—Coordination and Continuity of Care	9	9	9	0	0	0	100%
Standard IV—Member Rights and Protections	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	50	48	45	3	0	2	94%
Standard X—Quality Assessment and Performance Improvement	11	11	10	1	0	0	91%
Totals	**75**	**73**	**69**	**4**	**0**	**2**	**95%***

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

Table 3–7—Summary of Scores for DHMP's Record Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	80	79	79	0	1	100%
Recredentialing	80	77	77	0	3	100%
Total	**160**	**156**	**156**	**0**	**4**	**100%***

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

Strengths

DHMP maintained an experienced, qualified staff to perform care management and care coordination functions. In addition, organizing the utilization management, care support, and complex care management staff within one department facilitated efficiency and communications related to care coordination. The care management software Altruista Guiding Care was also a powerful program and resource to ensure consistent and complete documentation of complex care management. In addition, DHMP staff members took the initiative to add customized information to the auto-generated features of the system and ensure a more individualized plan of care. Integration of the Altruista Guiding Care system with the DHMP health information system and the Denver

Health and Hospital Authority (DHHA) clinical information system enhanced sharing of care management information with DHHA providers and ancillary departments. When necessary, DHMP used the member-signed release of information form to allow specifically for care coordination with external agencies and providers, including mental health providers.

DHMP had a variety of methods for keeping the topic of member rights visible to its staff and providers. Methods included periodic discussions and trainings in DHHA provider meetings and DHMP leadership meetings and availability of rights lists on the Web site and the staff portal. Staff members also reported that customer service and grievance staff members were encouraged to take the opportunity to explain member rights during member-initiated telephone calls to ensure member understanding. In addition, a reminder about member rights was published in the member newsletter at least once per year.

DHMP's credentialing and recredentialing files were well-organized and provided clear evidence that primary source verification and recredentialing activities occurred well within the prescribed time frames. Although DHMP is a subsidiary of DHHA, it entered into a delegation agreement with DHHA to document the relationship and ensure compliance with NCQA standards for credentialing. DHMP performed delegation oversight and monitoring activities, as required when credentialing activities are delegated.

DHMP had a comprehensive quality improvement (QI) program description that incorporated multiple QI monitoring components. DHHA's Medicaid line of business has developed processes to ensure compliance with contract requirements similar to those of the CHP+ program. This enabled DHMP to combine analysis of data for CHP+ members with Medicaid member data, when appropriate, and provided experience and a format for CHP+ QI program activities, including development of the 2013 QI Impact Analysis Report. In addition, many DHMP QI activities were conducted in conjunction with the QI activities performed in the DHHA delivery system, which enhanced the integration and quality of care for DHMP members within the overall DHHA care delivery system. This integration was facilitated through the participation of DHMP's staff and providers in the QI committees and the efforts of both DHMP and DHHA staff members. Staff members described the activities of the DHHA Guidelines Committee as an example of these efforts.

Recommendations

Based on the findings from the site review activities, DHMP was required to submit a corrective action plan to address the following required actions:

Credentialing and Recredentialing

- DHMP must either revise the medical staff bylaws or develop policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA allied health professionals (AHPs).
- DHMP must develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.
- DHMP must revise or develop documents that describe the range of actions available to DHHA to change the conditions of a practitioner's status based on quality reasons.

Quality Assessment and Performance Improvement clinical

- DHMP must revise its policies to allow the public (upon request) to access its CPGs at no cost. DHMP must also communicate to members the availability of CPGs and inform them how to access or request them.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: DHMP performed very well in the quality domain. It demonstrated a well-defined comprehensive care management program that helped ensure that its members with the most complex needs received needs assessments and care plans. DHMP had processes to ensure that members had an ongoing source of primary care and a designated person responsible for coordinating care. DHMP employed several methods to ensure member rights were taken into consideration by its staff and providers and that members were aware of their rights. The credentialing program was consistent with NCQA requirements and included ongoing monitoring of providers for sanction activity to ensure a robust network of qualified providers. The quality assessment and improvement program included a variety of mechanisms to monitor the provision of services and to evaluate the impact of quality initiatives on care and services. DHMP had mechanisms to review clinical practice guidelines and to monitor member perceptions about the access to and adequacy of services. DHMP's health information system had the capability to monitor over- and underutilization of services and report data essential to development of quality initiatives.

Timeliness: DHMP's performance as it related to timeliness was very good. DHMP communicated to its providers their responsibility to coordinate member care. Members with complex needs were also assigned a care manager to assist providers with ensuring that members' needs were met in a timely manner. On-site review of records demonstrated that DHMP coordinated with other providers to ensure timely services during transitions of care.

Access: DHMP also performed very well in the access domain. Its procedures allowed members with special health care needs direct access to specialists and DHMP staffed specialty clinics with care management personnel. DHMP used a variety of methods to remind its members and providers of members' rights to access care, and DHMP's robust credentialing program that ensured members had access to qualified providers.

Kaiser Permanente Colorado

Findings

Table 3–8 and Table 3–9 present the number of elements for each of the four standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year FY 2012–2013.

Table 3–8—Summary of Scores for the Standards for FY 2012–2013 *for* Kaiser

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard III—Coordination and Continuity of Care	9	9	8	1	0	0	89%
Standard IV—Member Rights and Protections	5	5	4	1	0	0	80%
Standard VIII—Credentialing and Recredentialing	50	49	49	0	0	1	100%
Standard X—Quality Assessment and Performance Improvement	11	11	11	0	0	0	100%
Totals	**75**	**74**	**72**	**2**	**0**	**1**	**97%***

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

Table 3–9—Summary of Scores for Kaiser's Record Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	80	75	75	0	5	100%
Recredentialing	80	78	78	0	2	100%
Total	**160**	**153**	**153**	**0**	**7**	**100%***

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

Strengths

The Kaiser staff model of an integrated system of care provided for an organization-wide, team-oriented approach. This approach allowed health plan staff members to work in partnership with providers and created a unified focus and a singular set of policies, guidelines, and objectives to ensure positive member outcomes. The Pediatric Case and Care Coordination (PCCC) program team functioned as an extension of the primary care provider (PCP) in the hands-on coordination of services for members with complex needs. In addition, medical care was provided to members within full-service medical offices, which facilitated access and coordination between primary care, specialty care, behavioral health care, ancillary services, and specialized programs.

Kaiser had a clear corporate message that members were the primary focus and at the center of Kaiser's mission. Kaiser's processes were such that member payer sources were transparent and not a part of the electronic medical record or daily work. The Principles of Responsibility document was powerful and articulated Kaiser's vision and commitment to creating positive relationships with members, employees, and providers. The document was used in initial and annual compliance training and was readily available on the employee and provider portals.

Kaiser's record-keeping processes across the credentialing program were meticulous. The credentialing and recredentialing files for individual practitioners as well as organizational providers were well-organized. Consistency among records made it easy to find the required elements in each file. Staff members used electronic databases to track assessment of organizational providers.

Kaiser demonstrated excellent physician leadership and participation of pediatric providers in achieving the goals of the Quality Assessment and Performance Improvement (QAPI) program, including an active Pediatric Care Quality Committee. QI activities included comprehensive and thorough review of QI data, studies, and improvement initiatives by QI oversight committees through a structured review process. Meeting minutes included documentation of analysis, recommendations, and actions for follow-up.

Kaiser had a sophisticated health information system to capture, compile, and report a wide variety of QI data. Kaiser compensated for the relatively small size of its CHP+ population by integrating CHP+ data with the greater pediatric population for more meaningful analysis, yet it retained the ability to segregate the CHP+ data, when appropriate. The QI process was facilitated by provider access to HealthConnect, the electronic health record (EHR) system that incorporated CPGs and other protocols, dashboard reports, and real-time gap analyses and alerts.

Recommendations

Based on the findings from the site review activities, Kaiser was required to submit a corrective action plan to address the following required actions:

Coordination and Continuity of Care

- Kaiser must have a written policy and procedure regarding coordination and continuity of care.

Member Rights and Protections

- Kaiser provider and member materials must include the member's right to amend or correct member medical records and the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: Kaiser performed well in the quality domain. It followed an integrated system service delivery with a patient-centered medical home model at the center. Kaiser's model included

coordination of member services through the primary care provider. In addition, Kaiser had a specialty children's care coordination program for children with special health care needs. Kaiser notified its members and providers of member rights and of the expectation that those rights be considered. Its rigorous credentialing processes helped ensure that qualified providers were available to all members. Kaiser had a well-defined quality assessment and performance improvement program that included a pediatric care quality committee, review of clinical practice guidelines, and monitoring for over- and underutilization and for member perceptions of the availability and adequacy of services. Kaiser also had a health information system capable of collecting and evaluating data essential to the development of effective quality initiatives.

Timeliness: Kaiser's strong care coordination program helped ensure members' access to timely care. The HealthConnect EHR was available to clinicians at all of Kaiser's medical offices as well as affiliated hospitals and skilled nursing facilities. This immediate access to member health records proved to be an asset.

Access: Kaiser's full-service medical offices facilitated access and coordination among primary care, specialty care, behavioral health care, ancillary services, and specialized programs. Kaiser had a variety of methods to ensure members and providers were aware of the services available to members. Furthermore, Kaiser managed its credentialing program in a manner that allowed its members access to a breadth of provider types. These benefits, as well as others, enabled Kaiser to perform well in the access domain.

Rocky Mountain Health Plans

Findings

Table 3–10 and Table 3–11 present the number of elements for each of the four standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2012–2013.

Table 3–10—Summary of Scores for the Standards for FY 2012–2013 *for* RMHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard III—Coordination and Continuity of Care	9	9	8	1	0	0	89%
Standard IV—Member Rights and Protections	5	5	2	3	0	0	40%
Standard VIII—Credentialing and Recredentialing	50	48	47	1	0	2	98%
Standard X—Quality Assessment and Performance Improvement	11	11	8	3	0	0	73%
Totals	**75**	**73**	**65**	**8**	**0**	**2**	**89%***

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

Table 3–11—Summary of Scores for RMHP's Record Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	80	75	75	0	5	100%
Recredentialing	80	76	76	0	4	100%
Total	**160**	**151**	**151**	**0**	**9**	**100%***

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

Strengths

RMHP had a well-trained and experienced care management staff of licensed registered nurses who were actively engaged in providing diverse support to members and families and in coordinating services with multiple providers and organizations. The RMHP care management program was supported by an electronic documentation software system that was comprehensive and well-organized for the ongoing monitoring of cases. The program supported creation of individualized goals and interventions driven by the case manager's critical thinking skills rather than preprogrammed system algorithms. Tools and formats within the system, such as comprehensive assessments and care plans, were aligned with the regulatory and contractual requirements but were flexible enough to encourage customized and detailed documentation of the member's needs and

progress. RMHP used multiple methods to identify members with the potential need for complex care management services. These methods included data-driven utilization and cost reports, member risk levels, and multiple sources of referral (member, provider, and staff members).

On site, RMHP staff members described a project recently initiated whereby the Member Experience Advisory Committee would evaluate member "touch points" (defined as points within the RMHP system wherein members would interact in some way with RMHP or its staff members), to evaluate the member's experience with RMHP and evaluate opportunities to improve the experience. The staff reported that this project involved all departments and regions served by RMHP and could impact members within all lines of business.

RMHP's policies and processes were well-organized and clearly NCQA-compliant. RMHP's processes for maintaining documents obtained for credentialing and recredentialing provided secure record-keeping while providing easy access to the staff for processing and accessing provider files, as needed. RMHP's Medical Practice Review Committees (MPRCs), which served as RMHP's geographical area-specific peer review and credentialing committees, incorporated the RMHP medical director, or a qualified designee, and included a variety of provider types.

Credentialing committee/MPRC meeting minutes demonstrated the role of the medical director consistent with the RMHP policy and that the committee reviewed files that did not initially meet criteria. The credentialing committees also reviewed ongoing monitoring for sanction activity, quality of care issues, and delegates' reports of credentialing activities.

Practitioner credentialing and recredentialing files were comprehensive and well-organized, as were organizational provider records. Practitioner and provider records demonstrated that RMHP performed all required credentialing and recredentialing activities.

RMHP implemented an active QI program and demonstrated diverse monitoring and improvement initiatives relative to the overall RMHP membership. RMHP had personnel expertise and systems to support a comprehensive QI program, and had made significant progress transitioning applicable CHP+ programs and processes to be consistent with the existing Medicaid processes. The corporatewide QI program appeared to be transitioning as RMHP developed strategies for improvement in operational approaches designed to support and integrate with other RMHP initiatives, such as the physician practice enhancement program and integration with the health information exchange. These initiatives were intended to improve the overall quality of services to members and enhance population-based outcomes. RMHP views CHP+ members as an important and integral component of the overall population and RMHP membership.

Recommendations

Based on the findings from the site review activities, RMHP was required to submit a corrective action plan to address the following required actions:

Coordination and Continuity of Care

- RMHP must implement a mechanism for initial screening of all CHP+ members upon enrollment to identify members with special health care needs.

Member Rights and Protections

- RMHP's internal policies, provider manual, and member materials must clearly describe CHP+ member rights.

Credentialing and Recredentialing

- RMHP must ensure that organizational providers are reassessed within the NCQA-required time frames.

Quality Assessment and Performance Improvement

- RMHP must include an assessment of the overall impact and effectiveness of the QI program in the annual QI report.
- RMHP must adopt clinical practice guidelines applicable to CHP+ members with disabilities or special health care needs.
- RMHP must modify its policies and processes to ensure that CPGs applicable to CHP+ members are reviewed and approved annually.

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: RMHP's performance in the quality domain was mixed. RMHP clearly communicated with its providers the expectation that PCPs serve as care coordinators and ensured that every member was assigned to a PCP. RMHP had comprehensive processes to protect the privacy and confidentiality of medical records, and member materials included a definitive statement that articulated RMHP's intention to provide equal opportunity and to prevent discrimination; however, the member rights lists were incomplete and communication to providers regarding CHP+ member rights was ambiguous. RMHP used its comprehensive credentialing program to ensure its members had access to qualified providers, and it had a comprehensive quality assessment and performance improvement program that included effective use of its health information system data to evaluate over- and underutilization of services and develop quality initiatives. RMHP adopted clinical practice guidelines for well-child and prenatal/postpartum care, but had not adopted guidelines applicable to the CHP+ population for members with special health care needs.

Timeliness: The Coordination and Continuity of Care standard was the only one HSAG determined to have requirements that could impact the timeliness domain, and RMHP's performance was mixed here, as well. RMHP's care coordination program included mechanisms for coordinating with multiple providers to ensure timely access to services during transitions of care. Members referred to RMHP's care management received a comprehensive needs assessment, an individual care coordination plan, an active case manager, and frequent follow-up; however, RMHP did not routinely contact all CHP+ members following enrollment to screen for the presence of special health care needs. HSAG encouraged RMHP to enhance these processes to ensure timely identification of members appropriate for care coordination and the timely identification of member needs.

Access: RMHP performed well in the access domain. Its care management program assisted members with complex health needs in accessing services from multiple providers, including

specialty providers and community-based programs. RMHP care management staff members worked closely with providers and members to ensure members received the appropriate services. The credentialing program ensured that all RMHP members had access to a robust network of providers.

