CHP+

Child Health Plan *Plus*

2015–2016 External Quality Review Technical Report for Child Health Plan *Plus*

December 2016

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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 health plans regarding quality, timeliness, and access to services, 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 Colorado's 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 Department required the CHP+ HMOs and the SMCN to participate in the three mandatory EQR activities and one optional activity, with the exception that the SMCN was not required to complete a performance improvement project (PIP) or Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-1] surveys. As set forth in 42 CFR 438.352, the three mandatory activities are:

- **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 four standard areas developed collaboratively with the Department.
- **Validation of performance measures.** HSAG validated each of the performance measures identified by the Department to assess 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.** HSAG reviewed the health plans' PIPs to ensure that the projects were designed, conducted, and reported in a methodologically sound manner.

The optional activity was:

- **CAHPS survey.** HSAG conducted surveys and reporting of results for all CHP+ health plans on behalf of the Department. For the CHP+ health plans' findings, a substantial increase is noted when a measure's rate increased by 5 percentage points or more from the previous year. A substantial decrease is noted when a measure's rate decreased by 5 percentage points or more from the previous year.

Definitions

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

Quality

Centers for Medicare & Medicaid Services (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 an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement."[1-2]

[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 81, May 6, 2016.

Timeliness

The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-3] NCQA further states 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—e.g., processing expedited appeals and providing timely follow-up care. In the final 2016 federal healthcare managed care regulations, CMS recognizes the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR 438.206(a) and by requiring states, at 42 CFR 438.68(b), to develop both time and distance standards for network adequacy.

Access

CMS defines access in the final 2016 regulations at 42 CFR 438.320 as follows: "*Access*, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."

Overall Conclusions

To draw conclusions about the quality and timeliness of, and access to, services provided by the CHP+ 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 health 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

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

[1-3] National Committee for Quality Assurance. 2013 Standards and Guidelines for MBHOs and MCOs.

Performance Measures	Quality	Timeliness	Access
Childhood Immunization Status	✓	✓	
Immunizations for Adolescents	✓	✓	
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	✓		
Appropriate Testing for Children With Pharyngitis	✓		
Prenatal and Postpartum Care	✓	✓	✓
Children's and Adolescents' Access to Primary Care Practitioners (PCPs)			✓
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
Antidepressant Medication Management	✓		
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Medication Management for People With Asthma	✓		
Asthma Medication Ratio	✓		
Ambulatory Care (Per 1,000 Member Months)			✓
Inpatient Utilization—General Hospital/Acute Care			✓
Antibiotic Utilization			✓
Performance Improvement Projects	**Quality**	**Timeliness**	**Access**
Performance Improvement Projects	✓		
CAHPS Topics	**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	✓		

Quality

Performance in the quality domain across all EQR activities and among the six CHP+ health plans (including the SMCN only for the compliance monitoring activity) was mixed. For compliance monitoring, HSAG assigned all four standards to the quality domain and found, overall, many statewide strengths. Three of the six health plans earned 100 percent compliance in the coordination and continuity of care standard, with another earning 90 percent. HSAG found that the remaining two health plans (earning 75 percent and 50 percent respectively in the care coordination standard) had systems issues that prevented the health plans from developing comprehensive care coordination programs. One of these health plans lacked an internal operational structure to support an effective care coordination program. While the scores for member rights and protections were the lowest (with a statewide score of 80 percent), all six health plans demonstrated a desire to comply with regulations. HSAG observed the strongest performance in the credentialing and recredentialing standard, followed closely by the quality assessment and performance improvement standard, in which the greatest number of health plans were found to be 100 percent compliant. HSAG assigned all four standards to the quality domain; therefore, it is important to note that the statewide overall compliance score was 91 percent, with five of the six health plans earning 94 percent or above and one health plan earning an overall compliance score of 72 percent.

For the performance measures activity, statewide weighted average performance in the quality domain was assessed based on rates for 29 quality-related Healthcare Effectiveness Data and Information Set (HEDIS®) measure indicators.[1-4,1-5] One measure indicator reported for HEDIS 2016 was new, and two measure indicators reported for HEDIS 2016 were based on low denominators (fewer than 30); therefore, the rates were designated as Not Available (NA) and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these three measures.

Two of the 26 quality-related measure rates ranked at or above the national Medicaid 90th percentile, specifically related to the percentage of adolescent females who unnecessarily received a cervical cancer screening and those members who have persistent asthma and received a ratio of controller medications. Five of the 26 measure rates reported for HEDIS 2016 comparable to HEDIS 2015 rates showed statistically significant improvement in the quality provided statewide, including rates related to immunizations for adolescents, the percentage of members who received the appropriate number of well-child and well-care visits, as well as documentation of a weight assessment and counseling for nutrition and physical activity for children and adolescent members.

Conversely, six of the 26 HEDIS 2016 measure rates fell below the national Medicaid 10th percentile, with three of these six HEDIS 2016 measures correlating to immunizations for children. Additionally, rates for six of the 26 quality-related measures demonstrated statistically significant declines in quality-related performance from 2015 to 2016, for which four of the six measures with statistically significant

[1-4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-5] The CHP+ SMCN's rates for two measure indicators related to prenatal and postpartum care were not reportable due to insufficient data; therefore, analyses and discussion of the rates were excluded both from this report and in the total count of measures assessed.

declines were related to immunizations for children. As a result, statewide weighted average rates indicated opportunity for improvement related to documentation of immunizations for children, administration of chlamydia screenings for women, and appropriate follow-up care visits for children prescribed ADHD medication.

For the validation of performance improvement projects activity, HSAG assigned all PIPs to the quality domain. While the focus of a health plan's PIP may have been to improve performance related to quality, timeliness, or access to services, PIP validation activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Three of the five PIPs validated by HSAG earned a *Met* validation status, demonstrating a sound application of design principles necessary to produce valid and reliable PIP results and strong quality improvement (QI) processes and activities needed to support desired improvement. For the two PIPs that received a *Partially Met* validation status, both health plans will need to address HSAG's feedback in Activity VIII (Improvement Strategies) to ensure that appropriate QI tools and processes are used to drive improvement in the outcomes stage of the PIP. In validation scores and validation status, all PIPs demonstrated solid performance in the PIP design stage; however, performance in the implementation stage varied. Three of the five PIPs reviewed by HSAG demonstrated strong performance in the implementation stage and received a *Met* validation status. The remaining two PIPs each received a *Partially Met* validation status, both because of deficiencies in Activity VIII (Improvement Strategies). One health plan did not report the QI tools used to identify barriers or the processes used to determine the relative priority of identified barriers. The second health plan did not describe the process used to prioritize identified barriers. This PIP also lacked timely, active interventions that could directly impact study indicator outcomes.

For the CAHPS activity, all measures within the CAHPS survey addressed quality. One statewide measure rate increased substantially, *Rating of All Health Care*. Seven measures demonstrated increases: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. As noted, no measures' rates decreased substantially; however, one measure, *Customer Service* showed a rate decrease.

Timeliness

Performance in the timeliness domain across all EQR activities and among the six CHP+ health plans was also mixed. For the compliance monitoring activity, HSAG determined that no standards reviewed in fiscal year (FY) 2015–2016 assessed elements within the timeliness domain.

Related to the validation of performance measures activity, statewide performance in the timeliness domain was assessed based on rates for 16 timeliness-related HEDIS measure indicators.[1-6] Similar to the quality-related performance, the statewide weighted average timeliness-related measure rates indicated positive performance with regard to immunizations for adolescents, documentation of

[1-6] The CHP+ SMCN's rates for two measure indicators related to prenatal and postpartum care were not reportable due to insufficient data; therefore, analyses and discussion of the rates were excluded both from this report and in the total count of measures assessed.

immunizations for children, and the number of members who received the appropriate number of well-child and adolescent well-care visits, ranking at or above the 25th national Medicaid percentile. Additionally, three of the 16 measure rates in the timeliness-related domain demonstrated statistically significant improvement from HEDIS 2015 to HEDIS 2016. Again, analogous to the statewide quality-related measures, statewide weighted average rates indicated opportunity for improved timeliness of care related to documentation of immunizations for children and appropriate follow-up care visits for children prescribed ADHD medication as rates for two of the 16 timeliness-related measures ranked below the national Medicaid 10th percentile and indicated statistically significant decline from HEDIS 2015.

For the CAHPS activity, one measure, *Getting Care Quickly* addressed the timeliness domain. This measure demonstrated an increase statewide. One health plan demonstrated a substantial increase for this measure. Three other health plans demonstrated decreases in this measure, none of which were substantial.

Access

HSAG found the statewide performance in the access domain also mixed. For the compliance monitoring activity, HSAG found elements that addressed the access domain in three of the four standards reviewed: Coordination and Continuity of Care, Member Rights and Protections, and Quality Assessment and Performance Improvement. Five of the six health plans had policies that described the processes and persons responsible for coordinating care for all members and provided additional support services for members with complex needs. All health plans allowed members direct access to specialty providers. The health plans' quality assessment and performance improvement (QAPI) programs included mechanisms to ensure that their networks were capable of providing members all necessary services. One health plan was found to have adequate QAPI policies and procedures related to access to care, but HSAG found that this health plan had not effectively implemented those policies and procedures.

For the validation of performance measures activity, statewide performance in the access domain was assessed based on HEDIS rates for four measure indicators and compared between HEDIS 2015 and HEDIS 2016. One of these rates exhibited a statistically significant increase from HEDIS 2015 to 2016, demonstrating improved children's access to primary care practitioners. Most notably, with regard to access-related measures, the statewide weighted average rate of emergency department utilization for HEDIS 2016 ranked at or above the national Medicaid 90th percentile, which potentially indicates avoidance of unnecessary emergency services for nonemergent conditions.

For the CAHPS activity, *Getting Needed Care* addressed the access domain. This measure demonstrated a slight statewide increase. Two health plans demonstrated an increase in this rate. Another health plan demonstrated a substantial decrease in this rate. Two additional health plans demonstrated decreases in this rate; however, those decreases were not substantial.

2. External Quality Review (EQR) Activities

Activities

This EQR report includes a description of four performance activities for the CHP+ health plans: compliance monitoring evaluations, validation of performance measures required by the State, validation of PIPs required by the State, 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 quality, timeliness, and access to services 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 the EQR activities. Also included are HSAG's recommendations for improving the health plans' performance. In addition, this section includes a summary assessment related to the quality and timeliness of and access to services furnished by each health plan as well as a summary of overall statewide performance related to the quality and timeliness of and access to services.

Compliance Monitoring Site Reviews

For the FY 2015–2016 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 to review these performance areas. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. For each standard, HSAG conducted a desk review of documents sent by the health plan prior to the on-site portion of the review, conducted interviews with key health plan staff members on-site, and reviewed additional key documents on-site.

HSAG also reviewed the health plans' administrative credentialing and recredentialing records to evaluate implementation of federal healthcare regulations and compliance with NCQA credentialing and recredentialing standards and guidelines, effective July 2015. Using a random sampling technique, HSAG selected a sample of 10 plus an oversample of five records from all of the health plans' credentialing and recredentialing that occurred between January 1, 2013, and December 31, 2015. 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 VIII—Credentialing and Recredentialing. HSAG also calculated an overall record review score separately.

HSAG determined which standards contained requirements that related to the domains of quality, timeliness, or access to services, as shown in Table 3-1. Appendix A contains further details about the methodology used to conduct the EQR compliance monitoring site review activities.

Table 3-1—Assignment of Compliance Standards to Performance Domains

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

Colorado Access

Findings

Table 3-2 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and Colorado Access' overall compliance score for FY 2015–2016.

Table 3-2—Summary of Scores for the Standards for Colorado Access

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	12	12	11	1	0	0	92%
IV—Member Rights and Protections	5	5	4	0	1	0	80%
VIII—Credentialing and Recredentialing	48	47	44	3	0	1	94%
X—Quality Assessment and Performance Improvement	15	15	15	0	0	0	100%
Totals	**80**	**79**	**74**	**4**	**1**	**1**	**94%**

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

Table 3-3 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and Colorado Access' overall compliance score for FY 2015–2016.

Table 3-3—Summary of Scores for the Record Reviews for Colorado Access

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	83	83	0	7	100%
Recredentialing	90	90	88	2	0	98%
Totals	**180**	**173**	**171**	**2**	**7**	**99%**

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

Strengths

Colorado Access policies and procedures outlined its processes for care coordination for members with intensive care coordination or special healthcare needs. These processes included completion of a health risk assessment (HRA), member outreach, care planning, developing interventions, and coordinating with external agencies and health plans. Colorado Access informed its primary care providers (PCPs) of their responsibility to coordinate care with specialists and that Colorado Access care managers are available to assist with members with complex needs. Colorado Access did not require referrals or prior authorization for access to in-network specialist services and arranged for members to receive services out of network, as necessary, through single-case provider agreements. Care managers followed up with all members identified as having special needs and/or potential transition-of-care needs to perform a more in-depth needs assessment, develop a care plan, connect the member to needed services, and ensure continuity of care with existing providers.

Colorado Access had policies and procedures that articulated its commitment to ensuring the rights of its members, provided guidance to staff members on how to report suspected and alleged rights violations, and described the process for investigating such reports. All Colorado Access customer service staff members participated in member rights training within the review period. Colorado Access offered new providers an introductory webinar training that included a review of member rights and how to report suspected and alleged rights violations and included this information in the provider manual and on the Colorado Access website. Colorado Access also included information about member rights in member newsletters, annual member mailings, on the website, and in the member handbook.

The Colorado Access policies and procedures related to credentialing and recredentialing individual and organizational providers were well-written, comprehensive, and compliant with NCQA credentialing and recredentialing standards and guidelines. HSAG encountered various scenarios during on-site record reviews that demonstrated that staff were credentialing and recredentialing providers in a manner consistent with the written procedures. HSAG reviewed credentialing committee meeting minutes that confirmed the credentialing committee met regularly, reviewed credentialing and recredentialing files from Colorado Access and from delegates, and made appropriate determinations.

Colorado Access' Quality Management Department conducted in-depth internal analysis of quality data, studies, and indicators, and worked with providers and the Executive Management Team regarding improvements required. The administrative management representatives from all lines of business met monthly to review quality performance data. Colorado Access reported outcomes of internal analysis and actions taken or recommended to the Quality Improvement Committee (QIC) (accountable to the Board of Directors). All CHP+ quality activities were reported to the QIC through a well-designed and comprehensive annual report which presented an overview and summary data from all quality activities performed throughout the year.

Recommendations

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

Standard III—Coordination and Continuity of Care

- Colorado Access was required to remove statements from the CHP+ member handbook that stipulated additional restrictions on when a member with special healthcare needs or a member in the second or third trimester of pregnancy may continue an ongoing course of treatment or services.

Standard IV—Member Rights and Protections

- Colorado Access was required to revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.

Standard VIII—Credentialing and Recredentialing

- Colorado Access was required to either revise its policy regarding verification of board certification of certified nurse midwives (CNMs) or ensure that it verifies board certification of CNMs in compliance with its policies.
- Colorado Access was required to develop and employ a process to ensure that organizations with which it contracts are recredentialed at least every three years.
- Colorado Access was required to ensure that unaccredited organizations with which it contracts credential practitioners in a manner consistent with Colorado Access' own policies, procedures, and standards.
- Colorado Access was required to specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified in Colorado Access' policy; that reviews used are no more than three years old at the time of the credentialing decision; and that, if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access will ensure and document that the organization completed those corrective actions.

Colorado Access: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of Colorado Access' compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined performance across all four standards when evaluating the quality of care—defined as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes"—provided by Colorado Access. The corrective actions required of Colorado Access were all related to the quality standard; however, these deficiencies were relatively minor. Colorado Access offered a multi-layered system of care coordination that ensured that every member received the most appropriate level of assistance with coordinating services. Colorado Access had processes to ensure that all members received a needs assessment and that members and their families participated in the development of individual treatment plans. Colorado Access informed members, providers, and staff about the rights afforded to members under State and federal laws and had processes to ensure that rights were taken into account when furnishing services. The NCQA-compliant credentialing and recredentialing processes helped ensure a comprehensive network of qualified providers. Colorado Access also demonstrated a robust QAPI program that provided for the ongoing evaluation of access and availability; utilization management; member satisfaction; clinical outcomes/performance measures; PIPs; and evaluation of internal operational performance, practice guidelines, and care management. Overall, Colorado Access' performance in the quality domain was strong.

Access: CMS defined access as "the timely use of services to achieve optimal outcomes." Colorado Access designed its coordination of care program to assist members with complex needs with accessing necessary behavioral and physical health services. Its policies allowed members with special healthcare needs and members who are pregnant to continue receiving services from existing providers, regardless of the provider's network affiliation. When and if members required services not available in network, Colorado Access had processes in place to provide members with access to out-of-network providers at no cost to the member.

Colorado Choice Health Plans

Findings

Table 3-4 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	12	12	6	1	5	0	50%
IV—Member Rights and Protections	5	5	4	1	0	0	80%
VIII—Credentialing and Recredentialing	48	39	30	9	0	9	77%
X—Quality Assessment and Performance Improvement	15	15	11	2	2	0	73%
Totals	**80**	**71**	**51**	**13**	**7**	**9**	**72%**

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

Table 3-5 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 3-5—Summary of Scores for the Record Reviews for Colorado Choice

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	89	79	10	1	89%
Recredentialing	90	87	84	3	3	97%
Totals	**180**	**176**	**163**	**13**	**4**	**93%**

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

Strengths

HSAG identified numerous areas for improvement within coordination and continuity of care. However, it is of note that, prior to the site visit, Colorado Choice had self-identified deficiencies in many of these areas and had begun taking action. A newly hired quality director appeared goal-oriented and demonstrated such with a self-imposed case management corrective action plan that Colorado Choice presented to HSAG during the site review. HSAG reviewers noted a sense of enthusiasm about the development of new systems and processes to better serve the member population.

Colorado Choice's Member Rights and Responsibilities policy described the processes used to educate staff members, providers, and members about member rights and Colorado Choice's responsibility to ensure adherence to member rights. Colorado Choice informed members about their rights in the member handbook and reminded them of their rights via an annual letter. Colorado Choice informed providers of their responsibility to uphold member rights in the professional services agreement and included the list of member rights in the provider manual. Colorado Choice also informed its staff about member rights during new hire orientation and again annually.

Colorado Choice demonstrated having a well-defined credentialing and recredentialing process. The credentialing plan specified the types of providers subject to being credentialed and recredentialed, verification sources used, and processes followed—and included measures to ensure a nondiscriminatory program. Procedures and documents described the range of actions available to Colorado Choice against practitioners who failed to meet its quality standards as well as the two-tiered appeal process available to practitioners and delineated the process for reporting actions to the appropriate authorities. Staff members described the process for monthly monitoring of the State licensing board for sanctions, restrictions, and limitations as well as the process for monthly monitoring for Medicare and Medicaid sanctions.

Colorado Choice's Quality Assurance Committee (QAC) met regularly to make recommendations regarding quality assurance/quality improvement processes to the Colorado Choice Board of Directors (BoD). The BoD was ultimately responsible for reviewing and approving the activities related to the quality improvement program. The Colorado Choice Physician Advisory Committee (PAC) adopted practice guidelines from a myriad of reliable sources and made them easily accessible on the Colorado Choice website. Colorado Choice calculated HEDIS and CAHPS measures and submitted results, as required. Colorado Choice had an electronic health information system that collected data on member and provider characteristics. The system was capable of analyzing, integrating, and reporting data.

Recommendations

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

Standard III—Coordination and Continuity of Care

- Colorado Choice was required to develop and implement comprehensive written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and promote service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living.
- Colorado Choice was required to develop and implement procedures to address care coordination for members who require complex coordination of benefits and services and who may require services from multiple providers and/or other community resources.
- Colorado Choice was required to develop and implement procedures to provide members an individual needs assessment within 30 days of enrollment and at any other necessary time. The

assessment was required to identify ongoing conditions that require a course of treatment or regular care monitoring.

- Colorado Choice was required to develop and implement comprehensive procedures to create an individual treatment plan based on the needs assessment. The treatment plan was also required to address treatment objectives, treatment follow-up, and monitoring of outcomes; and should be revised as necessary.
- Colorado Choice was required to develop procedures to identify and accommodate members' cultural needs.
- Colorado Choice was required to develop a process wherein the health plan is directly responsible for informing new members who are pregnant or have special healthcare needs of the option to continue care with their current providers for a specified period.

Standard IV—Member Rights and Protections

- Colorado Choice was required to remove from its member handbook and its provider manual any language implying that members are required to follow recommended treatments.

