2014–2015 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 & 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 health plan contractor with the Child Health Plan *Plus* (CHP+) insurance program to analyze and evaluate the quality and timeliness of, and access to, healthcare services furnished by the health plan to CHP+ beneficiaries.

CHP+ is Colorado's implementation of the Children's Health Insurance Program (CHIP), a healthcare 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 healthcare 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 CHP+ HMOs:

- Colorado Access
- Colorado Choice Health Plans (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 and one optional activity, with the exception that the SMCN was not required to complete a performance improvement project or Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-1] surveys. 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 selected standards based on the regulations at 42CFR.438 *et seq*.
- **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.

The optional activity was:

- **CAHPS survey.** HSAG conducted the surveys for all CHP+ HMOs on behalf of the Department, as well as the reporting of results.

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."[1-2]

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

[1-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-2] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 3, October 1, 2005.

accommodate the clinical urgency of a situation."[1-3] NCQA further discusses that the intent of this standard is to minimize any disruption in the provision of healthcare. 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.

Access

In the preamble to the BBA Rules and Regulations,[1-4] 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 the SMCN, HSAG assigned each of the components reviewed for each activity (compliance monitoring, performance measure validation [PMV], and validation of 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 V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		
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	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		

[1-3] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.
[1-4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Table 1-1—Assignment of Activities to Performance Domains			
	Quality	Timeliness	Access
Immunization for Adolescents	✓	✓	
Non-recommended Cervical Cancer Screening in Adolescent Females	✓		
Chlamydia Screening in Women	✓		
Appropriate Testing for Children With Pharyngitis	✓		
Follow-up Care for Children Prescribed ADHD Medication	✓	✓	
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Use of Appropriate Medications for People With Asthma	✓		
Medication Management for People With Asthma	✓		
Asthma Medication Ratio	✓		
Anti-depressant Medication Management (acute and continuation)	✓		
Follow-up After Hospitalization for Mental Illness	✓	✓	
Ambulatory Care			✓
Inpatient Utilization—General Hospital/Acute Care			✓
Mental Health Utilization			✓
Antibiotic Utilization			✓
Children and Adolescents' Access to Primary Care Practitioners			✓
Prenatal Care and Postpartum Care (for SMCN population only)	✓	✓	✓
Performance Improvement Projects			
All performance improvement projects	✓		
CAHPS			
Getting Needed Care	✓	✓	
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Shared Decision Making	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

Quality

Statewide compliance monitoring performance in the quality domain was primarily impacted by the need for improved clarity of the language and format of information in the member handbook and other communications. Overall performance in the Member Information standard varied from 52 to 91 percent compliance among the five HMOs. While two of five HMOs provided comprehensive member and provider materials as required, three of five HMOs required significant improvements to ensure that member materials are written in easy-to-understand language. In addition, three of

five HMOs had corrective actions related to the reading level of appeal resolution. Ensuring that members receive easy-to-understand information about the benefits and services available under the plan and how to access those benefits and services is essential to increasing the likelihood that members will achieve their desired health outcomes. One HMO had numerous deficiencies due to the absence of policies and procedures. Absence and/or inadequacy of written policies and procedures compromise the organization's structural and operational characteristics and diminish the ability to ensure consistent application of quality standards.

Statewide performance in this domain included the 16 quality-related measures required for plan reporting and the *Prenatal and Postpartum Care* non-audited rates from the SMCN. Of these 17 quality-related measures, one showed significant improvement from last year for one of its indicators, but five had significant decline in performance. The declines were found in *Prenatal and Postpartum Care* as well as in pediatric care. A change in the data collection requirement from hybrid to administrative might have been the reason for these declines. Compared to national benchmarks, statewide performance was diverse. Two measures performed above the national 90th percentile, but six had at least one indicator performing below the 25th percentile.

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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, demonstrating application of methodologically sound design principles necessary to produce valid and reliable PIP results.

All measures within the CAHPS survey addressed quality. For the statewide CHP+ population, rates for six of the eight comparable measures increased: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. However, the increases in rates for these measures were not substantial. The remaining two measures showed rates decreases; however, the measures' rates did not decrease substantially.

Timeliness

Grievance System was the only compliance monitoring standard assigned to the timeliness domain. With an overall score of 65 percent compliance, statewide performance was poorest for this standard. All HMOs had extensive policies and procedures related to processing of grievances and appeals. However, policies and procedures and/or member communications inaccurately documented required time frames in one or more instances. All five HMOs had required actions related to the time frames for filing an appeal or State fair hearing related to reduction or termination of previously approved services associated with a request for continuation of benefits. Record reviews demonstrated that three of five HMOs failed to consistently send acknowledgement letters in the required time frame, two of five HMOs did not consistently resolve grievances within the required time frame, and two of five HMOs did not consistently send appeal resolution letters within the required time frame.

Statewide performance in this domain included the seven timeliness-related measures required for plan reporting and the *Prenatal and Postpartum Care* non-audited rates from the SMCN. Of the eight timeliness-related measures, one reported significant increase and four had at least one indicator with significant rate decline from last year. The declines were found in *Prenatal and Postpartum Care* as well as in pediatric care. A change in the data collection requirement from hybrid to administrative may have been the reason for these declines. Compared to national benchmarks, no measures were at or above the national Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] Medicaid 90th percentile, and five had at least one indicator performing below the 25th percentile.

Getting Care Quickly was the only measure within the CAHPS survey that addressed timeliness. Scores across plans ranged from 79.7 percent to 93.2 percent, with a statewide average of 88.0 percent. Rates for all five HMOs experienced slight decreases compared to the prior year's scores, which led to a statewide average 1.5 percentage points lower than the FY 2013—2014 statewide average.

Access

All HMOs and SMCN maintained an adequate network of qualified providers to ensure adequate access to services, and two of five plans provided clear information to members regarding covered services and how to access services. However, three of five HMOs required increased clarity of member materials to ensure that members understand how to access the benefits and services available under the plan. Additionally, four of five HMOs had member communications that included erroneous or misleading statements regarding payment for services (e.g., disenrollment criteria, notification requirements, compliance with scheduled appointments) that may negatively impact a member's access to services. Three of five HMOs communicated incorrect procedures related to a member's access to appeals and State fair hearings.

Statewide performance in this domain included the five access-related measures required for plan reporting and the *Prenatal and Postpartum Care* non-audited rates from the SMCN. Only the *Children's and Adolescents' Access to Primary Care Practitioners* and *Prenatal and Postpartum Care* measures were population-based; the remaining measures were utilization-based. Both population-based measures had significant rate decline from last year. The Department changed its data collection requirement for the *Prenatal and Postpartum Care* measure from hybrid in FY 2013–2014 to administrative in FY 2014–2015. The decline was at least 25 percentage points, and the rates were below the national HEDIS Medicaid 10th percentile. Statewide performance of the *Children's and Adolescents' Access to Primary Care Practitioners* measure was diverse. The two younger age groups were below the national 10th percentile, while the *12 to 19 Years* age group ranked above the 50th percentile. Utilization-based measures are not risk-adjusted; therefore, the rates for these measures should be for information only.

Getting Needed Care was the only measure within the CAHPS survey that addressed timeliness. Scores across plans ranged from 71.0 percent to 89.5 percent, with a statewide average of 84.4 percent. Two HMO rates reflected slight increase, two experienced slight decrease, and one demonstrated no change. The statewide average increased 1.6 percentage points above the FY 2013–2014 statewide average.

[1-5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Activities

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

Appendices A through 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 healthcare quality, timeliness, and access for each health plan and statewide, across the health plans.

3. Findings, Strengths, and Recommendations With Conclusions Related to Healthcare 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 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 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

For the fiscal year (FY) 2014–2015 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 performance areas. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. For each standard, HSAG conducted a desk review of documents sent by the health plans prior to the on-site portion of the review, interviewed 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 managed care regulations related to CHP+ grievances and appeals. Using a random sampling technique, HSAG selected (to the extent possible) a sample of 10 plus an oversample of five from all applicable grievances and appeals filed between January 1, 2014, and December 31, 2014. HSAG used a standardized tool to review the records and document findings. Results of record reviews were considered in the scoring of applicable requirements in Standard VI—Grievance System. 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, and/or access. Table 3-1 shows 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 compliance monitoring site review activities.

Table 3-1—Assignment of Activities to Performance Domains			
Standard	Quality	Timeliness	Access
Standard V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		

Colorado Access

Findings

Table 3-2 and Table 3-3 present the number of elements for each standard 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 2014–2015.

Table 3-2—Summary of Scores for the Standards *for* Colorado Access							
Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	23	23	21	2	0	0	91%
Standard VI—Grievance System	26	26	20	6	0	0	77%
Standard VII—Provider Participation and Program Integrity	17	17	17	0	0	0	100%
Standard IX—Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**71**	**71**	**63**	**8**	**0**	**0**	**89%***

* The overall score is calculated by adding 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)
Appeals	60	57	43	14	3	75%
Grievances	45	30	23	7	15	77%
Total	**105**	**87**	**66**	**21**	**18**	**76%**

Strengths

Colorado Access' Explanation of Coverage (EOC) and other vital member materials were written in easy-to-understand language and were translated into Spanish and available in other languages upon request. Member materials were provided upon enrollment and at other times as required. The member welcome packet included a well-organized booklet that summarized major plan benefits and referred the member to the Colorado Access website or customer services for additional information.

Colorado Access thoroughly defined the appeals and grievance processes—including State fair hearings—in its policies and procedures, the provider manual, the EOC, and other member communications. Member and provider communications included the time frames for filing and processing grievances and appeals. Expedited appeal procedures and the option for members to request continuation of benefits were also adequately described in policies and member communications. Member communications also clearly defined the circumstances in which the member may or may not be responsible to pay for continuation of benefits.

Policies and procedures documented the process for credentialing and recredentialing providers in compliance with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Committee (URAC) standards. Policies also specified methods for monitoring for provider sanctions, grievances and other quality of care actions, medical record standards, access to care standards; and for profiling utilization patterns and HEDIS measures. Numerous policies, procedures, and plans documented robust and well-established procedures to guard against fraud, waste, and abuse and to maintain all corporate compliance standards.

Written delegation agreements detailed delegated responsibilities and required reporting, described processes for ongoing monitoring and annual audit by Colorado Access with corrective action plans to remedy any deficiencies, and informed about Colorado Access' ability to revoke delegated functions or the entire delegation agreement based on inadequate performance. Colorado Access maintained thorough documentation of ongoing monitoring, annual audits, and any required corrective actions and reported these findings to the appropriate committees.

Recommendations

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

Standard V—Member Information

- The EOC erroneously stated, "Your PCP may charge you a fee if you do not follow the appointment cancellation policy." Neither federal nor State regulation allow PCPs to charge CHP+ members for missed appointments. Colorado Access must remove statements from the CHP+ HMO EOC regarding the potential for members to be charged for missed appointments and ensure that providers do not charge CHP+ members for not following the PCP's appointment cancellation policies.
- The EOC did not describe a disenrolled member's right to file a grievance or how to contact the Department concerning disenrollment. In addition, the EOC listed "refusal to follow

recommended treatment" as a reason Colorado Access could terminate coverage. This statement is in conflict with federal member rights standards and is not a reason for "disenrollment for cause" as defined in the CHP+ contract. Colorado Access must remove the language concerning "refusal to follow recommended treatment" as a reason for potential termination of coverage. Colorado Access must include information in the EOC and related policies to ensure that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so and inform members about how to access the Department concerning disenrollment.

Standard VI—Grievance System

- The grievance record review included six records that were member requests for reimbursement of out-of-pocket expenses. A member request for reimbursement is not an "expression of dissatisfaction" and, therefore, not a grievance. Colorado Access should revise internal procedures to ensure that the grievance tracking system accurately designates "grievance" as a member complaint or "expression of dissatisfaction" about any matter other than an action.
- Four of nine grievance records reviewed on-site were not resolved within the required time frame because Colorado Access closed the grievance before it was resolved. Colorado Access mailed the member a letter informing that the case was being closed due to expiration of the allowed time frame. The letter assured the member that Colorado Access would continue working to resolve the matter but did not include documentation of any follow-up correspondence regarding ultimate resolution of the grievance. Colorado Access must:
  - Implement mechanisms to complete the resolution of grievances, whether or not the time frame has expired.
  - Revise member resolution letters to include an appropriate explanation of the disposition of the grievance. (Letters informing members that a case is being closed because the time frame has expired are not resolutions.) Resolution letters must include a description of the results of the resolution process and the date the grievance was resolved.
  - Ensure that it resolves grievances within the required time frame, unless it is clearly in the member's best interest to extend the time frame for resolution.
- Colorado Access must correct policies and procedures and related CHP+ member and provider communications to clearly state that the 10-day requirement for filing an appeal or requesting a State fair hearing applies only when the member is requesting continuation of benefits pending the outcome of an appeal or State fair hearing.
- Colorado Access must revise inaccuracies in the Appeal Upheld letter and CHP+ EOC to clarify that the member has a right to request a State fair hearing if not satisfied with the outcome of the appeal.
- Colorado Access must develop a mechanism to ensure that appeal resolution letters are written in language that is easy for members to understand.

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: HSAG assigned all four standards to the quality domain. While HSAG identified required actions for Colorado Access in two of the four standards, the majority of those actions were related to other domains. Overall, Colorado Access did a very good job providing its members with information about the benefits of the plan and how to use them in easy-to-understand language and format. It provided a well-defined process to appeal authorization decisions. Colorado Access implemented numerous procedures to ensure that its employees, providers, and contractors followed all applicable State and federal laws as well as a robust monitoring system that protected against fraud, waste, and abuse and that maintained all corporate compliance standards.

Timeliness: Grievance system was the only standard assigned to the timeliness domain. Colorado Access had policies and procedures to ensure timely review and response to grievances and appeals, but some of these policies included inaccurate information regarding the time frames for filing appeals and State fair hearings. Also, HSAG found evidence that grievances were not always resolved within the required time frames.

Access: Colorado Access' performance in the access domain, wherein it was required to improve three areas of performance related to the access domain, was mixed. The EOC mistakenly told members that they could be disenrolled from the CHP+ program for not following doctor's orders and provided inaccurate and confusing information regarding access to the appeals and the State fair hearing processes. Also, some content in the appeal resolution letters was not written in easy-to-understand language. Left uncorrected, these issues could cause barriers to members' access to appropriate services. However, Colorado Access also maintained a robust network of qualified providers and offered numerous mechanisms to ensure that members understood services available and how to access them.

Colorado Choice Health Plan

Findings

Table 3-4 and Table 3-5 present the number of elements for each of the two 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 2014–2015.

Table 3-4—Summary of Scores for the Standards *for* Colorado Choice

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	23	23	17	6	0	0	74%
Standard VI—Grievance System	26	26	7	19	0	0	27%
Standard VII—Provider Participation and Program Integrity	17	16	11	3	2	1	69%
Standard IX—Subcontracts and Delegation	5	5	3	2	0	0	60%
Totals	**71**	**70**	**38**	**30**	**2**	**1**	**54%***

* The overall score is calculated by adding 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)
Appeals	18	18	13	5	NA	72%
Grievances	NA	NA	NA	NA	NA	NA*
Total	**18**	**18**	**13**	**5**	**NA**	**72%**

*Colorado Choice reported no grievances for calendar year 2014.

Strengths

Colorado Choice had a process in place to ensure that the member welcome packet was sent to members within a week of receiving eligibility files from the Department. The member handbook informed members that they have the right to request a member handbook or provider directory at any time and that the handbook and all member information are available in other languages and formats at no charge. The handbook also adequately addressed emergency and poststabilization services as well as access standards, advance directives, co-pays, how to obtain covered benefits and services, how to choose and change PCPs, voluntary enrollment and disenrollment, and informed members that additional information is available upon request.

Colorado Choice had processes in place both for processing grievances and appeals and for informing members of their right to a State fair hearing. Colorado Choice recently designated one

staff member to process grievances and appeals. This will increase consistency and potentially improve compliance with requirements for processing grievances and appeals. The health plan had a desktop procedure (DTP), which included some definitions, time frames, and procedural directions for staff processing grievances and appeals.

Colorado Choice had policies and procedures for the selection and retention of providers that described the intent to comply with standards and guidelines for credentialing and recredentialing delineated by NCQA. Colorado Choice provided evidence of monitoring providers and services rendered as required by the managed care contract. The Colorado Choice provider agreement addressed all required elements. Colorado Choice had processes for ensuring that contracted providers, directors, and officers of Colorado Choice had not been excluded from federal healthcare participation.

Colorado Choice had an agreement with each delegate that included the required content. Colorado Choice also provided evidence of monitoring its delegates and working with the delegates to correct deficiencies found via monitoring 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:

Standard V—Member Information

- The member handbook and other vital member materials were written at a readability level significantly higher than sixth grade. Colorado Choice must consistently use some mechanism to ensure readability and understandability of documents.
- The handbook was not readily available in Spanish. In addition, neither the member welcome letter nor annual letter informed members of availability in Spanish. Colorado Choice must have a Spanish version of the member handbook and other vital materials (such as the welcome and annual letters) available in Spanish and inform members that all vital materials are available in Spanish.
- Colorado Choice's policy did not contain key required elements related to notifying members of significant changes. Colorado Choice must revise or develop a policy that includes the procedural components, time frames, departmental responsibility, and manner in which notice will be provided to members regarding a significant change in member handbook information.
- Member handbook information regarding time frames and information related to the member's right to request that the disputed services continue during an appeal or State fair hearing must be clarified. Colorado Choice must also provide specific notice to members that assistance in filing appeals may consist of help completing forms or putting oral requests for appeals or a State fair hearing in writing and providing interpreter services.
- The member handbook stated that a member's failure to notify Colorado Choice within 48 hours of an emergency hospital admission may result in a reduction or denial of coverage. Colorado Choice must remove from all member materials language indicating that Colorado Choice would refuse to pay for emergency services based on notification requirements.

- Colorado Choice must include in its member information regarding third party liability that members must follow the third party's protocols in receiving nonemergent services.

Standard VI—Grievance System

- Colorado Choice did not have policies and procedures that fully addressed the grievance system. Pertinent elements of the grievance system that Colorado Choice must address in policy/procedure include:
  - Complete description of an action—under what circumstances members may file an appeal. Missing from the list was failure to meet the time frames for resolution of grievances and appeals and denial of the member's rights to seek out-of network services under specific circumstances described at 42CFR438.52.
  - The definition of "appeal."
  - Who has authority to file grievances, appeals, and requests for State fair hearings.
  - Who may make decisions on grievances and appeals.
  - Time frames for filing and resolving appeals and requesting State fair hearings.
  - Processes for ensuring that members follow an oral request for an appeal with a written, signed appeal.
  - How the health plan will offer and provide assistance to members filing grievances and appeals or requesting a State fair hearing.
  - All provisions and member rights associated with the grievance system, as described in 10 CCR 2505-10 §8.209.
  - Required content of appeal and grievance resolution letters.
  - Extensions for processing grievances and appeals.
  - Expedited appeal processes.
  - The continuation of previously authorized services that the health plan has proposed to terminate, suspend, or reduce via a 10-day advance notice, including the time frame for continuation of those services and effectuation and payment of such services.
- Colorado Choice must ensure that grievance resolution letters address members' specific expressions of dissatisfaction. Colorado Choice must also ensure that all appeals are addressed and notice provided within the required time frames.
- Colorado Choice must revise the member handbook as follows:
  - Clarify that members have 30 days to file an appeal, except when they are requesting continuation of previously authorized services. If a member is requesting continuation of previously authorized services, the appeal must be filed within 10 days from the notice of action (or before the intended effective date of the action).
  - Describe the types of assistance available in filing grievances and appeals.
  - Include a complete description of an action and inform members under what circumstances members may file an appeal. Missing from the list was failure to meet the time frames for resolution of grievances and appeals and denial of the member's rights to seek out-of network services under specific circumstances described at 42CFR438.52.
  - Include a complete definition of "appeal."

- Colorado Choice must ensure that all appeals are acknowledged in writing within two working days after the receipt of the appeal and that appeals are resolved with written notice sent within the required time frames.
- Colorado Choice must revise information for the provider regarding the grievance system to include:
  - Time frames and processes for filing grievances and appeals and requesting a State fair hearing.
  - Procedures related to continuation of previously authorized services that the health plan has proposed to terminate, suspend, or reduce.
  - The complete definition of "appeal."

Standard VII—Provider Participation and Program Integrity

- Colorado Choice must revise provider materials to clearly depict the accurate time frame for processing service authorization requests.
- Colorado Choice must revise the credentialing plan to include the process for notifying provider applicants of the reason for denying participation in the network.
- Colorado Choice must develop a sufficient mechanism for reporting provider terminations that may cause insufficiency in the network.
- Colorado Choice's advance directives policy indicated that information regarding advance directives was posted on the Colorado Choice website; however, no information was found on the website. Colorado Choice must either follow through with provisions for community education regarding advance directives, as stated in its policy, or revise the policy to depict Colorado Choice's practices related to community education regarding advance directives.
- Colorado Choice did not have a policy that described Colorado Choice's response when allegations of fraud are reported and pending. Colorado Choice must develop policies and procedures that describe the health plan's intent and processes for suspending payments to providers against whom there is a credible allegation of and/or investigation of a credible allegation of fraud.

Standard IX—Subcontracts and Delegation

- Colorado Choice policies stated that predelegation assessment and monitoring activities are not required for delegates that are URAC accredited. Colorado Choice must perform predelegation assessment and monitoring activities (both ongoing and formal review) for all delegates regardless of URAC accreditation status. Colorado Choice must also revise policies and procedures accordingly.
- Colorado Choice must ensure that delegates are subjected both to formal review at least annually and to ongoing monitoring between formal review cycles.

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: HSAG assigned all four standards to the quality domain. With an overall compliance score of 54 percent, Colorado Choice's performance across the four standards was poor. This poor performance was due in large part to the absence or inadequacy of written policies and procedures. CMS's definition of quality requires consideration of the organization's structural and operational characteristics. While Colorado Choice appears to provide high-quality services in a consistent manner, the absence and/or inadequacy of written policies and procedures significantly decreases its ability to ensure consistent application of its standard. Additionally, Colorado Choice must perform and document predelegation assessments as well as continual and formal monitoring of its delegates, regardless of their accreditation status. Colorado Choice must also ensure it has well-defined process for responding to allegations of fraud, abuse, and waste that meet all State and federal requirements.