State Managed Care Network

Findings

Colorado Access, as the administrative services organization (ASO) for the Department of Health Care Policy and Financing, administers Colorado's CHP+ State Managed Care Network (SMCN). The SMCN provides services to the CHP+ population before CHP+ members enroll in the HMO of their choice, generally for a period of 30 to 45 days. In addition, SMCN provides services to qualifying pregnant women, who remain in the network through completion of the pregnancy and do not transition into an HMO. The majority of CHP+ enrollees are members of SMCN for only a short transitional period. The provider network for SMCN is statewide and often overlaps with the networks of the CHP+ HMOs in various regions, with the exception of three service areas in which no HMO is available. Provider reimbursement in SMCN is via the State's fee for service model. The SMCN and CHP+ HMO plans are subject to similar State CHP+ contract requirements.

Although the SMCN 2012–2013 site review was not scored, SMCN's strongest performances were in Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, and Standard X—Quality Assessment and Performance Improvement. Although HSAG identified opportunities for improvement or recommendations in each standard, SMCN demonstrated strong performance overall and Colorado Access, as the ASO, demonstrated an understanding of the federal health care regulations, the Colorado CHP+ managed care contract, and NCQA standards and guidelines.

Strengths

Colorado Access had a defined care coordination program and processes that were applicable to members served by all Colorado Access lines of business, including the SMCN population, and therefore was well-resourced with staffing and systems dedicated to care coordination. Because the SMCN Prenatal Care Program members were the largest population receiving care coordination, Colorado Access developed a specialized Healthy Moms, Healthy Babies pregnancy management program and related care management tools for this segment of the SMCN population. Colorado Access had qualified care coordination staff members who were health care professionals and demonstrated commitment to frequent monitoring of the members' needs and progress. Care coordination staff members were actively involved in coordinating necessary services with providers and agencies on behalf of the member and family. Colorado Access used the care management software Altruista Guiding Care to maintain documentation in a detailed comprehensive care coordination record.

Colorado Access/SMCN had processes to ensure that members and providers understood member rights. SMCN also provided periodic communication that reminded the staff, members, and providers about member rights and the need to ensure member rights were taken into consideration

at all times. Processes to ensure that member rights were taken into account were consistent across lines of business. Colorado Access/SMCN provided frequent training for the staff. SMCN had several mechanisms to engage providers in a partnership (e.g., a user-friendly Web site, frequent provider newsletters available electronically, and an impressive number of trainings delivered in person and/or via Webinar, publicized through the Web site.

The Credentials Committee meeting minutes described the role of the medical director in the credentialing program. The minutes also demonstrated that the committee reviewed files that did not initially meet the required criteria. The Credentials Committee also reviewed ongoing credentialing activities, monitoring for sanctions, quality of care issues, and delegates' reports of credentialing activities. Practitioner credentialing and recredentialing files were comprehensive, neat, and well-organized, as were organizational provider records. Practitioner and provider records demonstrated Colorado Access' performance of all required credentialing and recredentialing activities.

Colorado Access had an experienced management staff to support the SMCN line of business and who understood the unique characteristics of the SMCN population and related operations. Colorado Access' management staff worked closely with the Department to resolve issues and anticipate revisions to the 2013 SMCN contract. Colorado Access had a QI program that was applicable to all lines of business and that enabled the SMCN to be well-resourced with QI policies, staffing, systems, and committees. Colorado Access had a robust health information system with the ability to integrate SMCN QI data with CHP+ HMO member information, or segregate the data to enable the monitoring of SMCN members as a unique population.

Recommendations

Based on conclusions drawn from the review activities, HSAG made the following recommendations.

Coordination and Continuity of Care

- Colorado Access should consider implementing mechanisms to document the member's agreement with the care coordination plan and to inform providers of the requirement for members and families to participate in developing the treatment plan.
- Member materials should inform members that individuals with special health care needs may directly access specialists.

Member Rights and Protections

- Member rights information should be included under the provider tab on the Web site, and brief member rights trainings should be part of provider training.

Quality Assessment and Performance Improvement

- The SMCN member handbook and the SMCN provider manual should be updated to inform members and providers that CPGs are available and how to access or request them.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: SMCN demonstrated excellent performance as it related to the quality domain. Colorado Access appropriately coordinated with other health care providers and community-based organizations to obtain services to meet the member's needs and to prevent service duplication. SMCN notified members and providers of members' rights and had effective procedures to ensure the privacy and confidentiality of protected health information. Providers were also notified of the expectation that they consider member rights when furnishing services. Colorado Access' credentialing program was NCQA-compliant and included ongoing monitoring of providers and monitoring for sanction activity. Colorado Access had a comprehensive QAPI program applicable to all lines of business, including SMCN, which included methods to detect over- and underutilization, as well as mechanisms to evaluate member perceptions of the access to and adequacy of services.

Timeliness: Colorado Access also performed well in the timeliness domain. Coordination with multiple providers and agencies during transitions of care ensured that members received timely services.

Access: HSAG considered requirements within the Coordination and Continuity of Care, Member Rights and Protections, and Credentialing and Recredentialing standards when evaluating SMCN's performance in the access domain. SMCN's performance as it related to the access domain also proved to be strong, and its efforts to communicate and coordinate with multiple providers ensured referrals to specialists and community-based care and therefore access to services. Periodic communication with members regarding member rights reminded members of the availability of services. Finally, Colorado Access' credentialing program ensured members' access to comprehensive network of qualified providers.

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

Table 3–12 and Table 3–13 show the overall statewide average for each standard and record review. Appendix E contains summary tables showing the detailed site review scores for the standards and record reviews by health plan as well as the statewide average.

Table 3–12—Statewide Scores for Standards	
Standards	**FY 2012–2013 Statewide Average***
Standard III—Coordination and Continuity of Care	**82%**
Standard IV—Member Rights and Protections	**68%**
Standard VIII—Credentialing and Recredentialing	**86%**
Standard X—Quality Assessment and Performance Improvement	**76%**
Overall Statewide Compliance Score	**83%***

* Statewide average rates calculated by summing the individual numerators and dividing by the sum of the individual denominators for the standard scores.

Table 3–13—Statewide Score for Record Review	
Standards	**FY 2012–2013 Statewide Average***
Credentialing	**99%**
Recredentialing	**98%**
Overall Statewide Score for Record Reviews	**99%**

Quality: All four standards reviewed had requirements that impacted the quality domain. Statewide performance in the quality domain was mixed. Six of six health plans performed well in aspects of their programs essential to providing quality care to members. These program features included robust policies and practices to protect member privacy and the confidentially of member records and policies, as well as practices to prevent member discrimination. Six of six health plans had a health information system with the ability to collect, analyze, and report data to evaluate the quality of services furnished. In addition, six of six health plans performed credentialing on contracted or employed providers, ensured medical director input in the credentialing program, and performed initial and ongoing monitoring of provider sanctions to ensure providers in the network met the quality standards. One of the six health plans had a significant number of recommendations that, if implemented, could provide positive impact on its quality of services. These included development of processes to enhance the care coordination program, such as effective communication to providers regarding their role in coordinating care for members; processes for effective communication among providers to ensure coordination and continuity of care; processes to assess and provide treatment planning for members with special health care needs; and a more robust use of data to detect over- and underutilization of services. Other essential recommendations for this health plan included enhancing the quality oversight processes and developing methods to more consistently monitor member perceptions of satisfaction and to perform analysis of these data for review by the quality oversight program. Two of six health plans needed to communicate member rights to members more effectively, evaluate their quality assessment and performance

improvement programs more effectively, and develop one or more clinical practice guidelines that are contractually required.

Timeliness: Coordination and Continuity of Care was the only standard with requirements that impacted the timeliness domain. Most health plans performed well with the requirements to facilitate referrals when needed and coordinate among providers for members with special health care needs, and to ensure that members received essential services in a timely manner during transitions of care. Two of the six health plans had recommendations to enhance identification or assessment of members with special healthcare needs, which could impact the timely identification of member needs.

Access: Three of the four standards reviewed contained requirements that impacted the access domain. These standards were Coordination and Continuity of Care, Member Rights and Protections, and Credentialing and Recredentialing. Overall performance in the access domain was moderate. Six of six health plans performed some level of care coordination for members with special health care needs, which included referrals to specialists and nonmedical services needed to ensure access to care or transition of care to a lower or higher level of care. Six of six health plans also had credentialing programs that ensured access to a variety of qualified providers. Three of six health plans had recommendations related to the need for revised member materials to ensure accurate or complete information regarding member rights. One health plan was asked to enhance its member materials related to direct access to providers for members with special health care needs, and one health plan was asked to clarify provider materials related to direct access to care for members with special health care needs. In addition, one health plan was required to develop more robust methods to monitor and analyze member perceptions of accessibility and adequacy of services.

Validation of Performance Measures

HSAG's role in validating performance measures was to ensure that the validation activities were conducted as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities,* Final Protocol, Version 1.0, May 1, 2002 (the CMS Performance Measure Validation Protocol). For FY 2012–2013, the Department required that the HMOs and SMCN report seven standard HEDIS measures.

The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected by the HMOs and SMCN.
- Determine the extent to which the specific performance measures calculated by the HMOs and SMCN (or on behalf of the HMOs and SMCN) followed the specifications established for each performance measure.

For SMCN, HSAG performed an NCQA HEDIS Compliance Audit consistent with the CMS Performance Measure Validation Protocol. Each HMO underwent this compliance audit through an NCQA-licensed audit organization of its choice and submitted the audited results and audit statement to HSAG. HSAG reviewed all final audit reports (FARs) and data workbooks. HSAG found no questionable findings or inaccuracies in the reports and determined that the reports accurately represented the HMOs and SMCN.

Each of the measures reviewed by the licensed organizations received an audit result consistent with the NCQA categories listed in Table 3-14.

All HMOs' and SMCN's performance measures received an audit result of *Reportable (R)* for the current measurement cycle. In addition, all HMOs and SMCN were fully compliant with all information system standards relevant to the scope of the performance measure validation.

Table 3-14—HEDIS Audit Results

Audit Finding	Description	Audit Result
For HEDIS Measures		
The health plan followed HEDIS specifications and produced a reportable rate or result for the measure.	Reportable rate	**R**
The health plan followed HEDIS specifications but the denominator was too small to report a valid rate.	Denominator <30	**NA**
The health plan did not offer the health benefits required by the measure.	No Benefit	**NB**
1. The health plan calculated the measure but the rate was materially biased; 2. The health plan chose not to report the measure; or 3. The health plan was not required to report.	Not Reportable	**NR**

To make overall assessments about the quality and timeliness of, and access to, care provided by the health plans, HSAG assigned each of the performance measures to one or more of the three domains, as shown in Table 3-15. Appendix B contains further details about the NCQA audit process and the methodology used to conduct the EQR validation of performance measure activities. Additionally, Table 3-15 shows the data collection methodology required for each measure, as required by the Department. While some of the health plans chose to report rates using hybrid methodology for the performance measures required to be reported administratively, HSAG only reported administrative rates for these measures. Footnotes will be included for instances like these.

Table 3-15—HEDIS 2013 Performance Measures

Performance Measures	Data Collection Methodology Required by the Department	NCQA Hybrid Measures	Quality	Timeliness	Access
Childhood Immunization Status	Administrative	✓	✓	✓	
Well-Child Visits in the First 15 Months of Life	Administrative	✓	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Administrative	✓	✓		
Adolescent Well-Care Visits	Administrative	✓	✓		
Prenatal and Postpartum Care	Hybrid	✓		✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Hybrid	✓	✓		
Ambulatory Care	Administrative				✓

Colorado Access

Compliance with Information Systems (IS) Standards

Colorado Access was fully compliant with all IS standards relevant to the scope of the performance measure validation, except IS 2.0 (Enrollment Data—Data Capture, Transfer and Entry). The auditor noted that this was due to the lack of oversight of manual data entry in membership. Nonetheless, this issue resulted in a minimal impact on the plan's ability to report.[3-1] The auditor recommended in the Final Audit Report that oversight take place for any manual data entry processes, especially in the membership area, since membership data are critical for HEDIS reporting.

Based on the auditor's findings, Colorado Access is compliant with HEDIS IS Standard 2.0 and had captured sufficiently accurate and complete measure data. The minimal impact indicated there was a potential for a nonstatistically significant bias in the eligible population; the reported rates were not impacted.

Performance Measures

Table 3-16 shows the Colorado Access rates for HEDIS 2012 and HEDIS 2013, the percentile ranking for HEDIS 2013, and HEDIS 2013 audit results for each performance measure.

Table 3-16—Review Audit Results for Performance Measures *for* Colorado Access

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Pediatric Care				
Childhood Immunization Status—Combination 2	77.01%	**54.53%**[2]	<10th	**R**
Childhood Immunization Status—Combination 3	74.79%	**52.41%**[2]	<10th	**R**
Childhood Immunization Status—Combination 4	32.69%	**46.82%**[2]	75th-89th	**R**
Childhood Immunization Status—Combination 5	52.35%	**41.43%**[2]	10th-24th	**R**
Childhood Immunization Status—Combination 6	45.15%	**34.30%**[2]	25th-49th	**R**
Childhood Immunization Status—Combination 7	21.88%	**37.57%**[2]	75th-89th	**R**
Childhood Immunization Status—Combination 8	21.61%	**31.41%**[2]	≥ 90th	**R**
Childhood Immunization Status—Combination 9	35.18%	**28.13%**[2]	25th-49th	**R**
Childhood Immunization Status—Combination 10	16.07%	**25.82%**[2]	75th-89th	**R**
Well-Child Visits in the First 15 Months of Life—Zero Visits	4.59%[3]	2.14%[3]	50th-74th[3]	**R**
Well-Child Visits in the First 15 Months of Life—6+ Visits	11.66%[4]	13.64%[4]	<10th	**R**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.62%[5]	**63.20%**[5]	10th-24th	**R**

[3-1] HEDIS Compliance Audit, Final Audit Report, Colorado Access, July 2013

Table 3-16—Review Audit Results for Performance Measures *for* Colorado Access				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Adolescent Well-Care Visits	44.50%	43.39%	25th-49th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	52.55%	**63.99%**	50th-74th	R
Counseling for Nutrition: Total	55.23%	57.66%	50th-74th	R
Counseling for Physical Activity: Total	46.23%	52.31%	50th-74th	R
Use of Services[6]				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	28.97	32.93	<10th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013.

[1] Percentile ratings were assigned to the HEDIS 2013 reported rates based on the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios. Because NCQA published the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] The rate displayed reflects administrative data only. Colorado Access reported hybrid rates of 74.70 percent, 71.05 percent, 63.99 percent, 57.66 percent, 48.18 percent, 52.55 percent, 44.53 percent, 39.66 percent, and 36.74 percent for the *Childhood Immunization Status—Combinations 2* through *10* indicators for HEDIS 2013, respectively.

[3] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile). The rate displayed reflects administrative data only. Colorado Access reported a hybrid rate of 4.24 percent and 1.87 percent for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* indicator for HEDIS 2012 and HEDIS 2013, respectively.

[4] The rate displayed reflects administrative data only. Colorado Access reported a hybrid rate of 51.59 percent and 57.22 percent for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator for HEDIS 2012 and HEDIS 2013, respectively.

[5] The rate displayed reflects administrative data only. Colorado Access reported a hybrid rate of 71.97 percent and 66.37 percent for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for HEDIS 2012 and HEDIS 2013, respectively.

[6] Since the reported rates for measures under Utilization of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

Regarding Colorado Access' information systems and processes, the auditor noted that Colorado Access had a very experienced HEDIS team with a strong commitment to improving processes and patient care. Most processes were automated with good oversight of providers and claims submission. Commendable practices included the provider credentialing department with weekly reconciliation of the provider data in the claims and provider systems. This a best practice that supports the functions of accurate claims processing.