Standard VIII—Credentialing and Recredentialing

- Colorado Choice was required to update its credentialing plan and desktop procedure to include NCQA-approved verification sources for Drug Enforcement Agency (DEA) certification.
- Colorado Choice was required to revise its credentialing plan to accurately describe the criteria used for making credentialing and recredentialing decisions.
- Colorado Choice was required to revise its credentialing plan to ensure that its policy for delegating credentialing and recredentialing is compliant with NCQA requirements.
- Colorado Choice was required to revise applicable documents to convey a consistent procedure for ensuring the confidentiality of information obtained during the credentialing process.
- Colorado Choice was required to collect practitioner applications in an acceptable format that includes required elements and provider attestation.
- Colorado Choice was required to update its desktop procedure for office site visits to describe a process to ensure that practitioner offices meet stated standards. Colorado Choice was also required to describe interventions to be implemented in instances when provider sites do not meet standards.
- Colorado Choice was required to revise its policies and procedures to describe a process to ensure that organizational providers credential their practitioners.
- Colorado Choice was required to revise its policy and procedures to specify the circumstances under which it may substitute a CMS or State site visit in lieu of conducting its own site visit.

Standard X—Quality Assessment and Performance Improvement

- Colorado Choice was required to revise its QAPI program to ensure that it includes processes for reviewing areas identified as needing improvement and for taking action to improve these areas.
- Colorado Choice was required to expand its QAPI program to ensure that mechanisms are in place to effectively detect both under- and overutilization of services.
- Colorado Choice was required to expand its QAPI program to include mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs.
- Colorado Choice was required to develop a process to ensure that all expressions of dissatisfaction, no matter how "small" or how quickly remedied, are captured by staff and used for periodic trending. All areas where trends are identified—whether via the grievance and appeals system, CAHPS reports, anecdotal information, or enrollment and disenrollment information—must be monitored by the appropriate committee and assessed for appropriate action.

Colorado Choice: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of Colorado Choice's compliance monitoring site review results related to the domains of quality and access.

Quality: Colorado Choice's performance, as it relates to the quality domain, was poor. During the on-site interview, Colorado Choice staff openly acknowledged that they had not been providing care coordination as mandated by State contract and federal regulations. Colorado Choice did not consistently conduct needs assessments or develop treatment plans for its members. Its provider manual and member handbook included statements that implied doctors could refuse to treat members who refused recommended treatment. Colorado Choice's QAPI program addressed only basic federal and State requirements and had no system in place to allow for comprehensive utilization management, quality assurance, or improvement initiatives. Additionally, Colorado Choice had not been recording grievances appropriately for trending and QAPI committee action.

Access: The absence of a comprehensive coordination of care program also had a substantially negative impact on Colorado Choice's performance in the access domain. The rural location of Colorado Choice's membership presents barriers to care that many members are unable to overcome without additional assistance from the health plan. However, the health plan had processes to ensure that each member is assigned a primary care provider within the first few days of enrollment; it allowed members with special healthcare needs direct access to in-network specialty providers; and when medically necessary services were not available in-network, Colorado Choice had processes to make arrangements for members to receive services from out-of-network providers at no additional cost to the member.

Denver Health Medical Plan, Inc.

Findings

Table 3-6 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	13	12	12	0	0	1	100%
IV—Member Rights and Protections	5	5	5	0	0	0	100%
VIII—Credentialing and Recredentialing	48	48	47	1	0	0	98%
X—Quality Assessment and Performance Improvement	17	15	14	1	0	2	93%
Totals	**83**	**80**	**78**	**2**	**0**	**3**	**98%**

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

Table 3-7 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 3-7—Summary of Scores for the Record Reviews for DHMP

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	87	87	0	3	100%
Recredentialing	90	83	83	0	7	100%
Totals	**180**	**170**	**170**	**0**	**10**	**100%**

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

Strengths

DHMP's policies and procedures addressed service accessibility, case management, and continuity of care. DHMP had several programs designed to assist members with coordinating medical and behavioral health needs as well as non-clinical support services. DHMP's procedures required that all members be attributed to a primary care provider (or facility) and processes allowed members with special healthcare needs and members in their second or third trimester of pregnancy to continue services with an out-of-network provider.

DHMP's policies and procedures addressed both health plan employed and affiliated (contracted) providers' responsibilities to take member rights into account when providing services. Member rights included the right to grieve without fear of adverse consequences. DHMP trained staff in various departments, including pharmacy benefits, to manage and forward grievances when issues arose or were identified during interactions with members. Staff members provided evidence that DHMP complied with federal and State laws pertaining to various forms of discrimination.

Policies and procedures for the credentialing and privileging of providers were thorough and appropriate. The credentialing and recredentialing records reviewed by HSAG were complete and well-organized. It was evident that credentialing team leads were detail-oriented and took necessary consideration to ensure that all NCQA requirements were met and that credentialing and recredentialing activities were completed timely. During the on-site interview, staff were able to verbally describe the credentialing process from application to appointment. The process described was in alignment with policy and procedure and also evident in record review.

DHMP's QAPI program description addressed HEDIS, CAHPS, PIP topics, provider satisfaction surveys, member call center metrics, medical record reviews, mechanisms to detect over- and underutilization, care management programs for members with special healthcare needs, and clinical practice guidelines. The health plan's QAPI program description and related documentation (policies, procedures, brochures, articles, and committee meeting minutes) as well as the in-depth overview of the QI program provided during the on-site review demonstrated the health plan's commitment to improving quality of care provided to its members.

Recommendations

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

Standard VIII—Credentialing and Recredentialing

- DHMP was required to ensure that staff are aware of the threshold for provider site quality-related complaints which warrant site visits and the process, pursuant to the health plan's policy, for further follow-up.

Standard X—Quality Assessment and Performance Improvement

- DHMP was required to develop a mechanism to track clinical practice guideline review to ensure annual review of all guidelines as required by the CHP+ managed care contract with the State.

DHMP: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of DHMP's compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined performance across all four standards when evaluating the quality of care—defined as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes"—provided by DHMP. DHMP care coordinators assisted members with complex needs with navigating the healthcare system and coordinated efforts and care among providers. The health plan had policies and processes for ensuring that members are assigned to a primary care facility and provider, that members receive a needs assessment, and that members and their families participate in the development of individual treatment plans. DHMP informed members, providers, and staff about the rights afforded to members under State and federal laws and had processes to ensure that rights are taken into account when furnishing services. DHMP's NCQA-compliant credentialing and recredentialing processes ensured that DHMP's providers were qualified to address the needs of its members. DHMP also demonstrated a robust QAPI program that provided for the ongoing evaluation of services and the impact of quality improvement initiatives developed as a result of data analysis.

Access: CMS defined access as "the timely use of services to achieve optimal outcomes." DHMP designed its care coordination program to assist members with complex needs with accessing necessary behavioral and physical health services. DHMP staff members reported that members, once referred, have direct access to specialty providers. When and if a member required services not available in-network, DHMP had procedures for providing members with access to out-of-network providers.

Kaiser Permanente Colorado

Findings

Table 3-8 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	12	12	9	2	1	0	75%
IV—Member Rights and Protections	5	5	3	1	1	0	60%
VIII—Credentialing and Recredentialing	48	47	47	0	0	1	100%
X—Quality Assessment and Performance Improvement	15	15	10	5	0	0	67%
Totals	**80**	**79**	**69**	**8**	**2**	**1**	**87%**

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

Table 3-9 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 3-9—Summary of Scores for the Record Reviews for Kaiser

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	87	87	0	3	100%
Recredentialing	90	84	84	0	6	100%
Totals	**180**	**171**	**171**	**0**	**9**	**100%**

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

Strengths

Kaiser had policies and procedures related to member care coordination in the Primary Care Medical Home (PCMH) as well as care coordination by the Pediatric Care Coordination (PCC) team. The PCC team and the community resources team were the primary sources for coordinating with external agencies and community-based organizations. Members could be referred to or were auto-enrolled (based on designated diagnoses) in the programs. The PCC teams and PCMH providers communicated care coordination activities through the HealthConnect electronic medical record (EMR) online member interface system. Kaiser administered a brief health questionnaire after enrollment to all members who accessed the online system, followed by more detailed assessment, as indicated, to screen members for special healthcare needs. Staff members stated that Kaiser providers engaged members/parents in assessment and treatment planning and requested a release of information to allow Kaiser to share member information with appropriate entities for the purpose of care coordination.

Kaiser had documents and processes to ensure provision of member rights and to communicate expectations to members, providers, and staff. Kaiser had a clear passion for ensuring that members are the primary focus and at the center of Kaiser's mission. The *Principles of Responsibility* document articulated Kaiser's expectation of creating positive relationships with members, employees, and providers; and it was evident that interviewed staff members were committed to this vision.

Kaiser's policies and processes across the credentialing program were thorough and robust and demonstrated clear compliance with NCQA credentialing standards and guidelines. The credentialing and recredentialing files for individual practitioners and organizational providers were well-organized and complete and demonstrated that staff members implemented Kaiser's policies and procedures as written. Kaiser demonstrated evidence of oversight of all delegated credentialing and recredentialing activities, including receipt of contractually-required reports and completion of annual audits.

Kaiser had an *Integrated Patient Care Quality Program* description that applied to all Kaiser members. The program description outlined a comprehensive program with multi-layered analyses, accountabilities, and oversight functions. Kaiser conducted ongoing review of quality monitoring measures and implementation of quality initiatives through numerous committees, task forces, and teams. Staff members stated that the Medicaid and Charitable Program (MCP) management staff

performed "intermediary" oversight of quality data and initiatives related specifically to the CHP+ line of business, such as CHP+ PIPs, HEDIS measures, CAHPS results, grievances, appeals, quality of care (QOC) concern data, and care coordination activities.

Recommendations

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

Standard III—Coordination and Continuity of Care

- Kaiser was required to demonstrate that the member treatment plan includes treatment objectives, treatment follow-up, monitoring of outcomes, and revision as necessary.
- Kaiser was required to develop procedures to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment.
- Kaiser was required to clearly inform newly enrolled members involved in an ongoing course of treatment that they may continue care for 60 days with the current provider, receive continued ancillary services for 75 days, and continue (in the second or third trimester of pregnancy) with the current provider until completion of postpartum care. Kaiser was also required to have written procedures that address continuity of care for newly enrolled members.

Standard IV—Member Rights and Protections

- Kaiser was required to develop an overall member rights policy which describes all member rights afforded to CHP+ members.
- Kaiser was required to ensure that all documents, including listings on kp.org, that reference or describe member rights, are revised to be consistent and inclusive of all rights at 42 CFR438.100(b)(2) and (3) and CHP+ contract Exhibit A4.

Standard X—Quality Assessment and Performance Improvement

- Kaiser was required to adopt, or provide evidence that the Clinical Knowledge Coordination Network/Guideline Committee has adopted, postpartum clinical treatment/practice guidelines.
- Kaiser was required to document that it analyzes, responds to, and reports to quality oversight committees the results of CAHPS and HEDIS measures specific to the CHP+ line of business.
- Kaiser was required to implement a process for evaluating the effectiveness of the QAPI program for CHP+ members. Kaiser was required to produce an annual CHP+ QAPI report that addresses all requirements defined in section 4.7.2.1 of its CHP+ contract with the Department.

Kaiser: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of Kaiser's compliance monitoring site review results related to the domains of quality and access.

Quality: Kaiser's performance in the quality domain was mixed. It had a robust care coordination program and multiple mechanisms to align newly enrolled members with primary care providers. Kaiser demonstrated that all members receive a needs assessment; however, Kaiser was unable to demonstrate that member treatment plans include the required elements of treatment objectives, treatment follow-up, and outcomes monitoring. Kaiser had documents and processes to ensure provision of member rights and to communicate expectations to members, providers, and staff; however, the documents included incomplete and inconsistent information. Kaiser's policies and processes across the credentialing program were thorough and robust and demonstrated clear compliance with NCQA policies and processes. Kaiser's quality program description outlined a comprehensive program with multi-layered analyses, accountabilities, and oversight functions.

Access: Included in its multi-layered approach to care coordination, Kaiser designated teams of coordinators that specialized in coordinating care for members with specific chronic conditions. This specialized approach further ensured appropriate access to specialty services. Kaiser allowed members to self-refer to specialists within the Kaiser system, and Kaiser providers assisted members with referrals to subspecialists outside the network.

Rocky Mountain Health Plans

Findings

Table 3-10 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	12	12	12	0	0	0	100%
IV—Member Rights and Protections	5	5	4	1	0	0	80%
VIII—Credentialing and Recredentialing	48	46	46	0	0	2	100%
X—Quality Assessment and Performance Improvement	15	15	15	0	0	0	100%
Totals	**80**	**78**	**77**	**1**	**0**	**2**	**99%**

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

Table 3-11 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 3-11—Summary of Scores for the Record Reviews for RMHP

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	83	83	0	7	100%
Recredentialing	90	90	90	0	0	100%
Totals	**180**	**173**	**173**	**0**	**7**	**100%**

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

Strengths

RMHP's care coordination policy and procedure described a comprehensive, client- and family-centered, integrated care coordination program that promoted service accessibility, attention to individual needs, continuity of care, and maintenance of health and independent living for its members. RMHP used Essette—an electronic care management record—to assist with care coordination. This tool included both assessment and care planning functions. RMHP's process was extensive and included an assessment of the member's health, behavior risks, and medical and nonmedical needs. RMHP's policies and procedures stated (and staff confirmed) that RMHP would make arrangements for members to access providers outside the network if primary or specialty care could not be provided within the plan and that members with special healthcare needs could maintain their specialist as their PCP.

RMHP's policies and procedures regarding member rights were comprehensive and well written. Staff members described the various mechanisms used to provide members, providers, and employees with ongoing education regarding member rights. In addition to the policies and procedures, RMHP used newsletters to remind providers, members, and staff that the full list of member rights was available in the provider manual and the member handbook and on RMHP's website. RMHP also required staff members to participate in annual training that addressed member rights. The template letters used by RMHP's grievance and appeals department included written reminders that RMHP members are free to exercise their rights without fear of being treated adversely.

RMHP's written policies and procedures described a robust and comprehensive credentialing and recredentialing process for evaluating and selecting licensed providers that was consistent with the NCQA Credentialing and Recredentialing Standards and Guidelines. The policies described the processes used to collect and verify information within the required time frames, criteria required for acceptance, the role of the credentialing committees and medical director, and a well-defined applicant appeal process. On-site review of both credentialing and recredentialing records demonstrated that applications included all NCQA-required content, that staff members verified information using primary sources identified in the policies within the required time frames, and that RMHP's credentialing committees reviewed files for providers who failed to meet the criteria delineated in RMHP's policies. RMHP provided evidence that it monitored both State and federal websites monthly for sanctions,

complaints, and adverse events and followed up on information collected, as appropriate and as described in the policies.

RMHP's QAPI program addressed HEDIS, CAHPS, PIP topics, provider satisfaction surveys, member call center metrics, medical record reviews, measures that detected over- and underutilization, programs for members with special healthcare needs, and clinical practice guidelines. HSAG found that the QAPI program was well defined and included all requirements of the standard, including a comprehensive annual review of the overall QAPI program. RMHP focused on activities related to care quality, patient safety, physician access and availability, member and provider satisfaction, continuity and coordination of care, care management, pharmacy management, and member rights and responsibilities. RMHP used an extensive monitoring system to ensure delivery of quality services to its members.

Recommendations

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

Standard IV—Member Rights and Protections

- RMHP was required to revise its member rights policy and procedure to allow members to receive family planning services from any duly licensed provider, in or out of RMHP's network.

RMHP: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of RMHP's compliance monitoring site review results related to the domains of quality and access.

Quality: RMHP demonstrated having a comprehensive, client- and family-centered, integrated care coordination program that promoted service accessibility, attention to individual needs, continuity of care, and maintenance of health for its members. RMHP used comprehensive assessments as well as member and family input to design individual care plans. RMHP educated members, providers, and staff about member rights and had processes to ensure that member rights are taken into account when furnishing services. RMHP's credentialing and recredentialing program was NCQA-compliant and included mechanisms for ongoing monitoring of both individual and organizational providers. RMHP's QAPI program provided for the ongoing assessment of the quality and appropriateness of its services, investigation of all alleged quality-of -are concerns, and required corrective actions to address identified deficiencies.

Access: RMHP's care coordinators worked with members to ensure appropriate access to behavioral and physical health services and social services and assisted with transitions of care. It had processes to ensure that each member was assigned to a primary care provider and allowed members with special healthcare needs direct access to specialists. In the event that medically necessary services were not available in network, RMHP had procedures for allowing members access to out-of-network providers at no additional cost to the member.

State Managed Care Network

In addition to its role as a contracted CHP+ HMO, Colorado Access also administered the CHP+ SMCN. Colorado Access' policies and procedures are applicable across all lines of business; therefore, the findings for the SMCN are identical to those for the Colorado Access CHP+ HMO—except for instances in Standard III—Coordination and Continuity of Care, wherein some CHP+ HMO requirements were not applicable to the SMCN.

Table 3-12 presents the number of elements for each standard review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016. HSAG did not conduct record reviews for SMCN-specific cases.

Table 3-12—Summary of Scores for the Standards for SMCN

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	8	8	8	0	0	0	100%
IV—Member Rights and Protections	5	5	4	0	1	0	80%
VIII—Credentialing and Recredentialing	48	47	44	3	0	1	94%
X—Quality Assessment and Performance Improvement	10	9	9	0	0	1	100%
Totals	**71**	**69**	**65**	**3**	**1**	**2**	**94%**

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

Strengths

Colorado Access policies and procedures outlined its processes for care coordination for members with intensive care coordination or special healthcare needs. Processes included completion of an HRA, member outreach, care planning and interventions, and coordinating with outside agencies and health plans. Colorado Access informed its PCPs of their responsibility to coordinate care with specialists and that Colorado Access care managers are available to assist with members with complex needs. Colorado Access did not require referrals or prior authorization for access to in-network specialist services and arranged for members to receive services out of network, as necessary, through single-case provider agreements. Care managers followed up with all members identified as having special needs and/or potential transition-of-care needs to perform a more in-depth needs assessment, develop a care plan, connect the member to needed services, and ensure continuity of care with existing providers.

Colorado Access had policies and procedures that articulated its commitment to ensuring the rights of its members, provided guidance to staff members on how to report suspected and alleged rights violations, and described the process for investigating such reports. All Colorado Access customer service staff

members participated in member rights training within the review period. Colorado Access offered new providers an introductory webinar training that included a review of member rights and how to report suspected and alleged rights violations and included this information in the provider manual and on its website. Colorado Access included information about member rights in newsletters, annual mailings, on the website, and in the member handbook.

The Colorado Access policies and procedures related to credentialing and recredentialing individual and organizational providers were well-written, comprehensive, and compliant with NCQA credentialing and recredentialing standards and guidelines. HSAG encountered various scenarios during on-site record reviews that demonstrated staff were credentialing and recredentialing providers in a manner consistent with the written procedures. HSAG reviewed credentialing committee meeting minutes that confirmed the credentialing committee met regularly, reviewed all credentialing and recredentialing files from Colorado Access and from delegates, and made appropriate determinations.

Colorado Access' Quality Management Department conducted in-depth internal analysis of quality data, studies, and indicators, and worked with providers and the Executive Management Team regarding improvements required. The administrative management representatives from all lines of business met monthly to review quality performance data. Colorado Access reported outcomes of internal analysis and actions taken or recommended to the QIC (accountable to the Board of Directors). All CHP+ quality activities were reported to the QIC through a well-designed and comprehensive annual report which presented an overview and summary data from all quality activities performed throughout the year.

Recommendations

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

Standard IV—Member Rights and Protections

- Colorado Access was required to revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members may locate the list of specific rights.

Standard VIII—Credentialing and Recredentialing

- Colorado Access was required to either revise its policy regarding verification of board certification of CNMs or ensure that it verifies board certification of CNMs in compliance with its policies.
- Colorado Access was required to develop and employ a process to ensure that organizations with which it contracts are recredentialed at least every three years.
- Colorado Access was required to ensure that unaccredited organizations with which it contracts credential practitioners in a manner consistent with Colorado Access' policies, procedures, and standards.
- Colorado Access was required to specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified

in Colorado Access' policy; that reviews used are no more than three years old at the time of the credentialing decision; and that, if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access will ensure and document that the organization completed those corrective actions.