Timeliness: Colorado Choice also scored poorly in the timeliness domain. This performance was, again, due in part to the absence or inadequacy of written policies and procedures It is imperative that Colorado Choice have written guidelines to ensure its members, providers, and staff know about and adhere to State- and federally mandated time frames related to grievances, appeals, and State fair hearings, processing service authorization requests, reporting provider terminations, and notifying members of significant changes.

Access: As with the quality and timeliness domain, Colorado Choice's performance in the access domain also suffered from the lack of adequate policies and procedures. Colorado Choice was required to revise its member information to ensure that it provides information in an easy-to-understand language and format. Based on prevalent languages in Colorado Choice's service area, vital member materials are required to be readily available in both English and Spanish. Adherence to this requirement helps ensure that members understand the availability of covered benefits and services and how to access them.

Denver Health Medical Plan, Inc.

Findings

Table 3-6 and Table 3-7 present the number of elements for each of the two 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 2014–2015.

Table 3-6—Summary of Scores for the Standards *for* DHMP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	29	23	21	2	0	6	91%
Standard VI—Grievance System	26	26	21	5	0	0	81%
Standard VII—Provider Participation and Program Integrity	17	17	17	0	0	0	100%
Standard IX—Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**77**	**71**	**64**	**7**	**0**	**6**	**90%***

* The overall score is calculated by adding 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)
Appeals	12	12	8	4	0	67%
Grievances	5	3	3	0	2	100%
Total	**17**	**15**	**11**	**4**	**2**	**73%**

Strengths

DHMP had policies and procedures that addressed member rights and described DHMP's processes for ensuring that members are informed of and understand their rights. The member handbook and other member materials comprehensively defined member benefits and included the information required at 42CFR438.10. The handbook described member rights, including grievance and appeals procedures, in an easy-to-understand format. The member handbook stated that member materials are available in alternative languages and formats and explained how to obtain them.

DHMP had a well-defined grievance system that included policies and procedures to address grievances, appeals, and member access to State fair hearings. Most policies and procedures were clear and included the required content and accurate time frames for standard reviews, expedited reviews, and extension processes. HSAG found ample evidence that providers and members were notified of member rights related to the grievance system.

DHMP's provider manual was comprehensive and its policies and procedures delineated contractual obligations as well as requirements for ongoing monitoring. Monitoring activities included HEDIS, performance improvement projects, and CAHPS. In addition, the Denver Health and Hospitals Authority (DHHA) Integrity Office is contracted (through a memorandum of understanding [MOU]) to conduct medical record reviews. Credentialing policies and processes were thorough, and the monitoring of provider quality and appropriateness was comprehensive and adequately reported. Physicians, employees, directors, vendors, and officers were queried monthly for suspension, exclusion, and debarment. Systems were in place to ensure compliance with provider nondiscrimination, sanctions and exclusions, and freedom to act on behalf of members. DHMP had policies for reporting adverse licensure or professional review actions, and its compliance training was thorough and occurred at all levels.

Policies and procedures related to subcontracts and delegation included the required information. HSAG found evidence of a signed, executed agreement with each delegate that also included all required provisions. The agreements also outlined a process for providing oversight and monitoring of subcontractors and delegates while maintaining ultimate responsibility of all delegated tasks.

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:

Standard V—Member Information

- DHMP must revise information in the member handbook regarding the State-level grievance review to include the address where members may send the request for the second-level grievance review by the Department.
- DHMP must revise the CHP+ member handbook to accurately reflect appointment standards.

Standard VI—Grievance System

- DHMP must revise its Drug Utilization policy/procedure to depict that the termination, suspension, or reduction of a previously authorized service (in this case, a medication) is an action.
- DHMP must develop a mechanism to ensure that CHP+ appeal resolution letters are consistently sent to members within the required 10-working-day time frame and that the letters consistently include all required elements.
- DHMP must ensure that appeal decisions are reviewed by providers with the appropriate clinical expertise and who have not been involved in a previous level of decision.
- DHMP must review applicable policies and member and provider materials to ensure that it is clear that members need only comply with timely filing requirements delineated in 42CFR438.420 if requesting the continuation of previously authorized services that the MCO is proposing to terminate, suspend, or reduce. DHMP must review policies for consistency across programs and periodically train grievance/appeal staff members specifically regarding federal regulations.

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's overall compliance score was 90 percent, which indicates a solid foundation for delivering quality services and increases the likelihood that members achieve desired health outcomes. DHMP's policies and procedures described the processes for ensuring that members understand their rights and the benefits available under their plan and how to access them. DHMP's provider manual delineated the contractual obligations, and its policies and procedures described the processes used to continually monitor delivery of services and ensure consistent provision of quality services.

Timeliness: DHMP had only two corrective actions related to the timeliness domain: its policies and procedures did not accurately describe the timely filing requirements when requesting the continuation of previously authorized services and one of only two appeals filed within the review period was not resolved within the required time frame. Otherwise, HSAG found that DHMP policies and procedures correctly delineated the required time frames; that DHMP relayed the information to its members, staff, and providers; and that DHMP staff adhered to policies and procedures. DHMP's overall performance in the timeliness domain was good.

Access: HSAG assigned Member Information, Grievance System, and Provider Participation and Program Integrity standards to the access domain. While DHMP was required to implement corrective actions that may impact members' access to services, its overall performance in these three standards was very good. DHMP provided members with clear, easy-to-understand information about the benefits available under the plan and how to access them.

Kaiser Permanente Colorado

Findings

Table 3-8 and Table 3-9 present the number of elements for each of the two 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 2014–2015.

Table 3-8—Summary of Scores for the Standards *for* Kaiser

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	23	23	12	7	4	0	52%
Standard VI—Grievance System	26	26	17	7	2	0	65%
Standard VII—Provider Participation and Program Integrity	17	16	14	1	1	1	88%
Standard IX—Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**71**	**70**	**48**	**15**	**7**	**1**	**69%***

* The overall score is calculated by adding 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)
Appeals	24	24	18	6	0	75%
Grievances	50	32	16	16	18	50%
Total	**74**	**56**	**34**	**22**	**18**	**61%**

Strengths

Kaiser's CHP+ Evidence of Coverage (EOC) provided extensive information to members about every category of benefits. Member enrollment materials were distributed timely, and Kaiser had mechanisms in place to ensure that both member notifications for significant changes in benefits and provider terminations and member requests for information were completed within required time frames. Kaiser implemented a new Member Connect department in July 2014 as an enhancement to the ongoing functions performed by the Member Services department. Member Connect was designed to provide personal, individualized assistance to members with understanding the benefits of their individual health plan, selecting a primary care provider, and registering for website access. Members were informed of the Member Connect Service Center through the Quick-Start Guide included with the member identification (ID) card mailing.

Kaiser had policies and procedures in place to guide the grievance, appeal, and State fair hearing processes. Staff documented and tracked all grievances and appeals in the MACESS software system. While Kaiser completed grievance reviews within required time frames, members were also offered a second elevated level of review if dissatisfied with the resolution. Grievances related to quality of care concerns or member experiences in a specific clinic or department were referred to those departments for investigation and necessary corrective actions. Grievance staff made an effort to verbally interact with each member about any grievance to fully understand and respond to the member's concerns. Grievance and appeal staff members assisted members with preparing written grievances, appeals, and State fair hearings—including providing access to appeals files and medical record information when requested.

All providers, whether employed or contracted with Kaiser, are subject to credentialing and recredentialing policies and procedures in accordance with NCQA standards. Providers employed and contracted with Kaiser received relevant training and were monitored for quality, appropriateness, outcomes, and compliance with medical record documentation standards. Kaiser has instituted step-by-step instructions for reporting any adverse licensure or professional review actions to the National Practitioner Data Bank and other regulatory bodies as required. Kaiser had comprehensive advance directive policies and procedures and provided its members with an advance directive guide via the member portal of the website. Kaiser had a comprehensive compliance plan with appropriate training, monitoring, and confidential reporting mechanisms in place to guard against fraud, waste, and abuse.

Kaiser had agreements with University Physicians, Inc. for sub-specialty physician credentialing, the Children's Hospital Association for the after-hours call center, and Employers Mutual, Inc., for third-party administration services for transportation claims. Kaiser provided evidence of monitoring its delegates and working with the delegates to correct deficiencies found via monitoring activities.

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:

Standard V—Member Information

- Kaiser must implement mechanisms to ensure that the CHP+ EOC is written in easy-to-understand language—a sixth-grade reading level wherever possible—and format. Kaiser must inform members that enrollment materials are available in alternative formats and languages and how to access them.
- Kaiser must implement a mechanism to notify members annually of their right to request and obtain a member handbook/EOC and other written materials specific to 438.10 (f)(6) and (g).
- Kaiser must include in the CHP+ EOC a complete listing of member rights as outlined in 42CFR438.10(f)(6)(iii).
- Kaiser must include a complaint form in the CHP+ EOC and/or provide a written reference in the handbook to a readily accessible location to obtain a complaint form on the member website.

- Kaiser must include in the CHP+ EOC a statement informing the member that complaints concerning noncompliance with the advance directive requirements may be filed with the Colorado Department of Public Health and Environment (CDPHE).
- Kaiser must address in the CHP+ EOC the extent to which and how members may obtain family planning services from out-of-network providers.
- Kaiser must remove or clarify statements in the CHP+ EOC that are in conflict with the requirements specified in 42CFR438.10(f)(6)(viii) and must clearly communicate that members may obtain emergency services from any emergency facility in or out of network without restrictions. Kaiser must also ensure that it does not set arbitrary limits on coverage or payment for emergency services if the member believes he or she has an emergency (using the prudent layperson definition).
- Kaiser must address or clarify in the CHP+ EOC the poststabilization care rules applicable to members (including the definition of poststabilization services), that Kaiser is responsible for poststabilization services, that poststabilization services end when the member is well enough to be discharged or transferred to an in-network provider, and that the member is only financially responsible for applicable copays for poststabilization services—whether in or out of network.
- Kaiser must revise the EOC to accurately describe disenrollment information per the CHP+ contract with the Department. In addition, Kaiser must communicate to members that disenrollees who wish to file a grievance are given opportunity to do so and how to access the Department concerning disenrollment.
- Kaiser must include in the CHP+ EOC additional information pertaining both to how members will be notified of any change in services or service delivery sites and member participation on the Contractor's consumer advisory committee.
- Kaiser must review and revise the third-party liability section of the EOC for compliance with the ease of understanding requirements and must include the member's responsibility to follow any protocols of a liable third-party payor prior to receiving nonemergency services.

Standard VI—Grievance System

- Seventy percent of grievance records reviewed on-site did not include written acknowledgement to the member. Kaiser must implement mechanisms to ensure that all verbal and written grievances are acknowledged in writing within two working days of receipt of the grievance.
- Five of 10 grievance records reviewed on-site did not include a written notice of resolution sent within the required time frame (four of 10 had no written notice of resolution). Kaiser must implement mechanisms to ensure that it sends a written notice of grievance resolution to the member within 15 working days of receipt of the grievance.
- Two of four appeal records reviewed on-site did not include a written acknowledgement letter sent to the member within two working days. Kaiser must ensure that a written acknowledgement of a standard appeal is sent to the member within two working days of receiving the appeal.
- All appeal records reviewed included technical contract or procedural explanations of the reason the appeal was being upheld or overturned. Kaiser must ensure that appeal resolution letters are written in easy-to-understand language, as specified in 42CFR438.10(b)(1).

- Kaiser must ensure that each appeal resolution letter for cases in which the appeal was not resolved wholly in favor of the member includes both information on how the member may request continuation of benefits during the State fair hearing and the potential liability for the cost of continued benefits should the hearing decision upholds Kaiser's action.
- Kaiser must clarify policies and member communications to accurately state that the member may request a State fair hearing within 30 calendar days from the date of the notice of action (not the date of the appeal decision) and that the 30-day time frame applies to any action, unless the member is requesting continuation of benefits during the State fair hearing.
- Kaiser must clarify policy statements and member communications to ensure that Kaiser sends the member a written notice of the denial for an expedited resolution within two calendar days of receipt of the appeal.
- Kaiser must specify that timely filing requirements for requesting continuation of benefits during an appeal or State fair hearing are defined as on or before the later of the following: within 10 days of the Contractor mailing the notice of action or the intended effective date of the proposed action.
- Kaiser must develop mechanisms to ensure that all providers are informed, at the time of contracting, of the detailed grievance and appeals information outlined in 10 CCR 2505-10, Section 8.209.3.B.

Standard VII—Provider Participation and Program Integrity

- Kaiser must develop a policy statement that it does not discriminate against any provider solely on the basis of the provider's license or certification and does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment as stated in 42CFR438.12(a)(1) and (2) and 42CFR431.214(c).
- Kaiser must develop effective processes, controls, and communications to ensure that providers will not hold Kaiser members liable for covered services as required in 42CFR428.106. When made aware of such situations, Kaiser staff must expeditiously follow up on provider compliance issues related to the Provider Agreement to ensure that members are not adversely affected by Kaiser's payment decisions based on provider's procedural noncompliance.

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 achieved 69 percent compliance across the four standards associated with the quality domain. While the majority of deficiencies were more closely related to timeliness and access than to quality, the few elements related to quality have broad implications. Ensuring that members receive easy-to-understand information about the benefits and services available under the plan and how to access those benefits and services is essential to increasing the likelihood that members will achieve their desired health outcomes. HSAG encourages Kaiser to move forward with its plan to consolidate member information into one or two documents that include all required elements written and provided in easy-to-understand language and format and to ensure that members have ready access to those materials.

Timeliness: HSAG identified several deficiencies related to the timeliness domain both in Kaiser's policies and procedures and in its provision of services. While it may be rare that a plan receives a request for the continuation of benefits during an appeal and/or State fair hearing, it is important that Kaiser accurately convey to both members and providers the circumstances and time frames required for this type of request. Additionally, while Kaiser's policies accurately described the time frames associated with grievance and appeal acknowledgment and resolution, half of the grievance records and half of the appeal records reviewed on-site did not document that an acknowledgement letter was mailed within the required time frame.

Access: The greater part of Kaiser's required actions where related to the access domain. Building and maintaining an adequate network of qualified providers is important to ensuring adequate access to services; however, it is equally important to ensure that members understand how to access the benefits and services available under the plan. As mentioned earlier, consolidating member information and ensuring that it includes all required elements written and provided in easy-to-understand language and format will help Kaiser ensure that members have ready access to its vast network of qualified providers.

Rocky Mountain Health Plans

Findings

Table 3-10 and Table 3-11 present the number of elements for each of the two 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 2014–2015.

Table 3-10—Summary of Scores for the Standards *for* RMHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	23	23	12	11	0	0	52%
Standard VI—Grievance System	26	26	20	6	0	0	77%
Standard VII—Provider Participation and Program Integrity	17	16	15	1	0	1	94%
Standard IX—Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**71**	**70**	**52**	**18**	**0**	**1**	**74%***

* The overall score is calculated by adding 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)
Appeals	60	53	51	2	7	96%
Grievances	50	30	29	1	20	97%
Total	**110**	**83**	**80**	**3**	**27**	**96%**

Strengths

RMHP made clear to members that its customer service department is available to assist with understanding and using the benefits of the CHP+ plan. RMHP's member handbook offered members information in alternative formats and included instructions for contacting RMHP using TTY equipment. RMHP reminded members throughout the handbook to call customer service for help with any questions or concerns and included the local and toll free telephone number for customer service on every page. RMHP also informed members about the importance of having a primary care provider (PCP) who is responsible to monitor the member's overall health. Although referrals for specialty services are not required, RMHP encouraged members to work with their PCP to identify when a specialist's services are needed, to choose a specialist who is in-network, and to help arrange for any necessary prior approvals.

RMHP had effective systems for processing grievances and appeals and for assisting members with access to the State's fair hearing process. RMHP communicated the grievance system processes to members via the member handbook and to providers via the provider manual. RMHP also communicated that assistance with filing grievances and appeals was available. RMHP informed members that they must follow an oral request to appeal with a written request. RMHP maintained a grievance and appeal database as well as individual grievance and appeal records, reporting grievances and appeals to the Department quarterly, as required.

RMHP had a robust credentialing and recredentialing program that included comprehensive policies and procedures effectively articulating how RMHP complies with NCQA standards and guidelines. RMHP provided evidence that provider quality, appropriateness, and medical records standards were routinely monitored at both the aggregate level and at the provider level. RMHP routinely screened its providers and employees against regulatory databases, and policies and procedures regarding incentives met the requirements. Provider services contracts were thorough, included all regulatory requirements, and applied to all applicable lines of business. The corporatewide compliance plan and related fraud and abuse policies and procedures were thorough, employee training was conducted annually, and policies related to compliance were described in the provider manual and the member handbook.

RMHP delegated credentialing and recredentialing to 15 of its physician groups; specific utilization review activities to CareCore National, LLC (CCN); and pharmacy claims processing to MedImpact (RMHP's pharmacy benefit manager [PBM]). During the review period, RMHP terminated its contract with Express Scripts, the previous PBM. RMHP provided evidence of having monitored and imposed corrective actions on Express Scripts prior to terminating the contract. RMHP provided evidence of completing a comprehensive predelegation assessment of MedImpact prior to contracting. In addition, RMHP also expanded its contract with CCN during 2014 and performed a predelegation review of CCN's capacity to provide the additional scope of work. RMHP also delegated select activities related to the provision of behavioral health services and, during the review period, changed from Life Strategies to ValueOptions (VO). RMHP provided evidence of having monitored and imposed corrective action for Life Strategies prior to terminating its contract as well as having conducted a predelegation assessment of VO prior to signing a contract. RMHP provided evidence of ongoing monitoring (joint committee processes and regular review of delegates' reporting) and formal annual audits of each delegate. RMHP had a written delegation agreement with each delegate that included the required provisions.

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:

Standard V—Member Information

- RMHP must measure the readability of its entire CHP+ benefits booklet to determine which sections do not meet the sixth-grade reading level and then revise those sections accordingly. RMHP must also review appeal resolution letters to be sure they meet the required reading level.

- RMHP must add a statement to its CHP+ benefits booklet that tells members how to access interpreter services. HSAG also suggests that RMHP notify its members that interpreter services are free.
- RMHP must specify in its policy that it will notify members of any significant change at least 30 days before the intended effective date. RMHP must remove or correct the 60-day time frame included in the benefits booklet and add language that tells members how RMHP will notify them of any change in services or service delivery sites.
- RMHP must inform members in its annual notice both that RMHP will mail them a CHP+ benefits booklet any time it is requested and that members may request the booklet by calling customer service.
- RMHP must add a statement to its benefits booklet that informs members that complaints regarding noncompliance with advance directives may be filed with the Colorado Department of Public Health and Environment.
- RMHP must state in the CHP+ benefits booklet that some providers included in the print version of the provider directory are not available to the CHP+ members.
- RMHP must revise its discussion regarding emergency medical care to include the federal definition of "emergency medical condition."
- RMHP must revise its benefits booklet to include the statement that charges to members for out-of-network poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor.
- RMHP must include in its CHP+ benefits booklet information about how to enroll in and disenroll from the CHP+ program.
- RMHP must remove from the booklet language that informs members they can be disenrolled for refusing to follow recommended treatment.
- RMHP must revise information in its member handbook related to its utilization management program to clearly identify the department within RMHP that implements the utilization management program, describe how RMHP determines medical necessity, remind members of their right to appeal decisions, and provide appropriate points of contact and telephone numbers for use by members desiring more information or having more questions.

Standard VI—Grievance System

- RMHP must review and revise all applicable policies and procedures to ensure accurate, complete, and consistent definitions of "action."
- RMHP must revise the Complaint Form used by CHP+ members to ensure that members are accurately informed of the 30-day-filing time frame for grievances.
- RMHP must ensure that acknowledgement letters are sent within two working days of receipt of the grievance.
- RMHP must revise its grievance policy to accurately reflect the description of the second-level grievance review by the Department.

- RMHP must clarify its policy to state that members have 30 days from the notice of action to request a State fair hearing (unless the health plan has provided 10-day advance notice of termination, suspension, or reduction of the previously authorized and disputed service and the member is requesting continuation of the disputed services.

Standard VII—Provider Participation and Program Integrity

- RMHP must revise its applicable policies and procedures to include the required advance directive provisions.

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: The issues RMHP encountered related to the quality domain had to do with ensuring that members receive accurate information in an easy-to-understand language and format. Additionally, RMHP needs to clarify information in its member handbook related to its utilization management program and how it determines medical necessity. Making sure members understand the benefits and services available will increase the likelihood that members achieve their desired health outcomes.

Timeliness: HSAG assigned the grievance system standard to the timeliness domain. While RMHP's score of 77 percent compliance indicates room for improvement, on-site record review scores were very good and demonstrated that, with only one exception, RMHP adheres to the time frames required for processing grievances and appeals.

Access: Most of RMHP's required corrective actions were related to missing, incomplete, or inaccurate information that could potentially impede its members' access to services. RMHP must make sure that it clearly conveys accurate information to its members, providers, and staff regarding services and benefits available under the plan and how to access those services and benefits.

State Managed Care Network

Findings

Colorado Access, as the administrative services organization for the Department of Health Care Policy & 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, the SMCN provides services to qualifying pregnant women who remain in the network through their pregnancies and do not transition into an HMO. The majority of CHP+ enrollees are members of the SMCN for only a short transitional period. The provider network for the 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 other HMO is available. Reimbursement for providers enrolled with the SMCN is via the State's fee-for-service reimbursement process. The SMCN and CHP+ HMO plans are subject to similar State CHP+ contract requirements; however, at the time of the site review, Colorado Access' SMCN contract with the Department had not been updated to require compliance with the Medicaid managed care regulations. Therefore, HSAG documented compliance with federal regulations as *Implemented*, *Partially Implemented*, *Not Implemented*, or *Not Applicable*, and did not conduct administrative record review of grievances and appeals.