All of the performance measures for Colorado Access received an audit result of *Reportable (R)* for HEDIS 2013. The *BMI Assessment* and *Counseling for Physical Activity* indicators for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* had rate improvements greater than 6 percentage points between HEDIS 2012 and HEDIS 2013. The improvement for *BMI Assessment* was significant.

Although four of the *Childhood Immunization Status* indicators (*Combinations 4, 7, 8,* and *10*) had a significant increase in rate of at least 9.75 percentage points, HSAG cannot ascertain if the rate

increases reflect performance improvement because of a change in reporting requirements by the Department and a change in dosing requirement for hepatitis A, a vaccine that is related to *Combinations 4, 7, 8,* and *10*. Nonetheless, the administrative rates for these four indicators met or exceeded the national HEDIS Medicaid 75th percentile.

Recommendations

Colorado Access had significant rate decreases for six measures, including five *Childhood Immunization Status* indicators (*Combinations 2, 3, 5, 6,* and *9*) and the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. The rate declines ranged as high as 22.48 percentage points for the *Childhood Immunization Status—Combination 2* indicator. Additionally, the HEDIS 2013 rate for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator fell below the national HEDIS Medicaid 10th percentile. The observed decline on the *Childhood Immunization Status* indicators may be because the Department changed the data collection methodology from hybrid in HEDIS 2012 to administrative in HEDIS 2013. When Colorado Access' performance between both years was compared using the same hybrid methodology, two indicators (i.e., *Combinations 2* and *3*) had a decrease in rate (2.31 and 3.74 percentage points, respectively).

Colorado Access should investigate methods to improve performance for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure and *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator as well as these *Childhood Immunization Status* indicators. Colorado Access should ensure that providers are appropriately coding immunizations and well-child visit services. Providers should be aware of missed opportunities. For example, when a child presents for a sick visit, components of a well-child visit can be performed and any missing immunizations can be administered. Providers should take advantage of all appointments. Furthermore, Colorado Access should consider using the Colorado Immunization Registry data, if these data are not already being used.

Colorado Choice Health Plan

Compliance with Information Systems (IS) Standards

Colorado Choice was fully compliant with all IS standards relevant to the scope of the performance measure validation. The auditor did not identify any notable issues during the review of the standards that had any negative impact on HEDIS reporting. The auditor had no recommendations for Colorado Choice related to compliance with IS standards.[3-2]

Performance Measures

Table 3-17 shows the Colorado Choice rates for HEDIS 2013, the percentile ranking for HEDIS 2013, and the HEDIS 2013 audit results for each performance measure. As a new CHP+ health plan, Colorado Choice did not have a large enough population to report HEDIS rates for HEDIS 2012; therefore, rates are only presented for 2013.

Table 3-17—Review Audit Results for Performance Measures *for* Colorado Choice

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Pediatric Care				
Childhood Immunization Status—Combination 2	—	NA	NA	**NA**
Childhood Immunization Status—Combination 3	—	NA	NA	**NA**
Childhood Immunization Status—Combination 4	—	NA	NA	**NA**
Childhood Immunization Status—Combination 5	—	NA	NA	**NA**
Childhood Immunization Status—Combination 6	—	NA	NA	**NA**
Childhood Immunization Status—Combination 7	—	NA	NA	**NA**
Childhood Immunization Status—Combination 8	—	NA	NA	**NA**
Childhood Immunization Status—Combination 9	—	NA	NA	**NA**
Childhood Immunization Status—Combination 10	—	NA	NA	**NA**
Well-Child Visits in the First 15 Months of Life—Zero Visits	—	NA	NA	**NA**
Well-Child Visits in the First 15 Months of Life—6+ Visits	—	NA	NA	**NA**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	57.94%	<10th	**R**
Adolescent Well-Care Visits	—	36.33%	10th-24th	**R**

[2] HEDIS Compliance Audit, Final Audit Report, Colorado Choice, July 2013.

Table 3-17—Review Audit Results for Performance Measures *for* Colorado Choice				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	—	13.90%	10th-24th	R
Counseling for Nutrition: Total	—	11.41%	10th-24th	R
Counseling for Physical Activity: Total	—	15.63%	10th-24th	R
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	—	20.84	<10th	R

— is shown when the measure was not reported in last year's technical report.

[1] Percentile ratings were assigned to the HEDIS 2013 reported rates based on the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios. Because NCQA published the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

Strengths

Colorado Choice had the audit result *NA* for all of the *Childhood Immunization Status* indicators and two *Well-Child Visits* indicators due to a denominator of less than 30, but it had an audit result of *Reportable (R)* for the remaining measures.

Recommendations

The *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* measure fell below the national HEDIS Medicaid 10th percentile and the remaining reportable nonutilization measures fell below the national HEDIS Medicaid 25th percentile. Colorado Choice should identify sources of low rates and design and implement interventions to improve performance.

Denver Health Medical Plan, Inc.

Compliance With Information Systems (IS) Standards

DHMP was fully compliant with all IS standards relevant to the scope of the performance measure validation. The auditor noted that DHMP had some challenges working with its software vendor to capture complete membership data. DHMP and the vendor identified issues during the initial file loads. The auditor, in conjunction with an NCQA representative, assessed that there were communication issues with the plan and the vendor—specifically, what and how the membership files needed to be created and normalized to the vendor's software. Once these issues were identified and corrected, the membership was successfully and accurately captured. [3-3] The auditor recommended in the Final Audit Report that DHMP consider extracting data from the electronic medical record to be used as a supplemental data source and consider reducing medical record chart review processes. If implemented, this extraction should follow the new supplemental data guidelines, which impact the completion data and primary source documentation required.

Performance Measures

Table 3-18 shows the DHMP rates for HEDIS 2012 and HEDIS 2013, the percentile ranking for HEDIS 2013, and HEDIS 2013 audit results for each performance measure.

Table 3-18—Review and Audit Results for Performance Measures *for* DHMP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Pediatric Care				
Childhood Immunization Status—Combination 2	91.23%	83.33%	75th-89th	R
Childhood Immunization Status—Combination 3	91.23%	82.35%	75th-89th	R
Childhood Immunization Status—Combination 4	61.40%	**82.35%**	≥ 90th	R
Childhood Immunization Status—Combination 5	73.68%	64.71%	≥ 90th	R
Childhood Immunization Status—Combination 6	80.70%	69.61%	≥ 90th	R
Childhood Immunization Status—Combination 7	49.12%	64.71%	≥ 90th	R
Childhood Immunization Status—Combination 8	56.14%	69.61%	≥ 90th	R
Childhood Immunization Status—Combination 9	68.42%	56.86%	≥ 90th	R
Childhood Immunization Status—Combination 10	43.86%	56.86%	≥ 90th	R
Well-Child Visits in the First 15 Months of Life—Zero Visits	3.23%[2]	0.00%	<10th[2]	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	9.68%[3]	2.13%	<10th	R

[3-3] HEDIS Compliance Audit, Final Audit Report, Denver Health Medical Plan, Inc., July 2013

Table 3-18—Review and Audit Results for Performance Measures *for* DHMP				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.38%[4]	**58.53%**	<10th	**R**
Adolescent Well-Care Visits	49.55%[5]	**42.00%**	10th-24th	**R**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	89.05%	90.27%	≥ 90th	**R**
Counseling for Nutrition: Total	83.21%	**76.16%**	75th-89th	**R**
Counseling for Physical Activity: Total	72.26%	**63.26%**	75th-89th	**R**
Use of Services[6]				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	30.64	31.48	<10th	**R**

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013.

[1] Percentile ratings were assigned to the HEDIS 2013 reported rates based on the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios. Because NCQA published the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile). The rate displayed reflects administrative data only. DHMP reported a hybrid rate of 3.23 percent for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* indicator for HEDIS 2012. The administrative rate is the same as the hybrid rate because there were no medical record numerator events.

[3] The rate displayed reflects administrative data only. DHMP reported a hybrid rate of 67.74 percent for the *Well-Child Visits in the First 15 Months of Life—6+Visits* indicator for HEDIS 2012.

[4] The rate displayed reflects administrative data only. DHMP reported a hybrid rate of 73.94 percent for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for HEDIS 2012.

[5] The rate displayed reflects administrative data only. DHMP reported a hybrid rate of 56.69 percent for the *Adolescent Well-Care Visits* measure for HEDIS 2012.

[6] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

The auditor noted that DHMP had a very organized process to capture data abstracted from medical records thoroughly and accurately. DHMP was also instrumental in working with the State Medicaid office to correctly identify membership for twin births.

All of DHMP's performance measures received an audit result of *Reportable (R)* for HEDIS 2013. Eight measures, including the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment* indicator and seven *Childhood Immunization Status* indicators had rates benchmarking above the national HEDIS Medicaid 90th percentile. The *Childhood Immunization Status—Combination 4* indicator appeared to have a significant rate increase of 20.95 percentage points while three other *Childhood Immunization Status* indicators (*Combinations 7, 8* and *10*) had rate increases of 13 percentage points or greater. However, the increase on the *Childhood Immunization Status* indicators should be interpreted with caution since there was a change in reporting requirements by the Department and a change in the dosing

requirement for hepatitis A, from "Two hepatitis A vaccinations" in HEDIS 2012 to "At least one hepatitis A vaccination" in HEDIS 2013.

Recommendations

Four of DHMP's reported rates had significant performance declines between HEDIS 2012 and HEDIS 2013. Two of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators and the *Adolescent Well-Care Visits* measure had significant performance declines of 7 to 9 percentage points. The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure had a significant decline of 10.85 percentage points. DHMP should investigate possible reasons for the declined performances on these measures.

In addition, the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator and the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure had rates falling below the national HEDIS Medicaid 10th percentile. DHMP should ensure that providers are appropriately coding well-child visit services and that they should be aware of missed opportunities. For example, when a child presents for a sick visit, components of a well-child visit can be performed. Providers should take advantage of all appointments.

Kaiser Permanente Colorado

Compliance With Information Systems (IS) Standards

Kaiser was fully compliant with all IS standards relevant to the scope of the performance measure validation. During the review of the standards, the auditor did not identify any notable issues that had any negative impact on HEDIS reporting. Kaiser maintained an internal nonstandard supplemental database, HealthTRAC, to enhance performance for measures such as *Childhood Immunization Status* and *Immunizations for Adolescents*. The auditor had no recommendations for Kaiser related to compliance with IS standards. [3-4]

Performance Measures

Table 3-19 shows the Kaiser rates for HEDIS 2012 and HEDIS 2013, the percentile ranking for HEDIS 2013, and HEDIS 2013 audit results for each performance measure.

Table 3-19—Review and Audit Results for Performance Measures *for* Kaiser

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Pediatric Care				
Childhood Immunization Status—Combination 2	81.58%	90.00%	≥ 90th	R
Childhood Immunization Status—Combination 3	81.58%	88.89%	≥ 90th	R
Childhood Immunization Status—Combination 4	75.00%	**88.89%**	≥ 90th	R
Childhood Immunization Status—Combination 5	75.00%	74.44%	≥ 90th	R
Childhood Immunization Status—Combination 6	47.37%	55.56%	75th-89th	R
Childhood Immunization Status—Combination 7	72.37%	74.44%	≥ 90th	R
Childhood Immunization Status—Combination 8	46.05%	55.56%	≥ 90th	R
Childhood Immunization Status—Combination 9	44.74%	50.00%	≥ 90th	R
Childhood Immunization Status—Combination 10	43.42%	50.00%	≥ 90th	R
Well-Child Visits in the First 15 Months of Life—Zero Visits	0.00%	0.00%	<10th[2]	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	50.85%	54.35%	25th-49th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.79%	**66.35%**	25th-49th	R
Adolescent Well-Care Visits	58.16%	**52.03%**	50th-74th	R

[3-4] HEDIS Compliance Audit, Final Audit Report, Kaiser Foundation Health Plan of Colorado, July 2012

Table 3-19—Review and Audit Results for Performance Measures *for* Kaiser				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	96.67%	97.51%	≥ 90th	R
Counseling for Nutrition: Total	72.50%	**100.00%**	≥ 90th	R
Counseling for Physical Activity: Total	72.50%	**100.00%**	≥ 90th	R
Use of Services[3]				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	24.34	24.73	<10th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013.

[1] Percentile ratings were assigned to the HEDIS 2013 reported rates based on the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios. Because NCQA published the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

[3] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

All of Kaiser's performance measures received an audit result of *Reportable (R)* for HEDIS 2013. The *Counseling for Nutrition* and the *Counseling for Physical Activity* indicators for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* had exceptional performance, with nearly 30 percentage-point rate increases that raised both rates to 100 percent. In addition, 11 measures benchmarked above the national HEDIS Medicaid 90th percentile, including most of the *Childhood Immunization Status* indicators and all of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures. The *Well-Child Visits in the First 15 Months of Life—Zero Visits* indicator also performed very well, with a HEDIS 2013 rate of 0.00 percent, since a lower rate indicates better performance for this indicator. Although HSAG observed a significant increase of nearly 14 percentage points for the *Childhood Immunization Status—Combination 4* indicator, this performance could have been due to a change in reporting requirements or a change in dosing requirement for hepatitis A, a vaccine that is related to *Combinations 4,7,8*, and *10* indicators.

Recommendations

The *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* measure had a significant decline of nearly 10 percentage points, while the *Adolescent Well-Care Visits* measure had a significant decline of over 6 percentage points. Kaiser should investigate reasons for the declines. Kaiser should also ensure that providers are appropriately coding well-child visit services, and providers should be aware of missed opportunities. For example, when a child presents for a sick visit, components of a well-child visit can be performed. Providers should take advantage of any face-to-face encounters with a child and perform any services possible at each visit.

Rocky Mountain Health Plans

Compliance With Information Systems (IS) Standards

RMHP was fully compliant with all IS standards relevant to the scope of the performance measure validation. During the review of the standards, he auditor did not identify any notable issues that had any negative impact on HEDIS reporting. The auditor had no recommendations for RMHP related to compliance with IS standards.[3-5]

Performance Measures

Table 3-20 shows the RMHP rates for HEDIS 2012 and HEDIS 2013, the percentile ranking for HEDIS 2013, and HEDIS 2013 audit results for each performance measure.

Table 3-20—Review Audit Results for Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Pediatric Care				
Childhood Immunization Status—Combination 2	77.51%	**43.15%**[2]	<10th	**R**
Childhood Immunization Status—Combination 3	74.56%	**42.64%**[2]	<10th	**R**
Childhood Immunization Status—Combination 4	21.30%	**36.55%**[2]	50th-74th	**R**
Childhood Immunization Status—Combination 5	60.36%	**32.99%**[2]	<10th	**R**
Childhood Immunization Status—Combination 6	48.52%	**27.41%**[2]	10th-24th	**R**
Childhood Immunization Status—Combination 7	18.34%	**29.95%**[2]	50th-74th	**R**
Childhood Immunization Status—Combination 8	18.34%	25.38%[2]	50th-74th	**R**
Childhood Immunization Status—Combination 9	42.01%	**23.35%**[2]	25th-49th	**R**
Childhood Immunization Status—Combination 10	16.57%	22.34%[2]	75th-89th	**R**
Well-Child Visits in the First 15 Months of Life—Zero Visits	2.70%[3]	4.79%[3]	≥ 90th[3]	**R**
Well-Child Visits in the First 15 Months of Life—6+ Visits	23.42[4]	20.55%[4]	<10th	**R**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.98%	62.14%[5]	10th-24th	**R**
Adolescent Well-Care Visits	41.20%[6]	41.10%[6]	10th-24th	**R**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	66.67%	**74.12%**	75th-89th	**R**

[3-5] HEDIS Compliance Audit, Final Audit Report, Rocky Mountain Health Plans, July 2013.