SMCN: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of Colorado Access' compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined performance across all four standards when evaluating the quality of care—defined as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes"—provided by Colorado Access. The corrective actions required of Colorado Access were all related to the quality standard; however, deficiencies were relatively minor. Colorado Access offered a multi-layered system of care coordination that ensured every member received the most appropriate level of assistance with coordinating services. Colorado Access' processes ensured that all members received a needs assessment and that members and their families participated in the development of individual treatment plans. Colorado Access informed members, providers, and staff about the rights afforded to members under State and federal laws and had processes to ensure that rights were taken into account when furnishing services. The NCQA-compliant credentialing and recredentialing processes helped ensure a comprehensive network of qualified providers. Colorado Access also demonstrated a robust QAPI program that provided for the ongoing evaluation of access and availability; utilization management; member satisfaction; clinical outcomes/performance measures; PIPs; and evaluation of internal operational performance, practice guidelines, and care management. Overall, Colorado Access' performance in the quality domain was strong.

Access: CMS defined access as "the timely use of services to achieve optimal outcomes." Colorado Access designed its care coordination program to assist members with complex needs with accessing necessary behavioral and physical health services. Its policies allowed members with special healthcare needs and members who are pregnant to continue receiving services from existing providers, regardless of the provider's network affiliation. When and if members required services not available in network, Colorado Access had processes to provide members with access to out-of-network providers at no cost to the member.

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

Table 3-13 shows the FY 2015–2016 scores for each standard by health plan as well as the statewide average for each standard.

Table 3-13—Statewide Scores for Standards

Standards	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	SMCN	Statewide Average
III—Coordination and Continuity of Care	92%	50%	100%	75%	100%	100%	85%
IV—Member Rights and Protections	80%	80%	100%	60%	80%	80%	80%
VIII—Credentialing and Recredentialing	94%	77%	98%	100%	100%	94%	94%
X—Quality Assessment and Performance Improvement	100%	73%	93%	67%	100%	100%	88%
Overall Compliance Scores	**94%**	**72%**	**98%**	**87%**	**99%**	**94%**	**91%**

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

Table 3-14 shows, for each record review area, the FY 2015–2016 score by health plan as well as the statewide average.

Table 3-14—Statewide Scores for Record Reviews

Record Reviews	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average
Credentialing	100%	89%	100%	100%	100%	98%
Recredentialing	98%	97%	100%	100%	100%	99%
Overall Record Review Scores	**99%**	**93%**	**100%**	**100%**	**100%**	**98%**

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

Statewide Summary Assessment Related to Quality, Timeliness, and Access

Quality: HSAG assigned all four standards to the quality domain and found, overall, many statewide strengths. Three of the six health plans earned 100 percent compliance in the coordination and continuity of care standard, with another earning 90 percent. HSAG found that the final two health plans (earning 75 percent and 50 percent respectively in the care coordination standard) had systems issues that prevented the health plans from developing a comprehensive care coordination program. One of these health plans lacked an internal operational structure to support an effective care coordination program. While the scores for member rights and protections were the lowest, all six health plans demonstrated a desire to comply with regulations. HSAG observed the strongest performance in the credentialing and recredentialing standard, followed closely by the quality assessment and performance improvement standard, in which the greatest number of health plans were found to be 100 percent compliant.

Access: HSAG found elements that addressed the access domain in three of the four standards reviewed: Coordination and Continuity of Care, Member Rights and Protections, and Quality Assessment and Performance Improvement. Five of the six plans had policies that described the processes and persons responsible for coordinating care for all members and provided additional support services for members with complex needs. All health plans allowed members direct access to specialty providers. The health plans' QAPI programs included mechanisms to ensure that their networks were capable of providing members all necessary services.

Validation of Performance Measures

For the mandatory validation of performance measure activities, 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). The Department allowed the health plans to use their existing HEDIS auditors. Each CHP+ health plan, with the exception of the CHP+ SMCN, underwent an NCQA HEDIS Compliance Audit™,[3-1] through an NCQA-licensed audit organization of its choice and submitted the audited results and audit statement to HSAG. Appendix B contains further details about the NCQA audit process and the methodology used to validate performance measure activities.

The Department required that 19 performance measures, with a total of 51 measure indicators, be validated via the HEDIS methodology in FY 2015–2016 based on HEDIS 2016 specifications.[3-2] To make overall assessments about the quality and timeliness of and access to services provided by the health plans, HSAG assigned each performance measure to one or more of the three domains, as shown in Table 3-15.

Table 3-15—FY 2015–2016 Performance Measures Required for Validation

Performance Measures	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Childhood Immunization Status	Administrative	✓	✓	
Immunizations for Adolescents	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	✓		
Appropriate Testing for Children With Pharyngitis	Administrative	✓		
*Prenatal and Postpartum Care**	Administrative	✓	✓	✓
Children and Adolescents' Access to Primary Care Practitioners	Administrative			✓

[3-1] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

[3-2] CHP+ State Managed Care Network (SMCN) was only required to report one measure, *Prenatal and Postpartum Care (PPC)*. However, data were not available to support the calculation of these measure indicators according to the desired measure specifications. Therefore, a performance measure assessment of SMCN is excluded from this report.

Performance Measures	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Chlamydia Screening in Women	Administrative	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	Administrative	✓		
Antidepressant Medication Management	Administrative	✓		
Follow-Up Care for Children Prescribed ADHD Medication	Administrative	✓	✓	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Administrative	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	Administrative	✓		
Medication Management for People With Asthma	Administrative	✓		
Asthma Medication Ratio	Administrative	✓		
Ambulatory Care (Per 1,000 Member Months)	Administrative			✓
Inpatient Utilization—General Hospital/Acute Care	Administrative			✓
Antibiotic Utilization	Administrative			✓

* CHP+ State Managed Care Network's (SMCN's) rates for this measure were not reportable; therefore, analyses and discussion of the rates were excluded from this report.

In the performance measure results tables below, HEDIS 2015 and HEDIS 2016 measure rates are presented for measures deemed, by the NCQA-licensed audit organization, "Reportable," according to NCQA standards. With regard to the final measure rates for HEDIS 2015 and HEDIS 2016, none of the health plans' rates were deemed materially biased as a result of performance measure validation, and all the rates are presented. A measure result of Not Applicable (NA) indicates that the health plan followed HEDIS specifications but the denominator was too small (i.e., fewer than 30). An em dash (—) indicates that the measure was not presented in last year's technical report; therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined either because the HEDIS 2016 measure rate was not reportable or because the measure did not have an applicable benchmark.

The health plans' performance measure results were evaluated based on statistical comparisons between the current year's rates and the prior year's rates, where available, as well as on comparisons against the national Medicaid benchmarks, where appropriate.

In the tables following, rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are

based on the Chi-square test of statistical significance with a *p* value <0.05. Therefore, results reporting the percentages of measures that changed significantly from HEDIS 2015 rates may be under- or overstated.

Performance measure results for HEDIS 2016 were compared to HEDIS 2015 Quality Compass national Medicaid percentiles and are denoted in the measure results tables using the percentile rankings defined below in Table 3-16.

Table 3-16—Percentile Ranking Performance Levels

Percentile Ranking	Performance Level
<10th	Below the 10th percentile
10th–24th	At or above the 10th percentile but below the 25th percentile
25th–49th	At or above the 25th percentile but below the 50th percentile
50th–74th	At or above the 50th percentile but below the 75th percentile
75th–89th	At or above the 75th percentile but below the 90th percentile
≥90th	At or above the 90th percentile

Colorado Access

Compliance With Information Systems Standards

Colorado Access was fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. During review of the IS standards, the auditor identified no notable issues of any negative impact on HEDIS measure results reporting. The auditor made no recommendations for Colorado Access related to compliance with IS standards.

Pediatric Care Performance Measures

Table 3-17 shows the HEDIS 2015 and HEDIS 2016 Pediatric Care performance measure results for Colorado Access and the percentile rankings for the HEDIS 2016 rates. All performance measures under the Pediatric Care domain, with the exception of *Appropriate Testing for Children With Pharyngitis*, were collected by the health plan using the hybrid methodology. However, per the Department's guidance, all measure rates presented in this report, except for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, are based on administrative data only. Rates calculated using the hybrid methodology are located in Table B-3—Health Plan-Specific HEDIS 2016 Hybrid Measure Rates in Appendix B.

Table 3-17—Pediatric Care Performance Measure Results for Colorado Access

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	63.37%	59.54%	<10th
Combination 3	61.76%	57.26%	<10th
Combination 4	55.21%	51.74%	<10th
Combination 5	52.81%	49.82%	10th–24th
Combination 6	42.91%	**34.09%^^**	10th–24th
Combination 7	47.59%	46.22%	10th–24th
Combination 8	39.30%	**31.33%^^**	10th–24th
Combination 9	37.43%	**30.25%^^**	25th–49th
Combination 10	34.36%	**28.45%^^**	10th–24th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	64.35%	70.25%^	25th–49th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	1.33%	3.57%	10th–24th
Six or More Visits	62.83%	61.07%	50th–74th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.85%	69.36%^	25th–49th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	42.49%	49.70%^	50th–74th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	50.12%	57.91%^	25th–49th
Counseling for Nutrition—Total	52.80%	57.66%	25th–49th
Counseling for Physical Activity—Total[1]	48.66%	48.18%	25th–49th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	77.64%	79.59%	50th–74th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

Findings, Strengths, and Recommendations

Within the Pediatric Care measures domain, Colorado Access' measure rates ranked at or above the national Medicaid 50th percentile for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Adolescent Well-Care Visits*, and *Appropriate Testing for Children With Pharyngitis*.

Conversely, Colorado Access' measure rates for *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 4* fell below the 10th percentile and rates for *Childhood Immunization Status—Combination 5*, *Combination 6*, *Combination 7*, *Combination 8*, *Combination 10*, and *Well-Child Visits in the First 15 Months of Life—Zero Visits* fell below the national Medicaid 25th percentile, indicating areas for improvement. Within the Pediatric Care measures domain, no Colorado Access rates ranked at or above the 75th percentile. Of note, benchmark comparisons should be interpreted with caution as rates presented in this report are based on administrative data only, whereas benchmarking rates were established using administrative and/or medical record review data. Additionally, hybrid measure rates derived using administrative data only likely underestimate health plan performance. Rates calculated using the hybrid methodology are located in Table B-3—Health Plan-Specific HEDIS 2016 Hybrid Measure Rates in Appendix B.

HSAG recommends that Colorado Access monitor its performance with regard to documentation of immunizations for children and well-child visits for children to determine if interventions are warranted. Additionally, HSAG recommends that Colorado Access analyze any improvement strategies that could be linked to the overall success of the measures in the Pediatric Care measures domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Access to Care and Preventive Screening Performance Measures

Table 3-18 shows the HEDIS 2015 and HEDIS 2016 Access to Care and Preventive Screening performance measure results for Colorado Access and the percentile rankings for the HEDIS 2016 rates.

Table 3-18—Access to Care and Preventive Screening Performance Measure Results for Colorado Access

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	96.66%	**93.65%^^**	10th–24th
Ages 25 Months to 6 Years	85.23%	87.50%^	25th–49th
Ages 7 to 11 Years	92.71%	92.85%	50th–74th
Ages 12 to 19 Years	92.29%	92.81%	75th–89th
Preventive Screening			
Chlamydia Screening in Women			
Total	31.08%	29.34%	<10th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Non-Recommended Cervical Cancer Screening in Adolescent Females[1]*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.66%	0.31%	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

Findings, Strengths, and Recommendations

Within the Access to Care and Preventive Screening measure domain, one of Colorado Access' measure indicators for *Non-Recommended Cervical Cancer Screening in Adolescent Females* ranked at or above the national Medicaid 90th percentile. Additionally, rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years* ranked above the national Medicaid 75th percentile.

Conversely, Colorado Access' measure rate for *Chlamydia Screening in Women—Total* ranked below the national Medicaid 10th percentile and rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* fell below the national Medicaid 25th percentile.

HSAG recommends that Colorado Access monitor its rates for *Chlamydia Screening in Women—Total* and *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* to determine if interventions are warranted. HSAG recommends that Colorado Access analyze improvement strategies that could be linked to the overall success of the measures in the Access to Care and Preventive Screening measures domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Mental/Behavioral Health Performance Measures

Table 3-19 shows the HEDIS 2015 and HEDIS 2016 Mental/Behavioral Health performance measure results for Colorado Access and the percentile rankings for the HEDIS 2016 rates.

Table 3-19—Mental/Behavioral Health Performance Measure Results for Colorado Access

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	43.59%	**0.74%^^**	<10th
Continuation and Maintenance Phase	43.33%	**0.00%^^**	<10th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	6.56%	—

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Based on the rates reported by Colorado Access for the Mental/Behavioral Health measure domain, no strengths were identified for HEDIS 2016. Both HEDIS 2016 measure indicator rates comparable to HEDIS 2015 demonstrated statistically significant declines, indicating opportunities for improvement in *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*. HEDIS 2016 rates for these indicators also fell below the national Medicaid 10th percentile. HSAG recommends that Colorado Access monitor appropriate follow-up care for children prescribed ADHD medication to determine if interventions are warranted.

Respiratory Conditions Performance Measures

Table 3-20 shows the HEDIS 2015 and HEDIS 2016 Respiratory Conditions performance measure results for Colorado Access and the percentile rankings for the HEDIS 2016 rates.

Table 3-20—Respiratory Conditions Performance Measure Results for Colorado Access

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	90.84%	91.99%	50th–74th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	42.65%	45.83%	10th–24th
Medication Compliance 75%—Total	18.48%	19.44%	10th–24th
Asthma Medication Ratio			
Total	76.79%	75.00%	≥90th

Findings, Strengths, and Recommendations

Within the Respiratory Conditions measures domain, one of Colorado Access' HEDIS 2016 measure rates scored at or above the national Medicaid 90th percentile, *Asthma Medication Ratio—Total.* However, of note, HEDIS 2016 performance measure rates for *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total* scored lowest for Colorado Access compared to the national Medicaid benchmarks, ranking below the national Medicaid 25th percentile.

Although the health plan demonstrated positive performance in the ratio of asthma-controlling medications prescribed, HSAG recommends that Colorado Access analyze any potential strategies that could be linked to improvement in the percentage of asthmatic members who remain on an asthma-controller medication during the treatment period. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Use of Services Observations

Table 3-21 shows the HEDIS 2015 and HEDIS 2016 Use of Services measure results for Colorado Access and the percentile rankings for the HEDIS 2016 rates. Reported rates were not risk-adjusted; therefore, rate changes observed between HEDIS 2015 and HEDIS 2016 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2016 reported rates based on HEDIS 2015 ratios and percentiles for Medicaid populations and are presented for informational purposes only.

Table 3-21—Use of Services Performance Measure Results for Colorado Access

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	222.16	227.44	<10th
*Emergency Department Visits**	30.08	27.35	≥90th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.42	1.31	<10th
Days per 1,000 Member Months (Total Inpatient)	4.75	4.10	<10th
Average Length of Stay (Total Inpatient)	3.33	3.13	10th–24th
Discharges per 1,000 Member Months (Medicine)	1.09	0.93	<10th
Days per 1,000 Member Months (Medicine)	2.82	2.30	<10th
Average Length of Stay (Medicine)	2.58	2.48	<10th
Discharges per 1,000 Member Months (Surgery)	0.23	0.33	<10th
Days per 1,000 Member Months (Surgery)	1.67	1.67	<10th
Average Length of Stay (Surgery)	7.27	5.07	10th–24th
Discharges per 1,000 Member Months (Maternity)	0.23	0.13	<10th
Days per 1,000 Member Months (Maternity)	0.57	0.30	<10th
Average Length of Stay (Maternity)	2.51	2.40	10th–24th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.63	0.71	75th–89th
Average Days Supplied per Antibiotic Script	10.50	10.67	<10th
Average Scripts PMPY for Antibiotics of Concern	0.25	0.27	75th–89th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	39.05%	38.39%	75th–89th

* For this indicator, the percentile rankings were reversed to indicate that lower ratings were more favorable.

Findings, Strengths, and Recommendations

Reported rates for Colorado Access' Use of Services measures did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, Colorado Access' utilization results provide additional information that Colorado Access may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Colorado Access: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

The following is a summary assessment of Colorado Access' performance measure results related to the domains of quality, timeliness, and access.

Quality

Colorado Access' quality-related performance was assessed based on rates for 29 measure indicators. One measure indicator reported for HEDIS 2016 was new, and two measure indicators reported for HEDIS 2016 involved low denominators not presented in this report. Significance testing and percentile ranking comparisons were not performed for these three measures.

Of the remaining 26 measure rates, two rates ranked at or above the national Medicaid 90th percentile, indicating positive performance related to the percentage of adolescent females who unnecessarily received a cervical cancer screening as well as members with persistent asthma who had a ratio greater than 0.5 of controller medications. Four measure rates reported for HEDIS 2016 comparable to HEDIS 2015 rates showed statistically significant improvement in the quality provided by Colorado Access. Rates demonstrating statistically significant improvement from 2015 to 2016 indicated better documentation of adolescent immunizations, appropriate and timely well-child and well-care visits, and weight assessment and counseling for nutrition and physical activity for children and adolescent members.

Conversely, Colorado Access' HEDIS 2016 quality-related measure indicator rates related to immunizations for children, chlamydia screening, and appropriate follow-up for children on ADHD medication demonstrated opportunities for improvement by ranking below the national Medicaid 10th

percentile. Additionally, rates related to immunizations for children and appropriate follow-up for children on ADHD medication demonstrated statistically significant decline from 2015 to 2016.

Timeliness

Colorado Access' timeliness-related performance was assessed based on rates for 16 measure indicators. All 16 measure rates reported for HEDIS 2016 were comparable to the HEDIS 2015 rates and were ranked via comparisons to national Medicaid percentiles. Of the 16 measure rates, two rates related to well-child visits during the first 15 months of life and adolescent well-care visits ranked at or above the national Medicaid 50th percentile.

Analogous to Colorado Access' quality-related performance, the health plan's performance related both to documentation of adolescent immunizations and appropriate and timely well-child and well-care visits demonstrated improvement from 2015 to 2016; however, no Colorado Access' timeliness-related measure rates ranked at or above than the national Medicaid 75th percentile. Of note, comparison of these rates to benchmarks should be interpreted with caution due to the fact that the health plan's rates were reported using the hybrid methodology and these rates were presented administratively. Further, Colorado Access' performance with regard to immunizations for children and appropriate follow-up care visits for children prescribed ADHD medication indicated opportunity for improvement due to statistically significant declines in the rates for these measures from 2015 to 2016, ranking below the national Medicaid 10th percentile.

Access

Colorado Access' access-related performance was evaluated based on rates for 22 measure indicators; however, only four of these measures were related to health plan performance. These four measure rates were compared between HEDIS 2015 and HEDIS 2016 and ranked according to comparisons to national Medicaid percentiles. One rate demonstrated a statistically significant increase from 2015 to 2016, and one rate statistically decreased, demonstrating mixed performance with regard to children's access to primary care practitioners. For the remaining 18 measures, which assessed utilization of services, rate changes observed from year to year may not necessarily indicate actual improvement or decline. Many rates within the Use of Services measures domain fell below the national Medicaid 10th percentile.

Colorado Choice Health Plans

Compliance With Information Systems Standards

Colorado Choice was fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. During review of the IS standards, the auditor identified no notable issues of any negative impact on HEDIS measure results reporting. The auditor made no recommendations for Colorado Choice related to compliance with IS standards.

Pediatric Care Performance Measures

Table 3-22 shows the HEDIS 2015 and HEDIS 2016 Pediatric Care performance measure results for Colorado Choice and the percentile rankings for the HEDIS 2016 rates. All performance measures under the Pediatric Care domain, with the exception of *Appropriate Testing for Children With Pharyngitis*, were collected by the health plans using the hybrid methodology. However, per the Department's guidance, all measures except *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* are presented as administrative-only in this report. Rates calculated using the hybrid methodology are located in Table B-3—Health Plan-Specific HEDIS 2016 Hybrid Measure Rates in Appendix B.