Strengths

Despite the small SMCN population base, most of the processes used by Colorado Access for the CHP+ HMO also were applied to the SMCN population to the extent possible. Examples included provider contracting, provider and member communications, cultural competency and preventive services programs, and monitoring activities. When the SMCN population was too small or member characteristics were too distinct to warrant SMCN-specific activities (such as analysis of specific HEDIS measures or CAHPS results), any interventions carried out for Colorado Access' CHP+ HMO members were also applied to SMCN members. Colorado Access demonstrated its commitment to comply with federal regulations and has been diligent in aligning its SMCN policies, procedures, and activities with its CHP+ HMO activities whenever possible.

Recommendations

While scores and required actions were not assigned to the SMCN for this review, HSAG recommended that any changes to policies, templates, and processes applicable to Colorado Access' CHP+ HMO also apply to SMCN to ensure consistency between programs and to promote compliance with federal regulations.

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: Colorado Access did a good job providing SMCN members and providers with information about the benefits of the plan and how to use them in easy-to-understand language and format. It applied a well-defined process for appeal authorization decisions to SMCN members.

Colorado Access implemented numerous procedures to ensure that its employees, providers, and contractors followed all applicable State and federal laws and applied its robust monitoring system to protect against fraud, waste, and abuse to the SMCN network.

Timeliness: Grievance system was the only standard assigned to the timeliness domain. Colorado Access applied policies and procedures to ensure timely review and response to grievances and appeals to the SMCN population. Opportunities for improvement included clarification of information regarding the time frames for filing appeals and State fair hearings. Due to the limited population in the SMCN network, very few grievances and appeals are filed by members.

Access: Network Adequacy reports indicated that the provider networks statewide were adequate to meet member needs, including contracting with essential community providers, nurse midwives, and nurse practitioners. Colorado Access also offered numerous mechanisms to ensure that members understood services available and how to access them. As applicable, members were transferred expediently to an existing CHP+ HMO.

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 2014–2015 Statewide Average*
Standard V—Member Information	**72%**
Standard VI—Grievance System	**65%**
Standard VII—Provider Participation and Program Integrity	**90%**
Standard IX—Subcontracts and Delegation	**92%**
Overall Statewide Compliance Score	**75%***

* Statewide average rates were calculated by adding 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 2014–2015 Statewide Average*
Appeals	**81%**
Grievances	**75%**
Overall Statewide Score for Record Reviews	**79%***

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

Quality: HSAG assigned elements of all four standards to the Quality domain. All HMOs were compliant with credentialing providers using NCQA standards, and all HMOs had implemented

thorough systems for monitoring providers and staff to ensure program integrity and compliance with federal regulations. Performance in the quality domain was primarily impacted by the need for improved clarity of the language and format of information in the member handbook and other communications. Overall performance in the Member Information standard varied from 52 to 91 percent compliance among the five HMOs. While two of five HMOs provided comprehensive member and provider materials as required, three of five HMOs required significant improvements to ensure that member materials are written in easy-to-understand language. In addition, three of five HMOs had corrective actions related to the reading level of appeal resolution. Ensuring that members receive easy-to-understand information about the benefits and services available under the plan and how to access those benefits and services is essential to increasing the likelihood that members will achieve their desired health outcomes. One HMO had numerous deficiencies due to the absence of policies and procedures. Absence and/or inadequacy of written policies and procedures compromise the organization's structural and operational characteristics and diminish the ability to ensure consistent application of quality standards.

Timeliness: Grievance System was the only standard assigned to the timeliness domain. With an overall score of 65 percent compliance, statewide performance was poorest for this standard. All HMOs had extensive policies and procedures related to processing of grievances and appeals. However, policies and procedures and/or member communications inaccurately documented required time frames in one or more instances. All five HMOs had required actions related to the time frames for filing an appeal or State fair hearing related to reduction or termination of previously approved services associated with a request for continuation of benefits. Record reviews demonstrated that three of five HMOs failed to consistently send acknowledgement letters in the required time frame, two of five HMOs did not consistently resolve grievances within the required time frame, and two of five HMOs did not consistently send appeal resolution letters within the required time frame.

Access: HSAG assigned elements of member information, grievance system, and provider participation and program integrity standards to the access domain. All HMOs and SMCN maintained an adequate network of qualified providers to ensure adequate access to services, and two of five plans provided clear information to members regarding covered services and how to access services. However, three of five HMOs required increased clarity of member materials to ensure that members understand how to access the benefits and services available under the plan. Additionally, four of five HMOs had member communications that included erroneous or misleading statements regarding payment for services (e.g. disenrollment criteria, notification requirements, compliance with scheduled appointments) that may negatively impact a member's access to services. Three of five HMOs communicated incorrect procedures related to a member's access to appeals and State fair hearings.

Validation of Performance Measures

The Department elected to use HEDIS methodology to satisfy the CMS validation of performance measure protocol requirements, which also included an assessment of information systems (IS). For FY 2014–2015, the Department required that the CHP+ plans report a total of 23 measures. The Department allowed the health plans to use their existing auditors. Each CHP+ plan underwent an NCQA HEDIS Compliance Audit through an NCQA-licensed audit organization of its choice and submitted the audited results and audit statement to HSAG. For the SMCN, the Department did not contract with HSAG to perform an NCQA HEDIS Compliance Audit. Nonetheless, rates were calculated for the *Prenatal and Postpartum* measure. These rates, though not audited, are included in this report.

HSAG's role in validating performance measures was to ensure that the validation activities were conducted as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012 (the CMS Performance Measure Validation Protocol). Appendix B contains further details about the NCQA audit process and the methodology used to conduct the EQR validation of performance measure activities.

HSAG reviewed all final audit reports and data workbooks to identify any data issues reported by the licensed organizations during their NCQA HEDIS Compliance Audit. Each of the measures reviewed by the licensed organizations received an audit result consistent with the NCQA categories listed in Table 3-14.

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 CHP+ plans, HSAG assigned each of the performance measures to one or more of the three domains, as shown in Table 3-15. Assessments were made based on statistical comparisons between current year's rates and prior year's rates, where available, as well as on comparisons against the national Medicaid benchmarks, where appropriate. As denoted by an asterisk in Table 3-15, a

change in the Department-required data collection methodology (from hybrid to administrative) was made on four measures. While some CHP+ plans chose to report rates using hybrid methodology for the performance measures required to be reported administratively, per the Department's instructions, HSAG only reported administrative rates for these measures. Footnotes are included for instances like these.

In general, there is an impact on the CHP+ plan's overall performance on measures where the administrative-only rates are used to meet the Department-required data collection methodology. For these measures, although statistical comparisons and benchmark comparisons were made, these results may not represent the HMO's true performance and should be interpreted with caution. HSAG has noted these concerns where discussion of these results is made throughout the section.

Table 3-15—Assignment of Activities to Performance Domains

	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Pediatric Care				
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*	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Hybrid	✓		
Immunization for Adolescents	Administrative	✓	✓	
Appropriate Testing for Children With Pharyngitis	Administrative	✓		
Access to Care				
Prenatal and Postpartum Care (for SMCN population only)	Administrative*	✓	✓	✓
Children and Adolescents' Access to Primary Care Practitioners	Administrative			✓
Preventive Screening				
Non-recommended Cervical Cancer Screening in Adolescent Females	Administrative	✓		
Chlamydia Screening in Women	Administrative	✓		
Mental/Behavioral Health				
Antidepressant Medication Management	Administrative	✓		
Follow-up Care for Children Prescribed ADHD Medication	Administrative	✓	✓	
Follow-up After Hospitalization for Mental Illness	Administrative		✓	
Respiratory-Related				
Appropriate Treatment for Children With Upper Respiratory Infection	Administrative	✓		

Table 3-15—Assignment of Activities to Performance Domains				
	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Administrative	✓		
Use of Appropriate Medications for People With Asthma	Administrative	✓		
Medication Management for People With Asthma	Administrative	✓		
Asthma Medication Ratio	Administrative	✓		
Utilization				
Ambulatory Care	Administrative			✓
Inpatient Utilization—General Hospital/Acute Care	Administrative			✓
Antibiotic Utilization	Administrative			✓
Mental Health Utilization	Administrative			✓

* A change occurred in data collection methodology required by the Department from HEDIS 2014.

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. The auditor identified no notable issues during the review of the standards that had any negative impact on HEDIS reporting. The auditor had no recommendations for Colorado Access related to compliance with IS standards.[3-1]

Pediatric Care Performance Measures

Table 3-16 shows the Colorado Access rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each pediatric care performance measure.

Table 3-16—Review Audit Results for Pediatric Care Performance Measures *for* Colorado Access				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Childhood Immunization Status[2]				
Combination 2	72.51%	**63.37%**[2]	10th–24th	R
Combination 3	68.61%	**61.76%**[2]	10th–24th	R
Combination 4	61.31%	**55.21%**[2]	10th–24th	R
Combination 5	59.37%	**52.81%**[2]	25th–49th	R

[3-1] NCQA HEDIS Compliance Audit, Final Audit Report, Colorado Access, July 2015.

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

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Combination 6	49.64%	**42.91%**[2]	50th–74th	R
Combination 7	54.50%	**47.59%**[2]	25th–49th	R
Combination 8	45.50%	**39.30%**[2]	25th–49th	R
Combination 9	44.04%	**37.43%**[2]	50th–74th	R
Combination 10	41.12%	**34.36%**[2]	50th–74th	R
Well-Child Visits in the First 15 Months of Life				
*Zero Visits***	2.19%	1.33%[3]	25th–49th	R
Six or More Visits	70.80%	**62.83%**[3]	25th–49th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.35%	65.85%[4]	10th–24th	R
Adolescent Well-Care Visits	43.80%	42.49%[5]	25th–49th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	61.56%	**50.12%**	25th–49th	R
Counseling for Nutrition: Total	61.31%	**52.80%**	25th–49th	R
Counseling for Physical Activity: Total	53.28%	48.66%	25th–49th	R
Immunizations for Adolescents—Combination 1	64.96%	64.35%[6]	25th–49th	R
Appropriate Testing for Children with Pharyngitis	76.78%	77.64%	50th–74th	R

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was hybrid for HEDIS 2014 and was administrative for HEDIS 2015.

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2015. Colorado Access reported HEDIS 2015 hybrid rates of 69.10 percent, 67.40 percent, 59.37 percent, 58.15 percent, 48.66 percent, 51.58 percent, 44.77 percent, 42.58 percent, and 39.17 percent for the *Childhood Immunization Status—Combination 2* through *Combination 10* indicators, respectively.

[3] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2015. Colorado Access reported the HEDIS 2015 hybrid rate of 1.33 percent (same as the administrative rate) and 72.12 percent for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits* indicators, respectively.

[4] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. Colorado Access reported the HEDIS 2015 hybrid rate of 68.68 percent for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

[5] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. Colorado Access reported the HEDIS 2015 hybrid rate of 50.61 percent for *Adolescent Well-Care Visits*.

[6] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. Colorado Access reported the HEDIS 2015 hybrid rate of 66.58 percent for *Immunizations for Adolescents—Combination 1*.

Strengths

All performance measures in this domain received an audit result of *Reportable (R)* for HEDIS 2015. HSAG identified no measures with significant improvement from last year or performing above the national HEDIS Medicaid 90th percentile.

Recommendations

Many measures in this domain reported a significant rate decline from HEDIS 2014, due in part to Colorado Access using the administrative-only rates to meet the Department's data collection requirement. Although statistical tests were not performed, Colorado Access' final hybrid rates were lower than last year's rates. As such, HSAG recommends that Colorado Access monitor its performance on the *Childhood Immunizations* measure to determine if interventions are warranted. All well-child visits rates were below the federal Early and Periodic Screening Diagnosis, and Treatment (EPSDT) mandate of 80 percent; therefore, HSAG recommends that Colorado Access focus its efforts on improving this area. For those measures with the same data collection requirement in both years, all indicators under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* declined more than five percentage points each. HSAG also recommends that Colorado Access focuses its effort toward improving this measure.

Access to Care and Preventive Screening Performance Measures

Table 3-17 shows the Colorado Access rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Access to Care* and *Preventive Screening* performance measure.

Table 3-17—Review Audit Results for Access to Care and Preventive Screening Performance Measures *for* Colorado Access

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	92.78%	**96.66%**	25th–49th	R
Ages 25 Months to 6 Years	84.27%	85.23%	10th–24th	R
Ages 7 to 11 Years	89.96%	**92.71%**	50th–74th	R
Ages 12 to 19 Years	88.18%	**92.29%**	75th–89th	R
Preventive Screening				
*Non-recommended Cervical Cancer Screening in Adolescent Females***	—	0.66%	<10th	R
Chlamydia Screening in Women—Total	—	31.08%	<10th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year.
— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
** 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).
[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

All performance measures in both access to care and preventive screening domains received an audit result of *Reportable (R)* for HEDIS 2015. All the rates from *Children's and Adolescents' Access to Primary Care Practitioners* increased from last year, three of which were statistically significant improvement. For the *Non-recommended Cervical Cancer Screening in Adolescent Females* measure, since a low rate reflects better performance, Colorado Access' performance was within the top 10 percentiles of all HMO rates nationally.

Recommendations

Colorado Access had no measures showing a statistically significant rate decline. However, the *Chlamydia Screening in Women—Total* rate was below the national HEDIS Medicaid 10th percentile, and the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* rate was below the 25th percentile. These two indicators present opportunities for improvement.

Mental/Behavioral Health Performance Measures

Table 3-18 shows the Colorado Access rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Mental/Behavioral Health* performance measure.

Table 3-18—Review Audit Results for Mental/Behavioral Health Performance Measures *for* Colorado Access

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	NA	—	NA
Effective Continuation Phase Treatment	—	NA	—	NA
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	0.55%	**43.59%**	50th–74th	R
Continuation	0.00%	**43.33%**	25th–49th	R
Follow-up After Hospitalization for Mental Illness				
30-Day	—	68.27%	50th–74th	R
7-Day	—	47.12%	50th–74th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year.

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Two of the three performance measures in this domain received an audit result of Reportable (R) for HEDIS 2015. Both indicators under *Follow-up Care for Children Prescribed ADHD Medication* reported statistically significant improvement. The rates from this measure increased more than 40 percentage points from last year. When compared to national benchmarks, no measures in this domain performed above the 90th percentile.

Recommendations

Colorado Access had no measures showing a statistically significant rate decline, and none were below the national HEDIS Medicaid 25th percentile.

Respiratory-Related Performance Measures

Table 3-19 shows the Colorado Access rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each respiratory-related performance measure. Colorado Access chose not to report the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure.

Table 3-19—Review Audit Results for Respiratory-Related Performance Measures *for* Colorado Access

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Appropriate Treatment for Children With Upper Respiratory Infection	—	90.84%	50th–74th	R
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	NR	—	NR
Use of Appropriate Medications for People With Asthma—Total	—	94.20%	≥90th	R
Medication Management for People With Asthma—Total (Medication Compliance 50%)	—	42.65%	<10th	R
Medication Management for People With Asthma—Total (Medication Compliance 75%)	—	18.48%	<10th	R
Asthma Medication Ratio—Total	77.61%	76.79%	≥90th	R

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NR is shown because Colorado Access chose not to report the measure.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

All but one of the performance measures in this domain received an audit result of *Reportable (R)* for HEDIS 2015. Two (*Use of Appropriate Medications for People With Asthma—Total* and *Asthma Medication Ratio—Total)* were at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Colorado Access had no measures showing a statistically significant rate decline. However, both *Medication Management for People With Asthma—Total* measure indicators were below the national HEDIS Medicaid 10th percentile, presenting opportunities for improvement. Based on Colorado Access' excellent performance on the other two asthma-related measures (*Use of Appropriate Medications for People With Asthma—Total* and *Asthma Medication Ratio—Total)*, HSAG recommends that Colorado Access focus on encouraging asthmatic members' medication compliance.

Use of Services Observations

Table 3–20 shows the Colorado Access rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Use of Services* performance measure. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2014 and 2015 may not denote actual improvement or a decline in performance. Percentile rankings are presented for information only.

Table 3–20—Review Audit Results for Use of Services Measures *for* Colorado Access

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Ambulatory Care: Total (Per 1,000 MM)				
Outpatient Visits	239.95	222.16	<10th	R
Emergency Department Visits	30.97	30.08	<10th	R
Inpatient Utilization—General Hospital/Acute Care: Total				
Discharges per 1,000 MM (total inpatient)	1.42	1.42	<10th	R
Days per 1,000 MM (total inpatient)	5.22	4.75	<10th	R
Average Length of Stay (total inpatient)	3.68	3.33	25th–49th	R
Discharges per 1,000 MM (medicine)	0.97	1.09	<10th	R
Days per 1,000 MM (medicine)	2.85	2.82	<10th	R
Average Length of Stay (medicine)	2.93	2.58	<10th	R
Discharges per 1,000 MM (surgery)	0.33	0.23	<10th	R
Days per 1,000 MM (surgery)	2.10	1.67	<10th	R
Average Length of Stay (surgery)	6.34	7.27	50th–74th	R
Discharges per 1,000 MM (maternity)	0.25	0.23	<10th	R
Days per 1,000 MM (maternity)	0.61	0.57	<10th	R
Average Length of Stay (maternity)	2.44	2.51	25th–49th	R
Antibiotic Utilization				
Average Scrips for PMPY for Antibiotics (All Ages)	—	0.63	<10th	R
Average Days Supplied per Antibiotic Scrip (All Ages)	—	10.50	≥90th	R

Table 3–20—Review Audit Results for Use of Services Measures *for* Colorado Access				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.25	<10th	R
Percentage of Antibiotics of Concern of All Antibiotic Scrips (All Ages)	—	39.05%	25th–49th	R
Mental Health Utilization: Total				
Any Services	—	6.60%	10th–24th	R
Inpatient	—	0.35%	10th–24th	R
Intensive Outpatient/Partial Hospitalization	—	2.65%	≥90th	R
Outpatient/ED	—	5.36%	10th–24th	R

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

MM means member months.

PMPY means per member, per year.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Reported rates in the use of service domain did not take into account the characteristics of the population; therefore, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics each health plan's utilization results provide additional information that the health plans may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of Colorado Access' performance measure results related to the domains of quality, timeliness, and access. Measures with significant declines or low percentile rankings presented opportunities for improvement.

Quality: Colorado Access' performance from the 16 quality-related measures was mixed. The majority of measures had no rate change from last year. Both indicators from the *Follow-up Care for Children Prescribed ADHD Medication* measure increased significantly from last year by more than 40 percentage points, suggesting major improvement. Nonetheless, three measures had at least one rate decline significantly. Declines were found in *Childhood Immunization Status*, *Well-Child Visits in the First 15 Months of Life*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*. When compared to national benchmarks, Colorado Access' performance was diverse. Four measures had at least one rate ranked below the national 25th percentile, and three ranked at or above the 90th percentile. Significant rate decline or low percentile ranking noted in the immunization and well-child visit measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent Colorado Access' true performance.

Timeliness: Colorado Access' performance from the seven timeliness-related measures was mixed. Both indicators from the *Follow-up Care for Children Prescribed ADHD Medication* measure increased significantly from last year by more than 40 percentage points, suggesting major improvement. Two measures (*Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life)* had at least one rate decline significantly. When compared to national benchmarks, Colorado Access had no measures performing above the national 90th percentile. Two measures had at least one rate ranked below the national 25th percentile. Significant rate decline or low percentile ranking noted in the immunization and well-child visits measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent Colorado Access' true performance.

Access: Of the five access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. Three indicators under *Children's and Adolescents' Access to Primary Care Practitioners* had significant rate increase from the previous year, suggesting performance improvement. Nonetheless, one age group (*25 Months to 6 Years*) was below the 25th percentile. Utilization-based measures are not risk-adjusted; therefore, Colorado Access' rates reported for these measures should be for information only.

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]

Pediatric Care Performance Measures

Table 3-21 shows the Colorado Choice rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each pediatric care performance measure.

Table 3-21—Review Audit Results for Pediatric Care Performance Measures *for* Colorado Choice

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Childhood Immunization Status				
Combination 2	NA	NA	—	NA
Combination 3	NA	NA	—	NA
Combination 4	NA	NA	—	NA
Combination 5	NA	NA	—	NA

[3-2] NCQA HEDIS Compliance Audit, Final Audit Report, Colorado Choice, July 2015.

Table 3-21—Review Audit Results for Pediatric Care Performance Measures *for* Colorado Choice				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Combination 6	NA	NA	—	NA
Combination 7	NA	NA	—	NA
Combination 8	NA	NA	—	NA
Combination 9	NA	NA	—	NA
Combination 10	NA	NA	—	NA
Well-Child Visits in the First 15 Months of Life				
*Zero Visits***	NA	NA	—	NA
Six or More Visits	NA	NA	—	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	57.98%	48.92%[2]	<10th	R
Adolescent Well-Care Visits	37.02%	33.46%[3]	<10th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	39.52%	35.00%	10th–24th	R
Counseling for Nutrition: Total	29.94%	36.00%	<10th	R
Counseling for Physical Activity: Total	35.93%	40.00%	10th–24th	R
Immunizations for Adolescents—Combination 1	25.81%	26.32%[4]	<10th	R
Appropriate Testing for Children With Pharyngitis	57.14%	63.49%	25th–49th	R

Note: Measures shaded in blue with a black font indicate that the data collection methodology was hybrid for HEDIS 2014 and was administrative for HEDIS 2015.

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] Per the Department's required data collection methodology, the HEDIS 2015 rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. Colorado Choice's HEDIS 2015 hybrid rate was 51.80 percent for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

[3] The Department's required data collection methodology, the HEDIS 2015 rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. Colorado Choice's HEDIS 2015 hybrid rate was 36.09 percent for *Adolescent Well-Care Visits*.

[4] The Department's required data collection methodology, the HEDIS 2015 rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. Colorado Choice's HEDIS 2015 hybrid rate was 42.11 percent for *Immunizations for Adolescents—Combination 1*.

Strengths

HSAG identified no measures in this category with either significant performance improvement or performing at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Colorado Choice's performance was poorest in the pediatric care domain. No HEDIS 2015 rates were at or above the national HEDIS Medicaid 50th percentile. All but one measure with an audit result of *Reportable (R)* performed below the national 10th percentile. Although the Department's data collection requirement to report administrative-only rates for these measures may contribute to this low performance, Colorado Choice's performance in this domain was generally low, suggesting tremendous opportunities for improvement. Additionally, well-child visits rates were below the federal EPSDT mandate of 80 percent; therefore, HSAG recommends that Colorado Choice focus its efforts on improving this area.