Table 3-20—Review Audit Results for Performance Measures *for* RMHP				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Counseling for Nutrition: Total	59.49%	60.40%	50th-74th	R
Counseling for Physical Activity: Total	58.80%	58.63%	75th-89th	R
Use of Services[7]				
Use of Services: Ambulatory Care (Per 1,000 Member Months)				
ED Visits	24.02	22.76	<10th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013.

[1] Percentile ratings were assigned to the HEDIS 2013 reported rates based on the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios. Because NCQA published the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] The rate displayed reflects administrative data only. RMHP reported hybrid rates of 69.54 percent, 67.51 percent, 58.38 percent, 54.31 percent, 45.69 percent, 49.24 percent, 42.13 percent, 39.59 percent, and 37.06 percent for the *Childhood Immunization Status Combinations 2* through *10* indicators for HEDIS 2013, respectively.

[3] For this indicator, lower rates indicate better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile). The rate displayed reflects administrative data only. RMHP reported a hybrid rate of 1.80 percent and 3.42 percent for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* indicator for HEDIS 2012 and HEDIS 2013, respectively.

[4] The rate displayed reflects administrative data only. RMHP reported a hybrid rate of 63.96 percent and 65.75 percent for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator for HEDIS 2012 and HEDIS 2013, respectively.

[5] The rate displayed reflects administrative data only. RMHP reported a hybrid rate of 66.89 percent for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for HEDIS 2013.

[6] The rate displayed reflects administrative data only. RMHP reported a hybrid rate of 44.91 percent and 40.18 percent for the *Adolescent Well-Care Visits* for HEDIS 2012 and HEDIS 2013 measure, respectively.

[7] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

All of RMHP's performance measures received an audit result of *Reportable (R)* for HEDIS 2013. The indicator *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* has had significant improvement with a percentage point increase of more than 7 from the HEDIS 2012 rate. Although RMHP had a significant rate increase of over 11 percentage points for two of the *Childhood Immunization Status* indicators (*Combinations 4* and *7*), these increases could have been due to a change in reporting requirements or a change in the dosing requirement for hepatitis A, from "Two hepatitis A vaccinations" in HEDIS 2012 to "At least one hepatitis A vaccination" in HEDIS 2013.

Recommendations

With the exception of *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*, all three well-child measures exhibited an insignificant decline in performance in HEDIS 2013. In addition, five indicators for *Childhood Immunization Status* (*Combinations 2, 3, 5, 6,* and *9*) had significant declines in performance of at least 18 percentage points. This decline caused three of the *Childhood Immunization Status* rates to drop below the national HEDIS Medicaid 10th percentile.

The observed decline on the *Childhood Immunization Status* indicators may be partly because the Department changed the data collection methodology from hybrid in HEDIS 2012 to administrative in HEDIS 2013. When RMHP's performance between both years was compared using the same hybrid methodology, two indicators (*Combinations 2* and *3*) had a decrease in rate. RMHP should ensure that providers are appropriately coding immunizations and well-child visit services. Providers should be aware of missed opportunities. For example, when a child presents for a sick visit, components of a well-child visit can be performed and any missing immunizations can be administered. Providers should take advantage of all appointments.

State Managed Care Network

Compliance With Information Systems (IS) Standards

SMCN was fully compliant with all IS standards relevant to the scope of the performance measure validation. During the review of the standards, the auditor did not identify any notable issues that had any negative impact on HEDIS reporting. Colorado Access, the third-party administrator for claims submitted by the SMCN providers, had an adequate process to remedy a long-standing issue related to the loss of membership data during the transition from the Colorado Benefits Management System (CBMS) to the Medicaid Management Information System (MMIS).[3-6] The auditor recommended that responses provided by multiple entities in various sections of the Roadmap be organized to reflect the systematic approach adopted for future HEDIS audits.

Performance Measures

Table 3-21 shows the SMCN rates for HEDIS 2012 and HEDIS 2013, the percentile ranking for HEDIS 2013, and HEDIS 2013 audit results for each performance measure.

Table 3-21—Review Audit Results for Performance Measures *for* SMCN

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Pediatric Care				
Childhood Immunization Status—Combination 2	69.15%	**58.08%**	<10th	**R**
Childhood Immunization Status—Combination 3	65.96%	**53.54%**	<10th	**R**
Childhood Immunization Status—Combination 4	29.26%	**48.99%**	≥ 90th	**R**
Childhood Immunization Status—Combination 5	46.81%	40.91%	10th-24th	**R**
Childhood Immunization Status—Combination 6	27.66%	29.29%	10th-24th	**R**
Childhood Immunization Status—Combination 7	21.28%	**37.37%**	75th-89th	**R**
Childhood Immunization Status—Combination 8	13.83%	**27.78%**	75th-89th	**R**
Childhood Immunization Status—Combination 9	23.40%	23.23%	25th-49th	**R**
Childhood Immunization Status—Combination 10	12.23%	**21.72%**	75th-89th	**R**

[3-6] HEDIS Compliance Audit, Final Audit Report, Child Health Plan Plus, July 2013.

Table 3-21—Review Audit Results for Performance Measures *for* SMCN				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2013 Audit Result
	2012	2013		
Well-Child Visits in the First 15 Months of Life—Zero Visits	6.77%	3.13%	75th-89th[2]	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	48.12%	56.88%	25th-49th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	53.46%	52.15%	<10th	R
Adolescent Well-Care Visits	40.27%	**34.26%**	<10th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	42.82%	**57.18%**	50th-74th	R
Counseling for Nutrition: Total	53.28%	55.47%	50th-74th	R
Counseling for Physical Activity: Total	37.96%	44.53%	50th-74th	R
Access to Care				
Prenatal and Postpartum Care—Timeliness of Prenatal Care	72.26%	**78.59%**	10th-24th	R
Prenatal and Postpartum Care—Postpartum Care	67.88%	67.88%	50th-74th	R
Use of Services[3]				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	27.72	29.61	<10th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013.

[1] Percentile ratings were assigned to the HEDIS 2013 reported rates based on the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios. Because NCQA published the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] For this indicator, lower rates indicate better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

[3] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

All of the performance measures for SMCN received an audit result of *Reportable (R)* for HEDIS 2013. The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment* and the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator had significant increases of 14.36 percentage points and 6.33 percentage points, respectively. In addition, *Combinations 4, 7, 8* and *10* for the *Childhood Immunization Status* measure had significant rate increases of over 9 percentage points between HEDIS 2012 and HEDIS 2013. However, these results should be interpreted with caution since there was a change in reporting requirements and a change in measure specifications affecting the *Childhood Immunization Status—Combinations 4, 7, 8,* and *10* indicators.

Recommendations

SMCN reported three measures with significant declines in rates between HEDIS 2012 and HEDIS 2013, including two *Childhood Immunization Status* indicators (*Combinations 2* and *3*) and the *Adolescent Well-Care Visits* measure. These three measures had rate declines of over 6 percentage

points and fell below the national HEDIS Medicaid 10th percentile. The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure also fell below the national HEDIS Medicaid 10th percentile. The decrease in rates on the *Childhood Immunization Status* indicators may have occurred partly because the Department changed the data collection methodology from hybrid in HEDIS 2012 to administrative in HEDIS 2013.

SMCN should target measures that had significant rate declines or had performance below the national average. SMCN should identify and implement successful strategies for immunizations and well-care visits for children. Without an assigned PCP, the SMCN member's care is not being managed by a single provider who knows what required health services have not been provided. Each provider who administers services to an SMCN member should perform due diligence when a member presents for service and should administer as many required services as possible.

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

Table 3-22 shows the statewide weighted averages for HEDIS 2012 and HEDIS 2013, along with the percentile ranking for each performance measure.

Table 3-22—Statewide Review Audit Results for Performance Measures

Performance Measures	HEDIS Rate		Percentile Ranking[1]
	2012	2013	
Pediatric Care			
Childhood Immunization Status—Combination 2	76.73%	**58.04%**	<10th
Childhood Immunization Status—Combination 3	74.50%	**55.89%**	<10th
Childhood Immunization Status—Combination 4	35.36%	**51.43%**	≥ 90th
Childhood Immunization Status—Combination 5	56.16%	**44.11%**	10th-24th
Childhood Immunization Status—Combination 6	44.54%	**36.70%**	25th-49th
Childhood Immunization Status—Combination 7	27.37%	**41.16%**	≥ 90th
Childhood Immunization Status—Combination 8	23.73%	**34.73%**	≥ 90th
Childhood Immunization Status—Combination 9	37.01%	**30.45%**	50th-74th
Childhood Immunization Status—Combination 10	19.62%	**28.93%**	≥ 90th
Well-Child Visits in the First 15 Months of Life—Zero Visits	4.21%	2.67%	75th-89th[2]
Well-Child Visits in the First 15 Months of Life—6+ Visits	25.28%	25.48%	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.17%	**61.26%**	10th-24th
Adolescent Well-Care Visits	44.79%	**42.09%**	10th-24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment: Total	57.50%	**68.80%**	75th-89th
Counseling for Nutrition: Total	58.51%	62.24%	50th-74th
Counseling for Physical Activity: Total	49.16%	**56.68%**	75th-89th

Table 3-22—Statewide Review Audit Results for Performance Measures			
Performance Measures	HEDIS Rate		Percentile Ranking[1]
	2012	2013	
Access to Care			
Prenatal and Postpartum Care—Timeliness of Prenatal Care[3]	72.26%	**78.59%**	10th-24th
Prenatal and Postpartum Care—Postpartum Care[3]	67.88%	67.88%	50th-74th
Use of Services[4]			
Ambulatory Care (Per 1,000 Member Months)			
Emergency Department Visits	27.79	30.07	<10th

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decrease in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013.

[1] Percentile ratings were assigned to the HEDIS 2013 reported rates based on the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios. Because NCQA published the Medicaid HEDIS 2012 Audit Means, Percentiles, and Ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

[3] The statewide rate for the *Prenatal and Postpartum Care* measure was derived from SMCN only, as none of the CHP+ managed care plans reported this measure.

[4] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

The statewide rates showed significant improvement for a number of measures between HEDIS 2012 and HEDIS 2013. The *BMI Assessment: Total* and *Physical Activity Counseling: Total* indicators for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* had significant rate increases of at least 7.52 percentage points. Four *Childhood Immunization Status* indicators (*Combinations 4, 7, 8,* and *10*) had significant rate increases ranging from 9.31 percentage points to 16.07 percentage points, although this improvement could have been due to a change in reporting requirements or a change in the measure specification.

Recommendations

The statewide rates had significant declines for five *Childhood Immunization Status* indicators (i.e., *Combinations 2, 3, 5, 6,* and *9*) and for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* measures. Three measures ranked below the national HEDIS Medicaid 10th percentile. Please note that the decrease in rates on the *Childhood Immunization Status* indicators may be partly due to the Department changing the data collection methodology from hybrid in HEDIS 2012 to administrative in HEDIS 2013.

Overall, the HMOs and SMCN had significant improvement for a number of measures. However, year-to-year performance should be reviewed to determine barriers to improving rates, and sources of rate declines should be identified to target rates with declines.

Summary Assessment Related to Quality, Timeliness, and Access

Statewide performance showed both significant improvement and significant declines for several measures. The following is a summary assessment of statewide performance measure results related to the domains of quality, timeliness, and access.

Quality: Statewide performance in the quality domain was split, with significant increases and significant declines among the measures. Four *Childhood Immunization Status* indicators (*Combination 4, 7, 8,* and *10*) and two *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators (*BMI Assessment* and *Counseling for Physical Activity*) had rate increases of over 7.52 percentage points. However, seven measures/indicators, including *Childhood Immunization Status (Combination 2, 3, 5, 6, and 9); Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits* had significant rate declines of as much as 18.69 percentage points. Please note that the performance from the *Childhood Immunization Status* indicators should be interpreted with caution. The change on the dosing requirement for hepatitis A may have contributed to the rate increases for the *Combination 4, 7, 8,* and *10* indicators. The change on the data collection methodology from hybrid to administrative also may have contributed to the rate declines.

Timeliness: For the timeliness measures, the statewide results varied for the *Childhood Immunization Status* indicators. The *Combinations 4, 7, 8,* and *10* indicators for the *Childhood Immunization Status* measure had significant rate increases between HEDIS 2012 and HEDIS 2013, while *Combinations 2, 3, 5, 6,* and *9* had significant performance declines. Caution should be exercised, however, when interpreting the performance from the *Childhood Immunization Status* indicators since the decrease or increase in rates may not be solely caused by the plans' performance. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator had a significant increase of 6.33 percentage points while the *Postpartum Care* indicator was consistent with the previous year's result.

Access: The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator had a significant rate increase of over 6 percentage points, although it ranked below the national HEDIS Medicaid 25th percentile, while the *Prenatal and Postpartum Care—Postpartum Care* indicator had no change in rate. For the utilization-based performance measure, *Ambulatory Care: Total—Emergency Department Visits Per 1,000 Member Months*, the rate increased slightly in HEDIS 2013 but still fell below the national HEDIS Medicaid 10th percentile.

Validation of Performance Improvement Projects

For FY 2012–2013, HSAG validated one PIP for each of the five CHP+ HMOs, although SMCN was not required to participate. Appendix D describes how the validation of PIP activities was conducted and how the resulting data were aggregated and analyzed by HSAG.

Table 3–23 lists the HMOs and their PIP study titles.

Table 3–23—Summary of Each CHP's PIP

HMO	PIP Study
Colorado Access	*Improving Weight Assessment in Children and Adolescents*
Colorado Choice	*Asthma in Pediatric Patients*
DHMP	*Improving Well Care for Children 3–6 Years*
Kaiser	*Asthma Care*
RMHP	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

Colorado Access

Findings

The Colorado Access *Improving Weight Assessment in Children and Adolescents* PIP focused on improving the rate of body mass index (BMI) percentile documentation for children and adolescent members during the measurement year. This was the second validation year for this PIP. Colorado Access completed Activities I through IX and reported Remeasurement 1 data.

Table 3–24 provides a summary of Colorado Access' PIP validation results for the FY 2012–2013 validation cycle.

Table 3–24—FY12-13 Performance Improvement Project Validation Results *for* Colorado Access

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Study Indicator	100% (3/3)	0% (0/3)	0% (0/3)
	IV.	Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Sampling Techniques	100% (6/6)	0% (0/6)	0% (0/6)
	VI.	Data Collection	100% (6/6)	0% (0/6)	0% (0/6)
		Design Total	100% (19/19)	0% (0/19)	0% (0/19)

Table 3–24—FY12-13 Performance Improvement Project Validation Results *for* Colorado Access					
Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Implementation	VII.	Data Analysis and Interpretation	100% (5/5)	0% (0/5)	0% (0/5)
	VIII.	Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
		Implementation Total	100% (9/9)	0% (0/9)	0% (0/9)
Outcomes	IX.	Real Improvement	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement	Not Assessed		
		Outcomes Total	100% (4/4)	0% (0/4)	0% (0/4)
Percent Score of Applicable Evaluation Elements Met			**100% Percent (36/36)**		

Colorado Access demonstrated strength in its study design (Activities I–VI), study implementation (Activities VII and VIII), and study outcomes (IX) by receiving *Met* scores for all applicable evaluation elements. The plan documented a solid study design, which is essential to producing methodologically sound results. Colorado Access' overall score for the applicable evaluation elements *Met* was 100 percent, wherein 36 of 36 evaluation elements received a *Met* score. The percentage score of evaluation elements *Met* remained the same for 2011–2012 and 2012–2013; that is, 100 percent.