Table 3-22—Pediatric Care Performance Measure Results for Colorado Choice

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	NA	0.00%	<10th
Combination 3	NA	0.00%	<10th
Combination 4	NA	0.00%	<10th
Combination 5	NA	0.00%	<10th
Combination 6	NA	0.00%	<10th
Combination 7	NA	0.00%	<10th
Combination 8	NA	0.00%	<10th
Combination 9	NA	0.00%	<10th
Combination 10	NA	0.00%	<10th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	26.32%	11.90%	<10th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	NA	NA	—
Six or More Visits	NA	NA	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	48.92%	43.79%	<10th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	33.46%	30.70%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	35.00%	29.68%	<10th
Counseling for Nutrition—Total	36.00%	29.93%	<10th
Counseling for Physical Activity—Total[1]	40.00%	**27.01%^^**	<10th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	63.49%	73.85%	50th–74th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Pediatric Care measures domain, one of Colorado Choice's HEDIS 2016 measure rates, *Appropriate Testing for Children With Pharyngitis*, scored at or above the national Medicaid 50th percentile.

HEDIS 2016 performance measure rates for *Childhood Immunization Status, Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td), 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—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* scored lowest for Colorado Choice compared to the national Medicaid benchmarks, ranking below the national Medicaid 10th percentile. Within the Pediatric Care measures domain, no Colorado Choice rates ranked at or above the national Medicaid 75th percentile.

Additionally, one of the 16 HEDIS 2016 measure rates in this domain comparable to HEDIS 2015 demonstrated statistically significant decline: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total.*

HSAG recommends that Colorado Choice identify strategies to improve administrative documentation of services provided. HSAG also recommends that the health plan identify improvement strategies that could improve performance in the pediatric care measure domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Access to Care and Preventive Screening Performance Measures

Table 3-23 shows the HEDIS 2015 and HEDIS 2016 Access to Care and Preventive Screening performance measure results for Colorado Choice and the percentile rankings for the HEDIS 2016 rates.

Table 3-23—Access to Care and Preventive Screening Performance Measure Results for Colorado Choice

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	NA	NA	—
Ages 25 Months to 6 Years	73.86%	69.44%	<10th
Ages 7 to 11 Years	83.13%	80.81%	<10th
Ages 12 to 19 Years	92.86%	87.10%	10th–24th
Preventive Screening			
Chlamydia Screening in Women			
Total	NA	NA	—
Non-Recommended Cervical Cancer Screening in Adolescent Females[1]*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	4.08%	2.04%	75th–89th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Access to Care and Preventive Screening measures domain, one of Colorado Choice's four HEDIS 2016 measure rates, *Non-Recommended Cervical Cancer Screening in Adolescent Females*, scored at or above the national Medicaid 75th percentile.

Two of the four HEDIS 2016 performance measure rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Ages 7 to 11 Years* ranked below the national Medicaid 10th percentile.

HSAG recommends that Colorado Choice monitor its performance related to the *Children and Adolescents' Access to Primary Care Practitioners* measure indicators to determine if interventions are warranted. HSAG recommends that Colorado Choice analyze improvement strategies that could be linked to the overall success of the measures in the Access to Care and Preventive Screening measures domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Mental/Behavioral Health Performance Measures

Table 3-24 shows the HEDIS 2015 and HEDIS 2016 Mental/Behavioral Health performance measure results for Colorado Choice and the percentile rankings for the HEDIS 2016 rates.

Table 3-24—Mental/Behavioral Health Performance Measure Results for Colorado Choice

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	NA	NA	—
Continuation and Maintenance Phase	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	NA	—

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Colorado Choice's HEDIS 2016 rates in the Mental/Behavioral Health measures domain were based on small denominators; therefore, these rates were NA.

Respiratory Conditions Performance Measures

Table 3-25 shows the HEDIS 2015 and HEDIS 2016 Respiratory Conditions performance measure results for Colorado Choice and the percentile rankings for the HEDIS 2016 rates.

Table 3-25—Respiratory Conditions Performance Measure Results for Colorado Choice

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	81.72%	85.85%	25th–49th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	NA	NA	—
Medication Compliance 75%—Total	NA	NA	—

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Asthma Medication Ratio			
Total	NA	NA	—

— Indicates that the measure was not presented in last year's technical report. T therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Most of Colorado Choice's HEDIS 2016 rates in the Respiratory Conditions measures domain were based on small denominators; therefore, these rates were NA. One measure in this domain, *Appropriate Treatment for Children With Upper Respiratory Infection*, was reportable and ranked at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile, suggesting opportunity for improvement.

HSAG recommends that Colorado Choice analyze improvement strategies that could improve overall success of the measures in the Respiratory Conditions measures domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Use of Services Observations

Table 3-26 shows the HEDIS 2015 and HEDIS 2016 Use of Services measure results for Colorado Choice and the percentile rankings for the HEDIS 2016 rates. Reported rates were not risk-adjusted; therefore, rate changes observed between HEDIS 2015 and HEDIS 2016 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2016 reported rates based on HEDIS 2015 ratios and percentiles for Medicaid populations and are presented for informational purposes only.

Table 3-26—Use of Services Performance Measure Results for Colorado Choice

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	206.36	183.26	<10th
*Emergency Department Visits**	22.59	17.94	≥90th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	0.77	1.52	<10th
Days per 1,000 Member Months (Total Inpatient)	1.60	3.74	<10th
Average Length of Stay (Total Inpatient)	2.08[1]	2.46[1]	<10th
Discharges per 1,000 Member Months (Medicine)	0.47	1.30	<10th
Days per 1,000 Member Months (Medicine)	1.25	3.25	<10th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Average Length of Stay (Medicine)	2.63[1]	2.50[1]	<10th
Discharges per 1,000 Member Months (Surgery)	0.24	0.16	<10th
Days per 1,000 Member Months (Surgery)	0.30	0.43	<10th
Average Length of Stay (Surgery)	1.25[1]	2.67[1]	<10th
Discharges per 1,000 Member Months (Maternity)	0.00	0.11	<10th
Days per 1,000 Member Months (Maternity)	0.00	0.11	<10th
Average Length of Stay (Maternity)	NA[2]	1.00[1]	<10th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.61	0.59	≥90th
Average Days Supplied per Antibiotic Script	6.39	10.36	<10th
Average Scripts PMPY for Antibiotics of Concern	0.27	0.25	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	44.84%	42.20%	25th–49th

* For this indicator, the percentile rankings were reversed to indicate that lower ratings were more favorable.

[1] Fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

[2] Indicates that the rate was based on zero discharges; therefore, the average length of stay was not presented in this report.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Reported rates for Colorado Choice's Use of Services measures did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, Colorado Choice's utilization results provide additional information that Colorado Choice may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Colorado Choice: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

The following is a summary assessment of Colorado Choice's performance measure results related to the domains of quality, timeliness, and access.

Quality

Colorado Choice's quality-related performance was assessed based on rates for 29 measure indicators. Twelve measure indicators reported for HEDIS 2016 involved low denominators and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these measures.

Of the remaining 17 measure rates, no measure rates ranked at or above the national Medicaid 90th percentile. One measure rate related to the percentage of adolescent females who unnecessarily received a cervical cancer screening ranked at or above the national Medicaid 75th percentile.

Conversely, Colorado Choice's HEDIS 2016 quality-related measure indicator rates related to immunizations for adolescents, well-child visits for children and adolescents, and documentation of a weight assessment and counseling for nutrition and physical activity for children and adolescent members demonstrated opportunities for improvement, ranking below the national Medicaid 10th percentile for measures. The rate related to counseling for physical activity showed statistically significant decline in quality.

Of note, Colorado Choice's rates related to childhood immunizations indicated that no members received appropriate and timely immunizations; however, these rates are most likely indicative of low administrative data completeness.

Timeliness

Colorado Choice's timeliness-related performance was assessed based on rates for 16 measure indicators. Four of the 16 measure indicators reported for HEDIS 2016 involved low denominators and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these four measures. The remaining 12 measure rates reported for HEDIS 2016 were comparable to the HEDIS 2015 rates and ranked via comparisons to national Medicaid percentiles. All 12 measure rates ranked below the national Medicaid 10th percentile from 2015 to 2016, and none of the rates related to timeliness of care demonstrated statistically significant improvement.

Access

Colorado Choice's access-related performance was evaluated based on rates for four measure indicators. One of these measure rates involved low denominators and was not presented in this report. The remaining three measure rates fell below the national Medicaid 25th percentile. For the remaining 18 measures, which assessed utilization of services, rate changes observed from year to year may not necessarily indicate actual improvement or decline. Many rates within the Use of Services measures domain fell below the national Medicaid 10th percentile.

Denver Health Medical Plan, Inc.

Compliance With Information Systems Standards

According to the HEDIS Compliance Audit Report for the current reporting period, DHMP was found compliant with all IS standards. The licensed HEDIS auditor noted that DHMP experienced challenges when completing tasks related to HEDIS measure results reporting, due to groups responsible to perform HEDIS-related tasks being understaffed. Based on this observation, the auditor recommended that adding additional staff members and implementing automated processes and systems would help to complete HEDIS-related tasks in a timely manner.

Pediatric Care Performance Measures

Table 3-27 shows the HEDIS 2015 and HEDIS 2016 Pediatric Care performance measures results for DHMP and the percentile rankings for the HEDIS 2016 rates. All performance measures presented under the Pediatric Care domain, with the exception of *Appropriate Testing for Children With Pharyngitis*, were collected by the health plans using the hybrid methodology. However, per the Department's guidance, all measures except *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* are presented as administrative-only in this report. Rates calculated using the hybrid methodology are located in Table B-3—Health Plan-Specific HEDIS 2016 Hybrid Measure Rates in Appendix B.

Table 3-27—Pediatric Care Performance Measure Results for DHMP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	68.91%	70.87%	25th–49th
Combination 3	68.91%	70.08%	25th–49th
Combination 4	68.91%	70.08%	50th–74th
Combination 5	63.87%	63.78%	50th–74th
Combination 6	52.10%	50.39%	50th–74th
Combination 7	63.87%	63.78%	75th–89th
Combination 8	52.10%	50.39%	75th–89th
Combination 9	49.58%	48.03%	75th–89th
Combination 10	49.58%	48.03%	75th–89th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	73.39%	77.34%	50th–74th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	4.00%	7.84%	<10th
Six or More Visits	4.00%	0.00%	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	48.52%	59.57%^	<10th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	34.84%	44.41%^	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	90.27%	**77.86%^^**	50th–74th
Counseling for Nutrition—Total	78.59%	78.59%	75th–89th
Counseling for Physical Activity—Total[1]	62.77%	65.21%	75th–89th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	68.75%	NA	—

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Pediatric Care measures domain, DHMP's measure rates for *Childhood Immunization Status—Combination 7, Combination 8, Combination 9, Combination 10, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* ranked at or above the national Medicaid 75th percentile.

Conversely, DHMP's HEDIS 2016 measure rates for *Well-Child Visits in the First 15 Months of Life—Zero Visits, Six or More Visits,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* ranked below the national Medicaid 10th percentile. Within the Pediatric Care measure domain, no DHMP rates ranked at or above the national Medicaid 90th percentile. Of note, benchmark comparisons should be interpreted with caution as rates presented in this report are based on administrative data only whereas benchmarking rates were established using administrative and/or medical record review data. Additionally, hybrid measure rates derived using administrative data only likely underestimate health plan performance. Rates calculated using the hybrid methodology are located in Table B-3—Health Plan-Specific HEDIS 2016 Hybrid Measure Rates in Appendix B.

HSAG recommends that DHMP monitor its performance related to *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measures to determine if interventions are warranted. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Access to Care and Preventive Screening Performance Measures

Table 3-28 shows the HEDIS 2015 and HEDIS 2016 Access to Care and Preventive Screening performance measure results for DHMP and the percentile rankings for the HEDIS 2016 rates.

Table 3-28—Access to Care and Preventive Screening Performance Measure Results for DHMP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	89.29%	90.91%	<10th
Ages 25 Months to 6 Years	58.02%	72.65%^	<10th
Ages 7 to 11 Years	81.33%	84.53%	<10th
Ages 12 to 19 Years	83.70%	86.65%	10th–24th
Preventive Screening			
Chlamydia Screening in Women			
Total	45.65%	64.52%	75th–89th
Non-Recommended Cervical Cancer Screening in Adolescent Females[1]*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

Findings, Strengths, and Recommendations

Within the Access to Care and Preventive Screening measures domain, DHMP's measure rate for *Non-Recommended Cervical Cancer Screening in Adolescent Females*, wherein a lower rate indicates better performance, ranked at or above the national Medicaid 90th percentile with a rate of zero percent.

Conversely, three of the six HEDIS 2016 Access to Care and Preventive Screening measure rates, *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Ages 25 Months to 6 Years*, and *Ages 7 to 11 Years*, ranked below the national Medicaid 10th percentile.

HSAG recommends that DHMP monitor its performance on the *Children and Adolescents' Access to Primary Care Practitioners* measure indicators to determine if interventions are warranted. HSAG recommends that DHMP analyze improvement strategies that could be linked to the overall success of the measures in the Access to Care and Preventive Screening measure domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Mental/Behavioral Health Performance Measures

Table 3-29 shows the HEDIS 2015 and HEDIS 2016 Mental/Behavioral Health performance measure results for DHMP and the percentile rankings for the HEDIS 2016 rates.

Table 3-29—Mental/Behavioral Health Performance Measure Results for DHMP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	NA	NA	—
Continuation and Maintenance Phase	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	NA	—

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Mental/Behavioral Health measures domain, due to small denominators, no DHMP HEDIS 2016 measure rates were displayed.

Respiratory Conditions Performance Measures

Table 3-30 shows the HEDIS 2015 and HEDIS 2016 Respiratory Conditions performance measure results for DHMP and the percentile rankings for the HEDIS 2016 rates.

Table 3-30—Respiratory Conditions Performance Measure Results for DHMP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	97.42%	98.03%	≥90th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	NA	NA	—
Medication Compliance 75%—Total	NA	NA	—

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Asthma Medication Ratio			
Total	NA	NA	—

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Respiratory Conditions measures domain, DHMP's rate for *Appropriate Treatment for Children With Upper Respiratory Infection* scored at or above the national Medicaid 90th percentile. No opportunities for improvement were identified based on DHMP's HEDIS 2016 Respiratory Conditions rates.

Use of Services Observations

Table 3-31 shows the HEDIS 2015 and HEDIS 2016 Use of Services measure results for DHMP and the percentile rankings for the HEDIS 2016 rates. Reported rates were not risk-adjusted; therefore, rate changes observed between HEDIS 2015 and HEDIS 2016 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2016 reported rates based on HEDIS 2015 ratios and percentiles for Medicaid populations and are presented for informational purposes only.

Table 3-31—Use of Services Performance Measure Results for DHMP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	110.22	130.44	<10th
*Emergency Department Visits**	25.06	22.91	≥90th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.18	1.08	<10th
Days per 1,000 Member Months (Total Inpatient)	3.60	2.90	<10th
Average Length of Stay (Total Inpatient)	3.04	2.68	<10th
Discharges per 1,000 Member Months (Medicine)	0.80	0.95	<10th
Days per 1,000 Member Months (Medicine)	1.85	2.51	<10th
Average Length of Stay (Medicine)	2.31	2.64	<10th
Discharges per 1,000 Member Months (Surgery)	0.33	0.11	<10th
Days per 1,000 Member Months (Surgery)	1.65	0.32	<10th
Average Length of Stay (Surgery)	4.95[1]	3.00[1]	<10th
Discharges per 1,000 Member Months (Maternity)	0.11	0.04	<10th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Days per 1,000 Member Months (Maternity)	0.22	0.13	<10th
Average Length of Stay (Maternity)	2.00[1]	3.00[1]	≥90th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.13	0.14	≥90th
Average Days Supplied per Antibiotic Script	10.61	10.10	<10th
Average Scripts PMPY for Antibiotics of Concern	0.04	0.04	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	28.90%	28.31%	≥90th

* For this indicator, the percentile rankings were reversed to indicate that lower ratings were more favorable.

[1] Fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Findings, Strengths, and Recommendations

Reported rates for DHMP's Use of Services measures did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, DHMP's utilization results provide additional information that DHMP may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

DHMP: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

The following is a summary assessment of DHMP's performance measure results related to the domains of quality, timeliness, and access.

Quality

DHMP's quality-related performance was assessed based on rates for 29 measure indicators, and nine of these measure indicators involved low denominators and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these nine rates.

Of the remaining 20 measure rates, two rates ranked at or above the national Medicaid 90th percentile, indicating positive performance related to the percentage of adolescent females who unnecessarily received a cervical cancer screening and the rate of appropriate treatment for children with upper respiratory infections. Seven of the twenty measures ranked at or above the national Medicaid 75th percentile, demonstrating performance strengths in immunizations for children, counseling for nutrition and physical activity for children and adolescent members, and screenings for chlamydia in women.

Conversely, DHMP's HEDIS 2016 three quality-related measures scored below the national Medicaid 10th percentile, indicating low performance related to well-child visits for children under 6 years of age. Of note, comparison of these rates to benchmarks should be interpreted with caution due to the fact that the health plan's rates were reported using the hybrid methodology, and these rates were presented

administratively. Additionally, rates for weight assessment for children and adolescent members demonstrated statistically significant decline from 2015 to 2016.

Timeliness

DHMP's timeliness-related performance was assessed based on rates for 16 measure indicators, two of which involved small denominators and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these two measures.

Comparable to DHMP's quality-related performance, timely and appropriate well-child visits are an area indicating opportunities for improvement, as evidenced by comparisons to benchmarks. Despite the fact that some of these rates demonstrated statistically significant improvement from 2015 to 2016, these rates fell below the national Medicaid 50th percentile. Comparison of these rates to benchmarks should be interpreted with caution due to the fact that the health plan's rates were reported using the hybrid methodology and these rates were presented administratively.

Access

DHMP's access-related performance was evaluated based on four of these measure indicators. These four measure rates were compared between HEDIS 2015 and HEDIS 2016 and ranked according to comparisons to national Medicaid percentiles. One measure indicator rate pertaining to children's and adolescents' access to primary care practitioners demonstrated statistically significant improvement in 2016; however, all four indicators in this area fell below the national Medicaid 25th percentile, with three of the four rates falling below the national Medicaid 10th percentile. For the remaining 18 measures, which assessed utilization of services, rate changes observed from year to year may not necessarily indicate actual improvement or decline. Many of DHMP's rates within the Use of Services measures domain fell below the national Medicaid 10th percentile.

Kaiser Permanente Colorado

Compliance With Information Systems Standards

Kaiser was fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. During the review of the standards, the auditor identified no notable issues of negative impact on HEDIS measure results reporting. The auditor made no recommendations for Kaiser related to compliance with IS standards.

Pediatric Care Performance Measures

Table 3-32 shows the HEDIS 2015 and HEDIS 2016 Pediatric Care performance measure results for Kaiser and the percentile rankings for the HEDIS 2016 rates.

Table 3-32—Pediatric Care Performance Measure Results for Kaiser

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	78.62%	**58.67%^^**	<10th
Combination 3	77.36%	**57.14%^^**	<10th
Combination 4	76.73%	**56.38%^^**	10th–24th
Combination 5	59.12%	50.00%	10th–24th
Combination 6	52.83%	**38.52%^^**	25th–49th
Combination 7	59.12%	**49.74%^^**	25th–49th
Combination 8	52.83%	**38.01%^^**	25th–49th
Combination 9	41.51%	34.18%	25th–49th
Combination 10	41.51%	33.93%	25th–49th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	80.66%	80.09%	50th–74th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	0.00%	3.51%	10th–24th
Six or More Visits	72.88%	64.91%	50th–74th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.93%	65.70%^	25th–49th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	42.02%	40.56%	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	91.24%	97.87%^	≥90th
Counseling for Nutrition—Total	98.54%	**95.87%^^**	≥90th
Counseling for Physical Activity—Total[1]	98.30%	**95.87%^^**	≥90th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	92.28%	92.18%	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

Findings, Strengths, and Recommendations

Within the Pediatric Care measure domain, Kaiser's measure rates related to *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, *Counseling for Nutrition—Total*, *Counseling for Physical Activity—Total*, and *Appropriate Testing for Children With Pharyngitis* ranked at or above the national Medicaid 90th percentile.

Conversely, Kaiser's measure rates for *Childhood Immunization Status—Combination 2* and *Combination 3* ranked below the national Medicaid 10th percentile. Of note, benchmark comparisons should be interpreted with caution since rates for these measures presented in this report are based on administrative data only, whereas benchmarking rates were established using administrative and/or medical record review data. Additionally, hybrid measure rates derived using administrative data only likely underestimate health plan performance. Rates calculated using the hybrid methodology are located in Table B-3—Health Plan-Specific HEDIS 2016 Hybrid Measure Rates in Appendix B.