Access to Care and Preventive Screening Performance Measures

Table 3-22 shows the Colorado Choice rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Access to Care* and *Preventive Screening* performance measure.

Table 3-22—Review Audit Results for Access to Care and Preventive Screening Performance Measures *for* Colorado Choice

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	NA	NA	—	NA
Ages 25 Months to 6 Years	76.87%	73.86%	<10th	R
Ages 7 to 11 Years	88.89%	83.13%	<10th	R
Ages 12 to 19 Years	91.27%	92.86%	75th–89th	R
Preventive Screening				
*Non-recommended Cervical Cancer Screening in Adolescent Females***	—	4.08%	25th–49th	R
Chlamydia Screening in Women—Total	—	NA	—	NA

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Colorado Choice had an audit result of *Reportable (R)* for all but one measure in this domain. HSAG identified no measures either with significant performance improvement or performing at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Two of the three reportable rates from *Children and Adolescents' Access to Primary Care Practitioners* were below the national HEDIS Medicaid 10th percentiles. These measures presented opportunities for improvement for Colorado Choice.

Mental/Behavioral Health Performance Measures

Table 3-23 shows that two of the three measures in this domain were first-year measures for required reporting. Due to small denominators, Colorado Choice was unable to publicly report any measures. Percentile ranking could not be provided. HSAG recommends that Colorado Choice investigate the reasons behind the small number of members identified as the eligible population for these measures.

Table 3-23—Review Audit Results for Mental/Behavioral Health Performance Measures *for* Colorado Choice

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	NA	—	NA
Effective Continuation Phase Treatment	—	NA	—	NA
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	NA	NA	—	NA
Continuation	NA	NA	—	NA
Follow-up After Hospitalization for Mental Illness				
30-Day	—	NA	—	NA
7-Day	—	NA	—	NA

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Respiratory-Related Performance Measures

Table 3-24 shows the Colorado Choice rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each respiratory-related performance measure. Colorado Choice was unable to report rates for all but one measure due to small denominators. HSAG recommends that Colorado Choice investigate the reasons behind the small number of members identified as the eligible population for these measures. *Appropriate Treatment for Children With Upper Respiratory Infection* performed below the national HEDIS Medicaid 50th percentile.

Table 3-24—Review Audit Results for Respiratory-Related Performance Measures *for* Colorado Choice				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Appropriate Treatment for Children With Upper Respiratory Infection	—	81.72%	25th–49th	R
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	NA	—	NA
Use of Appropriate Medications for People With Asthma—Total	—	NA	—	NA
Medication Management for People With Asthma—Total (Medication Compliance 50%)	—	NA	—	NA
Medication Management for People With Asthma—Total (Medication Compliance 75%)	—	NA	—	NA
Asthma Medication Ratio—Total	NA	NA	—	NA

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Use of Services Observations

Table 3-25 shows the Colorado Choice rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Use of Services* performance measure. The reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2014 and 2015 may not denote actual improvement or a decline in performance. Percentile rankings are presented for information only.

Table 3-25—Review Audit Results for Use of Services Measures *for* Colorado Choice				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Ambulatory Care: Total (Per 1,000 MM)				
Outpatient Visits	189.86	206.36	<10th	R
Emergency Department Visits	19.09	22.59	<10th	R
Inpatient Utilization—General Hospital/Acute Care: Total				
Discharges per 1,000 MM (total inpatient)	1.06	0.77	<10th	R
Days per 1,000 MM (total inpatient)	2.89	1.60	<10th	R
Average Length of Stay (total inpatient)	2.74	2.08	<10th	R
Discharges per 1,000 MM (medicine)	0.39	0.47	<10th	R
Days per 1,000 MM (medicine)	1.28	1.25	<10th	R
Average Length of Stay (medicine)	3.29	2.63	<10th	R

Table 3-25—Review Audit Results for Use of Services Measures *for* Colorado Choice				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Discharges per 1,000 MM (surgery)	0.39	0.24	<10th	R
Days per 1,000 MM (surgery)	1.28	0.30	<10th	R
Average Length of Stay (surgery)	3.29	1.25	<10th	R
Discharges per 1,000 MM (maternity)	0.23	0.00	<10th	R
Days per 1,000 MM (maternity)	0.35	0.00	<10th	R
Average Length of Stay (maternity)	1.50	0.00	<10th	R
Antibiotic Utilization				
Average Scrips for PMPY for Antibiotics (All Ages)	—	0.61	<10th	R
Average Days Supplied per Antibiotic Scrip (All Ages)	—	6.39	<10th	R
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.27	<10th	R
Percentage of Antibiotics of Concern of All Antibiotic Scrips (All Ages)	—	44.84%	75th–89th	R
Mental Health Utilization: Total				
Any Services	—	3.98%	10th–24th	R
Inpatient	—	0.14%	<10th	R
Intensive Outpatient/Partial Hospitalization	—	1.78%	75th–89th	R
Outpatient/ED	—	3.98%	10th–24th	R

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Reported rates in the use of service domain did not take into account the characteristics of the population; therefore, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics each health plan's utilization results provide additional information that the health plans may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of Colorado Choice's performance measure results related to the domains of quality, timeliness, and access. Measures with significant declines or low percentile rankings presented opportunities for improvement.

Quality: Of the 16 quality-related measures, nine had a denominator too small (less than 30) to allow for public reporting. Performance assessment in this domain could only be determined based on the remaining

seven measures. Of these measures, none had any significant improvement or decline from last year. Four had at least one indicator ranking below the national HEDIS Medicaid 25th percentile. Only one measure was at or above the 50th percentile. Low percentile ranking noted in the well-child visit measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent Colorado Choice's true performance.

Timeliness: Of the seven timeliness-related measures, four had a denominator too small (less than 30) to allow for public reporting. Performance assessment in this domain could only be determined based on the remaining three measures. Of these measures, none had any significant improvement or decline from last year. All were below the national HEDIS Medicaid 10th percentile. Low percentile ranking noted in the well-child visit measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent Colorado Choice's true performance.

Access: Of the five access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. Performance for the *Children's and Adolescents' Access to Primary Care Practitioners* measure was quite diverse. The two younger age groups were below the national HEDIS Medicaid 10th percentile, while one other age group was above the 75th percentile. The utilization-based measures are not risk-adjusted; therefore, Colorado Choice's rates reported for these measures should be for information only.

Denver Health Medical Plan, Inc.

Compliance with Information Systems (IS) Standards

According to the NCQA HEDIS Compliance Audit Report,[3-3] DHMP was fully compliant with all but the following IS standards:

- IS 5.1 and 5.2 (Substantial compliance for both): The supplemental data source containing blood pressure data was not allowed. Other data sources had to be corrected. No other adverse impact on HEDIS was identified.
- IS 7.2 (Noncompliance) and 7.3 (Substantial compliance): Significant issues were experienced throughout the reporting cycle. Inpatient Utilization (IPU) and Ambulatory Care (AMB) measures were not reportable for the Medicaid product.

The auditor noted that DHMP had significant, continuing, and repetitive problems with data extraction and mapping into their calculation vendor's HEDIS reporting software. Due to a large conversion in the information technology (IT) department, there were no IT resources assigned to manage the HEDIS reporting project until February 2015. The lack of resources caused major delay in achieving multiple HEDIS project milestones (completing the hybrid sampling process and auditor's review of the convenience sample). Subsequently, DHMP adjusted its reporting strategy by removing some measures from hybrid pursuit to rotation. Although DHMP was able to report

[3-3] NCQA HEDIS Compliance Audit, Final Audit Report, Denver Health Medical Plan, Inc., July 2015.

almost a full measure set, the auditor recommended early extensive testing of the extraction and mapping processes into the calculation vendor's software.

The auditor also noted that the supplemental data sources extracted from Denver Health Care electronic medical record (EMR) systems contained a large amount of extraneous information with inadequate and incorrect documentation. More specifically, the documented mapping for the Blood Pressure extract was incorrect. Consequently, this data source was disapproved by the auditor for reporting. The auditor recommended that data extracts from the EMR be a more restricted set (e.g., the body mass index [BMI] extract contains only records necessary for the BMI values). Another recommendation related to the development of clear business requirements used to verify the accuracy of the extraction and mapping.

Pediatric Care Performance Measures

Table 3-26 shows the DHMP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each pediatric care performance measure.

Table 3-26—Review Audit Results for Pediatric Care Performance Measures *for* DHMP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Childhood Immunization Status				
Combination 2	89.33%	**68.91%**[2]	10th–24th	R
Combination 3	89.33%	**68.91%**[2]	25th–49th	R
Combination 4	89.33%	**68.91%**[2]	50th–74th	R
Combination 5	81.33%	**63.87%**[2]	50th–74th	R
Combination 6	76.00%	**52.10%**[2]	75th–89th	R
Combination 7	81.33%	**63.87%**[2]	75th–89th	R
Combination 8	76.00%	**52.10%**[2]	75th–89th	R
Combination 9	68.00%	**49.58%**[2]	75th–89th	R
Combination 10	68.00%	**49.58%**[2]	75th–89th	R
Well-Child Visits in the First 15 Months of Life				
*Zero Visits***	2.22%	4.00%[3]	75th–89th	R
Six or More Visits	62.22%	**4.00%**[3]	<10th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.15%	**48.52%**[3]	<10th	R
Adolescent Well-Care Visits	48.91%	**34.84%**[3]	<10th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	93.67%	90.27%	≥90th	R
Counseling for Nutrition: Total	79.32%	78.59%	≥90th	R
Counseling for Physical Activity: Total	66.67%	62.77%	75th–89th	R

Table 3-26—Review Audit Results for Pediatric Care Performance Measures *for* DHMP				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Immunizations for Adolescents—Combination 1	90.16%	**73.39%**[4]	50th–74th	R
Appropriate Testing for Children With Pharyngitis	84.21%	68.75%	50th–74th	R

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was hybrid for HEDIS 2014 and was administrative for HEDIS 2015.

R is shown when the rate was reportable, according to NCQA standards.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] The Department's required data collection methodology, the HEDIS 2015 rates displayed reflect administrative data only and are not the final, reported hybrid rates in the plan-submitted files. DHMP reported the HEDIS 2015 hybrid rate of 78.81 percent, 78.81 percent, 77.97 percent, 72.88 percent, 59.32 percent, 72.03 percent, 59.32 percent, 56.78 percent, and 56.78 percent for *Childhood Immunization Status—Combination 2 through 10*, respectively.

[3] The Department's required data collection methodology for the *Well-Child Visits in the First 15 Months of Life*, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, and *Adolescents Well-Care Visits* measures in HEDIS 2015 was administrative. DHMP followed this requirement; the rates displayed here were the HMO's final rates.

[4] The Department's required data collection methodology, the HEDIS 2015 rates displayed reflect administrative data only and are not the final, reported hybrid rates in the plan-submitted files. DHMP reported the HEDIS 2015 hybrid rate of 82.57 percent for *Immunizations for Adolescents—Combination 1*.

Strengths

All of DHMP's performance measures in this domain received an audit result of *Reportable (R)* for HEDIS 2015. Two rates under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* were at or above the national HEDIS Medicaid 90th percentiles.

Recommendations

Due to the continued challenge in capturing accurate membership data, the auditor recommended that DHMP focus on working with the Department to improve the quality of the data and the reconciliation process at the State level.

Many measures in this domain declined significantly from last year and ranked below the national Medicaid 25th percentile. Nonetheless, these findings may be attributed to using the administrative-only rates to meet the Department's data collection requirement and may not represent DHMP's true performance. For the *Childhood Immunization Status* measure, DHMP used the hybrid methodology to calculate its final rates. Although statistical tests were not performed to compare with the prior year's results, the final, hybrid rates were lower than the prior year's rates. HSAG recommends that DHMP monitor its performance in this measure to determine if additional interventions are warranted. All well-child visits rates were below the federal EPSDT mandate of 80 percent; therefore, HSAG recommends that DHMP focus its efforts on improving this area. For measures with the same data collection requirement in both years, the *Immunizations for Adolescents—Combination 1* and *Appropriate Testing for Children With Pharyngitis* rates declined

by more than 10 percentage points. The decline in *Immunizations for Adolescents—Combination 1* was statistically significant and also presented opportunities for improvement.

Access to Care and Preventive Screening Performance Measures

Table 3-27 shows the DHMP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Access to Care* and *Preventive Screening* performance measure.

Table 3-27—Review Audit Results for Access to Care and Preventive Screening Performance Measures *for* DHMP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	86.61%	89.29%	<10th	R
Ages 25 Months to 6 Years	74.84%	**58.02%**	<10th	R
Ages 7 to 11 Years	84.35%	81.33%	<10th	R
Ages 12 to 19 Years	87.68%	83.70%	10th–24th	R
Preventive Screening				
*Non-recommended Cervical Cancer Screening in Adolescent Females***	—	0.00%	<10th	R
Chlamydia Screening in Women—Total	—	45.65%	10th–24th	R

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year.

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

The auditor noted that DHMP had used its HEDIS reports to monitor overall progress toward the measures and to improve care. All of DHMP's performance measures in this domain received an audit result of *Reportable (R)* for HEDIS 2015. For the *Non-recommended Cervical Cancer Screening in Adolescent Females* measure, since a lower rate reflects better performance, DHMP's performance was within the top 10 percentiles of all HMO rates nationally.

Recommendations

All measures but *Non-recommended Cervical Cancer Screening in Adolescent Females* showed rate declines from HEDIS 2014 and were below the national HEDIS Medicaid 25th percentile; therefore, DHMP had many opportunities to improve in this domain.

Mental/Behavioral Health Performance Measures

Table 3-28 shows that two of the three measures in this domain were first-year measures for required reporting. Due to small denominators, DHMP was unable to publicly report any of the measures and percentile ranking could not be provided. HSAG recommends that DHMP investigate the reasons behind the small number of members identified as eligible population for these measures.

Table 3-28—Review Audit Results for Mental/Behavioral Health Performance Measures *for* DHMP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	NA	—	NA
Effective Continuation Phase Treatment	—	NA	—	NA
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	NA	NA	—	NA
Continuation	NA	NA	—	NA
Follow-up After Hospitalization for Mental Illness				
30-Day	—	NA	—	NA
7-Day	—	NA	—	NA

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Respiratory-Related Performance Measures

Table 3-29 shows the DHMP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each respiratory-related performance measure.

Table 3-29—Review Audit Results for Respiratory-Related Performance Measures *for* DHMP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Appropriate Treatment for Children With Upper Respiratory Infection	—	97.42%	≥90th	R
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	NA	—	NA
Use of Appropriate Medications for People With Asthma—Total	—	NA	—	NA
Medication Management for People With Asthma—Total (Medication Compliance – 50%)	—	NA	—	NA

Table 3-29—Review Audit Results for Respiratory-Related Performance Measures *for* DHMP				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Medication Management for People With Asthma—Total (Medication Compliance – 75%)	—	NA	—	NA
Asthma Medication Ratio—Total	NA	NA	—	NA

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Only one measure (*Appropriate Treatment for Children With Upper Respiratory Infection*) in this domain received an audit result of *Reportable (R)* for HEDIS 2015 reporting. This measure performed above the national HEDIS Medicaid 90th percentile.

Recommendations

DHMP was unable to report rates for the other measures due to small denominators. HSAG recommends that DHMP investigate the reasons behind the small number of members identified as the eligible population for these measures.

Use of Services Observations

Table 3-30 shows the DHMP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Use of Services* performance measure. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2014 and 2015 may not denote actual improvement or a decline in performance. Percentile rankings are presented for information only.

Table 3-30—Review Audit Results for Use of Services Measures *for* DHMP				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Ambulatory Care: Total (Per 1,000 MM)				
Outpatient Visits	111.45	110.22	<10th	R
Emergency Department Visits	29.68	25.06	<10th	R
Inpatient Utilization—General Hospital/Acute Care: Total				
Discharges per 1,000 MM (total inpatient)	1.01	1.18	<10th	R
Days per 1,000 MM (total inpatient)	2.72	3.60	<10th	R
Average Length of Stay (total inpatient)	2.70	3.04	10th–24th	R

Table 3-30—Review Audit Results for Use of Services Measures *for* DHMP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Discharges per 1,000 MM (medicine)	0.81	0.80	<10th	R
Days per 1,000 MM (medicine)	2.17	1.85	<10th	R
Average Length of Stay (medicine)	2.68	2.31	<10th	R
Discharges per 1,000 MM (surgery)	0.17	0.33	<10th	R
Days per 1,000 MM (surgery)	0.46	1.65	<10th	R
Average Length of Stay (surgery)	2.73	4.95	10th–24th	R
Discharges per 1,000 MM (maternity)	0.07	0.11	<10th	R
Days per 1,000 MM (maternity)	0.20	0.22	<10th	R
Average Length of Stay (maternity)	3.00	2.00	<10th	R
Antibiotic Utilization				
Average Scrips for PMPY for Antibiotics (All Ages)	—	0.13	<10th	R
Average Days Supplied per Antibiotic Scrip (All Ages)	—	10.61	≥90th	R
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.04	<10th	R
Percentage of Antibiotics of Concern of All Antibiotic Scrips (All Ages)	—	28.90%	<10th	R
Mental Health Utilization: Total				
Any Services	—	2.40%	<10th	R
Inpatient	—	0.14%	<10th	R
Intensive Outpatient/Partial Hospitalization	—	0.08%	25th–49th	R
Outpatient/ED	—	2.36%	<10th	R

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Reported rates in the use of service domain did not take into account the characteristics of the population; therefore, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics each health plan's utilization results provide additional information that the health plans may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of DHMP's performance measure results related to the domains of quality, timeliness, and access. Measures with significant declines or low percentile rankings presented opportunities for improvement.

Quality: Of the 16 quality-related measures, six had a denominator too small (less than 30) to allow for public reporting. Performance assessment in this domain could only be determined based on the remaining ten measures. Of these measures, five had at least one indicator with statistically significant rate decline from last year. These were immunization and well-child visits measures. Compared to national benchmarks, DHMP's performance was diverse. Three measures were above the national 90th percentiles, but five were below the national HEDIS Medicaid 25th percentiles. Nonetheless, significant rate decline or low percentile ranking noted in the immunization and well-child visits measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent DHMP's true performance.

Timeliness: Of the seven timeliness-related measures, two had a denominator too small (less than 30) to allow for public reporting. Performance assessment in this domain could only be determined based on the remaining five measures. All these measures had at least one indicator with significant rate decline from last year. Compared to national benchmarks, DHMP's performance was poor. Four of the five measures were also below the national HEDIS Medicaid 25th percentile. Nonetheless, significant rate decline or low percentile ranking noted in the immunization and well-child visits measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent DHMP's true performance.

Access: Of the five access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. Within the *Children's and Adolescents' Access to Primary Care Practitioners* measure, the *25 Months to 6 Years* age group declined significantly from last year. Additionally, the entire *Children's and Adolescents' Access to Primary Care Practitioners* measure was below the national HEDIS Medicaid 25th percentile. Utilization-based measures are not risk-adjusted; therefore, DHMP's rates reported for these measures should be for information only.

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. The auditor had no recommendations for Kaiser related to compliance with IS standards. [3-4]

Pediatric Care Performance Measures

Table 3-31 shows the Kaiser rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each pediatric care performance measure.

Table 3-31—Review Audit Results for Pediatric Care Performance Measures *for* Kaiser

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Childhood Immunization Status				
Combination 2	85.29%	78.62%[2]	50th–74th	R
Combination 3	84.31%	77.36%[2]	50th–74th	R
Combination 4	84.31%	76.73%[2]	75th–89th	R
Combination 5	68.63%	59.12%[2]	50th–74th	R
Combination 6	59.80%	52.83%[2]	75th–89th	R
Combination 7	68.63%	59.12%[2]	50th–74th	R
Combination 8	59.80%	52.83%[2]	75th–89th	R
Combination 9	51.96%	41.51%[2]	50th–74th	R
Combination 10	51.96%	41.51%[2]	50th–74th	R
Well-Child Visits in the First 15 Months of Life				
*Zero Visits***	0.00%[3]	0.00%[3]	<10th	R
Six or More Visits	51.92%[3]	**72.88%**[3]	75th–89th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.02%[3]	**60.93%**[3]	10th–24th	R
Adolescent Well-Care Visits	49.78%	**42.02%**[3]	25th–49th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	90.74%	91.24%	≥90th	R
Counseling for Nutrition: Total	90.74%	**98.54%**	≥90th	R
Counseling for Physical Activity: Total	90.74%	**98.30%**	≥90th	R

[3-4] NCQA HEDIS Compliance Audit, Final Audit Report, Kaiser Foundation Health Plan of Colorado, July 2015.

Table 3-31—Review Audit Results for Pediatric Care Performance Measures *for* Kaiser

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Immunizations for Adolescents—Combination 1	89.42%	**80.66%**[3]	50th–74th	R
Appropriate Testing for Children With Pharyngitis	91.15%	92.28%	≥90th	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 decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was hybrid for HEDIS 2014 and was administrative for HEDIS 2015.

R is shown when the rate was reportable, according to NCQA standards.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] The Department's required data collection methodology for this measure in HEDIS 2015 was administrative. Kaiser reported using a hybrid methodology but, since there was no numerator event by medical records for any indicator within this measure, the final rates reported were indeed the administrative data rates for Kaiser.

[3] The Department's required data collection methodology for these measures was administrative in HEDIS 2015 and hybrid in HEDIS 2014. For both years, Kaiser reported using the administrative-only methodology as its final rates for these measures.

Strengths

All of Kaiser's performance measures in this domain received an audit result of *Reportable (R)* for HEDIS 2015. Three rates increased significantly from HEDIS 2014. These rates were *Well-Child Visits in the First 15 Months of Life—Six or More Visits, Counseling for Nutrition*, and *Counseling for Physical Activity* under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*. For *Well-Child Visits in the First 15 Months of Life—Zero Visits*, a lower rate reflects better performance; therefore, Kaiser's performance was at or above the national HEDIS Medicaid 90th percentile. This indicator, along with four other rates (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Appropriate Testing for Children With Pharyngitis*), performed within the top 10 percentiles of all HMO rates nationally.