Table 3–25 provides a summary of Colorado Access' PIP-specific outcomes for the FY 2012–2013 validation cycle.

Table 3–25—FY12–13 Performance Improvement Project Specific Outcomes for Colorado Access				
PIP#1: *Improving Weight Assessment in Children and Adolescents*				
PIP Study Indicator	Baseline	Remeasurement 1	Percentage Point Change	Statistical Significance (*p* value)
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year.	23.11%	52.55%	29.44↑	*P* <0.00001♦ Statistically Significant

♦ Significance levels (*p* values) noted in the table demonstrated statistically significant performance between measurement periods. Statistical significance is traditionally reached when the *p* value is ≤ 0.05.

During Remeasurement 1, Colorado Access reported that 52.55 percent of members 3–17 years of age had an outpatient visit with a PCP or OB/GYN, and had evidence of BMI percentile documentation during the measurement year. The rate increase of 29.44 percentage points, from 23.11 percent in the baseline measurement period to 52.55 percent in Remeasurement 1, was statistically significant. The Remeasurement 1 result was 23.55 percentage points higher than the

Remeasurement 1 goal of 29 percent. The plan set a Remeasurement 2 goal of 58.8 percent, the HEDIS 2011 75th percentile for this measure.

Strengths

Colorado Access used a multitiered approach to its causal/barrier analysis. The Colorado Access quality management team discussed barriers with the Medical and Behavioral QI Committee members, performed a drill-down analysis on HEDIS results, and conducted a member focus group. The identified barriers were system-, provider-, and member-based. Colorado Access prioritized the identified barriers and implemented interventions that addressed the highest priority barriers.

Interventions

Colorado Access implemented provider- and member-based interventions. The member-based interventions included a monthly telephonic reminder to members to schedule a well-child visit. The provider-based interventions included conducting medical record reviews, including an article in the provider bulletin about the importance of documenting BMI percentiles, surveying provider office staff members about how frequently height/weight/BMI assessments were taken and where the information was located in the member record, compiling a list of nutritional referrals for providers, and discussing lack of documented BMI information with a high-volume provider.

Recommendations

As Colorado Access proceeds with the *Improving Weight Assessment in Children and Adolescents* PIP, HSAG has recommended that it implement more system- and provider-related interventions, since the plan documented that system- and provider-related barriers constituted the majority of identified barriers. The plan should regularly evaluate the efficacy of the interventions and determine which implemented interventions were successful. Successful interventions should be standardized. Additionally, Colorado Access may want to revisit its causal/barrier analysis process, since the priority assigned to the identified barriers may have changed given the success of the implemented interventions.

Colorado Choice Health Plan

Findings

In its *Asthma in Pediatric Patients* PIP, Colorado Choice focused on decreasing the percentage of asthma-related emergency department (ED) visits for children 6 through 18 years of age. This was the second validation cycle for this PIP. Colorado Choice completed Activities I through IV and Activities VI through IX and reported Remeasurement 1 data.

Table 3–26 shows Colorado Choice scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3–26—FY12–13 Performance Improvement Project Validation Results *for* Colorado Choice

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Study Indicator	100% (3/3)	0% (0/3)	0% (0/3)
	IV.	Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Sampling Techniques	Not Applicable	Not Applicable	Not Applicable
	VI.	Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (11/11)	0% (0/11)	0% (0/11)
Implementation	VII.	Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Interventions and Improvement Strategies	75% (3/4)	25% (1/4)	0% (0/4)
Implementation Total			92% (11/12)	8% (1/12)	0% (0/12)
Outcomes	IX.	Real Improvement	75% (3/4)	0% (0/4)	25% (1/4)
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			75% (3/4)	0% (0/4)	25% (1/4)
Percent Score of Applicable Evaluation Elements Met			**93% Percent (25/27)**		

The Colorado Choice overall score for applicable evaluation elements *Met* was 93 percent, wherein 25 of 27 elements received a *Met* score. Colorado Choice's only *Partially Met* score occurred in Activity VIII. Colorado Choice's only *Not Met* score occurred in Activity IX. The percentage score of evaluation elements *Met* decreased slightly from 94 percent during the 2011–2012 baseline measurement period to 93 percent during the 2012–2013 Remeasurement 1 period.

Table 3–27 provides a summary of Colorado Choice's PIP-specific outcomes for the FY 2012–2013 validation cycle.

Table 3–27—FY12–13 Performance Improvement Project Specific Outcomes *for* Colorado Choice

PIP#1: *Asthma in Pediatric Patients*				
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Percentage Point Change**	**Statistical Significance (*p* value)**
The percentage of members with a primary or secondary diagnosis of asthma who have been enrolled into the CHP+ program through Colorado Choice with an ICD-9 diagnosis code of 493 between the ages of ≥ 6 years of age and ≤ 18 years of age who have received asthma education and have had an emergency department visit (CPT codes 99281, 99282, 99283, 99284 and 99285). ♦	11.1%	6%	5.1↓♦	*P* =0.6070 Not Statistically Significant

♦ Lower rates indicate better performance for this study indicator.

The Remeasurement 1 rate for the Colorado Choice *Asthma in Pediatric Patients* PIP showed that 6 percent of members had an asthma-related ED visit. The goal of this study was to decrease the percentage of asthma-related ED visits for children 6–18 years of age. Although the Remeasurement 1 rate was 5.1 percentage points lower than the baseline rate, the plan exceeded its Remeasurement 1 goal and the rate decrease from baseline to Remeasurement 1 was not statistically significant.

Strengths

The data analysis and interpretation of the PIP results were appropriate and adhered to the statistical analysis techniques used. Colorado Choice documented that it performed a causal/barrier analysis in Remeasurement 1, which included staff members from the medical and compliance departments. Colorado Choice developed member- and provider-based interventions to address identified barriers.

Interventions

For its member-based intervention, Colorado Choice mailed an educational packet to each new member with a primary or secondary diagnosis of asthma. The packet contained a letter, information about how peak flow meters could help manage asthma, a notice of the availability of an asthma action plan that could be readily shared with the member's school, and contact information for the Colorado Choice nurse case manager.

The provider-based intervention included an educational packet that was mailed to plan-participating providers. Colorado Choice documented that the provider packets contained an

introductory letter outlining the PIP topic, an order form for peak flow meters, and a summary about the information sent to members and their families.

Recommendations

HSAG recommended that Colorado Choice perform a causal/barrier analysis annually to ensure the barriers are applicable to the current measurement year. The plan did not document any interventions directly linked to either of the barriers it identified: accessing after-hours and emergency services, and fluctuation in enrollment and eligibility. If accessing after-hours and emergency services and fluctuation in enrollment and eligibility are priority barriers to decreasing asthma-related ED visits for Colorado Choice, the plan should develop specific interventions for these barriers. Each intervention implemented should be directly linked to an identified barrier. Finally, the plan should describe how it regularly evaluates interventions to determine if they have/have not positively influenced the outcomes.

Denver Health Medical Plan, Inc.

Findings

DHMP's *Improving Well Care for Children 3–6 Years* PIP focused on increasing the rates of children 3–6 years of age who completed at least one well-child visit with a primary care practitioner during the measurement period. This was the second validation year for this PIP. HSAG validated Activities I through IV and Activities VI through IX, which included Remeasurement 1 data.

Table 3–28 shows DHMP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3–28—FY12–13 Performance Improvement Project Validation Results *for* DHMP

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Study Indicator	100% (3/3)	0% (0/3)	0% (0/3)
	IV.	Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Sampling Techniques	Not Applicable	Not Applicable	Not Applicable
	VI.	Data Collection	75% (3/4)	25% (1/4)	0% (0/4)
Design Total			91% (10/11)	9% (1/11)	0% (0/11)
Implementation	VII.	Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			100% (12/12)	0% (0/12)	0% (0/12)
Outcomes	IX.	Real Improvement	75% (3/4)	0% (0/4)	25% (1/4)
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			75% (3/4)	0% (0/4)	25% (1/4)
Percentage Score of Applicable Evaluation Elements Met			**93% Percent (25/27)**		

DHMP demonstrated strong performance in Activities I through IV, VII, and VIII. The DHMP overall score for applicable evaluation elements *Met* was 93 percent, wherein 25 of 27 elements received a *Met* score. The percentage score of evaluation elements *Met* decreased from 100 percent during the 2011–2012 baseline period to 93 percent during the 2012–2013 Remeasurement 1 period.

Table 3–29 provides a summary of DHMP's PIP-specific outcomes for the FY 2012–2013 validation cycle.

Table 3–29—FY12–13 Performance Improvement Project Specific Outcomes *for* DHMP

PIP#1: *Improving Well Care for Children 3–6 Years*				
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Percentage Point Change**	**Statistical Significance (*p* value)**
The percentage of children 3 to 6 years of age with at least one well-child visit with a PCP during the measurement year.	69.3%	73.9%	4.6↑	*p*=0.2028 Not Statistically Significant

The DHMP *Improving Well Care for Children 3–6 Years* PIP had one study indicator and reported a Remeasurement 1 rate of 73.9 percent. The rate increase of 4.6 percentage points, from 69.3 percent in the baseline measurement period to 73.9 percent in Remeasurement 1, was not statistically significant with a *p* value of 0.2028. The Remeasurement 1 result was 3.4 percentage points lower than the Remeasurement 1 goal of 77.3 percent. The DHMP Remeasurement 2 goal is to achieve a statistically significant increase from the baseline measurement, or to achieve or exceed the Medicaid HEDIS 75th percentile benchmark.

Strengths

DHMP demonstrated strength by receiving *Met* scores for all applicable evaluation elements in Activities I through V, VII, and VIII. DHMP documented a causal/barrier analysis process that included a Pediatric Preventive Workgroup that met monthly to discuss preventive care for patients. The work group determined that combining member outreach with provider-based interventions would improve the rate for this PIP. Interventions were monitored by the DHMP QI intervention manager.

Interventions

DHMP implemented two member-based interventions and two provider-based interventions. The member-based interventions included Healthy Heroes birthday cards and Back-2-School incentive reminders. The provider-focused interventions included a mini rapid improvement event (RIE) and a provider outreach list.

RIE was implemented well before the start of the PIP and HSAG was unable to determine its influence on the Remeasurement 1 rates. It appeared that the plan implemented a Saturday clinic at three different locations in response to parents who were unable to bring their children to a well-visit during regular business hours. However, neither the Saturday clinic intervention nor the related member-based barrier was included in the intervention table.

Recommendations

DHMP should ensure that all identified interventions and barriers are clearly documented in the PIP intervention table. The intervention table should include descriptions of the implemented interventions and the corresponding identified barriers. DHMP should document a process for evaluating its standardized interventions to ensure continued success. Although the rate increased during this measurement period, DHMP may benefit from conducting another causal/barrier analysis. Revisiting the causal/barrier analysis may help the plan identify new barriers, prioritize existing barriers, and determine if DHMP's original assumption about combining member outreach with provider-based interventions is still the most effective way to positively impact the outcomes. Additionally, the plan should ensure that any narrative about the type of statistical testing performed, the *p* value results, and the significance of the outcomes are updated accordingly and are consistent throughout the document.

Kaiser Permanente Colorado

Findings

The Kaiser *Asthma Care* PIP focused on improving asthma-related ED use. This was the first validation year for this PIP, and Kaiser completed Activities I through IV and Activities VI through IX. Kaiser reported baseline and Remeasurement 1 data for calendar years 2011 and 2012, respectively.

Table 3–30 shows Kaiser's scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3–30—FY12–13 Performance Improvement Project Validation Results *for* Kaiser

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Study Indicator	100% (3/3)	0% (0/3)	0% (0/3)
	IV.	Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Sampling Techniques	Not Applicable	Not Applicable	Not Applicable
	VI.	Data Collection	75% (3/4)	25% (1/4)	0% (0/4)
Design Total			91% (10/11)	9% (1/11)	0% (0/11)
Implementation	VII.	Data Analysis and Interpretation	88% (7/8)	12% (1/8)	0% (0/8)
	VIII.	Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			92% (11/12)	8% (1/12)	0% (0/12)
Outcomes	IX.	Real Improvement	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			100% (4/4)	0% (0/4)	0% (0/4)
Percent Score of Applicable Evaluation Elements Met			**93% Percent (25/27)**		

Kaiser demonstrated strong performance in Activities I through IV, VIII, and IX, indicating that the plan established a credible base for its PIP. The overall score for applicable evaluation elements *Met* was 93 percent, wherein 25 of 27 elements received a *Met* score. The percentage score of evaluation elements *Met* decreased from 100 percent during baseline to 93 percent during Remeasurement 1.

Table 3–31 provides a summary of Kaiser's PIP-specific outcomes for the FY 2012–2013 validation cycle.

Table 3–31—FY12–13 Performance Improvement Project Specific Outcomes *for* Kaiser

PIP#1: *Asthma Care*				
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Percentage Point Change**	**Statistical Significance (*p* value)**
The percentage of CHP+ members diagnosed with asthma who have had an asthma-related ED visit. ^	41.7%	13.7%	28.0↓^	*p*=0.0263* Statistically Significant

^Lower rates indicate better performance for this PIP.
*Significance levels (*p* values) noted in the table demonstrated statistically significant performance between measurement periods. Statistical significance is traditionally reached when the *p* value is ≤ 0.05.

The Kaiser *Asthma Care* PIP had one study indicator and reported a baseline rate of 41.7 percent and a Remeasurement 1 rate of 13.7 percent. The study indicator is inverse so a decrease in the rate represents improved outcomes. The baseline to Remeasurement 1 rate decrease from 41.7 percent to 13.7 percent was statistically significant and exceeded the plan's Remeasurement 1 goal of a 10 percent reduction.

Strengths

Kaiser demonstrated strength in Activities I–IV and VIII by receiving *Met* scores for all applicable evaluation elements. The plan's intervention and improvement strategies were designed to improve outcomes and change behavior at the member level. Kaiser performed a multistep causal/barrier analysis and three committees worked cooperatively to identify problem areas, develop interventions, and monitor the progress of the PIP. Kaiser used research and data analysis to identify and prioritize the barriers. The plan included a chart that clearly defined the primary and secondary barriers. Cross-functional care teams developed interventions and work processes to address the barriers.

Interventions

The three interventions Kaiser implemented were member-based, and the plan noted that the interventions were not fully operational until the end calendar year 2011. The plan implemented weekly proactive reviews of the asthma registry to determine which members were overusing beta-agonists and which members were underusing, or not using, inhaled steroid medication. The plan also implemented a twice-weekly review of ED visits for asthma members. All of the interventions included follow-up telephone outreach to members. Kaiser noted that the weekly proactive review interventions were designed to target asthma control medication therapy, members' knowledge deficit, and members' social determinants of health. The intervention involving the twice-weekly review of ED visits was designed to address members' lack of knowledge about asthma care and members' lack of relationship with a primary care provider. Kaiser documented that it standardized the interventions through written communication of work processes by setting clear expectations, developing documentation templates, and providing training. The plan refined the interventions as it

learned more about available community resources and enhanced existing working relationships to provide additional support to asthma members.

Recommendations

HSAG recommended that Kaiser revise its Remeasurement 2 goal to reflect the plan's goal of continued improvement from Remeasurement 1 to Remeasurement 2. Maintaining the current rate is not indicative of improvement. Kaiser should include a description of how the rate for each measurement period will be compared to the goal in the Activity VI data analysis plan. Finally, Kaiser should ensure that the narrative interpretation of study results in Activity VII includes a comparison of the results to the goal for each measurement period.