HSAG recommends that Kaiser monitor its performance on the *Childhood Immunization Status* measure indicators and measures evaluating well-child visits to determine if interventions are warranted. Additionally, HSAG recommends that Kaiser analyze the improvement strategies that could be linked to the overall success of the measures in the Pediatric Care measures domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Access to Care and Preventive Screening Performance Measures

Table 3-33 shows the HEDIS 2015 and HEDIS 2016 Access to Care and Preventive Screening performance measure results for Kaiser and the percentile rankings for the HEDIS 2016 rates.

Table 3-33—Access to Care and Preventive Screening Performance Measure Results for Kaiser

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	92.06%	89.88%	<10th
Ages 25 Months to 6 Years	81.05%	83.78%	10th–24th
Ages 7 to 11 Years	93.57%	**83.85%^^**	<10th
Ages 12 to 19 Years	94.14%	**85.51%^^**	10th–24th
Preventive Screening			
Chlamydia Screening in Women			
Total	81.46%	**58.56%^^**	50th–74th
Non-Recommended Cervical Cancer Screening in Adolescent Females[1]*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

Findings, Strengths, and Recommendations

Within the Access to Care and Preventive Screening measure domain, one of Kaiser's six HEDIS 2016 measure rates scored at or above the national Medicaid 90th percentile, *Non-Recommended Cervical Cancer Screening in Adolescent Females*, with a rate of zero percent. A lower rate indicates better performance for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure indicator.

Conversely, Kaiser's measure rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 7 to 11 Years* ranked below the national Medicaid 10th percentile. Additionally, three of the six HEDIS 2016 measure rates demonstrated statistically significant decline: *Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years*, *Ages 12 to 19 Years*, and *Chlamydia Screening in Women—Total.*

HSAG recommends that Kaiser monitor its performance on the *Children and Adolescents' Access to Primary Care Practitioners* and *Chlamydia Screening in Women—Total* measures to determine if interventions are warranted. HSAG recommends that Kaiser analyze improvement strategies that could be linked to the overall success of the measures in the Access to Care and Preventive Screening measures domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Mental/Behavioral Health Performance Measures

Table 3-34 shows the HEDIS 2015 and HEDIS 2016 Mental/Behavioral Health performance measure results for Kaiser and the percentile rankings for the HEDIS 2016 rates.

Table 3-34—Mental/Behavioral Health Performance Measure Results for Kaiser

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	51.35%	56.67%	≥90th
Continuation and Maintenance Phase	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	NA	—

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Mental/Behavioral Health measures domain, the only rate reportable for Kaiser scored at or above the national Medicaid 90th percentile for HEDIS 2016, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase.*

Respiratory Conditions Performance Measures

Table 3-35 shows the HEDIS 2015 and HEDIS 2016 Respiratory Conditions performance measure results for Kaiser and the percentile rankings for the HEDIS 2016 rates.

Table 3-35—Respiratory Conditions Performance Measure Results for Kaiser

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	95.81%	97.40%	≥90th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	NA	NA	—
Medication Compliance 75%—Total	NA	NA	—
Asthma Medication Ratio			
Total	NA	NA	—

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Respiratory Conditions measures domain, the only rate reportable for Kaiser scored at or above the national Medicaid 90th percentile for HEDIS 2016, *Appropriate Treatment for Children With Upper Respiratory Infection.*

Use of Services Observations

Table 3-36 shows the HEDIS 2015 and HEDIS 2016 Use of Services measures results for Kaiser and the percentile rankings for the HEDIS 2016 rates. Reported rates were not risk-adjusted; therefore, rate changes observed between HEDIS 2015 and HEDIS 2016 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2016 reported rates based on HEDIS 2015 ratios and percentiles for Medicaid populations and are presented for informational purposes only.

Table 3-36—Use of Services Performance Measure Results for Kaiser

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	178.96	290.97	10th–24th
*Emergency Department Visits**	16.29	14.00	≥90th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	0.88	0.83	<10th
Days per 1,000 Member Months (Total Inpatient)	3.49	2.89	<10th
Average Length of Stay (Total Inpatient)	3.99	3.48	25th–49th
Discharges per 1,000 Member Months (Medicine)	0.73	0.61	<10th
Days per 1,000 Member Months (Medicine)	2.11	2.05	<10th
Average Length of Stay (Medicine)	2.89	3.37	10th–24th
Discharges per 1,000 Member Months (Surgery)	0.12	0.15	<10th
Days per 1,000 Member Months (Surgery)	1.30	0.67	<10th
Average Length of Stay (Surgery)	10.55[1]	4.38[1]	<10th
Discharges per 1,000 Member Months (Maternity)	0.05	0.15	<10th
Days per 1,000 Member Months (Maternity)	0.16	0.36	<10th
Average Length of Stay (Maternity)	3.50[1]	2.50[1]	25th–49th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.05	1.44	<10th
Average Days Supplied per Antibiotic Script	11.04	12.87	<10th
Average Scripts PMPY for Antibiotics of Concern	0.01	0.36	50th–74th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	29.56%	25.23%	≥90th

* For this indicator, the percentile rankings were reversed to indicate that lower ratings were more favorable.

Findings, Strengths, and Recommendations

Reported rates for Kaiser's Use of Services measures did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, Kaiser's utilization results provide additional information that Kaiser may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Kaiser: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

The following is a summary assessment of Kaiser's performance measure results related to the domains of quality, timeliness, and access.

Quality

Kaiser's quality-related performance was assessed based on rates for 29 measure indicators. Eight of these measure indicators were based on low denominators and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these eight rates.

Of the remaining 21 measure rates, seven measure indicator rates ranked above the national Medicaid 90th percentile, indicating positive performance in the areas of weight assessments and counseling for nutrition and physical activity for children and adolescent members, appropriate testing and treatment for children with pharyngitis or upper respiratory infection, percentage of adolescent females who unnecessarily received a cervical cancer screening, and appropriate follow-up for children on ADHD medication during the initiation phase. Additionally, statistically significant improvements from 2015 to 2016 indicated strengths related to well-child visits for children and weight assessments for children and adolescent members.

Conversely, Kaiser's HEDIS 2016 quality-related measure indicator rates demonstrated opportunities for improvement with regard to immunizations, ranking below the national Medicaid 10th percentile. Additionally, rates related to immunizations for children and chlamydia screenings for women demonstrated statistically significant decline from 2015 to 2016, indicating opportunity for improvement.

Timeliness

Kaiser's timeliness-related performance was assessed based on rates for 16 measure indicators, two of which involved small denominators and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these two measures.

Appropriate follow-up for children on ADHD medication during the initiation phase and timely well-child visits are areas indicating performance strengths for Kaiser, with the rate for appropriate follow-up for children on ADHD medication ranking above the national Medicaid 90th percentile, and well-child visit rates showing statistically significant improvement from 2015 to 2016.

Conversely, Kaiser's performance in the area of childhood immunizations indicates opportunities for improvement with all measure indicator rates falling below the national Medicaid 50th percentile and six of the nine measure indicators demonstrating statistically significant decline in performance in 2016.

Access

Kaiser's access-related performance was evaluated based on rates four measure indicators. These four measure rates were compared between HEDIS 2015 to HEDIS 2016, and rates were ranked according to comparisons to national Medicaid percentiles.

Conversely, two measure indicator rates pertaining to children's and adolescents' access to primary care practitioners demonstrated opportunities for improvement, with all four of the measure indicators ranking below the national Medicaid 25th percentile and two measure indicators demonstrating

statistically significant decline in 2016. For the remaining 18 measures, which assessed utilization of services, rate changes observed from year to year may not necessarily indicate actual improvement or decline. Many rates within the Use of Services measures domain fell below the national Medicaid 10th percentile.

Rocky Mountain Health Plans

Compliance With Information Systems Standards

According to the HEDIS Compliance Audit Report for the current reporting period, RMHP was fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the health plan's HEDIS auditor. The auditor identified no notable issues of negative impact on HEDIS measure results reporting and made no recommendations for RMHP related to compliance with IS standards.

Pediatric Care Performance Measures

Table 3-37 shows the HEDIS 2015 and HEDIS 2016 Pediatric Care performance measure results for RMHP and the percentile rankings for the HEDIS 2016 rates. All performance measures presented under the Pediatric Care domain, with the exception of *Appropriate Testing for Children With Pharyngitis*, were collected by the health plans using hybrid methodology. Please note, HEDIS 2016 rates reported by RMHP using the hybrid methodology were deemed invalid by the health plan due to issues with its vendor's medical record review process. Therefore, all rates for these measures, including values submitted for the administrative components of the measure rates, are denoted as *Biased Rate (BR)* in this report.

Table 3-37—Pediatric Care Performance Measure Results for RMHP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	46.88%	BR	—
Combination 3	45.31%	BR	—
Combination 4	42.97%	BR	—
Combination 5	37.11%	BR	—
Combination 6	34.38%	BR	—
Combination 7	35.16%	BR	—
Combination 8	32.81%	BR	—
Combination 9	31.64%	BR	—
Combination 10	30.08%	BR	—
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	49.57%	BR	—
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	5.45%	BR	—

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Six or More Visits	17.27%	BR	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	54.81%	BR	—
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	34.56%	BR	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	74.56%	BR	—
Counseling for Nutrition—Total	63.05%	BR	—
Counseling for Physical Activity—Total	62.39%	BR	—
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	79.23%	79.42%	50th–74th

* For this indicator, a lower rate indicates better performance.

— Indicates that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

BR indicates that RMHP's reported rate was invalid; therefore, the rate is not presented.

Findings, Strengths, and Recommendations

RMHP had one reportable measure rate for the Pediatric Care measure domain, which ranked at or above the national Medicaid 50th percentile: *Appropriate Testing for Children With Pharyngitis.*

Access to Care and Preventive Screening Performance Measures

Table 3-38 shows the HEDIS 2015 and HEDIS 2016 Access to Care and Preventive Screening performance measure results for RMHP and the percentile rankings for the HEDIS 2016 rates.

Table 3-38—Access to Care and Preventive Screening Performance Measure Results for RMHP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	87.97%	95.48%^	25th–49th
Ages 25 Months to 6 Years	76.20%	86.26%^	25th–49th
Ages 7 to 11 Years	82.91%	85.23%	<10th
Ages 12 to 19 Years	83.42%	89.01%^	25th–49th
Preventive Screening			
Chlamydia Screening in Women			
Total	20.30%	30.84%	<10th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Non-Recommended Cervical Cancer Screening in Adolescent Females[1]*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.82%	0.38%	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

Findings, Strengths, and Recommendations

Within the Access to Care and Preventive Screening measures domain, one of RMHP's measure rates for *Non-Recommended Cervical Cancer Screening in Adolescent Females* ranked at or above the national Medicaid 90th percentile. Lower rates for *Non-Recommended Cervical Cancer Screening in Adolescent Females* indicate better performance.

For RMHP's Access to Care and Preventive Screening measures domain, two of the HEDIS 2016 performance measure rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years* and *Chlamydia Screening in Women—Total* ranked below the national Medicaid 10th percentile.

HSAG recommends that RMHP monitor its performance on the *Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years* and *Chlamydia Screening in Women—Total* measures to determine if interventions are warranted. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Mental/Behavioral Health Performance Measures

Table 3-39 shows the HEDIS 2015 and HEDIS 2016 Mental/Behavioral Health performance measure results for RMHP and the percentile rankings for the HEDIS 2016 rates.

Table 3-39—Mental/Behavioral Health Performance Measure Results for RMHP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	45.95%	35.29%	25th–49th
Continuation and Maintenance Phase	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	NA	—

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Based on the rates reported by RMHP for the Mental/Behavioral Health measures domain, no strengths were identified for HEDIS 2016.

For RMHP's Mental/Behavioral Health measures domain, four of the five HEDIS 2016 measure rates were not displayed due to small denominators. HEDIS 2016 performance measure rate for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* ranked at or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile.

HSAG recommends that RMHP analyze the improvement strategies that could be linked to the overall success of the measures in the Mental/Behavioral Health measures domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Respiratory Conditions Performance Measures

Table 3-40 shows the HEDIS 2015 and HEDIS 2016 Respiratory Conditions performance measure results for RMHP and the percentile rankings for the HEDIS 2016 rates.

Table 3-40—Respiratory Conditions Performance Measure Results for RMHP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	91.37%	93.30%	75th–89th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	54.55%	NA	—
Medication Compliance 75%—Total	27.27%	NA	—
Asthma Medication Ratio			
Total	70.73%	NA	—

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Respiratory Conditions measure domain, one of the four measure indicator rates was reportable for RMHP, *Appropriate Treatment for Children With Upper Respiratory Infection*. The 2016 rate for this indicator ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile.

Use of Services Observations

Table 3-41 shows the HEDIS 2015 and HEDIS 2016 Use of Services measure results for RMHP and the percentile rankings for the HEDIS 2016 rates. Reported rates were not risk-adjusted; therefore, rate changes observed between HEDIS 2015 and HEDIS 2016 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2016 reported rates based on HEDIS 2015 ratios and percentiles for Medicaid populations and are presented for informational purposes only.

Table 3-41—Use of Services Performance Measure Results for RMHP

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	208.05	230.04	<10th
*Emergency Department Visits**	20.65	20.86	≥90th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.14	1.01	<10th
Days per 1,000 Member Months (Total Inpatient)	4.31	3.65	<10th
Average Length of Stay (Total Inpatient)	3.77	3.63	25th–49th
Discharges per 1,000 Member Months (Medicine)	0.78	0.68	<10th
Days per 1,000 Member Months (Medicine)	1.82	2.31	<10th
Average Length of Stay (Medicine)	2.33	3.42	10th–24th
Discharges per 1,000 Member Months (Surgery)	0.33	0.27	<10th
Days per 1,000 Member Months (Surgery)	2.42	1.21	<10th
Average Length of Stay (Surgery)	7.28	4.42[1]	—
Discharges per 1,000 Member Months (Maternity)	0.07	0.13	<10th
Days per 1,000 Member Months (Maternity)	0.16	0.28	<10th
Average Length of Stay (Maternity)	2.33[1]	2.20[1]	<10th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.48	0.67	≥90th
Average Days Supplied per Antibiotic Script	10.57	10.06	<10th
Average Scripts PMPY for Antibiotics of Concern	0.20	0.29	75th–89th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	41.41%	43.16%	25th–49th

* For this indicator, the percentile rankings were reversed to indicate that lower ratings were more favorable.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Findings, Strengths, and Recommendations

Reported rates for RMHP's Use of Services measures did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, RMHP's utilization results provide additional information that RMHP may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

RMHP: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

The following is a summary assessment of RMHP's performance measure results related to the domains of quality, timeliness, and access.

Quality

RMHP's quality-related performance was assessed based on rates for 29 measure indicators, and seven of these measure indicators were based on low denominators and not presented in this report. Significance testing and percentile ranking comparisons were not performed for these seven rates. Additionally, 17 of RMHP's reported rates were deemed invalid and, therefore, are not presented in this report. These rates were designated as *Biased Rate (BR)*.

Of the remaining five measure rates, one measure indicator rate ranked above the national Medicaid 90th percentile, indicating positive performance in the area of percentage of adolescent females who unnecessarily received a cervical cancer screening.

One quality-related measure indicator pertaining to chlamydia screenings for women ranked below the national Medicaid 10th percentile.

Timeliness

RMHP's timeliness-related performance was assessed based on rates for 16 measure indicators, one of which was based on a small denominator and not presented in this report. Significance testing and percentile ranking comparisons were not performed for this measure. Additionally, 14 of RMHP's reported rates were deemed invalid and, therefore, are not presented in this report. These rates were designated as *BR*.

The remaining measure rate in this performance area was related to appropriate follow-up for children on ADHD medication during the initiation phase and fell below the national Medicaid 50th percentile.

Access

RMHP's access-related performance was evaluated based on rates for four measure indicators. These four measure rates were compared between HEDIS 2015 and HEDIS 2016, and rates were ranked according to comparisons to national Medicaid percentiles.

Two measure indicator rates pertaining to children's and adolescents' access to primary care practitioners demonstrated statistically significant improvement in 2016; however, all four measure indictor rates in this area fell below the national Medicaid 50th percentile, and one of these four rates fell below the national Medicaid 10th percentile. For the remaining 18 measures, which assessed utilization of services, rate changes observed from year to year may not necessarily indicate actual improvement or decline. Many rates within the Use of Services measure domain fell below the national 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 2015 and HEDIS 2016 along with the percentile ranking for each Pediatric Care performance measure. Statewide rates were calculated by HSAG using all CHP+ health plans' rates and were adjusted according to their respective eligible populations. All performance measures presented under the Pediatric Care domain, with the exception of *Appropriate Testing for Children With Pharyngitis*, were reported by the health plans using the hybrid methodology; however, excepting *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, weighted averages were derived using administrative data only in this report.

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

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	61.27%	58.04%	<10th
Combination 3	59.89%	56.19%	<10th
Combination 4	55.61%	52.70%	<10th
Combination 5	50.42%	49.22%	10th–24th
Combination 6	42.40%	**35.49%^^**	10th–24th
Combination 7	47.06%	47.01%	10th–24th
Combination 8	40.03%	**33.71%^^**	10th–24th
Combination 9	37.13%	**31.79%^^**	25th–49th
Combination 10	35.06%	**30.65%^^**	25th–49th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	64.11%	70.71%^	25th–49th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	3.07%	4.67%	<10th
Six or More Visits	45.18%	51.84%	25th–49th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.59%	67.00%^	25th–49th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	40.38%	46.61%^	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	60.81%	65.31%^	25th–49th
Counseling for Nutrition—Total	61.19%	64.85%^	50th–74th
Counseling for Physical Activity—Total[1]	57.49%	56.89%	50th–74th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	79.64%	80.78%	75th–89th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

Findings, Strengths, and Recommendations

Within the Pediatric Care measure domain, one of the statewide weighted average measure rates for *Appropriate Testing for Children With Pharyngitis* ranked at or above the national Medicaid 75th percentile.

Conversely, for the statewide weighted average rates calculated for the Pediatric Care measure domain, performance measure rates for *Childhood Immunization Status—Combination 2*, *Combination 3*, and *Combination 4*, and *Well-Child Visits in the First 15 Months of Life—Zero Visits* ranked below the national Medicaid 10th percentile. Of note, benchmark comparisons should be interpreted with caution as statewide rates presented in this report are based on administrative data only, whereas benchmarking rates were established using administrative and/or medical record review data. Additionally, hybrid measure rates derived using administrative data only likely underestimate health plan performance.

HSAG recommends that the health plans monitor performance on the *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life—Zero Visits* measures to determine if interventions are warranted. HSAG recommends that CHP+ health plans analyze improvement strategies that could be linked to the overall success of the measures in the Pediatric Care measure domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Access to Care and Preventive Screening Performance Measures

Table 3-43 shows the statewide weighted averages for HEDIS 2015 and HEDIS 2016 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 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	93.22%	92.74%	10th–24th
Ages 25 Months to 6 Years	80.57%	85.21%^	10th–24th
Ages 7 to 11 Years	89.64%	88.77%	10th–24th
Ages 12 to 19 Years	90.09%	89.90%	25th–49th
Preventive Screening			
Chlamydia Screening in Women			
Total	57.01%	**36.62%^^**	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females[1]*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.62%	0.29%	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

Findings, Strengths, and Recommendations

Within the Access to Care and Preventive Screening measure domain, one of the HEDIS 2016 statewide weighted average measure rates for *Non-Recommended Cervical Cancer Screening in Adolescent Females* ranked at or above the national Medicaid 90th percentile. The *Non-Recommended Cervical Cancer Screening in Adolescent Females* is an indicator wherein a lower rate indicates better performance.

For the statewide weighted average rates calculated for the Access to Care and Preventive Screening measure domain, one of the HEDIS 2016 measure rates: *Chlamydia Screening in Women—Total*, ranked below the national Medicaid 10th percentile and demonstrated statistically significant decline from HEDIS 2015 to HEDIS 2016.

HSAG recommends that CHP+ health plans monitor their performance on the *Chlamydia Screening in Women—Total* measure to determine if interventions are warranted. HSAG recommends that CHP+ health plans analyze improvement strategies that could be linked to the overall success of the measures in the Access to Care and Preventive Screening measure domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Mental/Behavioral Health Performance Measures

Table 3-44 shows the statewide weighted averages for HEDIS 2015 and HEDIS 2016 along with the percentile ranking for each Mental/Behavioral Health performance measure.

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

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	46.01%	**15.24%^^**	<10th
Continuation and Maintenance Phase	41.82%	27.03%	10th–24th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	4.65%	—

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Based on the rates reported for the statewide weighted averages for the Mental/Behavioral Health measure domain, no strengths were identified for HEDIS 2016.