Recommendations

Three rates (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits,* and *Immunizations for Adolescents—Combination 1)* declined significantly from HEDIS 2014. The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* also performed below the national 25th percentile. Some of the low performance could be related to Kaiser using the administrative-only rates to meet the Department's data collection requirement and may not represent Kaiser's true performance. Nonetheless, all well-child visits rates were below the federal EPSDT mandate of 80 percent; therefore, HSAG recommends that Kaiser focus efforts on improving this area as well as the *Immunizations for Adolescents—Combination 1* measure.

Access to Care and Preventive Screening Performance Measures

Table 3-32 shows the Kaiser rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Access to Care* and *Preventive Screening* performance measure.

Table 3-32—Review Audit Results for Access to Care and Preventive Screening Performance Measures *for* Kaiser				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	95.96%	92.06%	<10th	R
Ages 25 Months to 6 Years	90.78%	**81.05%**	<10th	R
Ages 7 to 11 Years	95.47%	93.57%	75th-89th	R
Ages 12 to 19 Years	95.97%	94.14%	75th-89th	R
Preventive Screening				
*Non-recommended Cervical Cancer Screening in Adolescent Females***	—	0.00%	<10th	R
Chlamydia Screening in Women—Total	—	81.46%	≥90th	R

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year.
— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
** 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).
[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

All of Kaiser's performance measures in this domain received an audit result of *Reportable (R)* for HEDIS 2015. Two rates, *Chlamydia Screening in Women—Total* and *Non-recommended Cervical Cancer Screening in Adolescent Females* (an inverse measure where a lower rate reflects better performance), were within the top 10 percentiles of all HMO rates nationally.

Recommendations

Children's and Adolescents' Access to Primary Care Practitioners was the only measure with HEDIS 2014 and HEDIS 2015 rates. The HEDIS 2015 rates declined in all age groups for this measure, with the *Ages 25 Months to 6 Years* group showing a significant decrease of more than nine percentage points. This finding presented opportunities for improvement.

Mental/Behavioral Health Performance Measures

Table 3-33 shows the Kaiser rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Mental/Behavioral Health* performance measure. Two of the three measures in this domain were first-year measures for required reporting.

Table 3-33—Review Audit Results for Mental/Behavioral Health Performance Measures *for* Kaiser				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	NA	—	NA
Effective Continuation Phase Treatment	—	NA	—	NA
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	38.71%	51.35%	75th–89th	R
Continuation	NA	NA	—	NA
Follow-up After Hospitalization for Mental Illness				
30-Day	—	NA	—	NA
7-Day	—	NA	—	NA

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Only one measure (*Follow-up Care for Children Prescribed ADHD Medication*) received an audit result of *Reportable (R)*. HSAG identified no measures either with statistically significant improvement or performing at or above the national Medicaid 90th percentile.

Recommendations

Due to small denominators, Kaiser was unable to publicly report five of the six rates from the measures in this domain. HSAG recommends that Kaiser investigate the reasons behind the small number of members identified as eligible population for these measures.

Respiratory-Related Performance Measures

Table 3-34 shows the Kaiser rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each respiratory-related performance measure.

Table 3-34—Review Audit Results for Respiratory-Related Performance Measures *for* Kaiser				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Appropriate Treatment for Children With Upper Respiratory Infection	—	95.81%	≥90th	R
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	NA	—	NA

Table 3-34—Review Audit Results for Respiratory-Related Performance Measures *for* Kaiser				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Use of Appropriate Medications for People With Asthma—Total	—	NA	—	NA
Medication Management for People With Asthma—Total (Medication Compliance 50%)	—	NA	—	NA
Medication Management for People With Asthma—Total (Medication Compliance 75%)	—	NA	—	NA
Asthma Medication Ratio—Total	NA	NA	—	NA

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Only one measure (*Appropriate Treatment for Children With Upper Respiratory Infection*) in this domain received an audit result of *Reportable (R)* for HEDIS 2015 reporting. This measure performed above the national HEDIS Medicaid 90th percentile.

Recommendations

Kaiser was unable to report rates for the other measures due to small denominators. HSAG recommends that Kaiser investigate the reasons behind the small number of members identified as the eligible population for these measures.

Use of Services Observations

Table 3-35 shows the Kaiser rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Use of Services* performance measure. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2014 and 2015 may not denote actual improvement or a decline in performance. Percentile rankings are presented for information only.

Table 3-35—Review Audit Results for Use of Services Measures *for* Kaiser				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Ambulatory Care: Total (Per 1,000 MM)				
Outpatient Visits	163.04	178.96	<10th	R
Emergency Department Visits	10.69	16.29	<10th	R

Table 3-35—Review Audit Results for Use of Services Measures *for* Kaiser

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Inpatient Utilization—General Hospital/Acute Care: Total				
Discharges per 1,000 MM (total inpatient)	0.78	0.88	<10th	R
Days per 1,000 MM (total inpatient)	2.41	3.49	<10th	R
Average Length of Stay (total inpatient)	3.09	3.99	50th-74th	R
Discharges per 1,000 MM (medicine)	0.58	0.73	<10th	R
Days per 1,000 MM (medicine)	1.73	2.11	<10th	R
Average Length of Stay (medicine)	2.98	2.89	<10th	R
Discharges per 1,000 MM (surgery)	0.13	0.12	<10th	R
Days per 1,000 MM (surgery)	0.51	1.30	<10th	R
Average Length of Stay (surgery)	3.83	10.55	≥90th	R
Discharges per 1,000 MM (maternity)	0.14	0.05	<10th	R
Days per 1,000 MM (maternity)	0.35	0.16	<10th	R
Average Length of Stay (maternity)	2.50	3.50	≥90th	R
Antibiotic Utilization				
Average Scrips for PMPY for Antibiotics (All Ages)	—	0.05	<10th	R
Average Days Supplied per Antibiotic Scrip (All Ages)	—	11.04	≥90th	R
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.01	<10th	R
Percentage of Antibiotics of Concern of All Antibiotic Scrips (All Ages)	—	29.56%	<10th	R
Mental Health Utilization: Total				
Any Services	—	<0.01%	<10th	R
Inpatient	—	<0.01%	<10th	R
Intensive Outpatient/Partial Hospitalization	—	0.00%	10th-24th	R
Outpatient/ED	—	<0.01%	<10th	R

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Reported rates in the use of service domain did not take into account the characteristics of the population; therefore, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics each health plan's

utilization results provide additional information that the health plans may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of Kaiser's performance measure results related to the domains of quality, timeliness, and access. Measures with significant declines or low percentile rankings presented opportunities for improvement.

Quality: Of the 16 quality-related measures, five had a denominator too small (less than 30) to allow for public reporting. Performance assessment could only be determined based on the remaining 11 measures. Two measures had at least one rate reporting significant improvement, but three had at least one rate with statistically significant decline. Compared to national benchmarks, Kaiser's performance was good. Six measures (three under pediatric care, two preventive screening measures, and one under respiratory-related condition) had at least one indicator performing at or above the 90th percentile. *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* was the only measure performing below the national 25th percentile. Some of the significant rate decline or low percentile ranking noted in the immunization or well-child visits measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent Kaiser's true performance.

Timeliness: Of the seven timeliness-related measures, one had a denominator too small (less than 30) to allow for public reporting. One measure (*Well-Child Visits in the First 15 Months of Life*) had at least one indicator reporting significant increase, but three had at least one indicator with significant rate decline from last year. Compared to national benchmarks, one indicator was at or above the national HEDIS Medicaid 90th percentile and one was below the 25th percentile. Some of the significant rate decline or low percentile ranking noted in the immunization or well-child visits measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent Kaiser's true performance.

Access: Of the five access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. Within the *Children's and Adolescents' Access to Primary Care Practitioners* measure, only the *25 Months to 6 Years* indicator showed a significant rate decline from last year. The two younger age groups were below the national HEDIS Medicaid 10th percentile, while the two older age groups ranked above the 75th percentile. Utilization-based measures are not risk-adjusted; therefore, Kaiser's rates reported for these measures should be for information only.

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. The auditor did not identify any notable issues that had any negative impact on HEDIS reporting and had no recommendations for RMHP related to compliance with IS standards.[3-5]

Pediatric Care Performance Measures

Table 3-36 shows the RMHP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each pediatric care performance measure.

Table 3-36—Review Audit Results for Pediatric Care Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Childhood Immunization Status				
Combination 2	69.87%	**46.88%**[2]	<10th	R
Combination 3	67.88%	**45.31%**[2]	<10th	R
Combination 4	57.95%	**42.97%**[2]	<10th	R
Combination 5	51.66%	**37.11%**[2]	<10th	R
Combination 6	49.67%	**34.38%**[2]	25th–49th	R
Combination 7	49.01%	**35.16%**[2]	<10th	R
Combination 8	44.70%	**32.81%**[2]	25th–49th	R
Combination 9	40.40%	**31.64%**[2]	25th–49th	R
Combination 10	38.74%	**30.08%**[2]	25th–49th	R
Well-Child Visits in the First 15 Months of Life				
*Zero Visits***	2.67%	5.45%[3]	≥90th	R
Six or More Visits	69.08%	**17.27%**[3]	<10th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	55.41%	54.81%[4]	<10th	R
Adolescent Well-Care Visits	40.40%	**34.56%**[5]	<10th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	77.92%	74.56%	75th–89th	R
Counseling for Nutrition: Total	58.72%	63.05%	50th–74th	R
Counseling for Physical Activity: Total	56.07%	62.39%	75th–89th	R

[3-5] NCQA HEDIS Compliance Audit, Final Audit Report, Rocky Mountain Health Plans, July 2015.

Table 3-36—Review Audit Results for Pediatric Care Performance Measures *for* RMHP				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Immunizations for Adolescents—Combination 1	55.13%	49.57%[6]	<10th	R
Appropriate Testing for Children With Pharyngitis	82.52%	79.23%	75th–89th	R

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was hybrid for HEDIS 2014 and was administrative for HEDIS 2015.

R is shown when the rate was reportable, according to NCQA standards.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] Per the Department's required data collection methodology, the rate displayed reflects administrative data only for HEDIS 2015. RMHP reported HEDIS 2015 hybrid rates of 66.02 percent, 64.06 percent, 58.98 percent, 52.73 percent, 49.22 percent, 49.22 percent, 45.70 percent, 44.14 percent, and 41.41 percent for the *Childhood Immunization Status—Combination 2* through *Combination 10* indicators respectively.

[3] RMHP followed the Department's required data collection methodology and submitted only the administrative rates to HSAG.

[4] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2015. RMHP reported the HEDIS 2015 hybrid rate of 63.17 percent for measure *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

[5] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. RMHP reported the HEDIS 2013 hybrid rate of 39.74 percent for the *Adolescent Well-Care Visits* measure.

[6] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. RMHP reported the HEDIS 2013 hybrid rate of 53.91 percent for the *Immunizations for Adolescents—Combination 1* measure.

Strengths

All of RMHP's performance measures in this domain received an audit result of *Reportable (R)* for HEDIS 2015. HSAG identified no measures either with statistical significant improvement or performing at or above the national Medicaid 90th percentile.

Recommendations

Three measures (*Childhood Immunizations Status* and two well-child visits measures) had at least one rate decline significantly from HEDIS 2014. When compared to the national benchmarks these measures, along with *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Immunizations for Adolescents—Combination 1*, also had at least one indicator performing below the national HEDIS Medicaid 10th percentile. Significant rate decline and/or low percentile ranking may be related to using the administrative-only rates to meet the Department's data collection requirement and may not represent RMHP's true performance. For the *Childhood Immunization Status* measure, RMHP used the hybrid methodology to calculate its final rates. Although statistical tests were not performed to compare with the prior year's results, the final, hybrid rates were lower than the prior year's rates. HSAG recommends that RMHP monitors its performance in this measure to see if additional interventions are warranted. All well-child visits rates were below the federal EPSDT mandate of 80 percent; therefore, HSAG recommends that RMHP focus its efforts on improving this area.

Access to Care and Preventive Screening Performance Measures

Table 3-37 shows the RMHP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Access to Care* and *Preventive Screening* performance measure.

Table 3-37—Review Audit Results for Access to Care and Preventive Screening Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	88.60%	87.97%	<10th	R
Ages 25 Months to 6 Years	77.74%	76.20%	<10th	R
Ages 7 to 11 Years	86.94%	**82.91%**	<10th	R
Ages 12 to 19 Years	86.55%	83.42%	10th-24th	R
Preventive Screening				
*Non-recommended Cervical Cancer Screening in Adolescent Females***	—	0.82%	<10th	R
Chlamydia Screening in Women—Total	—	20.30%	<10th	R

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year.
— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
** 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).
[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

All of RMHP's performance measures in this domain received an audit result of *Reportable (R)* for HEDIS 2015. For the *Non-recommended Cervical Cancer Screening in Adolescent Females* measure, since a lower rate reflects better performance, RMHP's performance was within the top 10 percentiles of all HMO rates nationally.

Recommendations

Children's and Adolescents' Access to Primary Care Practitioners was the only measure with both HEDIS 2014 and HEDIS 2015 rates. The HEDIS 2015 rates for all age groups declined from the prior year, with the *Ages 7 to 11 Years* group declining significantly. With all the measures performing below the national HEDIS Medicaid 25th percentile, RMHP had many opportunities to improve in this domain.

Mental/Behavioral Health Performance Measures

Table 3-38 shows the RMHP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Mental/Behavioral Health* performance measure. Two of the three measures in this domain were first-year measures for required reporting.

Table 3-38—Review Audit Results for Mental/Behavioral Health Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	NA	—	NA
Effective Continuation Phase Treatment	—	NA	—	NA
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	44.64%	45.95%	50th–74th	R
Continuation	NA	NA	—	NA
Follow-up After Hospitalization for Mental Illness				
30-Day	—	NA	—	NA
7-Day	—	NA	—	NA

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Percentile ranking results were only available to measures with reportable rates. HSAG identified no measures either with statistically significant improvement or performing at or above the national Medicaid 90th percentile.

Recommendations

Due to small denominators, RMHP was unable to publicly report five of the six rates from these measures. HSAG recommends that RMHP investigate the reasons behind the small number of members identified as eligible population for these measures.

Respiratory-Related Performance Measures

Table 3-39 shows the RMHP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each respiratory-related performance measure.

Table 3-39—Review Audit Results for Respiratory-Related Performance Measures *for* RMHP				
Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Appropriate Treatment for Children With Upper Respiratory Infection	—	91.37%	75th–89th	R
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	NA	—	NA
Use of Appropriate Medications for People With Asthma—Total	—	80.49%	10th–24th	R
Medication Management for People With Asthma—Total (Medication Compliance 50%)	—	54.55%	50th–74th	R
Medication Management for People With Asthma—Total (Medication Compliance 75%)		27.27%	25th–49th	R
Asthma Medication Ratio—Total	75.56%	70.73%	50th–74th	R

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

All but one of RMHP's performance measures received an audit result of *Reportable (R)* for HEDIS 2015. HSAG identified no measures either with statistically significant improvement or performing at or above the national Medicaid 90th percentile.

Recommendations

Although no measures declined significantly from HEDIS 2014, one rate (*Use of Appropriate Medications for People With Asthma—Total)* performed below the national HEDIS Medicaid 25th percentile. This represents an opportunity for improvement.

Use of Services Observations

Table 3-40 shows the RMHP rates for HEDIS 2014 and HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for each *Use of Services* performance measure. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2014 and 2015 may not denote actual improvement or a decline in performance. Percentile rankings are presented for information only.

Table 3-40—Review Audit Results for Use of Services Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ranking[1]	HEDIS 2015 Audit Result
	2014	2015		
Ambulatory Care: Total (Per 1,000 MM)				
Outpatient Visits	208.28	208.05	<10th	R
Emergency Department Visits	19.82	20.65	<10th	R
Inpatient Utilization—General Hospital/Acute Care: Total				
Discharges per 1,000 MM (total inpatient)	0.98	1.14	<10th	R
Days per 1,000 MM (total inpatient)	2.23	4.31	<10th	R
Average Length of Stay (total inpatient)	2.28	3.77	25th–49th	R
Discharges per 1,000 MM (medicine)	0.64	0.78	<10th	R
Days per 1,000 MM (medicine)	1.32	1.82	<10th	R
Average Length of Stay (medicine)	2.08	2.33	<10th	R
Discharges per 1,000 MM (surgery)	0.34	0.33	<10th	R
Days per 1,000 MM (surgery)	0.89	2.42	<10th	R
Average Length of Stay (surgery)	2.64	7.28	50th–74th	R
Discharges per 1,000 MM (maternity)	0.02	0.07	<10th	R
Days per 1,000 MM (maternity)	0.06	0.16	<10th	R
Average Length of Stay (maternity)	3.00	2.33	10th–24th	R
Antibiotic Utilization				
Average Scrips for PMPY for Antibiotics (All Ages)	—	0.48	<10th	R
Average Days Supplied per Antibiotic Scrip (All Ages)	—	10.57	≥90th	R
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.20	<10th	R
Percentage of Antibiotics of Concern of All Antibiotic Scrips (All Ages)	—	41.41%	25th–49th	R
Mental Health Utilization: Total				
Any Services	—	5.06%	10th–24th	R
Inpatient	—	0.19%	<10th	R
Intensive Outpatient/Partial Hospitalization	—	0.00%	10th–24th	R
Outpatient/ED	—	5.03%	10th–24th	R

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Reported rates in the use of service domain did not take into account the characteristics of the population; therefore, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics each health plan's utilization results provide additional information that the health plans may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of RMHP's performance measure results related to the domains of quality, timeliness, and access. Measures with significant declines or low percentile rankings presented opportunities for improvement.

Quality: Of the 16 quality-related measures, two had a denominator too small (less than 30) to allow for public reporting. Performance assessment could only be determined based on the remaining 14 measures. Of these measures, three measures had at least one indicator with statistically significant rate decline from last year. These were pediatric measures. Compared to national benchmarks, RMHP's performance was poor. Although one measure (*Non-recommended Cervical Cancer Screening in Adolescent Females*) performed at or above the 90th percentile, seven were below the 25th percentile. Significant rate decline and/or low percentile ranking noted in the immunization and well-child visit measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent RMHP's true performance.

Timeliness: Of the seven timeliness-related measures, one had a denominator too small (less than 30) to allow for public reporting. Of the six measures with reportable rates, none had any significant improvement from last year. Three had at least one indicator with significant rate decline. Compared to national benchmarks, RMHP's performance was poor. No measures were at or above the national HEDIS Medicaid 90th percentile. All measures except *Follow-up Care for Children Prescribed ADHD Medication* had at least one indicator performing below the 10th percentile. Significant rate decline and/or low percentile ranking noted in the immunization and well-child visit measures could be related to using the administrative-only rates to meet the state-required data collection requirement and may not represent RMHP's true performance.

Access: Of the five access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. Within the *Children's and Adolescents' Access to Primary Care Practitioners* measure, only the *25 Months to 6 Years* indicator showed a significant rate decline from last year. The two younger age groups were below the national HEDIS Medicaid 10th percentile, while the two older age groups ranked above the 75th percentile. Utilization-based measures are not risk-adjusted; therefore, RMHP's rates reported for these measures should be for information only.

State Managed Care Network

The SMCN did not undergo an NCQA HEDIS Compliance Audit. Nonetheless, the Department calculated the *Prenatal and Postpartum Care* measure using HEDIS 2015 specification. Table 3-41 shows the SMCN audited rates for HEDIS 2014 and the non-audited rates for HEDIS 2015, the percentile ranking for HEDIS 2015, and HEDIS 2015 audit results for the performance measure. The Department changed its reporting requirement for this measure from last year's hybrid to administrative. As such, both indicators showed statistically significant declines from HEDIS 2014. When compared to the national benchmark, both rates were below the national HEDIS Medicaid 10th percentile.

Table 3-41—Review Audit Results for Access to Care Performance Measures *for* SMCN

Performance Measures	HEDIS 2014 Rate	2015 Non-Audited Rate	Percentile Ranking[1]	HEDIS 2015 Audit Result
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	70.80%	**30.36%**	<10th	R
Postpartum Care	63.26%	**37.80%**	<10th	R

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year.
R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

HSAG identified no strength for the SMCN program based on this year's rates.

Recommendations

The Department should focus its efforts to improve the rates for the *Prenatal and Postpartum Care* measure. Both indicators exhibited a significant rate decrease from the previous year. This indicator also benchmarked at or below the national HEDIS Medicaid 10th percentile. This could be due to a change in the reporting requirement from hybrid to administrative.

Summary Assessment Related to Quality, Timeliness, and Access

Although SMCN had only one measure, this measure belonged to all three domains. The Department changed its reporting methodology from hybrid in FY 2013–2014 to administrative in FY 2014–2015, and both indicators of the *Prenatal and Postpartum Care* measure exhibited a significant decline in rate. The current year's rates (non-audited) for both indicators were below the national HEDIS Medicaid 10th percentile.

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

Pediatric Care Performance Measures

Table 3-42 shows the statewide weighted averages for HEDIS 2014 and HEDIS 2015 along with the percentile ranking for each pediatric care performance measure. The statewide rate was calculated from all CHP+ plans' rates, adjusted according to their respective eligible populations. Statewide rates were computed by HSAG and underwent no NCQA HEDIS Compliance Audit; therefore, no audit designation result was presented.

Table 3-42—Statewide Review Audit Results HEDIS 2015 Pediatric Care Performance Measures

Performance Measures	HEDIS Rate		Percentile Ranking[1]
	2014	2015	
Childhood Immunization Status			
Combination 2	73.25%	**61.27%**	<10th
Combination 3	70.33%	**59.89%**	10th–24th
Combination 4	63.50%	**55.61%**	10th–24th
Combination 5	58.90%	**50.42%**	10th–24th
Combination 6	51.53%	**42.40%**	25th–49th
Combination 7	55.43%	**47.06%**	10th–24th
Combination 8	47.79%	**40.03%**	25th–49th
Combination 9	44.66%	**37.13%**	50th–74th
Combination 10	42.56%	**35.06%**	50th–74th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits***	2.16%	3.07%	75th–89th
Six or More Visits	67.41%	**45.18%**	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.29%	**61.59%**	10th–24th
Adolescent Well-Care Visits	44.00%	40.38%	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment: Total	69.59%	**60.81%**	50th–74th
Counseling for Nutrition: Total	64.47%	61.19%	50th–74th
Counseling for Physical Activity: Total	58.26%	57.49%	50th–74th
Immunizations for Adolescents—Combination 1	66.27%	64.11%	25th–49th
Appropriate Testing for Children With Pharyngitis	79.09%	79.64%	75th–89th

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was hybrid for HEDIS 2014 and was administrative for HEDIS 2015.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

HSAG identified no measure where the statewide rate had statistical significant improvement or ranked at or above the national Medicaid 90th percentile. One statewide rate (*Appropriate Testing for Children With Pharyngitis)* was at or above the national HEDIS Medicaid 75th percentile.