Rocky Mountain Health Plans

Findings

This was the first year for RMHP's *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP. The PIP focused on improving the rates of documented BMI, counseling for nutrition, and counseling for physical activity. RMHP completed Activities I through VIII at the time of submission and reported baseline data.

Table 3–32 shows RMHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3–32—FY12–13 Performance Improvement Project Validation Results *for* RMHP

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
	IV.	Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Sampling Techniques	100% (6/6)	0% (0/6)	0% (0/6)
	VI.	Data Collection	100% (5/5)	0% (0/5)	0% (0/5)
Design Total			100% (17/17)	0% (0/17)	0% (0/17)
Implementation	VII.	Data Analysis and Interpretation	100% (5/5)	0% (0/5)	0% (0/5)
	VIII.	Interventions and Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total			100% (7/7)	0% (0/7)	0% (0/7)
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**100% Percent (24/24)**		

RMHP demonstrated strong performance in Activities I through VIII, indicating that the plan documented a solid study design, which is essential to producing methodologically sound results. Additionally, the interpretation of the PIP results was appropriate. RMHP's overall score for the applicable evaluation elements *Met* was 100 percent, wherein 24 of 24 elements received a *Met* validation status.

Table 3–33 provides a summary of RMHP's PIP-specific outcomes for the FY 2012–2013 validation cycle.

Table 3–33—FY12–13 Performance Improvement Project Specific Outcomes *for* RMHP

PIP#1: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

PIP Study Indicator	Baseline	Remeasurement 1	Percentage Point Change	Statistical Significance (*p* value)
Study Indicator 1: The percentage of the eligible population with BMI percentile documentation by a PCP or OB/GYN during the measurement year.	66.7%	*	*	*
Study Indicator 2: The percentage of the eligible population with documentation of counseling for nutrition or referral for nutrition education during the measurement year by a PCP or OB/GYN.	59.4%	*	*	*
Study Indicator 3: The percentage of the eligible population with documentation of counseling for physical activity or referral for physical activity during the measurement year by a PCP or OB/GYN.	58.6%	*	*	*

* The PIP had not progressed past reporting baseline data.

The RMHP *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP had three study indicators and reported baseline rates of 66.7 percent, 59.4 percent, and 58.6 percent, respectively. The plan set a Remeasurement 1 goal of a 5 percent increase from the baseline rate for each of the study indicators.

Strengths

RMHP demonstrated strength in its study design and implementation by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII. A solid study design and implementation are essential to producing methodologically sound results. RMHP documented that its HEDIS Improvement Team performed a causal barrier analysis and the QI Department facilitated intradepartmental discussions about possible study barriers and past intervention efforts. RMHP submitted two fishbone cause-and-effect diagrams and documented a need to address member- and provider-based barriers to improve study outcomes. Based on that need, RMHP selected five priority barriers: one member-based and four provider-based.

Interventions

RMHP recorded that it implemented six interventions during this measurement period. Two were member-based and involved creating well-child brochures. The remaining four were provider-based and included (1) Beacon project staff consulting with practices regarding electronic medical record (EMR) capacity, (2) Beacon project QI associates partnering with provider/practice staff on improving work flows for collecting BMI documentation, (3) Beacon project staff providing interviewing skills training to the practice staff, and (4) Beacon project staff assisting in improving patient education materials in the EMR. RMHP noted that the member-based interventions were designed to motivate parents to schedule and attend well visits, while the provider-based interventions were designed to help practices improve performance.

Recommendations

Improving BMI percentile and nutritional and physical activity documentation in member records is a provider- and system-based PIP topic. Member-based interventions aimed at increasing preventive care visits are unlikely to succeed if provider and system barriers are not adequately addressed. HSAG recommended that RMHP consider implementing interventions designed to address the specific provider- and system-based barriers RMHP identified in its causal/barrier analysis. Additionally, in future submissions the plan should ensure that the documented data analysis plan is applicable to subsequent measurement periods and fully describes how the rates will be calculated and compared to the goal, the type of statistical testing used to compare study results between measurement periods, and a detailed description of how the data will be analyzed.

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

Table 3–34 shows the health plans' overall performance based on HSAG's validation of the FY 2012–2013 PIPs that were submitted for validation.

Table 3–34—Summary of Each HMO's PIP Validation Scores and Validation Status

HMO	PIP Study	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Colorado Access	*Improving Weight Assessment in Children and Adolescents*	100%	100%	*Met*
Colorado Choice	*Asthma in Pediatric Patients*	93%	100%	*Met*
DHMP	*Improving Well Care for Children 3–6 Years*	93%	100%	*Met*
Kaiser	*Asthma Care*	93%	100%	*Met*
RMHP	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	100%	100%	*Met*

Overall, the validation scores and validation status of the PIPs suggests a thorough application of the PIPs' design. All of the HMOs' PIPs reviewed by HSAG received a *Met* validation status.

Table 3–35 shows a comparison of the health plans' improvement results.

Table 3–35—Statewide Summary of Improvement					
	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Number of comparable rates (previous measurement to current measurement)	1*	1*	1*	1*	0*
Number of rates that improved	100% (1/1)	100% (1/1)	100% (1/1)	100% (1/1)	**
Number of rates that declined	0% (0/1)	0% (0/1)	0% (0/1)	0% (0/1)	**
Number of rates that showed statistically significant improvement over the previous measurement period	100% (1/1)	0% (0/1)	0% (0/1)	100% (1/1)	**
Number of rates that showed statistically significant improvement over baseline	100% (1/1)	0% (0/1)	0% (0/1)	100% (1/1)	**

*Numbers are based on the total number of indicators that had comparable rates for all PIPs submitted by the health plan.

** The RMHP PIP had not progressed past reporting baseline data.

All of the comparable PIP rates improved; however, only two plans had rates that demonstrated statistically significant improvement: Colorado Access and Kaiser. The rates for Colorado Choice and DHMP demonstrated improvement, but the improvement was not statistically significant. The RMHP PIP had not progressed past reporting baseline data; therefore, rates were not available for comparison.

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. All five PIPs validated by HSAG earned a *Met* validation status. This demonstrates that each health plan exhibited a strong understanding and implementation of processes required to conduct a valid study for its PIPs.

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

Introduction

Following EQR activities conducted in FY 2011–2012, the Department asked each health plan to address recommendations and required actions. This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations from FY 2011–2012.

Colorado Access

Compliance Monitoring Site Reviews

For the FY 2011–2012 compliance monitoring site reviews, HSAG assessed readiness to comply with federal managed care regulations. HSAG did not assign scores and the Department did not require the plans to submit corrective action plans; however, HSAG identified several areas where the Colorado Access CHP+ program was not compliant with federal managed care regulations. Areas identified as needing revisions and examples of the recommended revisions follow.

HSAG suggested that Colorado Access revise its member handbook to read at a sixth grade level and to include all of the member rights. Member materials needed to be updated to reflect federal managed care regulations as they relate to the grievance process, rather than the State rules that formerly governed the program. HSAG suggested that Colorado Access update its policies and procedures to align with federal health care regulations. HSAG also recommended that Colorado Access implement processes for analyzing claims payment patterns to detect possible fraud/abuse.

Colorado Access reported completion of the following activities to respond to recommendations made during the FY 2011–2012 site review:

- Revision of the member handbook to achieve a sixth-grade reading level and to include all rights as depicted in the CHP+ managed care contract.
- Revision of the provider manual to inform providers of all member rights.
- Revision of the grievance policies and procedures to reflect the federal managed care regulations.
- Communication regarding revised grievance procedures to Colorado Access' member population and CHP+ contracted providers via the Colorado Access CHP+ Web site, the CHP+ member handbook, and the provider manual.
- Partnering of Colorado Access with a third-party entity contracted to review, research, and analyze submitted claims and claims payments for the sole purpose of identifying inconsistencies, fraud, or abuse. HSAG's audit department performs a secondary review of any patterns or inconsistencies identified by the third party.

Validation of Performance Measures

Although none of Colorado Access' performance measures showed a significant decline in performance between HEDIS 2011 and HEDIS 2012, the plan did experience a slight decline in rates for *Childhood Immunization Status—Combination 2* (4.1 percentage points) and *Combination 3* (3.7 percentage points. Colorado Access also experienced a slight decline in the *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Well-Child Visits in the first 15 months of Life—6+ Visits* (1.6 percentage points and 1.1 percentage points, respectively). HSAG suggested that Colorado Access ensure providers were appropriately coding immunizations and well-child visits. HSAG also suggested that providers be reminded that components of a well-child visit as well as administering missing immunizations can be performed when a child presents for a sick visit, and that Colorado Access encourage providers to take advantage of all appointments.

Although the HEDIS 2013 *Childhood Immunization Status—Combination 2* and *Combination 3* rate changes listed in Table 3–16 of Section 3 of this report are statistically significant, they reflect the fact that the HEDIS 2012 rates were collected and reported using a hybrid methodology while the HEDIS 2013 rate was obtained using the administrative methodology. Nevertheless, Colorado Access' HEDIS 2013 hybrid rates, as listed in the footnotes of Table 3–16, also reflect a decline of 2.31 and 3.74 percentage points for *Combination 2* and *Combination 3*, respectively. Colorado Access' *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator fell below the national HEDIS Medicaid 10th percentile. HSAG suggested that Colorado Access continue to investigate methods to improve performance for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure and *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator as well as *Childhood Immunization Status—Combination 2* and *Combination 3* indicators.

Validation of Performance Improvement Projects

Colorado Access scored 100 percent of applicable evaluation elements *Met* for the 2012 submission of its *Improving Weight Assessment in Children and Adolescents* PIP. HSAG recommended that as Colorado Access proceeded with the project, it should consider conducting and documenting a causal/barrier analysis—that regular evaluation of the implemented interventions would help Colorado Access determine the success of its interventions. In response, the Colorado Access quality management team discussed barriers with the Medical and Behavioral QI Committee members, performed a drill-down analysis on HEDIS results, and conducted a member focus group. Colorado Access prioritized the identified barriers and implemented interventions that addressed the highest-priority barriers. Its 2013 overall percentage score of applicable evaluation elements *Met* for the *Improving Weight Assessment in Children and Adolescents* PIP was, again, 100 percent.

Colorado Choice Health Plan

Compliance Monitoring Site Reviews

For the FY 2011–2012 compliance monitoring site reviews, HSAG assessed readiness to comply with federal managed care regulations. HSAG did not assign scores and the Department did not require the plans to submit corrective action plans; however, HSAG identified several areas where Colorado Choice's CHP+ program was not compliant with federal managed care regulations. Areas identified as needing revisions and examples of the recommended revisions follow.

HSAG suggested that the plan's member materials should meet the sixth-grade reading level, be available in alternative formats, include all covered services, and be aligned with federal health care regulations. HSAG also suggested that the CHP+ provider directory be provided to members and that grievance and appeals polices reflect the federal managed care requirements. Minor policy revisions were recommended for poststabilization, program integrity, and delegation subcontracts.

Colorado Choice reported completion of the following activities to respond to recommendations made during the 2011–2012 site review:

- Colorado Choice revised its member handbook to address all issues raised during the audit process (including reading level, benefits, format, member rights, poststabilization rules, appeals and grievance timelines, disclaimers, etc.). Colorado Choice also revised its provider manual per HSAG's suggestions.
- Colorado Choice revised its provider directory to include additional specialty categories and the languages spoken. Because hard copy directories are obsolete as soon as printed, Colorado Choice steers members to the online directory to ensure CHP+ members always have access to current information.

Additionally, the following revisions were in process as of July 2013:

- Colorado Choice's appeals and grievances, poststabilization, and delegation subcontracts policies and procedures were in the process of being revised as part of Colorado Choice's URAC—formerly known as the Utilization Review Accreditation Commission—accreditation process.

Validation of Performance Measures

Colorado Choice did not participate in the 2012 HEDIS reporting because its population size did not meet HEDIS reporting requirements and the State did not require it.

Validation of Performance Improvement Projects

FY 2011–2012 was the first year Colorado Choice submitted its *Asthma in Pediatric Patients* PIP. Although Colorado Choice identified factors that may have threatened the internal and external validity of the PIP, it did not document how those factors may have impacted the outcomes. HSAG

recommended that Colorado Choice document the impact of, and resolutions for, all factors it identified as threats to the validity of the PIP findings. The FY 2012–2013 validation process showed that Colorado Choice had addressed HSAG's recommendations; however, the overall number of evaluation elements scored as *Met* was less than in FY 2011–2012. HSAG made additional recommendations for the Colorado Choice PIP process.

Denver Health Medical Plan, Inc.

Compliance Monitoring Site Reviews

For the FY 2011–2012 compliance monitoring site reviews, HSAG assessed readiness to comply with federal managed care regulations. HSAG did not assign scores and the Department did not require that the plans submit corrective action plans; however, HSAG identified a few areas where DHMP's CHP+ program was not compliant with federal managed care regulations. Areas identified as needing revisions and examples of the recommended revisions follow.

HSAG recommended that DHMP revise its member handbook to meet the required sixth-grade reading level, clarify the description of poststabilization services in member materials, communicate the requirements regarding financial responsibility for poststabilization care, and have grievance and appeals polices reflect the federal managed care requirements.

DHMP reported completion of the following activities to respond to recommendations made during the 2011–2012 site review:

- Revision of the DHMP CHP+ member handbook to increase comprehension for all members and comply with federal health care regulations.
- Revision of all CHP+ member materials, including the DHMP CHP+ member handbook, to include language related to emergency care services and to include a description of poststabilization services and the health plan's financial responsibility.
- Revision of the DHMP CHP+ grievance and appeals policies and procedures to reflect the changes brought about by the Children's Health Insurance Program Reauthorization Act (CHIPRA) requirement to comply with the BBA.
- Revision of the CHP+ member handbook to reflect changes in the CHP+ grievance and appeals processes.

Validation of Performance Measures

Between HEDIS 2011 and HEDIS 2012, DHMP experienced a decline in both *Well-Child Visits in the First 15 Month of Life—Zero Visits* and *Well-Child Visits in the First 15 Months of Life—6+ Visits*. DHMP also saw a slight decrease in the rate for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition: Total*. HSAG suggested that the decline may be related to Interactive Data Submission System (IDSS) reporting issues and recommended that DHMP review all IDSS submitted data for accuracy.

DHMP's HEDIS 2013 rate for *Well-Child Visits in the First 15 Month of Life—Zero Visits* increased to the national HEDIS Medicaid 10th percentile (for this indicator, a lower rate indicates better performance). Unfortunately, *Well-Child Visits in the First 15 Month of Life—6+ Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition: Total* experienced further rate declines. HSAG suggested that DHMP ensure providers are appropriately coding well-child visit services.

Validation of Performance Improvement Projects

DHMP scored 100 percent of applicable evaluation elements *Met* for the 2012 submission of its *Improving Well Care for Children 3–6* PIP. HSAG recommended that as it proceeded with the project, DHMP regularly evaluate the implemented interventions to help determine if the interventions were successful. Review of the 2012–2013 PIP showed that DHMP implemented an intervention but did not include the intervention or the barrier in the intervention table. HSAG reminded DHMP to ensure that all identified interventions and barriers are clearly documented in the PIP intervention table.