Conversely, for the statewide weighted average rates calculated for the Mental/Behavioral Health measure domain, one measure rate ranked below the national Medicaid 10th percentile: *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase.* Additionally, this measure indicated a statistically significant decline from 2015 to 2016.

HSAG recommends that CHP+ health plans monitor their performance on the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure to determine if interventions are warranted. HSAG recommends that CHP+ health plans analyze improvement strategies that could be linked to the overall success of the measures in the Mental/Behavioral Health measures domain. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Respiratory Conditions Performance Measures

Table 3-45 shows the statewide weighted averages for HEDIS 2015 and HEDIS 2016 along with the percentile ranking for each Respiratory Conditions performance measure.

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

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	91.50%	92.66%	75th–89th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	46.96%	49.64%	25th–49th
Medication Compliance 75%—Total	20.27%	21.79%	10th–24th
Asthma Medication Ratio			
Total	74.20%	74.59%	≥90th

Findings, Strengths, and Recommendations

Within the Respiratory Conditions measures domain, one of the HEDIS 2016 statewide weighted average rates ranked at or above the national Medicaid 90th percentile, *Asthma Medication Ratio—Total.* Conversely, the statewide weighted average performance measure rate for *Medication Management for People With Asthma—Medication Compliance 75%—Total* ranked below the national Medicaid 25th percentile.

Although the statewide weighted rate demonstrated positive performance in the ratio of asthma-controlling medications prescribed, HSAG recommends that the health plans analyze any potential improvement strategies that could be linked to improvements in the percentage of asthmatic members who remained on an asthma-controller medication during the treatment period. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Use of Services Observations

Table 3-46 shows the statewide weighted averages for HEDIS 2015 and HEDIS 2016 along with the percentile ranking for each Use of Services performance measure. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2015 and HEDIS 2016 may not denote actual improvement or decline in performance. Percentile rankings are presented for information only.

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

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	204.21	227.93	<10th
*Emergency Department Visits**	26.31	23.80	≥90th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.28	1.18	<10th
Days per 1,000 Member Months (Total Inpatient)	4.34	3.75	<10th
Average Length of Stay (Total Inpatient)	3.41	3.17	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.96	0.86	<10th
Days per 1,000 Member Months (Medicine)	2.46	2.31	<10th
Average Length of Stay (Medicine)	2.56	2.70	<10th
Discharges per 1,000 Member Months (Surgery)	0.24	0.27	<10th
Days per 1,000 Member Months (Surgery)	1.69	1.31	<10th
Average Length of Stay (Surgery)	7.06	4.81	10th–24th
Discharges per 1,000 Member Months (Maternity)	0.16	0.12	<10th
Days per 1,000 Member Months (Maternity)	0.41	0.29	<10th
Average Length of Stay (Maternity)	2.51	2.36	10th–24th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.49	0.65	≥90th
Average Days Supplied per Antibiotic Script	10.39	10.55	<10th
Average Scripts PMPY for Antibiotics of Concern	0.19	0.25	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	39.19%	39.06%	50th–74th

* For this indicator, a lower rate indicates better performance.

Findings, Strengths, and Recommendations

Reported rates for statewide weighted averages for the Use of Services measure domain did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, the statewide weighted average utilization results provide additional information that CHP+ health plans may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Statewide Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

The following is a summary assessment of the statewide performance measure results related to the domains of quality, timeliness, and access.

Quality

Statewide weighted average performance in this domain was assessed based on rates for 29 quality-related measure indicators.[3-3] One measure indicator reported for HEDIS 2016 was new, and two measure indicators reported for HEDIS 2016 were based on low denominators (fewer than 30); therefore, the rates were designated as Not Available (NA) and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these three measures.

Two of the remaining 26 measure rates ranked at or above the national Medicaid 90th percentile, specifically related to the percentage of adolescent females who unnecessarily received a cervical cancer screening and those members who have persistent asthma and received a ratio of controller medications. Five of the 26 measure rates reported for HEDIS 2016 comparable to HEDIS 2015 rates showed statistically significant improvement in the quality provided statewide, including rates related to immunizations for adolescents, the percentage of members who received the appropriate number of well-child and well-care visits, and documentation of a weight assessment and counseling for nutrition and physical activity for children and adolescent members.

Conversely, six of the 26 HEDIS 2016 measure rates ranked below the national Medicaid 10th percentile, with three of these six HEDIS 2016 measures correlating to immunizations for children. Additionally, rates for six of the 26 quality-related measures demonstrated statistically significant decline in quality-related performance from 2015 to 2016, in which four of the six measures with statistically significant declines were related to immunizations for children. As a result, statewide weighted average rates indicated opportunity for improvement related to documentation of immunizations for children, administration of chlamydia screenings for women, and appropriate follow-up care visits for children prescribed ADHD medication.

Timeliness

Statewide performance in this domain was assessed based on rates for 16 timeliness-related measure indicators.[3-4] Similar to the quality-related performance, the statewide weighted average timeliness-related measure rates indicated positive performance with regard to immunizations for adolescents,

[3-3] The CHP+ SMCN's rates for two measure indicators related to prenatal and postpartum care were not reportable due to insufficient data; therefore, analyses and discussion of the rates were excluded both from this report and in the total count of measures assessed.

[3-4] The CHP+ SMCN's rates for two measure indicators related to prenatal and postpartum care were not reportable due to insufficient data; therefore, analyses and discussion of the rates were excluded both from this report and in the total count of measures assessed.

documentation of immunizations for children, and the number of members who received the appropriate number of well-child and adolescent well-care visits, ranking at or above the national Medicaid 25th percentile. Additionally, three of the 16 measure rates in the timeliness-related domain demonstrated statistically significant improvement from HEDIS 2015 to HEDIS 2016. Again, analogous to the statewide quality-related measures, statewide weighted average rates indicated opportunity for improved timeliness of care related to documentation of immunizations for children and appropriate follow-up care visits for children prescribed ADHD medication as rates for two of the 16 timeliness-related measures ranked below the national Medicaid 10th percentile and indicated statistically significant decline from HEDIS 2015.

Access

Statewide performance in this domain was assessed based on rates for four measure indicators and compared between HEDIS 2015 and HEDIS 2016. The remaining 18 measures assessed Use of Services; therefore, rate changes observed from year to year may not necessarily indicate actual improvement or decline. With regard to the four access-related measure indicators, one rate showed statistically significant increase from HEDIS 2015 to 2016, demonstrating improved children's access to primary care practitioners. Most notably, with regard to access-related measures, the statewide weighted average rate of emergency department utilization for HEDIS 2016 ranked at or above the national Medicaid 90th percentile, potentially indicating avoidance of unnecessary emergency services for nonemergent conditions. Many statewide weighted average rates within the Use of Services measure domain fell below the national Medicaid 10th percentile.

Validation of Performance Improvement Projects

For FY 2015–2016, HSAG validated one PIP for each of the five HMOs. Table 3-47 lists the PIP topics identified by each HMO.

Table 3-47—FY2015–2016 PIP Topics Selected by HMOs

HMO	PIP Topic
Colorado Access	*Improving the Transition Process for Children Aging Out of the CHP+ HMO health plan*
Colorado Choice	*Adolescent Positive Depressive 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*

Appendix C, EQR Activities—Validation of Performance Improvement Projects, describes how HSAG validated the PIPs and how it aggregated and analyzed the resulting data.

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 birthdays. This was the second validation year for the PIP. Colorado Access reported the baseline results for the PIP and completed Activities I through VIII of the PIP Summary Form.

Table 3-48 provides a summary of Colorado Access' PIP validation results for the FY 2015–2016 validation cycle.

Table 3-48—Performance Improvement Project Validation Results for Colorado Access

Stage	Activity	Percentage 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)**

Stage	Activity	Percentage of Applicable Elements		
		Met	Partially Met	Not Met
Implementation	VII. Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total		**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percent Score of Applicable Evaluation Elements Met		**100% (16/16)**	**0% (0/16)**	**0% (0/16)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design and Implementation stages (Activities I through VIII) were validated.

Table 3-49 provides a summary of Colorado Access' PIP outcomes for the FY 2015–2016 validation cycle.

Table 3-49—Performance Improvement Project Outcomes for Colorado Access
PIP Topic: *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan*

Study Indicator	Baseline Period (01/01/2014–12/31/2014)	Remeasurement 1 (01/01/2015–12/31/2015)	Remeasurement 2 (01/01/2016–12/31/2016)	Sustained Improvement
The percentage of eligible high-risk members who received care management outreach within 90 days prior to their 19th birthday.	0%			

The baseline rate for high-risk members who received care management outreach within 90 days prior to their 19th birthday was zero. Colorado Access' goal is to increase the rate to 75 percent at the first remeasurement. With a baseline rate of zero, Colorado Access should ensure that a Remeasurement 1 goal of 75 percent is reasonable and attainable.

Strengths

Colorado Access designed a scientifically sound project supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Colorado Access reported and interpreted its baseline data accurately. The health plan completed its initial causal/barrier analysis using the appropriate quality improvement tools to identify and prioritize the identified barriers. The interventions implemented were implemented in a timely manner to allow for impact to the study indicator outcomes. Colorado Access developed a methodologically sound project and has set the foundation from which to move forward.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The health plan's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to overall success in improving PIP rates.

For the *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan* PIP, Colorado Access identified two key barriers to address:

- No transition program in place.
- Options for health insurance transition unknown to the member.

To address these barriers, Colorado Access implemented the following interventions:

- Conducted a mailing to members 18 years of age reminding of the importance of having health insurance and knowing what options are available as well as to provide contact information for assistance in obtaining health insurance.
- Conducted transition-specific care management outreach within 90 days prior to the member losing CHP+ coverage.
- Referred members to the Access Medical Enrollment Services (AMES) program to identify eligibility for government health insurance programs.

Recommendations

As the PIP progresses, HSAG recommends the following:

- Use and describe quality improvement tools such as a causal/barrier analysis, key driver diagram, process mapping, or failure modes and effects analysis at least annually to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.
- Describe methods used to prioritize the identified barriers.
- Develop active, innovative interventions that can directly impact the study indicator outcomes.
- Use techniques based on quality improvement science such as the Plan-Do-Study-Act (PDSA) model as part of its improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- Develop a process or plan to evaluate the effectiveness of each implemented intervention.
- Ensure that goals set for the remeasurement period will yield statistically significant improvement and are reasonable and attainable.

Colorado Access: Summary Assessment Related to Quality, Timeliness, and Access for Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to quality, timeliness, or access to services, PIP validation 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 and the use of appropriate QI activities to support improvement of PIP 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 depressive disorder screening performed by a primary care provider and who have a behavioral health provider follow-up visit within 30 days of the positive depressive disorder screening. This was the second validation year for the PIP. Colorado Choice reported the baseline results for the PIP and completed Activities I through VIII of the PIP Summary Form.

Table 3-50 provides a summary of Colorado Choice's PIP validation results for the FY 2015–2016 validation cycle.

Table 3-50—Performance Improvement Project Validation Results for Colorado Choice

Study Stage	Activity	Percentage 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	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total		**100% (7/7)**	**0% (0/7)**	**0% (0/7)**

Study Stage	Activity	Percentage of Applicable Elements		
		Met	Partially Met	Not Met
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percent Score of Applicable Evaluation Elements Met		**100% (16/16)**	**0% (0/16)**	**0% (0/16)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design and Implementation stages (Activities I through VIII) were validated.

Table 3-51 provides a summary of Colorado Choice's PIP outcomes for the FY 2015–2016 validation cycle.

Table 3-51—Performance Improvement Project Outcomes for Colorado Choice
PIP Topic: *Adolescent Positive Depressive Disorder Screening and Transition of Care to a Behavioral Health Provider*

Study Indicator	Baseline Period (07/01/2014–06/30/2015)	Remeasurement 1 (07/01/2015–06/30/2016)	Remeasurement 2 (07/01/2016–06/30/2017)	Sustained Improvement
The percentage of adolescents 12 to17 years of age with a follow-up visit with a behavioral health provider within 30 days of a positive depressive disorder screening with a primary care provider.	0%			

The baseline rate for members 12 to 17 years of age who have a follow-up visit with a behavioral health provider within 30 days of a positive screening with a primary care provider was zero. The denominator size was only one member. The HMO's goal is to increase the rate to 5 percent at the first remeasurement. Based on the growth of the eligible population for this project, Colorado Choice may need to revisit its goal to make sure that the desired outcome yields statistically significant improvement.

Strengths

Colorado Choice designed a scientifically sound project supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Colorado Choice reported and interpreted its baseline data

accurately. The HMO completed its initial causal/barrier analysis using the appropriate quality improvement tools to identify and prioritize the identified barriers. The interventions were implemented in a timely manner to allow for impact to the study indicator outcomes.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The HMO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the HMO's overall success in improving PIP rates.

For the *Adolescent Positive Depressive Disorder Screening and Transition of Care to a Behavioral Health Provider* PIP, Colorado Choice identified several barriers:

- Its claims system was not capturing whether or not the primary care providers were completing the depression screening tools during routine adolescent visits.
- It was also not clear whether the provider had processes in place for referring members or for providing access to behavioral health.
- Not all primary care providers had processes in place for completing the adolescent depression screening.

  Colorado Choice prioritized these barriers, with the top priority being to address primary care providers who did not have processes in place for completing the depression screening, followed by ensuring that claims data included whether or not providers are completing the depression screening on routine well-visits. To address these barriers, the health plan implemented the following interventions:
- Educated primary care providers about using standardized depression screening tools, reimbursement rates, and correct billing codes.
- Conducted a provider survey to capture how the health plan can better support the providers in conducting depression screenings.
- Conducted telephonic outreach to the providers to gain a better understanding of how the providers conduct follow-up with, or referral to a behavioral health provider when a positive depressive disorder screening occurs.
- Conducted telephonic outreach to the CHP+ behavioral health providers under contract to gain a better understanding of how they are receiving referrals from primary care providers who have identified a member with a positive depressive disorder screening. Are these members seen within 30 days, and what process is in place to follow up with the referring physician?
- Developed a mechanism to ensure ongoing assessment of its provider network adequacy and a process to make changes in the network if needed so that members' needs are met.

Recommendations

As the PIP progresses, HSAG recommends the following:

- Use and describe quality improvement tools such as a causal/barrier analysis, key driver diagram, process mapping, or failure modes and effects analysis at least annually to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.
- Describe methods used to prioritize the identified barriers.
- Develop active, innovative interventions that can directly impact the study indicator outcomes.
- Use techniques based on quality improvement science such as the PDSA model as part of its improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- Develop a process or plan to evaluate the effectiveness of each implemented intervention.

Colorado Choice: Summary Assessment Related to Quality, Timeliness, and Access for Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to quality, timeliness, or access to services, PIP validation 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 and the use of appropriate QI activities to support improvement of PIP 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 second validation year for the PIP. DHMP reported the baseline results for the PIP and completed Activities I through VIII of the PIP Summary Form.

Table 3-52 provides a summary of DHMP's PIP validation results for the FY 2015–2016 validation cycle.

Table 3-52—Performance Improvement Project Validation Results for DHMP

Study Stage	Activity	Percentage 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	67% (2/3)	0% (0/3)	33% (1/3)
	VIII. Interventions and Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total		**80% (4/5)**	**0% (0/5)**	**20% (1/5)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percent Score of Applicable Evaluation Elements Met		**93% (13/14)**	**0% (0/14)**	**7% (1/14)**

Overall, 93 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, only the Design and Implementation stages (Activities I through VIII) were validated.

Table 3-53 provides a summary of DHMP's PIP outcomes for the FY 2015–2016 validation cycle.

Table 3-53—Performance Improvement Project Outcomes for DHMP
PIP Topic: *Improving Follow-Up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*

Study Indicator	Baseline Period (07/01/2014–06/30/2015)	Remeasurement 1 (07/01/2015–06/30/2016)	Remeasurement 2 (07/01/2016–06/30/2017)	Sustained Improvement
1. The percentage of patients with referrals to the Healthy Lifestyle Clinic for overweight or obesity, with a completed visit and whose referring provider and PCP (if PCP is not the referring provider) receives a specialty report within 7 days of the patient visit.	100%			
2. The percentage of patients with referrals to the Children's Hospital Lifestyle Medicine Clinic for overweight or obesity, with a completed visit and whose referring provider and PCP (if PCP is not the referring provider) receives a specialty report within 30 days of the patient visit.	NA			

DHMP's baseline rate for Study Indicator 1 was 100 percent, which demonstrates no opportunity for improvement. For Study Indicator 2, there was no eligible population for the denominator. The health plan will be determining a new PIP topic for the next year.

Strengths

DHMP designed a scientifically sound project supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Although DHMP will not be continuing this PIP topic because the baseline results did not support the need for improvement, the health plan reported and interpreted its available baseline data accurately. The health plan also conducted a causal/barrier analysis using appropriate quality improvement tools and prioritized its identified barriers.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The health plan's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in improving PIP rates.

Although the health plan will be proposing a new topic for next year, for this PIP DHMP completed a process map and failure modes and effects analysis and identified the following barriers:

- Members do not show up for appointments.
- Lack of effective follow-up activities by the provider.
- Appointment request list protocols are not being followed by provider and staff when entering the reason for the referral.
- Lack of synchronization between EPIC and Denver Health referral information systems.

At the PIP time of submission, DHMP had not implemented any interventions.

Recommendations

DHMP's baseline PIP documentation demonstrated that the PIP's eligible population was very small, and the baseline rate for one study indicator was 100 percent. This rate does not lend itself to a quality improvement project. For the second study indicator, the denominator was zero; therefore, no baseline results exist. During a technical assistance call with DHMP and the Department, it was decided that the health plan will conduct further analysis and determine a new PIP topic. As DHMP initiates a new PIP topic, it should seek technical assistance from HSAG to ensure a sound study design.

DHMP: Summary Assessment Related to Quality, Timeliness, and Access for Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to quality, timeliness, or access to services, PIP validation 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 and the use of appropriate QI activities to support improvement of PIP 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 through 17 years of age who screened positive for depression with a primary care provider. This was the second validation year for the PIP. Kaiser reported the baseline results for the PIP and completed Activities I through VIII of the PIP Summary Form.

Table 3-54 provides a summary of Kaiser's PIP validation results for the FY 2015–2016 validation cycle.

Table 3-54—Performance Improvement Project Validation Results for Kaiser

Study Stage	Activity	Percentage 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	0% (0/1)	100% (1/1)	0% (0/1)
	IV. Study Indicator	50% (1/2)	50% (1/2)	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		**78% (7/9)**	**22% (2/9)**	**0% (0/9)**
Implementation	VII. Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	50% (2/4)	50% (2/4)	0% (0/4)
Implementation Total		**71% (5/7)**	**29% (2/7)**	**0% (0/7)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percent Score of Applicable Evaluation Elements Met		**75% (12/16)**	**25% (4/16)**	**0% (0/16)**

Overall, 75 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design and Implementation stages (Activities I through VIII) were validated.

Table 3-55 provides a summary of Kaiser's PIP outcomes for the FY 2015–2016 validation cycle.

Table 3-55—Performance Improvement Project Outcomes for Kaiser
PIP Topic: *Access and Transition to Behavioral Health Services*

Study Indicator	Baseline Period (01/01/2014–12/31/2014)	Remeasurement 1 (01/01/2015–12/31/2015)	Remeasurement 2 (01/01/2016–12/31/2016)	Sustained Improvement
1. The percentage of Kaiser CHP+ members 13 through 17 years of age who were screened for depression by a primary care practitioner office during the measurement year.	16.9%			
2. The total number of Kaiser CHP+ members 13 through 17 years of age who screened positive for depression by a primary care practitioner office and were seen by a behavioral health practitioner within 14 days of the positive screening.	22.2%			

The baseline rate for members 13 through 17 years of age who were screened for depression by a PCP's office during the measurement year was 16.9 percent. This rate is 8.1 percentage points below the Remeasurement 1 goal of 25 percent. For Kaiser's members 13 through 17 years of age who screened positive for depression by a PCP's office and were seen by a behavioral health practitioner within 14 days of the positive screening, the baseline rate was 22.2 percent. This rate is 17.8 percentage points below the first remeasurement goal of 40 percent.

Strengths

Kaiser designed a scientifically sound project supported by the use of key research principles. The health plan reported and interpreted its baseline data accurately. Kaiser described the staff involved with the QI activities, as required. Kaiser initiated interventions that were implemented in a timely manner and have the potential to impact the study indicator outcomes.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The health plan's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in improving PIP rates.