Recommendations

Due to the Department's requirements to report administrative-only rates for measures that allow hybrid methodology, many statewide rates declined significantly from HEDIS 2014 and may not reflect true performance from all the CHP+ plans. When these rates were compared to the national benchmarks, their percentile ranks were generally below the national 25th percentile. As such, HSAG recommends that the Department allow the use of medical record data for measures that allow hybrid methodology. HSAG also noted that the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment* rate declined significantly by more than eight percentage points. This measure presented opportunities for improvement.

Access to Care and Preventive Screening Performance Measures

Table 3-43 shows the statewide weighted averages for HEDIS 2014 and HEDIS 2015 along with the percentile ranking for each *Access to Care* and *Preventive Screening* performance measure.

Table 3-43—Statewide Review Audit Results for Access to Care and Preventive Screening Performance Measures

Performance Measures	HEDIS Rate		Percentile Ranking[1]
	2014	2015	
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	91.36%	93.22%	<10th
Ages 25 Months to 6 Years	82.41%	**80.57%**	<10th
Ages 7 to 11 Years	89.16%	89.64%	25th–49th
Ages 12 to 19 Years	88.60%	90.09%	50th–74th
Prenatal and Postpartum Care[2]			
Timeliness of Prenatal Care	70.80%	**30.36%**	<10th
Postpartum Care	63.26%	**37.80%**	<10th
Preventive Screening			
*Non-recommended Cervical Cancer Screening in Adolescent Females***	—	0.62%	<10th
Chlamydia Screening in Women—Total	—	57.01%	50th–74th

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year.

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] This measure was required for SMCN reporting only. The SMCN did not undergo an NCQA HEDIS Compliance audit; therefore, the rates displayed here were non-audited rates.

Strengths

One statewide rate (*Non-recommended Cervical Cancer Screening in Adolescent Females*), being an inverse measure where a lower rate reflects better performance, ranked within the top 10 percentiles of all HMO rates nationally. Additionally, the *Chlamydia Screening in Women—Total* rate was also at or above the national 50th percentile.

Recommendations

Three statewide rates declined significantly from last year. Of these three, two belonged to *Prenatal and Postpartum Care*. The decline could be related to using the administrative-only rates to meet the Department's data collection requirement from hybrid to administrative. These two rates, along with two under *Children's and Adolescents' Access to Primary Care Practitioners,* also performed below the national HEDIS Medicaid 10th percentile. One of the children's access rates also declined significantly. HSAG recommends that children's access be a targeted area for Colorado's improvement efforts.

Mental/Behavioral Health Performance Measures

Table 3-44 shows the statewide weighted averages for HEDIS 2014 and HEDIS 2015 along with the percentile ranking for each *Mental/Behavioral Health* performance measure. Two of the three measures in this domain were first-year measures for required reporting.

Table 3-44—Statewide Review Audit Results for Mental/Behavioral Health Performance Measures

Performance Measures	HEDIS Rate		Percentile Ranking[1]
	2014	2015	
Antidepressant Medication Management			
Effective Acute Phase Treatment	—	NA	—
Effective Continuation Phase Treatment	—	NA	—
Follow-up Care for Children Prescribed ADHD Medication			
Initiation	16.78%	**46.01%**	50th–74th
Continuation	30.77%	41.82%	25th–49th
Follow-up After Hospitalization for Mental Illness			
30-Day	—	69.40%	50th–74th
7-Day	—	47.01%	50th–74th

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year.

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the health plan followed HEDIS specifications, but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

The statewide rates increased from HEDIS 2014 for *Follow-up Care for Children Prescribed ADHD Medication*, with the *Initiation* indicator showing statistically significant improvement. HSAG identified no measures performing at or above the national Medicaid 90th percentile.

Recommendations

Due to small denominators from all the HMOs, the entire *Antidepressant Medication Management* measure had fewer than 30 members at the statewide level. HSAG recommends that the Department consider whether this measure is suitable for plan reporting. Although no measures with reportable rates showed decline from HEDIS 2014, the *Continuation* rate from *Follow-up Care for Children Prescribed ADHD Medication* was below the national HEDIS Medicaid 50th percentile.

Respiratory-Related Performance Measures

Table 3-45 shows the statewide weighted averages for HEDIS 2014 and HEDIS 2015 along with the percentile ranking for each respiratory-related performance measure.

Table 3-45—Statewide Review Audit Results for Respiratory-Related Performance Measures

Performance Measures	HEDIS Rate		Percentile Ranking[1]
	2014	2015	
Appropriate Treatment for Children With Upper Respiratory Infection	—	91.50%	75th–89th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	NA	NA
Use of Appropriate Medications for People With Asthma—Total	—	92.21%	≥90th
Medication Management for People With Asthma—Total (Medication Compliance 50%)	—	46.96%	10th–24th
Medication Management for People With Asthma—Total (Medication Compliance 75%)		20.27%	10th–24th
Asthma Medication Ratio—Total	73.78%	74.17%	75th–89th

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards. NA is shown when the denominator is smaller than 30 to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Although no statewide rates showed significant improvement in this domain, one measure (*Use of Appropriate Medications for People With Asthma—Total)* was at or above the national HEDIS Medicaid 90th percentile. Two additional rates *(Appropriate Treatment for Children With Upper Respiratory Infection* and *Asthma Medication Ratio—Total)* also performed at or above the national 75th percentile.

Recommendations

The statewide rates for the *Medication Management for People With Asthma—Total* benchmarked at or below the national HEDIS Medicaid 25th percentiles. The other asthma-related measures in this domain showed good performance; therefore, HSAG recommends that the HMOs investigate the reasons behind low member medication compliance and target improvement efforts in this area.

Use of Services Observations

Table 3-46 shows the statewide weighted averages for HEDIS 2014 and HEDIS 2015 along with the percentile ranking for each *Use of Services* performance measure. Reported rates are not risk-adjusted, rate changes observed between HEDIS 2014 and 2015 may not denote actual improvement or a decline in performance. Percentile rankings are presented for information only.

Table 3-46—Statewide Review Audit Results for Use of Services Measures

Performance Measures	HEDIS Rate		Percentile Ranking[1]
	2014	2015	
Ambulatory Care: Total (Per 1,000 MM)			
Outpatient Visits	214.08	204.21	<10th
Emergency Department Visits	26.47	26.31	<10th
Inpatient Utilization—General Hospital/Acute Care: Total			
Discharges per 1,000 MM (total inpatient)	1.23	1.28	<10th
Days per 1,000 MM (total inpatient)	4.16	4.34	<10th
Average Length of Stay (total inpatient)	3.37	3.41	25th–49th
Discharges per 1,000 MM (medicine)	0.85	0.96	<10th
Days per 1,000 MM (medicine)	2.38	2.46	<10th
Average Length of Stay (medicine)	2.81	2.56	<10th
Discharges per 1,000 MM (surgery)	0.30	0.24	<10th
Days per 1,000 MM (surgery)	1.56	1.69	<10th
Average Length of Stay (surgery)	5.27	7.06	50th–74th
Discharges per 1,000 MM (maternity)	0.19	0.16	<10th
Days per 1,000 MM (maternity)	0.45	0.41	<10th
Average Length of Stay (maternity)	2.44	2.51	25th–49th
Antibiotic Utilization			
Average Scrips for PMPY for Antibiotics (All Ages)	—	0.49	<10th
Average Days Supplied per Antibiotic Scrip (All Ages)	—	10.39	≥90th
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.19	<10th
Percentage of Antibiotics of Concern of All Antibiotic Scrips (All Ages)	—	39.19%	25th–49th

Table 3-46—Statewide Review Audit Results for Use of Services Measures			
Performance Measures	HEDIS Rate		Percentile Ranking[1]
	2014	2015	
Mental Health Utilization: Total			
Any Services	—	0.68%	<10th
Inpatient	—	0.03%	<10th
Intensive Outpatient/Partial Hospitalization	—	0.22%	50th–74th
Outpatient/ED	—	0.57%	<10th

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.

R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Statewide rates in the use of service domain did not take into account the characteristics of the population from individual HMOs; therefore, HSAG cannot draw conclusions about performance based on the utilization results.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of statewide performance measure results related to the domains of quality, timeliness, and access. Measures with significant declines or low percentile rankings presented opportunities for improvement. Of the 22 measures which the Department required the CHP+ plans to report for HEDIS 2015, seven had at least two CHP+ plans with denominators too small (<30) to report valid rates. Although a statewide rate was still calculated by aggregating the numerators and denominators from all the CHP+ plans, performance could only be determined at the statewide level and for plans with sufficient denominators.

Quality: Statewide performance in this domain included the 16 quality-related measures required for plan reporting and the *Prenatal and Postpartum Care* non-audited rates from the SMCN. Of these 17 quality-related measures, one showed significant improvement from last year for one of its indicators, but five had significant decline in performance. The declines were found in *Prenatal and Postpartum Care* as well as in pediatric care. A change in the data collection requirement from hybrid to administrative may have been the reason for these declines. Compared to national benchmarks, statewide performance was diverse. Two measures performed above the national 90th percentile, but six had at least one indicator performing below the 25th percentile.

Timeliness: Statewide performance in this domain included the seven timeliness-related measures required for plan reporting and the *Prenatal and Postpartum Care* non-audited rates from the SMCN. Of the eight timeliness-related measures, one reported significant increase and four had at least one indicator with significant rate decline from last year. The declines were found in *Prenatal and Postpartum Care* as well as in pediatric care. A change in the data collection requirement from hybrid to administrative may have been the reason for these declines. Compared to national benchmarks, no measures were at or above the national HEDIS Medicaid 90th percentile, and five had at least one indicator performing below the 25th percentile.

Access: Statewide performance in this domain included the five access-related measures required for plan reporting and the *Prenatal and Postpartum Care* non-audited rates from the SMCN. Only the *Children's and Adolescents' Access to Primary Care Practitioners* and *Prenatal and Postpartum Care* measures were population-based; the remaining measures were utilization-based. Both population-based measures had significant rate decline from last year. The Department changed its data collection requirement for the *Prenatal and Postpartum Care* measure from hybrid in FY 2013–2014 to administrative in FY 2014–2015 and the decline was at least 25 percentage points, and its rates were below the national HEDIS Medicaid 10th percentile. Statewide performance of the *Children's and Adolescents' Access to Primary Care Practitioners* measure was diverse. The two younger age groups were below the national 10th percentile, while the *12 to 19 Years* age group ranked above the 50th percentile. Utilization-based measures are not risk-adjusted; therefore, the rates for these measures should be for information only.

Validation of Performance Improvement Projects

For FY 2014–2015, HSAG validated one PIP for each of the five CHP+ HMOs. Appendix C describes how the validation of PIP activities was conducted and how the resulting data were aggregated and analyzed.

Table 3-47 lists the HMOs and their PIP study titles.

Table 3-47—Summary of Each HMO's PIP

HMO	PIP Study
Colorado Access	*Improving the Transition Process for Children Aging Out of the CHP + HMO Plan*
Colorado Choice	*Adolescent Positive Depression Disorder Screening and Transition to a Behavioral Health Provider*
DHMP	*Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*
Kaiser	*Access and Transition to Behavioral Health Services*
RMHP	*CHP+ Members With Asthma Transitioning Out of Plan Coverage*

Colorado Access

Findings

The Colorado Access *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan* PIP focused on improving the percentage of members with a chronic medical or mental illness who receive case management outreach within 90 days of their 19th birthday. This was the first validation year for the PIP. Colorado Access reported the study design for the PIP and completed Activities I through VI.

Table 3-48 provides a summary of Colorado Access' PIP validation results for the FY 2014–2015 validation cycle.

Table 3-48—FY 2014–2015 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 Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Sampling Techniques	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Table 3-48—FY 2014–2015 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	*Not Assessed*		
	VIII.	Interventions and Improvement Strategies	*Not Assessed*		
Implementation Total			*Not Assessed*		
Outcomes	IX.	Real Improvement	*Not Assessed*		
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			*Not Assessed*		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

Colorado Access demonstrated strength throughout the study design of its PIP by receiving *Met* scores for all applicable evaluation elements in Activities I through VI. The health plan documented a methodologically sound study design. The Colorado Access PIP received a *Met* score for 100 percent of nine applicable evaluation elements.

Strengths

Colorado Access documented a solid study design, supported by key research principles, for the *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan* PIP. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission of the PIP received a *Met* score for 100 percent of applicable evaluation elements in Activities I through VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for the Colorado Access *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan* PIP, in which the PIP received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG identified no opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. Colorado Access earned a *Met* validation status, demonstrating a strong application of PIP study design principles, facilitating progression to the subsequent stages of PIP implementation and outcomes.

Colorado Choice Health Plan

Findings

The Colorado Choice *Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider* PIP focused on improving the transition of care for adolescents 12 to 17 years of age with a positive depression screening that was performed by a primary care provider and who have a behavioral health provider follow-up visit within 30 days of the positive depression screening. This was the first validation year for the PIP. Colorado Choice reported the study design for the PIP and completed Activities I through VI.

Table 3-49 provides a summary of Colorado Choice's PIP validation results for the FY 2014–2015 validation cycle.

Table 3-49—FY 2014–2015 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 Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Sampling Techniques	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Interventions and Improvement Strategies	*Not Assessed*		
Implementation Total			*Not Assessed*		
Outcomes	IX.	Real Improvement	*Not Assessed*		
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			*Not Assessed*		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

Strengths

Colorado Choice documented a scientifically sound study design for the *Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider* PIP. The technical design of the PIP, based on key research principles, was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission of the PIP received a *Met* score for 100 percent of applicable evaluation elements in Activities I through VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for the Colorado Choice *Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider* PIP, in which the PIP received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG identified no opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. Colorado Choice earned a *Met* validation status, demonstrating a strong application of PIP study design principles, facilitating progression to the subsequent stages of PIP implementation and outcomes.

Denver Health Medical Plan, Inc.

Findings

The DHMP *Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics* PIP focused on improving transitions of care for a population of overweight and obese pediatric members and their families. This was the first validation year for the PIP. DHMP reported the study design for the PIP and completed Activities I through VI.

Table 3-50 provides a summary of DHMP's PIP validation results for the FY 2014–2015 validation cycle.

Table 3-50—FY 2014–2015 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 Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Sampling Techniques	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Interventions and Improvement Strategies	*Not Assessed*		
Implementation Total			*Not Assessed*		
Outcomes	IX.	Real Improvement	*Not Assessed*		
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

Strengths

DHMP documented a scientifically sound study design for the *Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics* PIP. The technical design of the PIP, based on key research principles, was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission of the PIP received a *Met* score for 100 percent of applicable evaluation elements in Activities I–VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for the DHMP *Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics* PIP, in which the PIP received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG identified no opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. DHMP earned a *Met* validation status, demonstrating a strong application of PIP study design principles, facilitating progression to the subsequent stages of PIP implementation and outcomes.

Kaiser Permanente Colorado

Findings

The Kaiser *Access and Transition to Behavioral Health Services* PIP focused on improving behavioral health follow-up for members 13–17 years of age who screened positive for depression with a primary care provider. This was the first validation year for the PIP. Kaiser reported the study design for the PIP and completed Activities I through VI.

Table 3-51 provides a summary of Kaiser's PIP validation results for the FY 2014–2015 validation cycle.

Table 3-51—FY 2014–2015 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 Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Sampling Techniques	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Table 3-51—FY 2014–2015 Performance Improvement Project Validation Results *for* Kaiser					
Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Implementation	VII.	Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Interventions and Improvement Strategies	*Not Assessed*		
Implementation Total			*Not Assessed*		
Outcomes	IX.	Real Improvement	*Not Assessed*		
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			*Not Assessed*		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

Strengths

Kaiser documented a solid study design, supported by key research principles, for the *Access and Transition to Behavioral Health Services* PIP. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission of the PIP received a *Met* score for 100 percent of applicable evaluation elements in Activities I through VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for the Kaiser *Access and Transition to Behavioral Health Services* PIP, in which the PIP received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG identified no opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. Kaiser earned a *Met* validation status, demonstrating a strong application of PIP study design principles, facilitating progression to the subsequent stages of PIP implementation and outcomes.

Rocky Mountain Health Plans

Findings

The RMHP *CHP+ Members With Asthma Transitioning Out of Plan Coverage* PIP focused on improving the transition of care process for members with asthma who will be aging out of the CHP+ plan. This was the first validation year for the PIP. RMHP reported the study design for the PIP and completed Activities I through VI.

Table 3-52 provides a summary of RMHP's PIP validation results for the FY 2014–2015 validation cycle.

Table 3-52—FY 2014–2015 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 Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Sampling Techniques	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Interventions and Improvement Strategies	*Not Assessed*		
Implementation Total			*Not Assessed*		
Outcomes	IX.	Real Improvement	*Not Assessed*		
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			*Not Assessed*		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

Strengths

RMHP documented a solid study design, supported by key research principles, for the *CHP+ Members With Asthma Transitioning Out of Plan Coverage* PIP. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission of the PIP received a *Met* score for 100 percent of applicable evaluation elements in Activities I through VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for the RMHP *CHP+ Members With Asthma Transitioning Out of Plan Coverage* PIP, in which the PIP received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG identified no opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. RMHP earned a *Met* validation status, demonstrating a strong application of PIP

study design principles, facilitating progression to the subsequent stages of PIP implementation and outcomes.

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

Table 3-53 shows the health plans' overall performance based on HSAG's validation of the FY 2014–2015 PIPs submitted for validation.

Table 3-53—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 the Transition Process for Children Aging Out of the CHP+ HMO Plan*	100%	100%	*Met*
Colorado Choice	*Adolescent Positive Depression Disorder Screening and Transition to a Behavioral Health Provider*	100%	100%	*Met*
DHMP	*Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*	100%	100%	*Met*
Kaiser	*Access and Transition to Behavioral Health Services*	100%	100%	*Met*
RMHP	*CHP+ Members With Asthma Transitioning Out of Plan Coverage*	100%	100%	*Met*

The validation scores and validation status of the PIPs demonstrated solid PIP study designs that will support the progression to the subsequent stages of PIP implementation and outcomes. All five of the PIPs reviewed by HSAG received a *Met* validation status. Additionally, all PIPs received a *Met* score for 100 percent of all applicable evaluation elements.

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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, demonstrating application of methodologically sound design principles necessary to produce valid and reliable PIP results.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

For each of the four global ratings (*Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of All Health Care,* and *Rating of Health Plan*), the rates were based on responses by members who chose a value of 9 or 10 on a scale of 0 to 10. For four of the five composites (*Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Customer Service*), the rates were based on responses by members who chose a response of "Usually" or "Always." For one composite (*Shared Decision Making*), the rates were based on responses by members who chose a response of "Yes." For purposes of this report, results are reported for a CAHPS measure even when the minimum reporting threshold of 100 respondents was not met; therefore, caution should be exercised when interpreting these results. Measures that did not meet the minimum number of 100 responses are denoted with a cross (+). Appendix E contains additional details about the technical methods of data collection and analysis of survey data.[3-6]

For all health plan findings, a substantial increase is noted when a measure's rate increased by more than 5 percentage points. A substantial decrease is noted when a measure's rate decreased by more than 5 percentage points.

[3-6] Due to changes to the *Shared Decision Making* composite measure for 2015, comparisons of the current year's (FY 2014–2015) and prior year's (FY 2013–2014) results could not be performed.

Colorado Access

Findings

Table 3-54 shows the results achieved by Colorado Access for the current year (FY 2014–2015) and the prior year (FY 2013–2014).

Table 3-54—Question Summary Rates and Global Proportions *for* Colorado Access

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	81.8%	84.7%
Getting Care Quickly	88.0%	87.3%
How Well Doctors Communicate	94.9%	95.3%
Customer Service	81.0%	83.5%
Shared Decision Making	NC	78.3% +
Rating of Personal Doctor	65.2%	72.2%
Rating of Specialist Seen Most Often	66.0% +	68.0%
Rating of All Health Care	57.3%	58.5%
Rating of Health Plan	58.4%	58.5%

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

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Recommendations

Colorado Access did not demonstrate a substantial decrease in rate for any comparable measures; however, one measure, *Getting Care Quickly*, showed a slight decrease. Colorado Access should continue to direct quality improvement activities toward this measure. In order to improve members' perceptions on the *Getting Care Quickly* composite measure, Colorado Access' quality improvement activities should focus on evaluating no show appointments, encouraging the use of electronic communication between providers and members where appropriate, establishing nurse advice help lines, open access scheduling, and assisting providers with monitoring patient flow.

Summary Assessment Related to Quality, Timeliness, and Access

All measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness. For Colorado Access, rates for seven of the eight comparable measures increased: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. Of these measures, one measure's rate demonstrated a substantial increase: *Rating of Personal Doctor* (7.0 percentage points). In addition, one measure had the highest rate among the health plans in FY 2014–2015, *Shared Decision Making*. These findings indicate strong performance across the three domains.

Colorado Choice

Findings

Table 3-55 shows the results achieved by Colorado Choice for the current year (FY 2014–2015) and the prior year (FY 2013–2014).

Table 3-55—Question Summary Rates and Global Proportions *for* Colorado Choice

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	89.5%	89.5%
Getting Care Quickly	89.8%	91.1%
How Well Doctors Communicate	93.2%	95.4%
Customer Service	74.3%+	81.8%+
Shared Decision Making	NC	76.0%+
Rating of Personal Doctor	59.7%	60.3%
Rating of Specialist Seen Most Often	51.0%+	63.6%+
Rating of All Health Care	48.5%	54.3%
Rating of Health Plan	50.2%	54.1%

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

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Recommendations

Colorado Choice did not demonstrate a substantial rate decrease for any of the comparable measures. The rate for one measure, *Getting Needed Care*, demonstrated no change, and rates for the remaining seven measures increased. Colorado Choice should continue to direct quality improvement activities toward this measure.