Kaiser Permanente Colorado

Compliance Monitoring Site Reviews

For the FY 2011–2012 compliance monitoring site reviews, HSAG assessed readiness to comply with federal managed care regulations. HSAG did not assign scores and the Department did not require that the plans submit corrective action plans; however, HSAG identified several areas where Kaiser's CHP+ program was not compliant with federal managed care regulations. Areas identified as needing revisions and examples of the recommended revisions follow.

HSAG recommended that Kaiser combine its Evidence of Coverage and Member Resources Guide into one handbook with an expanded member rights and responsibilities section, and that it update policies regarding required member notifications and associated time frames. HSAG suggested that Kaiser carefully review the grievance system timelines anticipated to take effect in July 2012 and revise its policies, procedures, and processes accordingly. HSAG recommended that Kaiser clarify the description of poststabilization services in member materials and determine the best mechanism to communicate the rules of financial responsibility for poststabilization care. HSAG also suggested relatively minor adjustments to Kaiser's provider agreements to inform providers of non-discrimination policies and fraud and abuse reporting requirements.

Kaiser reported completion of the following activities to respond to recommendations made during the 2011–2012 site review:

- Expansion of the Kaiser member rights and responsibilities document to include federal- and state-mandated member rights and responsibilities.
- Review and revision of the grievance system timelines, policies, and procedures to comply with federal health care regulations.

Additionally, the following revisions were in process as of July 2013:

- Revisions to the poststabilization services policy and member materials are in process to clearly define Kaiser's responsibilities.
- Revisions to the provider agreements are also in process to clarify member responsibilities related to nondiscrimination and reporting fraud and abuse.

Validation of Performance Measures

Although none of Kaiser's HEDIS 2012 performance experienced a statistically significant decline, Kaiser experienced a slight decline in rates for *Childhood Immunization Status—Combination 2* and *Childhood Immunization Status—Combination 3*. HSAG recommended that Kaiser investigate reasons for the declines and suggested checking the Colorado Immunization Registry data. Kaiser experienced a statistically significant increase in both of these rates between HEDIS 2012 and HEDIS 2013.

Validation of Performance Improvement Projects

Kaiser scored 100 percent of applicable evaluation elements *Met* for the 2012 submission of its *Asthma Care* PIP. HSAG recommended that as it proceeded with the project, Kaiser conduct a barrier analysis exercise, and that it prioritize identified barriers and implement interventions directly related to the barriers. The 2012–2013 PIP submission showed that Kaiser performed a multistep causal/barrier analysis and that it identified problem areas, developed interventions, and monitored the progress of the PIP.

Rocky Mountain Health Plans

Compliance Monitoring Site Reviews

For the FY 2011–2012 compliance monitoring site reviews, HSAG assessed readiness to comply with federal managed care regulations. HSAG did not assign scores and the Department did not require that the plans submit corrective action plans; however, HSAG identified several areas where RMHP's CHP+ program was not compliant with federal managed care regulations. Areas identified as needing revisions and examples of the recommended revisions follow.

RMHP needed to revise its member handbook to meet the sixth-grade reading level and include a member rights statement. HSAG suggested RMHP evaluate its policy that addressed internal auditing and monitoring for identification of potential fraud and abuse and develop procedures for the threshold and frequency of auditing described in the policy. HSAG recommended that RMHP clarify the description of poststabilization services in member materials and determine the best mechanism to communicate the rules of financial responsibility for poststabilization care. HSAG also suggested that RMHP carefully review the grievance system timelines anticipated to take effect in July 2012 and revise its policies, procedures, and processes accordingly.

HSAG expressed concerns related to inaccurate and inconsistent information found during review of member appeal records. In several cases the denial letter, the acknowledgement letter, and the resolution letter each depicted different reasons for the denial. HSAG advised that better quality control of the consistency of member and provider communications and the reasons for denial decisions would improve clarity of communications and overall efficiency of the appeal process. HSAG also recommended that RMHP evaluate its claims system to ensure compliance with federal emergency claims payment regulations.

RMHP reported completion of the following activities to respond to recommendations made during the 2011–2012 site review:

- The CHP+ member handbook was modified to achieve a reading level that more closely approximated that of the sixth grade, and to include member rights that were previously omitted.
- RMHP revised policies and member materials to include the federal definition of postabilization services and accurately reflect the rules as they relate to financial responsibility.
- RMHP reviewed and revised grievance and appeals materials, as well as policies and procedures, to ensure compliance with federal health care requirements.
- RMHP programmed a process by which the claim denial reason listed in the claims processing system is the denial reason that appears on the denial (notice of action) letter, the appeal acknowledgement letter, and the resolution letter, resolving the issue of conflicting denial reasons.
- RMHP has evaluated its claims system and determined that it is in compliance with federal emergency claims payment regulations.

Additionally, the following revisions were in process as of July 2013:

- RMHP's fraud and abuse unit is rewriting its policy and procedures with a focus on review thresholds and frequency of auditing. This remains a work in progress.
- As to the overall claims and appeals process, RMHP has begun to consider all member communications documents in the context of the overall process, rather than viewing documents as independent of one another and driven by the claims system.

Validation of Performance Measures

Three of RMHP's four well-child measures exhibited a decline in performance for HEDIS 2012. The *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure rate dropped 15.3 percentage points from HEDIS 2011 to HEDIS 2012. HSAG recommended RMHP investigate the reasons for the declines in administrative rates. HSAG suggested RMHP encourage its providers to take advantage of all encounters with members to ensure that any required or needed services are performed. With the exception of *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, which experienced a very slight increase, all of RMHP's HEDIS 2013 well-care measures exhibited continued decline. HSAG repeated its 2012 recommendations.

Validation of Performance Improvement Projects

RMHP scored 100 percent of applicable evaluation elements *Met* for the 2012 submission of its *Asthma Care* PIP. HSAG recommended that as it proceeded with the PIP, RMHP conduct a barrier analysis exercise, prioritizing identified barriers and implementing interventions directly related to the barriers. RMHP's 2012–2013 PIP documented that RMHP performed a causal barrier analysis and facilitated discussions about study barriers and past intervention efforts. RHMP prioritized and implemented six interventions based on the needs identified.

State Managed Care Network

Compliance Monitoring Site Reviews

Colorado Access is a health plan with several lines of business, one of which is the State Managed Care Network (SMCN) that provides administrative services to the State of Colorado. For the FY 2011–2012 compliance monitoring site reviews, HSAG assessed readiness to comply with federal managed care regulations. HSAG did not assign scores and the Department did not require that the plans submit corrective action plans; however, HSAG identified several areas where Colorado Access' execution of the SMCN program was not compliant with federal managed care regulations. Areas identified as needing revisions and examples of the recommended revisions follow.

HSAG suggested that the SMCN member benefits booklet be revised to meet the required sixth-grade reading level and include instructions on how members can request information. Policies and procedures related to the grievance system needed to be updated to incorporate federal regulations. HSAG also recommended that Colorado Access communicate its nondiscrimination statement to its providers, clarify the description of poststabilization services in member materials, and communicate the rules of financial responsibility for poststabilization care.

Colorado Access reported completion of the following activities to respond to recommendations made during the 2011–2012 site review:

- Revision of the SMCN member handbook to achieve a sixth-grade reading level and to outline the options members have for accessing and requesting information related to their CHP+ benefits plan.
- Revision of the grievance policies and procedures to reflect the federal managed care regulations.
- Communication, via the SMCN Web site, to the SMCN member population and contracted providers regarding revised grievance procedures, the SMCN member handbook, and the provider manual.
- Inclusion of a nondiscrimination statement in the provider manual explaining that Colorado Access does not discriminated against any current or potential provider.
- A simplification of the poststabilization definition and information for member interpretation.to meet the sixth-grade reading level. This has been included in the member handbook.

- Providing a member handbook to each new member upon enrollment. Copies are available anytime on the SMCN Web site or by request from Colorado Access' customer service.

Validation of Performance Measures

Two SMCN reported measures, *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Well-Child Visits in the First 15 Months of Life—6+ Visits*, and the two *Prenatal and Postpartum Care* indicators showed a decline in performance from HEDIS 2011 to HEDIS 2012; however, the decrease was less than 5 percentage points. HSAG suggested that Colorado Access remind each provider who administers services to an SMCN member to perform its due diligence when a member presents for service, and to administer as many required services as possible. The HEDIS 2013 rate for both *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator and the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator showed statistically significant increases. The *Well-Child Visits in the First 15 Months of Life—6+ Visits* indictor increased slightly and the *Prenatal and Postpartum Care—Postpartum Care* indicator did not change.

Validation of Performance Improvement Projects

SMCN was not required to conduct a performance improvement project.

Appendix A. EQR Activities—Compliance Monitoring Site Reviews

Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the compliance monitoring site review activities were conducted and the resulting data were aggregated and analyzed.

For the FY 2012–2013 site review process, the Department requested a review of four areas of performance: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. HSAG developed a review strategy and monitoring tools that corresponded with the areas identified by the Department.

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plans' contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. The site review processes were developed to ensure consistency with the February 11, 2003, CMS final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs),* since the site review process was initiated prior to the CMS release of updated protocols. HSAG reviewed its processes to ensure that the 2012–2013 site review processes were also consistent with *CMS EQRO Protocol 1, Version 2, September 1, 2012.*

Objectives

Private accreditation organizations, state licensing agencies, 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.

The objective of each site review was to provide meaningful information to the Department and the health plans regarding:

- The health plans' compliance with federal health care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and recommendations to bring the health plan into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the health plan, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the plan's services related to the area reviewed.

Technical Methods of Data Collection

For the health maintenance organizations (HMOs) and the State Managed Care Network (SMCN), HSAG performed the seven compliance monitoring activities described in the February 11, 2003, CMS final protocol. These activities were: planning for monitoring activities, obtaining background information from the State Medicaid agency (the Department), reviewing documents, conducting interviews, collecting accessory information, analyzing/compiling findings, and reporting results to the Department.

Pre-on-site review activities consisted of scheduling and developing timelines for the site reviews and report development; developing data collection tools, report templates, and on-site agendas; and reviewing the HMOs' and SMCN's documents prior to the on-site portion of the review.

On-site review activities included a review of additional documents, policies, and committee minutes to determine compliance with federal health care regulations and implementation of the organizations' policies. As part of Standard VIII—Credentialing and Recredentialing, HSAG conducted an on-site review of 10 credentialing records and 10 recredentialing records. HSAG incorporated the results of the record reviews into the findings for the standard.

Also during the on-site portion of the review, HSAG conducted an opening conference to review the agenda and objectives of the site review and to allow the HMOs and SMCN to present any important information to assist the reviewers in understanding the unique attributes of each organization. HSAG used the on-site interviews to provide clarity and perspective to the documents reviewed both prior to the site review and on-site. HSAG then conducted a closing conference to summarize preliminary findings and anticipated recommendations and opportunities for improvement.

Table A–1 describes the tasks performed for each activity in the CMS final protocol for monitoring compliance during FY 2012–2013.

Table A–1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Planned for Monitoring Activities**
	Prior to the compliance monitoring site review activities: ◆ HSAG and the Department held teleconferences and in-person meetings to determine the content of the review. ◆ HSAG coordinated with the Department and the health plan to set the dates of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool, the report template, and HSAG's project plan for completion of site review activities. ◆ HSAG's staff attended Medical Quality Improvement Committee (MQUIC) meetings to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff members to the review team. ◆ Prior to the review, HSAG representatives also responded to questions from the health plans via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring site review.

Table A–1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the federal Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the health plans' managed care contracts with the Department to develop HSAG's monitoring tool, on-site agenda, record review tools, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific managed care regulations or contract requirements. ◆ HSAG considered the Department's responses when determining compliance and analyzing findings.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG emailed the desk review request form, the compliance monitoring tool, and an on-site agenda to each health plan. The desk review request form included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the scheduled site review, each health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents that were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review or interviews.)
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with health plan staff members to provide an overview of preliminary findings. ◆ HSAG used the FY 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement and made recommendations based on the review findings.

Table A–1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 Site Review Report. ◆ HSAG submitted the report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.

Description of Data Sources

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and handouts
- Policies and procedures
- The QAPI program plan, work plan, and annual evaluation
- Quality studies and reports
- Management/monitoring reports
- Quarterly reports
- Provider and delegation agreements and contracts
- Clinical review criteria
- Practice guidelines
- Provider manual and directory
- Consumer handbook and informational materials
- Staff training materials and documentation of attendance
- Consumer satisfaction results
- Correspondence
- Records or files related to administrative tasks
- Interviews with key health plan staff members conducted on-site

Data Aggregation, Analysis, and How Conclusions Were Drawn

Upon completion of the site review, HSAG aggregated all information obtained. HSAG analyzed the findings from the document and record reviews and from the interviews. Findings were scored using a *Met, Partially Met, Not Met,* or *Not Applicable* methodology for each requirement. Each HMO was given an overall percentage-of-compliance score. This score represented the percentage of the applicable elements met by the health plan. This scoring methodology allowed the Department to identify areas of best practice and areas where corrective actions were required or training and technical assistance was needed to improve performance.

The health plans' administrative records were also reviewed to evaluate implementation of NCQA Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the health plan received a score of Yes (compliant), No (not compliant), or Not Applicable for each of the elements evaluated. Compliance with applicable federal managed care regulations was evaluated through review of the four standards. HSAG calculated a percentage-of-compliance score for each standard and an overall percentage-of-compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

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 and how the resulting data were aggregated and analyzed.

Objectives

As set forth in 42 CFR 438.358, validation of performance measures was one of the mandatory EQR activities. 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.

Technical Methods of Data Collection

HSAG followed a set of outlined policies and procedures to conduct the validation of performance measures. The Department specified that HSAG would conduct an NCQA HEDIS Compliance Audit of Department-specified measures to satisfy the requirements. The Department required that each HMO undergo an NCQA HEDIS Compliance Audit performed by an NCQA-certified HEDIS compliance auditor (CHCA) contracted with an NCQA-licensed organization.

The CMS Performance Measure Validation Protocol identifies key types of data that should be reviewed. As part of the validation process, HSAG aggregated several sources of HEDIS-related data to determine if the licensed organizations' audit process met CMS requirements.

Description of Data Obtained

As identified in the HEDIS audit methodology, key types of data were obtained and reviewed as part of the validation of performance measures. Table B-1 identifies the key audit steps that HSAG validated and the sources of the data used.