For the *Access and Transition to Behavioral Health Services* PIP, Kaiser identified these barriers to address:

- Inconsistent screening across PCPs.
- Additional time required for staff to accurately enter PHQ-9 results in the member's chart.
- Additional time required for providers to administer the PHQ-9 or PHQ-2.
- Appropriate billing code entry to capture completed depression screening.
- Lack of a standard process for connecting the member to a behavioral health practitioner following the PCP visit.
- Lack of continued provider engagement and recognition of this process as a key effort in addressing depression.

To address these barriers, Kaiser implemented the following interventions:

- Added PHQ-like depression screening tool to well-teen questionnaire for use in all well-visits.
- Communicated to all pediatric primary care departments regarding the PHQ-like screening tool.
- Added appropriate billing codes to the well-visit SMART sets to capture depression screening V-codes.
- Modified the well-teen tool to reflect PHQ-2 questions.
- Reeducated primary care departments about the depression screening process using the PHQ-2 and follow-up screening with the PHQ-9M, if PHQ-2 was positive.
- Held a continuing education seminar on teen depression with emphasis on using the depression screening tools.
- Created a new work flow for PCPs to start to prescribe antidepressants with a better referral and follow-up process with the behavioral health department.

Recommendations

As the PIP progresses, HSAG recommends the following for Kaiser:

- Include the anchor date for the PIP eligible population definition.
- In the denominator for Study Indicator 2, specify that the member's positive depressive disorder screen was performed by the PCP.
- Use, and describe the quality improvement tools used (such as a causal/barrier analysis, key driver diagram, process mapping, or failure modes and effects analysis) at least annually to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.
- Develop active, innovative interventions that can directly impact the study indicator outcomes.
- Develop a process or method to evaluate the effectiveness for each intervention. Use techniques based on quality improvement science such as the PDSA model as part of the HMO's improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.

Kaiser: Summary Assessment Related to Quality, Timeliness, and Access for Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to quality, timeliness, or access to services, PIP validation 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 *Partially Met* validation status for the *Access and Transition to Behavioral Health Services* PIP. Kaiser demonstrated a strong application of PIP study design principles, in general; however, the health plan will need to address HSAG's feedback on study design documentation and QI activities to achieve the desired improvement in PIP 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 second validation year for the PIP. RMHP reported the baseline results for the PIP and completed Activities I through VIII of the PIP Summary Form.

Table 3-56 provides a summary of RMHP's PIP validation results for the FY 2015–2016 validation cycle.

Table 3-56—Performance Improvement Project Validation Results for RMHP

Study Stage	Activity	Percentage 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	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	25% (1/4)	75% (3/4)	0% (0/4)
Implementation Total		**57% (4/7)**	**43% (3/7)**	**0% (0/7)**

Study Stage	Activity	Percentage of Applicable Elements		
		Met	Partially Met	Not Met
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percent Score of Applicable Evaluation Elements Met		**81% (13/16)**	**19% (3/16)**	**0% (0/9)**

Overall, 81 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, only the Design and Implementation stages (Activities I through VIII) were validated.

Table 3-57 provides a summary of RMHP's PIP outcomes for the FY 2015–2016 validation cycle.

Table 3-57—Performance Improvement Project Outcomes for RMHP
PIP Topic: *CHP+ Members With Asthma Transitioning Out of Plan Coverage*

Study Indicator	Baseline Period (01/01/2014–12/31/2014)	Remeasurement 1 (01/01/2015–12/31/2015)	Remeasurement 2 (01/01/2016–12/31/2016)	Sustained Improvement
The percentage of CHP+ members with asthma who turn 18 years of age during the measurement year who have at least one visit with a primary care provider.	10%			

The baseline rate for CHP+ members with asthma who turn 18 years of age during the measurement year and who had at least one visit with a PCP was 10 percent. This rate is 2 percentage points below the first remeasurement goal of 12 percent (20 percent increase over baseline). RMHP should revisit its goal to ensure that the Remeasurement 1 goal will yield statistically significant improvement.

Strengths

RMHP designed a scientifically sound project supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. RMHP reported and interpreted its baseline data accurately. The health plan has opportunities for improvement in its improvement strategies and activities. RMHP described the staff involved with the QI activities and the QI tools used; however, it did not describe how the identified barriers were prioritized. In addition, RMHP will need to implement active interventions to allow enough time for these interventions to impact the study indicator outcomes.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The health plan's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in improving PIP rates.

For the *CHP+ Members With Asthma Transitioning Out of Plan Coverage* PIP, RMHP identified these barriers:

- Lack of members' knowledge to manage their condition during and after transitioning out of the health plan
- Members needing reminders of the importance of wellness visits

To address these barriers, RMHP implemented the following interventions:

- Telephone outreach to parent or guardian of member in targeted population to discuss the transition and importance of primary care visits
- Mailings of educational materials to the parent or guardian of members in the targeted population

Recommendations

RMHP has opportunities for improvement in its improvement strategies and activities. The health plan described the staff involved with the QI activities and the QI tools used; however, it did not describe how the identified barriers were prioritized. In addition, RMHP will need to implement active interventions to allow enough time for these interventions to impact the study indicator outcomes. As the PIP progresses, HSAG recommends the following for RMHP:

- Use and describe quality improvement tools (such as a causal/barrier analysis, key driver diagram, process mapping, or failure modes and effects analysis) at least annually to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving desired outcomes.
- Describe methods used to prioritize identified barriers.
- Develop active, innovative interventions that can directly impact study indicator outcomes.
- Use techniques based on quality improvement science such as the PDSA model as part of the HMO's improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- Develop a process or plan to evaluate the effectiveness of each implemented intervention.
- Ensure that goals set for the remeasurement period will yield statistically significant improvement.

RMHP: Summary Assessment Related to Quality, Timeliness, and Access for Performance Improvement Projects

While the focus of a health plan's PIP may have been to improve performance related to quality, timeliness, or access to services, PIP validation 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 *Partially Met* validation status for the *CHP+ Members With Asthma Transitioning Out of Plan Coverage* PIP. RMHP demonstrated a strong application of PIP study design principles; however, the health plan will need to address HSAG's feedback on QI activities to achieve the desired improvement in PIP outcomes.

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

Table 3-58 shows the health plans' overall performance based on HSAG's validation of the FY 2015–2016 PIPs submitted for validation.

Table 3-58—Summary of Each HMO's PIP Validation Scores and 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 Depressive 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*	93%	100%	*Met*
Kaiser	*Access and Transition to Behavioral Health Services*	75%	63%	*Partially Met*
RMHP	*CHP+ Members With Asthma Transitioning Out of Plan Coverage*	81%	88%	*Partially Met*

The validation scores and validation status of PIPs demonstrated solid performance in the PIP design stage; however, performance in the implementation stage varied. Three of the five PIPs reviewed by HSAG demonstrated strong performance in the implementation stage and each of those received a *Met* validation status. The remaining two PIPs, Kaiser's *Access and Transition to Behavioral Health Services* and RMHP's *CHP+ Members With Asthma Transitioning Out of Plan Coverage*, received a *Partially Met* validation status. Both those PIPs received a *Partially Met* status because of deficiencies in Activity VIII (Improvement Strategies). Kaiser did not report the QI tools used to identify barriers or the processes used to determine the relative priority of identified barriers. RMHP did not describe the

process used to prioritize identified barriers. RMHP's PIP also lacked timely, active interventions that could directly impact study indicator outcomes.

While the focus of a health plan's PIP may have been to improve performance related to quality, timeliness, or access to services, PIP validation 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. Three of the five PIPs validated by HSAG earned a *Met* validation status, demonstrating a sound application of design principles necessary to produce valid and reliable PIP results and strong QI processes and activities needed to support desired improvement. For the two PIPs that received a *Partially Met* validation status, Kaiser and RMHP will need to address HSAG's feedback in Activity VIII (Improvement Strategies) to ensure that appropriate QI tools and processes are used to drive improvement in the outcomes stage of the PIP.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

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.

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 members who chose a response of "Usually" or "Always." For one composite (*Shared Decision Making*), the rates were based on 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 has not been 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 (+).

For the CHP+ health plans' findings, a substantial increase is noted when a measure's rate increased by 5 percentage points or more from the previous year. A substantial decrease is noted when a measure's rate decreased by 5 percentage points or more from the previous year.

Colorado Access

Findings

Table 3-59 shows the results achieved by Colorado Access for FY 2014–2015 and FY 2015–2016.

Table 3-59—Question Summary Rates and Global Proportions for Colorado Access

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Getting Needed Care	84.7%	87.1%
Getting Care Quickly	87.3%	92.3%
How Well Doctors Communicate	95.3%	97.7%
Customer Service	83.5%	81.5%
Shared Decision Making	78.3%+	80.3%
Rating of Personal Doctor	72.2%	76.3%
Rating of Specialist Seen Most Often	68.0%	68.5%+
Rating of All Health Care	58.5%	71.5%
Rating of Health Plan	58.5%	60.4%

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

Recommendations

Colorado Access experienced no substantial decrease in rates. However, one composite measure, *Customer Service*, showed a slight decrease. Colorado Access should continue to direct quality improvement activities toward this measure.

In order to improve members' perceptions on the *Customer Service* composite measure, Colorado Access' quality improvement activities should focus on evaluating call centers, enhancing customer service training programs, and developing customer service performance measures.

Colorado Access: Summary Assessment Related to Quality, Timeliness, and Access for CAHPS

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

Two measure rates increased substantially: *Getting Care Quickly* and *Rating of All Health Care*. Six measures demonstrated slight increases: *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. As noted, no measures' rates decreased substantially; however, one measure did demonstrate a rate decrease.

Colorado Choice Health Plans

Findings

Table 3-60 shows the results achieved by Colorado Choice for FY 2014–2015 and FY 2015–2016.

Table 3-60—Question Summary Rates and Global Proportions for Colorado Choice

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Getting Needed Care	89.5%	90.1%
Getting Care Quickly	91.1%	90.6%
How Well Doctors Communicate	95.4%	94.4%
Customer Service	81.8%+	85.2%+
Shared Decision Making	76.0%+	78.1%+
Rating of Personal Doctor	60.3%	58.4%
Rating of Specialist Seen Most Often	63.6%+	72.7%+
Rating of All Health Care	54.3%	52.7%
Rating of Health Plan	54.1%	49.3%

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

Recommendations

Colorado Choice experienced no substantial decrease in rates. However, five measures, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan*, showed slight decreases. Colorado Choice should continue to direct quality improvement activities toward these measures.

In order to improve members' perceptions on the *Getting Care Quickly* composite measure, Colorado Choice's quality improvement activities should focus on evaluating no-show appointments, encouraging the use of electronic communication between providers and members where appropriate, open-access scheduling, and assisting providers with monitoring member flow. To improve satisfaction on the *How Well Doctors Communicate* composite measure, Colorado Choice should focus on communication tools, improving health literacy, and language barriers. For the *Rating of Personal Doctor* global rating, Colorado Choice should continue to focus efforts on monitoring appointment scheduling, obtaining direct member feedback, enhancing physician-member communication, improving shared decision making, and training care managers about the principles of member/family centered care. To improve in the area of *Rating of All Health Care*, Colorado Choice should explore activities that target member perception of access to care, member and family engagement advisory councils, member- and family-centered care, and involving families in care coordination. For the *Rating of Health Plan* global rating, Colorado Choice should focus on alternatives to one-on-one visits, improving health plan operations, enhancing online patient portals, promoting QI initiatives, and coordinating health services.

Colorado Choice: Summary Assessment Related to Quality, Timeliness, and Access for CAHPS

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

One measure rate increased substantially, *Rating of Specialist Seen Most Often*. Three measures demonstrated slight increases: *Getting Needed Care*, *Customer Service*, and *Shared Decision Making*. As noted, no measures' rates decreased substantially; however, the remaining five measures showed rate decreases.

Denver Health Medical Plan

Findings

Table 3-61 shows the results achieved by DHMP for FY 2014–2015 and FY 2015–2016.

Table 3-61—Question Summary Rates and Global Proportions for DHMP

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Getting Needed Care	71.0%	65.8%
Getting Care Quickly	79.7%	76.4%
How Well Doctors Communicate	92.8%	93.6%
Customer Service	85.2%	82.2%
Shared Decision Making	76.0%+	74.2%+
Rating of Personal Doctor	73.1%	75.6%
Rating of Specialist Seen Most Often	63.6%+	58.3%+
Rating of All Health Care	60.3%	61.7%
Rating of Health Plan	55.4%	62.4%

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

Recommendations

DHMP experienced substantial decreases in rates for two measures: *Getting Needed Care* and *Rating of Specialist Seen Most Often*. In addition, three measures, *Getting Care Quickly*, *Customer Service*, and *Shared Decision Making*, showed slight decreases. DHMP should continue to direct quality improvement activities toward these measures.

In order to improve members' perceptions on the *Getting Needed Care* composite measure, DHMP's quality improvement activities should focus on assessing the need for additional healthcare providers based on member/network needs; providing interactive workshops in promoting health education, health literacy, preventive health care, and a general understanding of members' healthcare needs; developing language concordance programs; and facilitating coordinated care. To improve in the area of *Rating of*

Specialist Seen Most Often, DHMP should focus on working with providers to implement skills training for specialists, including telemedicine, and enhancing care coordination teams.

DHMP: 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.

One measure rate increased substantially, *Rating of Health Plan*. Three measures demonstrated slight increases: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of All Health Care*. As noted, two measures' rates decreased substantially: *Getting Needed Care* and *Rating of Specialist Seen Most Often*, and three other measures showed rate decreases: *Getting Care Quickly*, *Customer Service*, and *Shared Decision Making*.

Kaiser Permanente Colorado

Findings

Table 3-62 shows the results achieved by Kaiser for FY 2014–2015 and FY 2015–2016.

Table 3-62—Question Summary Rates and Global Proportions for Kaiser

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Getting Needed Care	89.9%	87.8%
Getting Care Quickly	91.1%	92.5%
How Well Doctors Communicate	96.6%	96.8%
Customer Service	86.2%	84.6%
Shared Decision Making	77.2%+	86.0%+
Rating of Personal Doctor	75.2%	72.2%
Rating of Specialist Seen Most Often	72.1%+	58.3%+
Rating of All Health Care	63.6%	65.0%
Rating of Health Plan	62.3%	57.0%

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

Recommendations

Kaiser experienced substantial decreases in rates for two measures: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. In addition, three measures, *Getting Needed Care*, *Customer Service*, and *Rating of Personal Doctor*, showed slight decreases. Kaiser should continue to direct quality improvement activities toward these measures.

To improve in the area of *Rating of Specialist Seen Most Often*, Kaiser should focus on working with providers in its network to enhance planned visit management systems to prompt general follow-up contact or ensure that necessary tests are completed before an appointment, provide skills training for specialists, include telemedicine, and develop care coordination teams. For the *Rating of Health Plan* global rating, Kaiser should focus on alternatives to one-on-one visits such as telephone consultations, health plan operations to view its operations as collections of microsystems (providers, administrators, and other staff that provide services to members), promoting QI initiatives, and coordination of health services.

Kaiser: Summary Assessment Related to Quality, Timeliness, and Access for CAHPS

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

One measure rate increased substantially, *Shared Decision Making*. Three measures demonstrated slight increases: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*. As noted, two measures' rates decreased substantially and three measures showed rate decreases.

Rocky Mountain Health Plans

Findings

Table 3-63 shows the results achieved by RMHP for FY 2014–2015 and FY 2015–2016.

Table 3-63—Question Summary Rates and Global Proportions for RMHP

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Getting Needed Care	86.9%	86.1%
Getting Care Quickly	93.1%	90.2%
How Well Doctors Communicate	96.9%	96.5%
Customer Service	79.4%	78.0%
Shared Decision Making	73.8%+	80.7%
Rating of Personal Doctor	70.4%	70.1%
Rating of Specialist Seen Most Often	68.6%+	78.8%
Rating of All Health Care	57.9%	62.9%
Rating of Health Plan	60.0%	59.1%

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

Recommendations

RMHP experienced no substantial decrease in rates. However, six measures, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan*, showed slight decreases. RMHP should continue to direct quality improvement activities toward these measures.

In order to improve members' perceptions on the *Getting Needed Care* composite measure, RMHP's quality improvement activities should focus on assessing the need for additional healthcare providers based on member/network needs; providing interactive workshops in promoting health education, health literacy, preventive health care, and general understanding of the healthcare needs; developing language concordance programs; and facilitating coordinated care. To improve members' perceptions on 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, open-access scheduling, and assisting providers with monitoring patient flow. To improve satisfaction on the *How Well Doctors Communicate* composite measure, RMHP should focus on communication tools to effectively communicate with physicians and improve health literacy and mitigate language barriers by hiring interpreters to ensure accurate communication among non-English speaking members and physicians. In order to improve members' perceptions on the *Customer Service* composite measure, RMHP's quality improvement activities should focus on evaluating call centers and customer service training programs and developing performance measures for customer service operations. For the *Rating of Personal Doctor* global rating, RMHP should continue to focus efforts on monitoring appointment scheduling, obtaining direct member feedback, enhancing physician-member communication, improving shared decision making, and training care managers about the principles of member/family-centered care. For the *Rating of Health Plan* global rating, RMHP should focus on alternatives to one-on-one visits, health plan operations, enhancing online patient portals, promoting QI initiatives, and coordination of health services.

RMHP: Summary Assessment Related to Quality, Timeliness, and Access for CAHPS

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

Three measure rates increased substantially: *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*. As noted, no measures' rates decreased substantially; however, the remaining six measures showed rate decreases.

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 3-64 shows the CHP+ statewide averages for FY 2014–2015 and FY 2015–2016.

Table 3-64—Statewide Question Summary Rates and Global Proportions

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Getting Needed Care	84.4%	85.7%
Getting Care Quickly	88.0%	90.8%
How Well Doctors Communicate	95.4%	96.9%
Customer Service	83.2%	81.7%
Shared Decision Making	77.2%	80.8%
Rating of Personal Doctor	71.9%	73.6%
Rating of Specialist Seen Most Often	67.9%	68.1%
Rating of All Health Care	58.9%	67.3%
Rating of Health Plan	58.6%	59.2%

Recommendations

The CHP+ health plans experienced no substantial decrease in rates. However, one measure, *Customer Service*, showed a slight decrease. The CHP+ health plans should continue to direct quality improvement activities toward this measure.

In order to improve members' perceptions on the *Customer Service* composite measure, the CHP+ health plans' quality improvement activities should focus on evaluating call centers, customer service training programs, and performance measures.

Statewide 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.

One measure rate increased substantially, *Rating of All Health Care*. Seven measures demonstrated increases: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. As noted, no measures' rates decreased substantially; however, one measure, *Customer Service*, showed a rate decrease.

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 2014–2015 site review, Colorado Access was required to address a total of eight *Partially Met* findings: two for Standard V—Member Information and six for Standard VI—Grievance System. For Standard V, Colorado Access was required to remove statements from the member handbook regarding the potential for members to be charged for missed appointments and the potential for members to be disenrolled for refusing to follow recommended treatment. The required actions for Standard VI were related to time frames for appeals and State fair hearings and timely resolution of grievances. Colorado Access submitted its CAP to HSAG and the Department in April 2015. HSAG and the Department required a few minor revisions before approving the proposed actions. Colorado Access began to submit documents that demonstrated implementation of its plan in August 2015. HSAG and the Department required periodic clarifications or enhancements to documents submitted and, in November 2015, determined that Colorado Access had successfully implemented all corrective actions.

Validation of Performance Measures

During the FY 2014–2015 review, HSAG recommended that Colorado Access monitor performance related to immunizations for children and adolescents and well-child visits to determine if interventions were warranted. Further, based on analyses of Colorado Access' HEDIS 2015 measure rates compared to the previous year's rates and national Medicaid benchmarks, HSAG recommended that Colorado Access develop strategies to improve chlamydia screening, children's and adolescents' access to primary care practitioners, and asthmatic members' medication compliance.

As a result, Colorado Access advised that wellness incentives for flu shots and well visits were implemented for its members. It also created a new Access to Care program, developed new Access to Care metrics, and focused efforts on customer service training and education opportunities. Colorado Access' rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* demonstrated statistically significant improvement from HEDIS 2015 to HEDIS 2016, ranking at or below the national Medicaid 75th percentile. Additionally, rates within the Access to Care domain showed statistically significant improvements. Specifically, *Children and Adolescents' Access to*

Primary Care Practitioners—Ages 25 Months to 6 Years statistically significantly improved from the prior year and ranked at or below the national Medicaid 50th percentile, while last year the measure indicator ranked at or below the national Medicaid 25th percentile.