In order to improve members' perceptions of the *Getting Needed Care* composite measure, Colorado Choice's quality improvement activities should focus on identifying appropriate healthcare providers for members, interactive workshops aimed at increasing members' health literacy, models such as "max packing," for maximizing each member's office visit, and language concordance programs.

Summary Assessment Related to Quality, Timeliness, and Access

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

For Colorado Choice, rates for seven of the eight comparable measures increased. Of these measures, three measures' rates demonstrated a substantial increase: *Customer Service* (7.5 percentage points), *Rating of Specialist Seen Most Often* (12.6 percentage points), and *Rating of All*

Health Care (5.8 percentage points). As noted, the rate for one measure, *Getting Needed Care*, demonstrated no change.

Furthermore, four measures had the lowest rates among the health plans in FY 2014-2015: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*.

Denver Health Medical Plan

Findings

Table 3-56 shows the results achieved by DHMP for the current year (FY 2014–2015) and the prior year (FY 2013–2014).

Table 3-56—Question Summary Rates and Global Proportions *for* DHMP

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	66.5%	71.0%
Getting Care Quickly	82.2%	79.7%
How Well Doctors Communicate	90.7%	92.8%
Customer Service	80.0%	85.2%
Shared Decision Making	NC	76.0%+
Rating of Personal Doctor	72.4%	73.1%
Rating of Specialist Seen Most Often	68.1%+	63.6%+
Rating of All Health Care	56.6%	60.3%
Rating of Health Plan	54.5%	55.4%

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

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Recommendations

DHMP did not demonstrate a substantial decrease in rate for any of the comparable measures; however, a decrease in rates was shown for two measures: *Getting Care Quickly* and *Rating of Specialist Seen Most Often*. DHMP should continue to direct quality improvement activities toward these measures.

In order to improve members' perceptions with the *Getting Care Quickly* composite measure, DHMP's quality improvement activities should focus on evaluating no-show appointments, encouraging the use of electronic communication between providers and members where appropriate, establishing nurse advice help lines, open access scheduling, and assisting providers with monitoring patient flow. To improve members' satisfaction in the area of *Rating of Specialist Seen Most Often*, DHMP could focus on working with providers to implement planned visit management systems, skills training for specialists, and telemedicine.

Summary Assessment Related to Quality, Timeliness, and Access

All measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness. For DHMP, rates for six of the eight comparable measures increased: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan*. Of these measures, one measure's rate demonstrated a substantial increase: *Customer Service* (5.2 percentage points). As noted, the remaining two measures showed rate decreases; however, the decreases in the measures' rates were not substantial.

In addition, four measures had the lowest rates among the health plans in FY 2014–2015: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Specialist Seen Most Often*.

Kaiser Permanente

Findings

Table 3-57 shows the results achieved by Kaiser for the current year (FY 2014–2015) and the prior year (FY 2013–2014).

Table 3-57—Question Summary Rates and Global Proportions *for* Kaiser

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	87.4%	89.9%
Getting Care Quickly	92.1%	91.1%
How Well Doctors Communicate	94.3%	96.6%
Customer Service	84.8%	86.2%
Shared Decision Making	NC	77.2%+
Rating of Personal Doctor	71.6%	75.2%
Rating of Specialist Seen Most Often	65.8%+	72.1%+
Rating of All Health Care	69.5%	63.6%
Rating of Health Plan	63.0%	62.3%

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

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Recommendations

Kaiser demonstrated a substantial decrease in rate for one of the comparable measures, *Rating of All Health Care*. Kaiser should continue to direct quality improvement activities toward this measure.

In order to improve members' satisfaction with *Rating of All Health Care*, Kaiser's quality improvement activities should focus on identifying potential barriers for members receiving

appropriate access to care and creating member and family engagement advisory councils that include the members and families who represent the population Kaiser serves.

Summary Assessment Related to Quality, Timeliness, and Access

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

For Kaiser, rates for five of the eight comparable measures increased: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. Of these measures, one measure's rate demonstrated a substantial increase: *Rating of Specialist Seen Most Often* (6.3 percentage points). The remaining three measures showed rate decreases: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan*. Of these measures, the rate for one measure showed a substantial decrease, *Rating of All Health Care* (5.9 percentage points).

Furthermore, six measures had the highest rates among the health plans in FY 2014–2015: *Getting Needed Care*, *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*.

Rocky Mountain Health Plans

Findings

Table 3-58 shows the results achieved by RMHP for the current year (FY 2014–2015) and the prior year (FY 2013–2014).

Table 3-58—Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	86.3%	86.9%
Getting Care Quickly	93.7%	93.1%
How Well Doctors Communicate	95.0%	96.9%
Customer Service	80.7%	79.4%
Shared Decision Making	NC	73.8%+
Rating of Personal Doctor	70.5%	70.4%
Rating of Specialist Seen Most Often	58.1%+	68.6%+
Rating of All Health Care	62.7%	57.9%
Rating of Health Plan	55.4%	60.0%

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

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Recommendations

RMHP did not demonstrate a substantial decrease in rate for any of the comparable measures; however, some decrease in rate was shown for four measures: *Getting Care Quickly*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of All Health Care*.

In order to improve members' perceptions with the *Getting Care Quickly* composite measure, RMHP's quality improvement activities should focus on evaluating no-show appointments, encouraging the use of electronic communication between providers and members where appropriate, establishing nurse advice help lines, open access scheduling, and assisting providers with monitoring patient flow. To improve members' satisfaction with *Customer Service*, RMHP should focus on evaluating call center hours and practices, customer service training programs geared towards the fundamentals of effective communication, and establishing customer service performance measures. For *Rating of Personal Doctor*, RMHP should focus on assisting providers with monitoring appointment scheduling, additional methods for obtaining direct patient feedback, physician-patient communication, and improving shared decision making between patients and providers. In order to improve in the area of *Rating of All Health Care*, RMHP should focus on identifying potential barriers for members receiving appropriate access to care and creating member and family engagement advisory councils that include the members and families who represent the population RMHP serves.

Summary Assessment Related to Quality, Timeliness, and Access

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

For RMHP, rates for four of the eight comparable measures increased: *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. Of these measures, one measure's rate demonstrated a substantial increase: *Rating of Specialist Seen Most Often* (10.5 percentage points). The remaining four measures showed rate decreases; however, the measures' rates did not decrease substantially.

In addition, two measures had the highest rates among the health plans in FY 2014–2015: *Getting Care Quickly* and *How Well Doctors Communicate*; and two measures had the lowest rates among the health plans in FY 2014–2015: *Customer Service* and *Shared Decision Making*.

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

The statewide averages presented in this section are derived from the combined results of the five CHP+ plans. Table 3-59 shows the CHP+ statewide averages for the current year (FY 2014–2015) and the prior year (FY 2013–2014).[3-7]

Table 3-59—Statewide Question Summary Rates and Global Proportions		
Measure	**FY 2013–2014 Rate**	**FY 2014–2015 Rate**
Getting Needed Care	82.4%	84.4%
Getting Care Quickly	89.1%	88.0%
How Well Doctors Communicate	94.5%	95.4%
Customer Service	81.1%	83.2%
Shared Decision Making	NC	77.2%
Rating of Personal Doctor	67.1%	71.9%
Rating of Specialist Seen Most Often	64.3%	67.9%
Rating of All Health Care	59.3%	58.9%
Rating of Health Plan	57.9%	58.6%

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Recommendations

The statewide averages for the CHP+ population demonstrated no substantial decrease in rate for any of the comparable measures; however, the rates for two measures showed a slight decrease: *Getting Care Quickly* and *Rating of All Health Care*.

Summary Assessment Related to Quality, Timeliness, and Access

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

For the statewide CHP+ population, rates for six of the eight comparable measures increased: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. However, the increases in rates for these measures were not substantial. The remaining two measures showed rates decreases; however, the measures' rates did not decrease substantially.

[3-7] The Colorado CHP+ statewide average results for the current year (FY 2014–2015) and prior year (FY 2013–2014) represent weighted results. The results were weighted based on the total eligible population for each of the plan's CHP+ population for that corresponding year. In prior years, the Colorado CHP+ statewide average results were not weighted; therefore, the FY 2013–2014 CAHPS results presented in this section for the Colorado CHP+ statewide average may not match the prior year's report.

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

Introduction

Following EQR activities conducted in FY 2013–2014, 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 2014–2015.

Colorado Access

Compliance Monitoring Site Reviews

As a result of the FY 2013–2014 site review, Colorado Access was required to:

- Revise the Medication Utilization Review Procedure policy to accurately depict the standard authorization decision time frame as being within 10 calendar days from the date of the request for service.
- Develop processes to ensure that physician reviewers are cognizant of the requirement that notices of action and other member-specific communications are written at the sixth-grade reading level whenever possible.
- Revise applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination.
- Clarify the Utilization Review Determinations policy to state that a notice of action is not needed if the extension is used and that, although a notice of action is required when the time frames expire, this notification period includes the extension time, if used.
- Inform the member of his or her right to file a grievance if the member does not agree with the decision to extend the time frame.
- Remove from the CHP+ HMO member handbook any exceptions to coverage for urgent care outside the service area.
- Require providers to maintain for CHP+ members hours of operation that are no less than are hours of operation for commercial members.

Colorado Access submitted its corrective action plan (CAP) to HSAG and the Department in June 2014. HSAG and the Department reviewed Colorado Access' CAP and determined that, if implemented as written, Colorado Access would achieve compliance with all required actions.

Colorado Access submitted documents to HSAG and the Department as they became available to demonstrate compliance with the required actions. After careful review of all submitted information, HSAG and the Department determined in August 2014 that Colorado Access had successfully completed the required actions.

Validation of Performance Measures

During its FY 2013–2014 review, HSAG recommended that Colorado Access focus improvement efforts on the *Follow-up Care for Children Prescribed ADHD Medication* measure, which benchmarked below the national HEDIS Medicaid 10th percentile. Colorado Access' HEDIS 2015 rates showed significant increases for this measure. The rates were at least 40 percentage points higher than for HEDIS 2014. This finding suggests that Colorado Access followed up with HSAG's recommendations targeting this measure.

Validation of Performance Improvement Projects

This was Colorado Access' first submission of its *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan* PIP; therefore, no prior requirements or recommendations existed.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Colorado Access experienced a substantial decrease in rate between FY 2012–2013 and FY 2013–2014 for the *Customer Service* measure. HSAG suggested that Colorado Access focus its effort on improving this rate. Colorado Access' FY 2014–2015 rate for this measure was 83.5 percent—a 2.5 percentage point increase over last year's rate. While this increase was not substantial, it may indicate that Colorado Access followed up with HSAG's recommendation.

Colorado Choice Health Plan

Compliance Monitoring Site Reviews

As a result of the FY 2013–2014 site review, Colorado Choice was required to address one *Not Met* and nine *Partially Met* findings for Standard I—Coverage and Authorization of Services. Many actions required were due to the absence of written policies and procedures and incorrect time frames related to utilization management decisions and notices of action. Colorado Choice was also required to address six *Partially Met* findings for Standard II—Access and Availability. The actions required for this standard were also related to the absence or insufficiency of policies and procedures as well as the communication and monitoring of appointment availability standards.

Colorado Choice submitted its CAP to HSAG and the Department in May 2014 and began submitting documents to demonstrate implementation of the planned interventions in June. HSAG and the Department worked closely with Colorado Choice throughout the remainder of 2014 to monitor implementation of Colorado Choice's CAP.

At the time of the FY 2014–2015 site review, Colorado Choice was still working to resolve four outstanding actions related to Standard I—Coverage and Authorization. Colorado Choice was required to:

- Submit policies and procedures that address the time frames for standard pre-service authorization decisions and the process for extending those time frames when necessary.
- Submit example notice of action letters that demonstrate that notices of action are written at a sixth-grade reading level, to the extent possible.
- Submit policies and procedures, notice of action templates, and examples of explanation of benefits to demonstrate that all compliance documents and member information accurately depict the appeal and State fair hearing filing time frames as 30 calendar days and that the appeal resolution time frame is accurately depicted as 10 working days.
- Submit revised emergency and poststabilization action policies that clearly state that CHP+ members are not held responsible for payment of emergency or poststabilization services.

Colorado Choice submitted the necessary documents; and on March 19, 2015, the Department and HSAG determined that Colorado Choice had completed its FY 2013–2014 CAP.

Validation of Performance Measures

During its FY 2013–2014 review, HSAG recommended that Colorado Choice focus improvement efforts on measures with rates benchmarked at or below the national HEDIS Medicaid 10th percentiles. These measures were:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition*
- *Immunization for Adolescents—Combination 1*
- Two of the younger age groups under *Children's and Adolescents' Access to Primary Care Practitioners*

Colorado Choice's HEDIS 2015 rates showed that no measure demonstrated a significant rate change from HEDIS 2014. The lack of rate increase could be related to a change in reporting requirement from hybrid to administrative or potential member increase related to Medicaid expansion. HSAG could not ascertain whether improvement efforts had been implemented by Colorado Choice.

Validation of Performance Improvement Projects

This was Colorado Choice's first submission of its *Adolescent Positive Depression Disorder Screening and Transition to a Behavioral Health Provider* PIP; therefore, no prior requirements or recommendations existed.

Consumer Assessment of Healthcare Providers and Systems

Colorado Choice demonstrated a substantial decrease in rates between FY 2012–2013 and FY 2013–2014 for four measures: *Getting Care Quickly*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of all Health Care*. HSAG recommended Colorado Choice direct quality improvement activities toward these measures.

Colorado Choice's FY 2014–2015 rates increased for all four of these measures—with three of the four measures experiencing substantial increases of between 5.8 and 12.6 percentage points. Although two of four measures had fewer than 100 respondents and might not be an accurate representation of the population as a whole, these increases may indicate that Colorado Choice followed up with HSAG's recommendation.

Denver Health Medical Plan, Inc.

Compliance Monitoring Site Reviews

As a result of the 2013–2014 site review, DHMP was required to address the following:

- Ensure that notices of action are sent within the required time frames and that they include the required content.
- Revise language in member handbooks to clarify that DHMP uses a prudent layperson standard to determine payment for emergency services and that DHMP will not refuse to cover emergency care based on DHMP's notification requirements.
- Develop a mechanism to more fully explore wait list processes and develop a process to specifically track, by individual, the length of time members remain on the wait list.
- Work with the Department to remove barriers that create the need for the wait list and develop mechanisms to ensure that new adult Medicaid members are not waitlisted beyond the required access to care standards.
- Further define what is meant by "open panel," in the Strategic Access reports and more accurately describe the processes for access into the DHHA clinic system.
- Implement policies to provide out-of-network care when care within the network is not available, or consider options to expand the DHMC network through expansion of the DHHA provider network or through contracts with non-DHHA providers.
- Develop an effective process for monitoring scheduling wait times, identify barriers to complying with appointment guidelines delineated in the Medicaid and CHP+ managed care contracts, and take appropriate action to ensure that appointment scheduling standards are met.
- Develop a mechanism to review claims denials to ensure ease of understanding, provide clearer information to members, and ensure accuracy of the information.

DHMP submitted its initial CAP on June 6, 2014. Between June 2014 and December 2014 HSAG and the Department reviewed several variations of the proposed plan, each time providing feedback regarding the sufficiency of the plan and/or requesting evidence of completion for approved

interventions. At the time of the FY 2014–2015 site review (January 5, 2015), DHMP had not provided evidence of having implemented interventions to address the following:

- Timeliness of notice of action mailings.
- Revision to the DHMP member handbook to delete language concerning refusal to cover emergency care based on DHMP's notification requirements.
- Ensuring that notices of action contain the required content and are written at approximately the sixth-grade level for ease of understanding.

In addition, as of January 2015, DHMP had not sufficiently addressed the required actions related to timely access to care. This dynamic affected several requirements within the Coverage and Authorization standard as well as the Access and Availability standard.

As of August 2015, HSAG and the Department continued to work with DHMP.

Validation of Performance Measures

During its FY 2013–2014 review, HSAG recommended that DHMP focus its improvement efforts on measures with low performance ranking results. These measures were:

- Two younger age groups under *Children's and Adolescents' Access to Primary Care Practitioners (*These indicators benchmarked at or below the national HEDIS Medicaid 10th percentiles).
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (The rate was below the 25th percentile).

DHMP's HEDIS 2015 rates showed that these measures either had no significant rate change or had significant decline from HEDIS 2014. For *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, there was a change in reporting requirement from hybrid to administrative, which may have contributed to the HEDIS 2015 rate being approximately 20 percentage points lower than the HEDIS 2014 rate. With the exception of the youngest age groups, all other groups from *Children's and Adolescents' Access to Primary Care Practitioners* experienced a rate decline from HEDIS 2014. The entire measure continued to have low performance ranking results (none above the national HEDIS Medicaid 25th percentile). HSAG could not ascertain whether improvement efforts had been implemented by DHMP.

Validation of Performance Improvement Projects

This was DHMP's first submission of its *Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics* PIP; therefore, no prior requirements or recommendations existed.

Consumer Assessment of Healthcare Providers and Systems

DHMP demonstrated a substantial decrease in rates between FY 20012–2013 and FY 2013–2014 for five measures: *Getting Needed Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. HSAG recommended that DHMP direct quality improvement activities toward these measures.

Although none of the five measures experienced substantial changes in FY 2014–2015, DHMP experienced an increase of between 0.7 and 4.5 percentage points for four of the five measures. The FY 2014–2015 rate for *Rating of Specialist Seen Most Often* continued to decline by 4.5 percentage points; however, this measure had fewer than 100 respondents and may not be an accurate representation of the population as a whole. These results may indicate that DHMP followed up with HSAG's recommendation.

Kaiser Permanente Colorado

Compliance Monitoring Site Reviews

As a result of the 2013–2014 site review, Kaiser was required to address three *Partially Met* findings for Standard I—Coverage and Authorization related to (1) appeal rights information included in the Explanation of Benefits (EOB), and (2) time frames associated with notices of action. Kaiser was also required to address one *Partially Met* finding for Standard II—Access and Availability related to informing CHP+ members of scheduling guidelines.

Kaiser submitted a CAP to the Department and HSAG in April 2014, and in June Kaiser began submitting documents to demonstrate implementation of the planned interventions. The Department and HSAG determined in October 2014 that Kaiser had successfully implemented all planned interventions.

Validation of Performance Measures

During its FY 2013–2014 review, HSAG recommended that Kaiser focus its improvement efforts on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, where a statistically significant rate decline was noted.

Kaiser's HEDIS 2015 rates for this measure showed significant improvement of at least 5.0 percentage points on two indicators. The entire measure was at or above the national HEDIS Medicaid 90th percentile. This finding suggested that Kaiser had followed up with HSAG's recommendation.

Validation of Performance Improvement Projects

This was Kaiser's first submission of its *Access and Transition to Behavioral Health Services* PIP; therefore, there were no prior requirements or recommendations.

Consumer Assessment of Healthcare Providers and Systems

Kaiser had no substantial decreases in the rates; however, four measures had a slight decrease in rates between FY 2012–2013 and FY 2013–2014: *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. HSAG recommended Kaiser direct quality improvement activities toward these measures.

All four of these measures experienced a rate increase of between 1.4 and 6.3 percentage points in FY 2014–2015. The FY 2014–2015 rate for *Rating of Specialist Seen Most Often* experienced a substantial increase of 6.3 percentage points; however, this measure had fewer than 100 respondents and may not be an accurate representation of the population as a whole. These results may indicate that Kaiser followed up with HSAG's recommendation.

Rocky Mountain Health Plans

Compliance Monitoring Site Reviews

As a result of the 2013–2014 site review, RMHP was required to implement five corrective actions related to Coverage and Authorization of Services and three corrective actions related to Access and Availability. For Coverage and Authorization of Services, RMHP was required to address issues that had resulted in inappropriate denials of claims payment, confusing and inaccurate notifications to members, and holding members responsible for payment without indicating to them what the member or provider could do to see that the service was covered. For Access and Availability, RMHP was required to have an effective mechanism to regularly monitor CHP+ provider scheduling standards and to address areas of the CAHPS survey results that perform below the 50th percentile. RMHP was also required to develop policies and procedures to address cultural characteristics broader than linguistics (e.g., providing programs and services that incorporate the beliefs, attitudes, and practices of specific cultures) as well as to perform outreach to specific cultures for prevention and treatment of diseases prevalent in those groups.

RMHP submitted its proposed corrective action plan to HSAG and the Department in April 2014. HSAG and the Department worked with RMHP to ensure that planned interventions would fully address the required actions. HSAG reviewed documents on-site in June of 2014 and subsequently submitted in August 2014, when HSAG and the Department determined that RMHP had completed all required actions.

Validation of Performance Measures

During its FY 2013–2014 review, HSAG recommended that RMHP focus its improvement efforts on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Children's and Adolescents' Access to Primary Care Practitioners (Ages 12 to 24 Months* and the *Ages 25 Months to 6 Years*) measures. These indicators reported either a statistically significant decline in performance from the previous year or benchmarked below the national HEDIS Medicaid 10th percentiles.

With the exception of one age group under *Children's and Adolescents' Access to Primary Care Practitioners* reporting a statistically significant rate decline, RMHP's HEDIS 2015 rates on these two measures showed no significant changes. Most rates were still below the national HEDIS Medicaid 10th percentile. The lack of rate increase may be related to a change in the reporting requirement from hybrid to administrative and also potential membership increase related to Medicaid expansion. HSAG could not ascertain whether improvement efforts had been implemented by RMHP.

Validation of Performance Improvement Projects

This was RMHP's first submission of its *CHP+ Members with Asthma Transitioning Out of Plan Coverage* PIP; therefore, no prior requirements or recommendations existed.

Consumer Assessment of Healthcare Providers and Systems

RMHP had no substantial decreases in the rates between FY 2012–2013 and FY 2013–2014; however, rates decreased slightly for four measures: *Getting Needed Care*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan*. HSAG recommended that RMHP direct quality improvement activities toward these measures.