Table B-1—Description of Data Sources Reviewed	
Data Reviewed	**Source of Data**
Pre-on-site Visit/Meeting—The initial conference call or meeting between the licensed organizations and the HMO or the SMCN staff. HSAG verified that key HEDIS topics such as timelines and on-site review dates were addressed by the licensed organizations.	HEDIS 2013 FAR
Roadmap Review—This review provided the licensed organizations with background information on policies, processes, and data in preparation for on-site validation activities. The HMOs and the SMCN were required to complete the Roadmap to provide the audit team with the necessary information to begin review activities. HSAG looked for evidence in the final report that the licensed organizations completed a thorough review of all components of the Roadmap.	HEDIS 2013 FAR
Certified Software Review—If an NCQA-certified software vendor was used, HSAG assessed whether or not the software vendor was certified for the measures required by the Department.	HEDIS 2013 FAR and Software Certification Letters
Source Code Review—HSAG ensured that the licensed organizations reviewed the programming language for calculating the HEDIS measures if an NCQA-certified software vendor was not used. Source code review is used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (to determine if rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately). This process is not necessary if NCQA-certified software is used.	HEDIS 2013 FAR
Survey Vendor—If the HMO and SMCN used a survey vendor to perform the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, HSAG verified that an NCQA-certified survey vendor was used. A certified survey vendor must be used if the HMO or SMCN performed a CAHPS survey as part of HEDIS reporting.	HEDIS 2013 FAR
CAHPS Sample Frame Validation—HSAG validated that the licensed organizations performed detailed evaluations of the computer programming (source code) used to access and manipulate data, reviewed the source code to ensure that data were correctly queried in the output files, and conducted a detailed review of the survey eligibility file elements, including the health care organization's name, product line, product, unique member ID, and subscriber ID, as well as the member name, gender, telephone number, date of birth, mailing address, continuous enrollment history, and prescreen status code (if applicable).	HEDIS 2013 FAR
Primary Source Verification—This verification is performed to determine the validity of the source data used to generate the HEDIS rates. Auditors verify that the information from the primary source matches the output information used for HEDIS reporting. Auditors do this by tracing the movement of the data from the originating source to the HEDIS repository. HSAG verified that the licensed organizations used this methodology as part of their on-site audit process.	HEDIS 2013 FAR

Table B-1—Description of Data Sources Reviewed	
Data Reviewed	**Source of Data**
Convenience Sample Validation—The auditor reviews a small number of processed medical records to uncover potential problems that may require corrective action early in the MRR process. A convenience sample must be prepared unless the auditor determines that a health plan is exempt. NCQA allows organizations to be exempt from the convenience sample if they participated in a HEDIS audit the previous year and passed MRR validation, and if the current MRR process has not changed significantly from the previous year and the organization does not report hybrid measures that the auditor determines to be at risk of inaccurate reporting. HSAG verified that the licensed organizations determined whether or not the HMOs and the SMCN were required to undergo a convenience sample validation. HSAG also verified that if a convenience sample validation was not required by a licensed organization, the specific reasons were documented.	HEDIS 2013 FAR
Medical Record Review—The licensed organizations are required to perform a more extensive validation of medical records reviewed, which is conducted late in the abstraction process. This validation ensures that the review process was executed as planned and that the results are accurate. HSAG reviewed whether or not the licensed organizations performed a re-review of a minimum random sample of 30 medical records for each of two reported measures (if applicable) to ensure the reliability and validity of the data collected.	HEDIS 2013 FAR
IDSS Review—The HMOs and the SMCN are required to complete NCQA's IDSS for the submission of audited rates to NCQA. The auditor finalizes the IDSS by completing the audit review and entering an audit result. This process verifies that the auditor validated all activities that culminated in a rate by the HMOs or the SMCN. The auditor locks the IDSS so that no information can be changed. HSAG verified that the licensed organizations completed the IDSS review process.	HEDIS 2013 IDSS

Table B-2 identifies the key elements reviewed by HSAG during validation activities. HSAG identified whether or not each HMO and the SMCN were compliant with the key elements as described by the licensed organizations in the final report and the IDSS. As presented in Table B-2, a checkmark indicates that the licensed organization reviewed the HEDIS activities, which confirmed that HEDIS methodology was being followed. Some activities are identified as being compliant by inserting the name of the company the HMOs and the SMCN contracted with to perform the required tasks.

Table B-2—Validation Activities

	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	SMCN
Licensed Organization	HealthcareData Company, LLC	DTS Group	HealthcareData Company, LLC	DTS Group	DTS Group	Health Services Advisory Group, Inc. (HSAG)
Pre-on-site Visit Call/Meeting	✓	✓	✓	✓	✓	✓
Roadmap Review	✓	✓	✓	✓	✓	✓
Software Vendor	Verisk Health	Altegra	Verisk Health	None	Inovalon, Inc.	Q Mark, Inc.
Source Code/ Certified Software Review	✓	✓	✓	✓	✓	✓
Survey Vendor	HSAG	NA	Morpace Inc.	DSS Research	CSS	HSAG
CAHPS Sample Frame Validation	✓	NA	✓	✓	✓	✓
Primary Source Verification	✓	✓	✓	✓	✓	✓
Medical Record Review	✓	✓	✓	✓	✓	✓
IDSS Review	✓	✓	✓	✓	✓	✓

Table B-2 indicates that audits conducted for the HMOs and the SMCN included all of the listed validation activities. The HMOs and the SMCN used an NCQA-licensed organization to perform their HEDIS audits. In addition, all the HMOs and the SMCN, except Kaiser, used an NCQA-certified software vendor for calculating rates; therefore, source code review was only performed for Kaiser. Kaiser's source code was reviewed and subsequently approved by the LO to be within the technical specifications. Four of the five HMOs and the SMCN also used an NCQA-certified HEDIS survey vendor to administer the CAHPS survey(s).

HSAG summarized the results from Table B-2 and determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology. Therefore, any rates and audit results are determined to be valid, reliable, and accurate.

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 the SMCN. HSAG forwarded this report to the Department and the SMCN. The HMOs forwarded their final audit reports and final IDSS to the Department. HSAG reviewed and evaluated all data sources to assess health plan compliance with the HEDIS Compliance Audit Standards. The information system (IS) standards are listed as follows:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry
- IS 6.0—Member Call Center Data—Capture, Transfer, and Entry (this standard is not applicable to the measures under the scope of the performance measure validation)
- IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

Appendix C. Medicaid HEDIS 2012 Percentiles

Performance Measures	P10	P25	P50	P75	P90
Pediatric Care					
Childhood Immunization Status—Combination 2	64.23%	69.10%	75.35%	80.79%	84.18%
Childhood Immunization Status—Combination 3	58.88%	64.72%	71.93%	77.49%	82.48%
Childhood Immunization Status—Combination 4	20.92%	27.78%	33.92%	40.39%	46.93%
Childhood Immunization Status—Combination 5	36.50%	46.47%	52.92%	59.76%	64.68%
Childhood Immunization Status—Combination 6	20.19%	30.90%	37.57%	45.50%	56.20%
Childhood Immunization Status—Combination 7	15.29%	20.92%	26.03%	33.33%	38.50%
Childhood Immunization Status—Combination 8	10.90%	14.36%	20.88%	25.69%	31.25%
Childhood Immunization Status—Combination 9	14.81%	22.87%	29.79%	38.19%	45.05%
Childhood Immunization Status—Combination 10	8.10%	11.54%	16.51%	21.41%	27.49%
Immunizations for Adolescents—Combination 1	39.77%	50.36%	62.29%	70.83%	80.91%
*Well-Child Visits in the First 15 Months of Life—Zero Visits**	0.46%	0.72%	1.22%	2.43%	3.89%
Well-Child Visits in the First 15 Months of Life—6+ Visits	43.80%	54.31%	62.95%	70.70%	77.31%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.07%	65.51%	72.26%	79.32%	83.04%
Adolescent Well-Care Visits	35.52%	42.11%	49.65%	57.61%	64.72%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Assessment: Total	1.55%	29.20%	47.45%	66.67%	77.13%
Counseling for Nutrition: Total	0.82%	42.82%	54.88%	67.15%	77.61%
Counseling for Physical Activity: Total	0.16%	31.63%	43.29%	56.20%	64.87%
Utilization of Services					
Ambulatory Care (Per 1,000 Member Months)					
Emergency Department Visits	42.03	52.45	63.15	72.77	80.04

* For this measure, a lower rate indicates better performance; therefore, the 10th percentile is a better-performing level than the 90th percentile.

Appendix D. 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 PIP activities was conducted and how the resulting data were aggregated and analyzed.

Objectives

As part of its QAPI program, each CHP+ health plan was required by the Department to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs was to achieve, through ongoing measurements and intervention, significant, sustained improvement in both clinical and nonclinical areas. This structured method of assessing and improving health plan processes was designed to have a favorable effect on health outcomes and consumer satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State was required to validate the PIPs conducted by its contracted MCOs and PIHPs. The Department contracted with HSAG to meet this validation requirement.

The primary objective of PIP validation was to determine each CHP+ 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.

HSAG performed validation activities on five PIPs for the CHP+ health plans. Table D-1 below lists the health plans and their PIP study titles.

Table D-1—Summary of Each Health Plan's PIP

Health Plans	PIP Study
Colorado Access	*Improving Weight Assessment in Children and Adolescents*
Colorado Choice	*Asthma in Pediatric Patients*
DHMP	*Improving Well Care for Children 3–6 Years*
Kaiser	*Asthma Care*
RMHP	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*

Technical Methods of Data Collection

The methodology used to validate PIPs was based on CMS guidelines as outlined in *Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, which each CHP submitted to HSAG for review and validation. 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. Select the Study Topic(s)
- Activity II. Define the Study Question(s)
- Activity III. Select the Study Indicator(s)
- Activity IV. Use a Representative and Generalizable Study Population
- Activity V. Use Sound Sampling Techniques
- Activity VI. Reliably Collect Data
- Activity VII.* Analyze Data and Interpret Study Results
- Activity VIII.* Implement Intervention and Improvement Strategies
- Activity IX. Assess for Real Improvement
- Activity X. Assess for Sustained Improvement

*To ensure that health plans analyzed and interpreted data prior to identifying and implementing interventions, HSAG reversed the order of Activities VII and VIII in the PIP Summary Form for new PIPs that were implemented during FY 2011–2012. Thus, for all PIPs developed during and after FY 2011–2012, health plans are required to provide an analysis and interpretation of data in Activity VII followed by the description of the planned interventions and improvement strategies.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the CHP+ health plans' 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. HSAG validates PIPs only as far as the PIP has progressed. Activities in the PIP Summary Form that have not been completed are scored *Not Assessed* by the HSAG PIP Review Team.

Data Aggregation, Analysis, and How Conclusions Were Drawn

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. HSAG designates some of the evaluation elements that are deemed pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all of the critical elements must receive a score of *Met*. Given the importance of critical elements to the scoring methodology, any

critical element that receives a score of *Partially Met* or *Not Met* will result in a corresponding overall PIP validation status of *Partially Met* or *Not Met*.

Additionally, some of the evaluation elements may include a *Point of Clarification*. A *Point of Clarification* indicates that while an evaluation element may have the basic components described in the narrative of the PIP to meet the evaluation element, enhanced documentation would demonstrate a stronger understanding of the CMS protocol.

The scoring methodology used for all PIPs is as follows:

- *Met*: All critical elements were *Met* and 80 percent to 100 percent of all critical and noncritical elements were *Met*.
- *Partially Met*: All critical elements were *Met* and 60 percent 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)*: Elements that were *NA* were removed from all scoring (including critical elements if they were not assessed).

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

HSAG assessed the validity and reliability of the results as follows:

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

HSAG PIP reviewers validated each PIP twice—once when originally submitted and then again when the PIP was resubmitted. The CHP+ health plans had the opportunity to receive technical assistance, incorporate HSAG's recommendations and resubmit the PIPs to improve the validation scores and validation status. HSAG organized, aggregated, and analyzed the health plans' data to draw conclusions about their quality improvement efforts. HSAG prepared a report of these findings, including the requirements and recommendations for each validated PIP. HSAG provided the Department and health plans with final PIP Validation Reports.

Appendix E. Summary Tables of EQR Activity Results—All Plans

Introduction

This appendix presents tables with the detailed findings for all CHP+ health plans and for each EQR activity performed in FY 2012–2013.

Results from the Compliance Monitoring Site Reviews

Table E-1 and Table E-2 show the compliance summary scores and record review scores for each health plan as well as the statewide average. Statewide average scores were calculated by dividing the total number of elements that were *Met* across all plans by the total number of applicable elements across all plans. This was the first year HSAG applied scores to HMO performance; therefore, scores are only available for the standards reviewed this year. SMCN was also subject to a compliance site review; however, the Department requested that the SMCN compliance review not be scored. For this reason, it is not included in Table E–1 or Table E–2.

Table E-1—FY 2012–2013 Compliance

Description of Component	CO Access	CO Choice	DHMP	Kaiser	RMHP	Statewide Average
Standard III—Coordination and Continuity of Care	100%	33%	100%	89%	89%	82%
Standard IV—Member Rights and Protections	100%	20%	100%	80%	40%	68%
Standard VIII—Credentialing and Recredentialing	98%	39%	94%	100%	98%	86%
Standard X—Quality Assessment and Performance Improvement	100%	34%	91%	100%	73%	76%

Table E-2—FY 2012–2013 Record Reviews

Description of Component	CO Access	CO Choice	DHMP	Kaiser	RMHP	Statewide Average
Credentialing	100%	97%	100%	100%	100%	99%
Recredentialing	100%	91%	100%	100%	100%	98%

Results from the Validation of Performance Measures

Table E-3 presents performance measure results for each health plan and the statewide average.

Table E-3—2012–2013 Performance Measure Results for each HMO and Statewide Average							
Performance Measures	CO Access	CO Choice	DHMP	Kaiser	RMHP	SMCN	Statewide Average
Childhood Immunization Status—Combination 2	54.53%	NA	83.33%	90.00%	43.15%	58.08%	58.04%
Childhood Immunization Status—Combination 3	52.41%	NA	82.35%	88.89%	42.64%	53.54%	55.89%
Childhood Immunization Status—Combination 4	46.82%	NA	82.35%	88.89%	36.55%	48.99%	51.43%
Childhood Immunization Status—Combination 5	41.43%	NA	64.71%	74.44%	32.99%	40.91%	44.11%
Childhood Immunization Status—Combination 6	34.30%	NA	69.61%	55.56%	27.41%	29.29%	36.70%
Childhood Immunization Status—Combination 7	37.57%	NA	64.71%	74.44%	29.95%	37.37%	41.16%
Childhood Immunization Status—Combination 8	31.41%	NA	69.61%	55.56%	25.38%	27.78%	34.73%
Childhood Immunization Status—Combination 9	28.13%	NA	56.86%	50.00%	23.35%	23.23%	30.45%
Childhood Immunization Status—Combination 10	25.82%	NA	56.86%	50.00%	22.34%	21.72%	28.93%
Well-Child Visits in the First 15 Months of Life—Zero Visits	2.14%	NA	0.00%	0.00%	4.79%	3.13%	2.67%
Well-Child Visits in the First 15 Months of Life—6+ Visits	13.64%	NA	2.13%	54.35%	20.55%	56.88%	25.48%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.20%	57.94%	58.53%	66.35%	62.14%	52.15%	61.26%
Adolescent Well-Care Visits	43.39%	36.33%	42.00%	52.03%	41.10%	34.26%	42.09%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Assessment: Total	63.99%	13.90%	90.27%	97.51%	74.12%	57.18%	68.80%
Counseling for Nutrition: Total	57.66%	11.41%	76.16%	100%	60.40%	55.47%	62.24%
Counseling for Physical Activity: Total	52.31%	15.63%	63.26%	100%	58.63%	44.53%	56.68%
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	—	—	—	—	—	78.59%	78.59%
Postpartum Care	—	—	—	—	—	67.88%	67.88%
Ambulatory Care (Per 1,000 Member Months)							
Emergency Department Visits	32.93	20.84	31.48	24.73	22.76	29.61	30.07

Results from the Validation of Performance Improvement Projects

Table E-4 lists the PIP study conducted by each health plan and the corresponding summary scores.

Table E-4—Summary of Each HMO's PIP Validation Scores and Validation Status				
Health Plan	**PIP Study**	**% of All Elements *Met***	**% of Critical Elements *Met***	**Validation Status**
Colorado Access	*Improving Weight Assessment in Children and Adolescents*	100%	100%	*Met*
Colorado Choice	*Asthma in Pediatric Patients*	93%	100%	*Met*
DHMP	*Improving Well Care for Children 3–6 Years*	93%	100%	*Met*
Kaiser	*Asthma Care*	93%	100%	*Met*
RMHP	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	100%	100%	*Met*