Of these four measures, two experienced a rate increase in FY 2014–2015 of between 0.6 and 4.6 percentage points while the other two experienced slight declines of 0.1 and 1.3. HSAG is not able to determine from these results whether RMHP implemented improvement efforts.

State Managed Care Network

Compliance Monitoring Site Reviews

The SMCN was not required to complete a corrective action plan in FY 2013–2014.

Validation of Performance Measures

During its FY 2013–2014 review, HSAG recommended that the Department focus its improvement efforts on the *Prenatal and Postpartum Care* measure. Both indicators exhibited a rate decrease from the previous year, with the *Timeliness* indicator showing a statistically significant decline. This indicator also benchmarked at or below the national HEDIS Medicaid 10th percentile.

For FY 2014–2015, SMCN did not undergo a NCQA HEDIS Compliance Audit; therefore, the calculated rates were not audited. Current year's rates for both indicators declined significantly (more than 20 percentage points) from last year. This decline may be due to a change in the reporting requirement from hybrid to administrative. HSAG could not ascertain whether improvement efforts had been implemented targeting this measure.

Validation of Performance Improvement Projects

The SMCN was not required to conduct a performance improvement project.

Consumer Assessment of Healthcare Providers and Systems

For FY 2013–2014, HSAG did not conduct CAHPS surveys of the SMCN population.

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 2014–2015 site review process, the Department requested a review of four areas of performance. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. HSAG developed a strategy and monitoring tools to review compliance with federal managed care regulations and managed care contract requirements related to each standard.

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plans' contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 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 healthcare. 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 healthcare regulations and contract requirements in the areas selected for review.
- Strengths, opportunities for improvement, and recommendations to bring the health plans into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the health plans, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the plans' services related to the areas reviewed.

Technical Methods of Data Collection

For the HMOs and the SMCN, HSAG performed the five compliance monitoring activities described in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. These activities were: establishing compliance thresholds, performing preliminary review, conducting site visits, compiling and analyzing 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 healthcare regulations and implementation of the organizations' policies. As part of Standard VI—Grievance System, HSAG conducted an on-site review of 10 appeal records and 10 grievance records, to the extent possible, to evaluate implementation of federal healthcare regulations and CHP+ managed care contract requirements as specified in 42CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. HSAG incorporated the results of the record reviews into the findings for the standard. HSAG also separately calculated a grievance record review score, an appeal record review score, and an overall record review score.

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 on-site interviews to provide clarity and perspective to the documents reviewed and processes/procedures in place to implement the requirements in the standards. 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 2014–2015.

Table A-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal healthcare regulations and managed care contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, and on-site agendas, and to set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.

Table A-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Medical Quality Improvement Committee meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG e-mailed the health plans a request for desk review documents, including the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site activities. Thirty days prior to the review, the health plans provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ grievances and appeals that occurred between January 1, 2014, and December 31, 2014. HSAG used a random sampling technique to select records for review during the site visit. ◆ 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 3:	**Conduct Site Visit**
	◆ During the on-site portion of the review, HSAG met with the health plans' key staff members to obtain a complete picture of the health plans' compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plans' performance. ◆ HSAG reviewed a sample of administrative records and evaluated implementation of managed care regulations related to CHP+ appeals and grievances. ◆ Also while on-site, 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 were confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with the plan's staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2014–2015 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, recommendations, and required actions based on the review findings.

Table A-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.

Description of Data Sources

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

- Committee meeting agendas, minutes, and handouts
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Consumer handbook and informational materials
- Staff training materials and documentation of attendance
- 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 and 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.

A sample of the health plan's administrative records related to CHP+ grievances and appeals was also reviewed to evaluate implementation of federal healthcare regulations and CHP+ managed care contract requirements as specified in 42CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all CHP+ grievances and appeals that occurred between January 1, 2014, and December 31, 2014, to the extent available at the time of the site review request. HSAG reviewed a

sample of 10 grievance records and 10 appeal records, to the extent possible. For the record review, the health plan received a score of *M* (*Met*), *N* (*Not Met*), or *NA* (*Not Applicable*) for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievance record review score, an appeal record review score, and an overall record review score.

All *Not Met* or *Partially Met* findings resulted in a required action, which was documented by HSAG in the corrective action plan (CAP) template approved by the Department. The CAP template was included in the final report to the health plan and the Department, and was used by the health plan to submit its intended corrective actions to HSAG and the Department for review. Corrective actions were monitored by HSAG and the Department until successfully completed.

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 is 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.

Technical Methods of Data Collection

HSAG followed a set of outlined policies and procedures to conduct the validation of performance measures. 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. HSAG conducted no NCQA HEDIS Compliance Audit of the Department's SMCN program.

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 staff. HSAG verified that key HEDIS topics such as timelines and on-site review dates were addressed by the licensed organizations.	HEDIS 2015 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 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 2015 FAR
Certified Measure Review—If a vendor with NCQA-certified measures was used, HSAG assessed whether all the required measures developed by the vendor were certified by NCQA.	HEDIS 2015 FAR and Measure Certification Reports
Source Code Review—HSAG ensured that the licensed organizations reviewed the programming language for calculating any HEDIS measures that did not undergo NCQA's measure certification process. 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).	HEDIS 2015 FAR
Survey Vendor—If the HMO used a survey vendor to perform the CAHPS surveys, HSAG verified that an NCQA-certified survey vendor was used. A certified survey vendor must be used if the HMO performed a CAHPS survey as part of HEDIS reporting.	HEDIS 2015 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 for CAHPS sample frames. This validation reviewed the source code to ensure that data were correctly queried in the output files, and HSAG conducted a detailed review of the survey eligibility file elements, including the healthcare 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 2015 FAR
Supplemental Data Validation—If the HMO used any supplemental data for reporting, the licensed organization was to validate the supplemental data according to NCQA's guideline. HSAG verified whether the licensed organization was following the NCQA-required approach while validating the supplemental databases.	HEDIS 2015 FAR
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	HEDIS 2015 FAR

Table B-1—Description of Data Sources Reviewed	
Data Reviewed	**Source of Data**
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 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.	
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 2015 FAR
IDSS Review—The HMOs 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. The auditor locks the IDSS so that no information can be changed. HSAG verified that the licensed organizations completed the IDSS review process. In a situation where the HMO did not submit the rates via IDSS, HSAG validated the accuracy of the rates submitted by the HMO in a State-specified reporting template.	HEDIS 2015 IDSS

Table B-2 identifies the key elements reviewed by HSAG during validation activities. HSAG identified whether or not each HMO was 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 contracted with to perform the required tasks.

Table B-2—Validation Activities

	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Licensed Organization	HealthcareData Company, LLC	DTS Group	Attest Health Care Advisors	DTS Group	DTS Group
Pre-on-site Visit Call/Meeting	✓	✓	✓	✓	✓
Roadmap Review	✓	✓	✓	✓	✓
Software Vendor	Verisk Health, Inc.	Altegra Health	Verisk Health, Inc.	None used	Inovalon, Inc.
Source Code/ Certified Measure Review	✓	✓	✓	✓	✓
Survey Vendor	Not applicable; Colorado Access did not conduct a CAHPS survey.	The Myers Group (for marketplace)	Morpace Inc. (product line not specified)	DSS Research (for commercial product line)	Center for the Study of Services (CSS) (all product lines)
CAHPS Sample Frame Validation	Not applicable; Colorado Access did not conduct a CAHPS survey.	✓	✓	✓	✓
Supplemental Data Validation	✓	✓	✓	✓	✓
Medical Record Review	✓	✓	✓	✓	✓
IDSS Review	✓	✓	✓	✓	✓

Table B-2 indicates that audits conducted for the HMOs included all of the listed validation activities. The HMOs used an NCQA-licensed organization to perform their HEDIS audits. In addition, all the HMOs, except Kaiser, used a vendor that underwent NCQA's measure certification process for calculating rates; therefore, source code review was only performed for Kaiser. Kaiser's source code was reviewed and subsequently approved by the licensed organization to be within the technical specifications. Four of the five HMOs 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. 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

HSAG determined results for each performance measure based on the validation activities previously described.

Appendix C. EQR Activities—Validation of Performance Improvement Projects

Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the validation of 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 completed validation activities on five PIPs for the CHP+ health plans. Table C-1 below lists the health plans and their PIP study titles.

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

Health Plans	PIP Study
Colorado Access	*Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan*
Colorado Choice	*Adolescent Positive Depression Disorder Screening and Transition to a Behavioral Health Provider*
DHMP	*Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*
Kaiser	*Access and Transition to Behavioral Health Services*
RMHP	*CHP+ Members with Asthma Transitioning Out of Plan Coverage*

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+ health plan 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. Use a Representative and Generalizable Study Population
- Activity IV. Select the Study Indicator(s)
- 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 PIPs that were initiated during or after 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 in Activity VIII.

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. 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.

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 PIP reviewers validated each PIP upon original submission; resubmitted PIPs were validated a second time. 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 D. EQR Activities—Consumer Assessment of Healthcare Providers and Systems

Introduction

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

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on the level of satisfaction that members have with their healthcare experiences.

Technical Methods of Data Collection

The technical method of data collection was through the administration of the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set for the CHP+ population. The survey includes a set of standardized items (48 items for the CAHPS 5.0 Child Medicaid Health Plan Survey without the Children with Chronic Conditions [CCC] measurement set) that assesses patient perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed for member selection and survey distribution. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instrument and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis.

The survey questions were categorized into nine measures of satisfaction that included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their personal doctors, specialists, all healthcare, and health plans. The composite scores were derived from sets of questions addressing different aspects of care (e.g., getting needed care and how well doctors communicate). Where a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the CAHPS survey fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," or "Always;" and (2) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

It is important to note that, with the release of the 2015 CAHPS 5.0 Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure; therefore, comparisons to NCQA national average data could not be performed for this measure for 2015.

Description of Data Obtained

Table D-1 and Table D-2 present the question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for the 2015 global ratings and 2015 composite scores, respectively, for the CHP+ plans. The tables also show the program average. Measures at or above the 2014 NCQA national averages are highlighted in yellow.

Table D-1—Global Proportions for Composite Scores

Measure of Member Satisfaction	CHP+ 2015					
	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	CHP+ Program Average
Getting Needed Care	84.7%	89.5%	71.0%	89.9%	86.9%	84.4%
Getting Care Quickly	87.3%	91.1%	79.7%	91.1%	93.1%	88.0%
How Well Doctors Communicate	95.3%	95.4%	92.8%	96.6%	96.9%	95.4%
Customer Service	83.5%	81.8%+	85.2%	86.2%	79.4%	83.2%
Shared Decision Making	78.3%+	76.0%+	76.0%+	77.2%+	73.8%+	77.2%

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

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

Due to changes to the *Shared Decision Making* composite measure, comparisons to national data could not be performed for 2015.

Indicates a rate is at or above the 2014 NCQA CAHPS national average.

Table D-2—Question Summary Rates for Global Ratings

Measure of Member Satisfaction	CHP+ 2015					
	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	CHP+ Program Average
Rating of Personal Doctor	72.2%	60.3%	73.1%	75.2%	70.4%	71.9%
Rating of Specialist Seen Most Often	68.0%	63.6%+	63.6%+	72.1%+	68.6%+	67.9%
Rating of All Health Care	58.5%	54.3%	60.3%	63.6%	57.9%	58.9%
Rating of Health Plan	58.5%	54.1%	55.4%	62.3%	60.0%	58.6%

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

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

Indicates a rate is at or above the 2014 NCQA CAHPS national average.

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate quality, timeliness, and access. HSAG recognized the interdependence of quality, timeliness, and access and has assigned each of the CAHPS survey measures to one or more of the three domains. Using this framework, Table D-3 shows HSAG's assignment of the CAHPS measures to these performance domains.

Table D-3—Assignment of CAHPS Measures to Performance Domains

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

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 2014–2015.

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. 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—Compliance Summary Scores

Description of Component	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services (2014)	88%	71%	85%	91%	85%	84%
Standard II—Access and Availability (2014)	91%	73%	81%	95%	86%	85%
Standard III—Coordination and Continuity of Care (2013)	100%	33%	100%	89%	89%	82%
Standard IV—Member Rights and Protections (2013)	100%	20%	100%	80%	40%	68%
Standard V—Member Information (2015)	91%	74%	91%	52%	52%	72%
Standard VI—Grievance System (2015)	77%	27%	81%	65%	77%	65%
Standard VII—Provider Participation and Program Integrity (2015)	100%	69%	100%	88%	94%	90%
Standard VIII—Credentialing and Recredentialing (2013)	98%	39%	94%	100%	98%	86%
Standard IX—Subcontracts and Delegation (2015)	100%	60%	100%	100%	100%	92%
Standard X—Quality Assessment and Performance Improvement (2013)	100%	34%	91%	100%	73%	76%

Standards in black were reviewed in FY 2014–2015.

Standards presented in green text were reviewed in FY 2013–2014.

Standards presented in blue text were reviewed in FY 2012–2013.

Table E-2—Record Review Scores						
Record Reviews	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average
Appeals (2015)	75%	72%	67%	75%	96%	81%
Denials (2014)	95%	56%	87%	62%	71%	69%
Grievances (2015)	77%	NA*	100%	50%	97%	75%
Credentialing (2013)	100%	97%	100%	100%	100%	99%
Recredentialing (2013)	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—2014–2015 Performance Measure Results for each HMO and Statewide Average							
Performance Measures	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	SMCN	Statewide Average
Childhood Immunization Status							
Combination 2	63.37%	NA	68.91%	78.62%	46.88%	—	61.27%
Combination 3	61.76%	NA	68.91%	77.36%	45.31%	—	59.89%
Combination 4	55.21%	NA	68.91%	76.73%	42.97%	—	55.61%
Combination 5	52.81%	NA	63.87%	59.12%	37.11%	—	50.42%
Combination 6	42.91%	NA	52.10%	52.83%	34.38%	—	42.40%
Combination 7	47.59%	NA	63.87%	59.12%	35.16%	—	47.06%
Combination 8	39.30%	NA	52.10%	52.83%	32.81%	—	40.03%
Combination 9	37.43%	NA	49.58%	41.51%	31.64%	—	37.13%
Combination 10	34.36%	NA	49.58%	41.51%	30.08%	—	35.06%
Well-Child Visits in the First 15 Months of Life							
Zero Visits	1.33%	NA	4.00%	0.00%[3]	68.18%	—	18.20%
6+ Visits	62.83%	NA	4.00%	72.88%	17.27%	—	45.18%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.85%	48.92%	48.52%	60.93%	54.81%	—	61.59%
Adolescent Well-Care Visits	42.49%	33.46%	34.84%	42.02%	34.56%	—	40.38%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Assessment: Total	50.12%	35.00%	90.27%	91.24%	74.56%	—	60.81%
Counseling for Nutrition: Total	52.80%	36.00%	78.59%	98.54%	63.05%	—	61.19%
Counseling for Physical Activity: Total	48.66%	40.00%	62.77%	98.30%	62.39%	—	57.49%

Table E-3—2014–2015 Performance Measure Results for each HMO and Statewide Average							
Performance Measures	**Colorado Access**	**Colorado Choice**	**DHMP**	**Kaiser**	**RMHP**	**SMCN**	**Statewide Average**
Immunizations for Adolescents—Combination 1	64.35%	26.32%[1]	73.39%	80.66%	49.57%	—	64.11%
Appropriate Testing for Children with Pharyngitis	77.64%	63.49%	68.75%	92.28%	79.23%	—	79.64%
Children's and Adolescents' Access to Primary Care Practitioners							
Ages 12 to 24 Months	96.66%	NA	89.29%	92.06%	87.97%	—	93.22%
Ages 25 Months to 6 Years	85.23%	73.86%	58.02%	81.05%	76.20%	—	80.57%
Ages 7 to 11 Years	92.71%	83.13%	81.33%	93.57%	82.91%	—	89.64%
Ages 12 to 19 Years	92.29%	92.86%	83.70%	94.14%	83.42%	—	90.09%
Non-recommended Cervical Cancer Screening in Adolescent Females	0.66%	4.08%	0.00%	0.00%	0.82%	—	0.62%
Chlamydia Screening in Women—Total	31.08%	NA	45.65%	81.46%	20.30%	—	57.01%
Antidepressant Medication Management							
Effective Acute Phase Treatment	NA	NA	NA	NA	NA	—	NA
Effective Continuation Phase Treatment	NA	NA	NA	NA	NA	—	NA
Follow-up Care for Children Prescribed ADHD Medication							
Initiation	43.59%	NA	NA	51.35%	45.95%	—	46.01%
Continuation	43.33%	NA	NA	NA	NA	—	41.82%
Follow-up After Hospitalization for Mental Illness							
30-Day	68.27%	NA	NA	NA	NA	—	69.40%
7-Day	47.12%	NA	NA	NA	NA	—	47.01%
Appropriate Treatment for Children With Upper Respiratory Infection	90.84%	81.72%	97.42%	95.81%	91.37%	—	91.05%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	NR	NA	NA	NA	NA	—	NA
Use of Appropriate Medications for People With Asthma—Total	94.20%	NA	NA	NA	80.49%	—	92.21%
Medication Management for People With Asthma—Total (Medication Compliance 50%)	42.65%	NA	NA	NA	54.55%	—	46.96%
Medication Management for People With Asthma—Total (Medication Compliance 75%)	18.48%	NA	NA	NA	27.27%	—	20.27%
Asthma Medication Ratio—Total	76.79%	NA	NA	NA	70.73%	—	74.17%

Table E-3—2014–2015 Performance Measure Results for each HMO and Statewide Average							
Performance Measures	**Colorado Access**	**Colorado Choice**	**DHMP**	**Kaiser**	**RMHP**	**SMCN**	**Statewide Average**
Ambulatory Care (per 1,000 member months)							
Outpatient Visits	222.16	206.36	110.22	178.96	208.05	—	204.21
Emergency Department Visits	30.08	22.59	25.06	16.29	20.65	—	26.31
Inpatient Utilization—General Hospital/Acute Care: Total							
Discharges per 1,000 MM (total inpatient)	1.42	0.77	1.18	0.88	1.14	—	1.28
Days per 1,000 MM (total inpatient)	4.75	1.60	3.60	3.49	4.31	—	4.34
Average Length of Stay (total inpatient)	3.33	2.08	3.04	3.99	3.77	—	3.41
Discharges per 1,000 MM (medicine)	1.09	0.47	0.80	0.73	0.78	—	0.96
Days per 1,000 MM (medicine)	2.82	1.25	1.85	2.11	1.82	—	2.46
Average Length of Stay (medicine)	2.58	2.63	2.31	2.89	2.33	—	2.56
Discharges per 1,000 MM (surgery)	0.23	0.24	0.33	0.12	0.33	—	0.24
Days per 1,000 MM (surgery)	1.67	0.30	1.65	1.30	2.42	—	1.69
Average Length of Stay (surgery)	7.27	1.25	4.95	10.55	7.28	—	7.06
Discharges per 1,000 MM (maternity)	0.23	0.00	0.11	0.05	0.07	—	0.16
Days per 1,000 MM (maternity)	0.57	0.00	0.22	0.16	0.16	—	0.41
Average Length of Stay (maternity)	2.51	0.00	2.00	3.50	2.33	—	2.51
Antibiotic Utilization							
Average Scrips for PMPY for Antibiotics (All Ages)	0.63	0.61	0.13	0.05	0.48	—	0.49
Average Days Supplied per Antibiotic Scrip (All Ages)	10.50	6.39	10.61	11.04	10.57	—	10.39
Average Scrips PMPY for Antibiotics of Concern (All Ages)	0.25	0.27	0.04	0.01	0.20	—	0.19
Percentage of Antibiotics of Concern of All Antibiotic Scrips (All Ages)	39.05%	44.84%	28.90%	29.56%	41.41%	—	39.19%
Mental Health Utilization: Total							
Any Services	6.60%	3.98%	2.40%	<0.01%	5.06%	—	0.68%
Inpatient	0.35%	0.14%	0.14%	<0.01%	0.19%	—	0.03%

Table E-3—2014–2015 Performance Measure Results for each HMO and Statewide Average							
Performance Measures	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	SMCN	Statewide Average
Intensive Outpatient/Partial Hospitalization	2.65%	1.78%	0.08%	0.00%	0.00%	—	0.22%
Outpatient/ED	5.36%	3.98%	2.36%	<0.01%	5.03%	—	0.57%
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	—	—	—	—	—	30.36%	30.36%
Postpartum Care	—	—	—	—	—	37.80%	37.80%

— is shown when no data were available or the measure was not reported.
NA is shown when the health plan followed HEDIS specifications but the denominator is too small (<30) to report a valid rate.

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				
HMO	PIP Study	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Colorado Access	*Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan*	100%	100%	*Met*
Colorado Choice	*Adolescent Positive Depression Disorder Screening and Transition to a Behavioral Health Provider*	100%	100%	*Met*
DHMP	*Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*	100%	100%	*Met*
Kaiser	*Access and Transition to Behavioral Health Services*	100%	100%	*Met*
RMHP	*CHP+ Members With Asthma Transitioning Out of Plan Coverage*	100%	100%	*Met*

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

Table E-5 shows each health plan's summary rates and global proportions for the child CAHPS survey.

Table E-5—CHP+ Question Summary Rates and Global Proportions

Measure	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average
Getting Needed Care	84.7%	89.5%	71.0%	89.9%	86.9%	84.4%
Getting Care Quickly	87.3%	91.1%	79.7%	91.1%	93.1%	88.0%
How Well Doctors Communicate	95.3%	95.4%	92.8%	96.6%	96.9%	95.4%
Customer Service	83.5%	81.8%	85.2%	86.2%	79.4%	83.2%
Shared Decision Making	78.3%	76.0%	76.0%	77.2%	73.8%	77.2%
Rating of Personal Doctor	72.2%	60.3%	73.1%	75.2%	70.4%	71.9%
Rating of Specialist Seen Most Often	68.0%	63.6%	63.6%	72.1%	68.6%	67.9%
Rating of All Health Care	58.5%	54.3%	60.3%	63.6%	57.9%	58.9%
Rating of Health Plan	58.5%	54.1%	55.4%	62.3%	60.0%	58.6%

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