Additionally, during the FY 2014–2015 review, HSAG recommended that Colorado Access monitor its performance related to immunizations for children. However, the statistically significant decline reported in the FY 2014–2015 review may not have been due to performance but rather a result of the health plan reporting measures to NCQA using the hybrid methodology and the rates being presented administratively for EQRO purposes in FY 2014–2015 and FY 2015–2016.

At the time of this report, Colorado Access had not provided information regarding quality initiatives developed as a result of HSAG's FY 2014–2015 recommendations related to improving rates for chlamydia screening, children's and adolescents' access to primary care practitioners, and encouraging medication compliance among asthmatic members. HEDIS 2016 rates related to *Chlamydia Screening in Women—Total* decreased and ranked below the national Medicaid 10th percentile. Three of the measure indicators related to *Children and Adolescents' Access to Primary Care Practitioners* showed signs of increase, with varying percentile rankings—from the lowest indicator ranking below the national Medicaid 50th percentile to the highest indicator ranking below the national Medicaid 90th percentile. The remaining measure related to *Children and Adolescents' Access to Primary Care Practitioners* demonstrated a statistically significant decline and ranked below the national Medicaid 25th percentile. Both measure indicators related to *Medication Management for People With Asthma* improved slightly from the previous year and ranked below the national Medicaid 25th percentile.

HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014–2015 was the first year for Colorado Access' *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan* PIP. Validated for Activities I through VI, the PIP received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Between FY 2014–2015 and FY 2015–2016, Colorado Access experienced increases in rates for a majority of the measures. Only one measure showed a decrease, *Customer Service*. During FY 2015–2016, the rate for *Rating of All Health Care* increased by 13 percentage points and the rate for *Getting Care Quickly* increased by 5 percentage points. The remaining measures demonstrated slight increases, between 0.5 and 4.1 percentage points. These increases may indicate that Colorado Access followed up on HSAG's recommendations by creating programs such as incentive programs for accessing care (i.e., providing wellness incentives for flu shots and well visits and improving internal customer service processes). Additionally, Colorado Access established committees to work on provider opportunities

(i.e., identify provider challenges and needs, update provider training/materials, develop best practices workshops, analyze provider network adequacy, and identify gaps).

Colorado Choice Health Plans

Compliance Monitoring Site Reviews

As a result of the FY 2014–2015 site review, Colorado Choice was required to address six *Partially Met* findings for Standard V—Member Information, 19 *Partially Met* findings for Standard VI—Grievance System, three *Partially Met* and two *Not Met* findings for Standard VII—Provider Participation and Program Integrity, and two *Partially Met* findings for Standard IX—Subcontracts and Delegation. Colorado Choice submitted its CAP to HSAG and the Department in May 2015 and began submitting documents to demonstrate implementation of the planned interventions in September 2015. HSAG and the Department worked closely with Colorado Choice throughout the remainder of 2015 to monitor implementation of Colorado Choice's CAP. At the time of the FY 2015–2016 site review (January 28–29, 2016), Colorado Choice had completed two of the 32 required actions. The majority of outstanding issues were pending approval of revised policies and procedures by appropriate governing bodies and comprehensive staff training; however, Colorado Choice continued to misinterpret the time frames related to continuation of services during an appeal and/or State fair hearing. As of August 2016, HSAG and the Department continued to monitor Colorado Choice's progress and will ensure appropriate implementation and full compliance with all required actions.

Validation of Performance Measures

During the FY 2014–2015 review, HSAG recommended that Colorado Choice focus on improvements within the Pediatric Care domain as all but one reportable rates ranked at or below the 25th national Medicaid percentile. Further, HSAG recommended that Colorado Choice develop strategies to improve children's and adolescents' access to primary care practitioners.

As a result, Colorado Choice reported that it implemented changes in its medical department in order to increase quality of care. Additionally, Colorado Choice has implemented member outreach and interventions to help familiarize and educate members concerning the importance of keeping appointments and requesting necessary services. Additionally, the health plan is educating members to provide documentation to their providers for additional services that members may have received elsewhere (i.e., health fairs, immunization at a local pharmacy or school).

While Colorado Choice reported low percentile rankings for measure indicators within the Pediatric Care domain in FY 2014–2015 and FY 2015–2016, the low percentile rankings may not have been due to performance but rather that the health plan reported measures to NCQA using the hybrid methodology and that the rates were presented administratively in FY 2014–2015 and FY 2015-2016 for EQR purposes. Measures related to *Appropriate Testing for Children With Pharyngitis* improved from the prior year and ranked above the national Medicaid 50th percentile.

At the time of this report, Colorado Choice had not provided information regarding quality initiatives developed as a result of HSAG's FY 2014–2015 recommendations related to improving rates for children's and adolescents' access to primary care practitioners. This measure showed slight decreases; one measure indicator ranked below the national Medicaid 25th percentile, while the remaining two measure indicators ranked below the national Medicaid 10th percentile.

HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014–2015 was the first year for Colorado Choice's *Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider* PIP. Validated for Activities I through VI, the PIP received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Between FY 2014–2015 and FY 2015–2016, Colorado Choice experienced decreases in rates for five measures; however, these decreases were not substantial. One measure, *Rating of Specialist Seen Most Often*, demonstrated a substantial increase of more than 9 percentage points. In order to improve the quality of care and CAHPS scores and to increase quality throughout the organization, Colorado Choice added staff to their medical department. Additionally, Colorado Choice has reached out to members to assist them in registering for access to the online patient portal. The online patient portal helps members manage their health by consolidating member information such as medical history, medications taken, scheduled appointments, diagnosed illnesses and conditions, and a summary of medical visits. To improve access to care, Colorado Choice implemented two new procedures: provider office site evaluation, and facility site evaluation. These procedures are designed to evaluate and track, on a specified time frame, elements of NCQA Standard CR6. Furthermore, Colorado Choice has improved member communication and informed members of the importance of selecting a PCP to help improve the quality of care obtained. Colorado Choice has seen an improvement in members proactively returning telephone calls and selecting PCPs. Even though Colorado Choice implemented numerous quality improvement initiatives, the recent CAHPS scores indicate that Colorado Choice needs to continue work on its quality initiative to avoid score decreases.

Denver Health Medical Plan, Inc.

Compliance Monitoring Site Reviews

As a result of the 2014–2015 site review, DHMP was required to address two *Partially Met* scores related to Standard V—Member Information and five *Partially* Met scores related to Standard VI—Grievance System. DHMP submitted its CAP in April 2015. After HSAG and the Department reviewed and approved the plan, Denver Health began submitting documents to demonstrate compliance with the proposed plan. As of December 2015, DHMP had completed all required actions related to its CHP+ line of business.

Validation of Performance Measures

During the FY 2014–2015 review, HSAG recommended that DHMP monitor its performance related to immunizations for children and adolescents, well-child and well-care visits, and access to primary care practitioners.

As a result, DHMP reported that it has worked to provide better availability and capacity for members to schedule appointments. DHMP's rates, including *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, *Adolescent Well-Care Visits*, and *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* experienced statistically significant improvement over the prior year; however, two of the rates ranked below the national Medicaid 10th percentile. HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014–2015 was the first year for DHMP's *Improving Follow-Up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics* PIP. Validated for Activities I through VI, the PIP received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Between FY 2014–2015 and FY 2015–2016, DHMP experienced substantial decreases in rates for two measures: *Getting Needed Care* and *Rating of Specialist Seen Most Often*. In addition, three measures, *Getting Care Quickly*, *Customer Service*, and *Shared Decision Making*, showed slight decreases in rates. One measure, *Rating of Health Plan*, showed a substantial increase of 7 percentage points. DHMP implemented an initiative to provide greater appointment availability for its members by expanding capacity. In the past year, DHMP expanded access to care in numerous clinics and expanded its partnership with the NurseLine to allow members to access advice, schedule appointments, and receive care or medications for certain conditions over the phone. However, DHMP's measure rates for *Getting Needed Care* and *Rating of Specialist Seen Most Often* had substantial decreases; therefore, an evaluation of the existing quality initiative efforts in place is warranted to ensure that these efforts are meeting members' healthcare needs.

Kaiser Permanente Colorado

Compliance Monitoring Site Reviews

As a result of the FY 2014–2015 site review, Kaiser was required to address seven *Partially Met* elements and four *Not Met* elements in Standard V—Member Information, seven *Partially Met* elements and two *Not Met* elements in Standard VI—Grievance System, and one *Partially Met* element and one *Not Met* element in Standard VII—Provider Participation and Program Integrity. Kaiser submitted its proposed CAP in May 2015. After reviewing Kaiser's proposed plan, HSAG and the Department approved some proposed actions and required additional detail for others. Kaiser began submitting documents to demonstrate completion of the plan in August 2015. As of November 2015, Kaiser had completed 11 of the 22 required actions.

Kaiser proposed, and the Department approved, a substantial rewrite of Kaiser's Evidence of Coverage (EOC) to comply with the requirement for ease of understanding for members—with other interim documents produced to correct critical elements of inaccuracy in information for members. The critical corrections to the EOC were completed in August 2015, with the full re-write—as well as all other outstanding corrective actions— completed in July 2016.

Validation of Performance Measures

During the FY 2014–2015 review, HSAG recommended that Kaiser monitor performance related to well-child visits, well-care visits for adolescents, and immunizations for adolescents. Further, based on analyses of Kaiser's HEDIS 2015 measure rates compared to the previous year's rates and national Medicaid benchmarks, HSAG recommended that Kaiser develop strategies to improve children's and adolescents' access to primary care practitioners. Additionally, HSAG recommended that Kaiser investigate the reasons behind the small denominators within the Mental/Behavioral Health and Respiratory Conditions domains.

At the time of this report, Kaiser did not provide information regarding quality initiatives that may have been developed as a result of HSAG's FY 2014–2015 recommendations. However, during FY 2015–2016, Kaiser's reported rates experienced statistically significant improvement from the prior year for one measure indicator related to well-child visits and ranked below the national Medicaid 50th percentile. Meanwhile, six of the nine measure indicators related to childhood immunizations showed statistically significant decline from the prior year and ranked below the national Medicaid 50th percentile. The measure indicator related to adolescent immunizations' ranked below the 75th percentile. Kaiser's rates related to children's and adolescents' access to care demonstrated statistically significant decline for two of the measure indicators, and all four measure indicators ranked below the national Medicaid 25th percentile. Additionally, Kaiser continued to experience small denominators within the Mental/Behavioral Health and Respiratory Conditions domains, with the exception of *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Appropriate Treatment for Children With Upper Respiratory Infection.*

HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014–2015 was the first year for Kaiser's *Access and Transition to Behavioral Health Services* PIP. Validated for Activities I through VI, the PIP received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Between FY 2014–2015 and FY 2015–2016, Kaiser experienced substantial decreases in rates for two measures: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. In addition, three measures, *Getting Needed Care*, *Customer Service*, and *Rating of Personal Doctor*, showed slight decreases in rates. One measure, *Shared Decision Making*, demonstrated a substantial increase of more than 8 percentage points. At the time of this report, Kaiser provided no information regarding quality initiatives that may have been developed as a result of HSAG's FY 2014–2015 recommendations.

Rocky Mountain Health Plans

Compliance Monitoring Site Reviews

As a result of the 2014–2015 CHP+ site review, RMHP was required to implement 11 corrective actions related to Member Information, six corrective actions related to Grievance System, and one corrective action related to Provider Participation and Program Integrity. For Member Information, RMHP was required to revise its member handbook to lower the reading level. Other corrective actions were related to enhancing information regarding advance directives and the utilization management program and clarifying definitions of "emergency medical care" and "poststabilization services." For the Grievance System, RMHP was required to expand its definition of an "action" and revise member information to ensure accurate and consistent time frames. RMHP submitted its proposed corrective action plan to HSAG and the Department in July 2015. HSAG and the Department worked with RMHP to ensure that planned interventions would fully address the required actions. HSAG reviewed documents in October 2015 and again in January 2016, when HSAG and the Department determined that RMHP had completed all required actions.

Validation of Performance Measures

During the FY 2014–2015 review, HSAG recommended that RMHP monitor its performance related to immunizations for children and adolescents, well-child and well-care visits, and access to primary care practitioners. Further, based on analyses of RMHP's HEDIS 2015 measure rates compared to the previous year's rates and national Medicaid benchmarks, HSAG recommended that RMHP develop

strategies to improve the percentage of asthmatic members who remain on an asthma-controller medication. Additionally, HSAG recommended that RMHP investigate the reasons behind the small denominators within the Mental/Behavioral Health domain.

As a result, RMHP reported having been actively involved assisting members to access primary care services. Additionally, RMHP's HEDIS auditor granted the health plan permission to map current national drug codes to RMHP's Generic Product Identifier to assist in national drug codes being included within the HEDIS metrics.

RMHP's FY 2015–2016 rates for the following measure indicators experienced statistically significant improvement from the prior year: *Children and Adolescents' Access to Primary Care Practitioners* (three of the four indicators for this measure). The statistically significant decline reported in the FY 2014–2015 review may not have been due to performance but rather that the health plan reported measures to NCQA using the hybrid methodology and that the rates were presented administratively in FY 2014–2015 and FY 2015–2016 for EQR purposes. Additionally, several of RMHP's rates for the following measures that were recommended for improvement based on HEDIS 2015 reporting were not reportable (i.e., the health plan followed the specifications but the denominator was too small [<30] to report a valid rate, resulting in a *Not Applicable [NA]* audit designation, or RMHP's reported rate was invalid, and the rate is therefore not presented): *Childhood Immunization Status*; *Immunizations for Adolescents*; *Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Adolescent Well-Care Visits*.

HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014–2015 was the first year for RMHP's *CHP+ Members With Asthma Transitioning Out of Plan Coverage* PIP. Validated for Activities I through VI, the PIP received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Between FY 2014–2015 and FY 2015–2016, RMHP experienced no substantial decrease in rates. However, six measures, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan*, showed slight decreases in rates. Three measure rates increased substantially: *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*. One measure, *Rating of Specialist Seen Most Often*, demonstrated a substantial increase of more than 10 percentage points. RMHP's customer service department and care management teams have been actively involved in assisting members with access to primary care services. RMHP should continue to focus on existing quality improvement initiatives to improve rates for the measures that demonstrated decreases during FY 2015–2016.

State Managed Care Network (SMCN)

Compliance Monitoring Site Reviews

Colorado Access administers the SMCN and uses the same policies, procedures, and organizational processes for both lines of business; therefore, the SMCN was not required to complete a separate corrective action plan in FY 2014–2015.

Validation of Performance Measures

During the FY 2014–2015 review, HSAG recommended that the Department focus its efforts to improve the rates for the *Prenatal and Postpartum Care (PPC)* measures, which had both experienced statistically significant decline and ranked at or below the national Medicaid 10th percentile. However, data were not available during FY 2015–2016 to support the calculation of these measure indicators according to the desired measure specifications. Therefore, a performance measure assessment of SMCN is excluded from this report.

Validation of Performance Improvement Projects

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Between FY 2014–2015 and FY 2015–2016, SMCN experienced no substantial decreases in rates. However, one measure, *Customer Service*, showed a slight decrease. The CHP+ health plans should continue to direct quality improvement activities toward this measure. One measure rate, for *Rating of All Health Care*, increased substantially—over 8 percentage points. The remaining measures demonstrated slight increases. As indicated, Colorado Access administers the SMCN. These increases may indicate that Colorado Access followed up on HSAG's recommendations by creating programs applicable to its SMCN population, such as improving internal customer service processes. Additionally, Colorado Access established committees to work on provider opportunities (i.e., identify provider challenges and needs, update provider training/materials, develop best practices workshops, analyze provider network adequacy, and identify gaps).

Appendix A. EQRO Activities—Compliance Monitoring

Introduction

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

For the FY 2015–2016 site review process, the Department requested a review of four areas of performance. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. HSAG developed a strategy and monitoring tools to review compliance with federal managed care regulations and managed care contract requirements related to each standard. HSAG also reviewed the health plan's administrative records to evaluate implementation of federal healthcare regulations and compliance with NCQA requirements, effective July 2015.

In developing the data collection tools and in reviewing documentation related to the standards, HSAG used the CHP+ managed care 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. According to 42 CFR 438.358, the state or its EQRO must conduct a review of all Medicaid managed care requirements within a three-year period to determine an MCO's compliance with required program standards. To complete this requirement, HSAG, through its EQRO contract with the State of Colorado, performed on-site compliance evaluations—i.e., site reviews—of the five CHP+ health plans with which the State contracts as well as the SMCN.

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 health plans, 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 health plans' documents prior to the on-site portion of the review.

On-site review activities included a review of additional documents, policies, and key committee meeting minutes to determine compliance with federal healthcare regulations and implementation of the organizations' policies. As part of Standard VIII—Credentialing and Recredentialing, HSAG conducted an on-site review of 10 credentialing records and 10 recredentialing records to evaluate implementation of federal healthcare regulations and compliance with NCQA requirements, effective July 2015. HSAG incorporated the record review results into the findings for the credentialing and recredentialing standards. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score.

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

Table A-1 describes the tasks performed for each activity in the CMS final protocol for monitoring compliance during FY 2015–2016.

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 health plans.
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 notified the health plans in writing of the request for desk review documents via email delivery of 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 record reviews. Thirty days prior to the review, the health plans provided documentation for the desk review, as requested. • Documents submitted for the desk review and the 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 of the health plans' credentialing and recredentialing records that occurred between January 1, 2013, and December 31, 2015. 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 to evaluate implementation of

For this step,	HSAG completed the following activities:
	federal healthcare regulations and compliance with NCQA credentialing and recredentialing standards and guidelines. • 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 health plan's staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2015–2016 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.
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
- Member handbook and informational materials
- Staff training materials and documentation of attendance
- Applicable 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 each site review, HSAG aggregated all information and analyzed the findings from the document review, record reviews, and the on-site interviews. Findings were scored using a *Met*, *Partially Met*, *Not Met*, or *Not Applicable* methodology for each requirement. Each health plan 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 42 CFR 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, 2015, and December 31, 2015, 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 required element. 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. EQRO 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

The Department required that each health plan, with the exception of the SMCN, undergo an NCQA HEDIS Compliance Audit performed by an NCQA-certified HEDIS compliance auditor (CHCA) contracted with an NCQA-licensed organization. CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012,[B-1] identifies key types of data that should be reviewed. NCQA HEDIS Compliance Audits meet the requirements of the CMS protocol. Therefore, HSAG requested copies of the Final Audit Report (FAR) for each health plan and aggregated several sources of HEDIS-related data to confirm that the health plans met the HEDIS IS compliance standards and had the ability to report HEDIS data accurately.

[B-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Sept 30, 2016.

Description of Data Obtained

As identified in the HEDIS audit methodology, key data sources were obtained and reviewed to ensure that data were validated in accordance with CMS' requirements and confirm that only valid results were included in this report. Table B-1 outlines those activities of the audit steps reviewed by HSAG, along with the corresponding source data.

Table B-1—Description of Data Sources Reviewed

Data Reviewed	Source of Data
Pre-On-Site Visit/Meeting—This was the initial conference call or meeting between the HEDIS compliance auditor and the health plan staff. HSAG verified that key HEDIS topics such as timeliness and on-site review dates were addressed by the licensed organizations.	HEDIS 2016 FAR
Roadmap Review—This review provided the health plan's HEDIS compliance auditors with background information on policies, processes, and data in preparation for on-site validation activities. The health plans were required to complete the Roadmap to provide their lead auditor audit team with the necessary information to begin validation activities. HSAG looked for evidence in the final report that the licensed HEDIS auditor completed a thorough review of all components of the Roadmap.	HEDIS 2016 FAR
Certified Measure Review— If any health plan used a vendor whose measures were certified by NCQA to calculate that health plan's measure rates, HSAG verified that the certification was available and that all required measures developed by the vendor were certified by NCQA.	HEDIS 2016 FAR and Measure Certification Reports
Source Code Review—HSAG ensured that the licensed HEDIS auditor reviewed the programming language for calculating any HEDIS measures that did not undergo NCQA's measure certification process. Source code review was 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 2016 FAR
Survey Vendor—If the health plan 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 health plan performed a CAHPS survey as part of HEDIS reporting.	HEDIS 2016 FAR

Data Reviewed	Source of Data
CAHPS Sample Frame Validation—HSAG validated that the licensed organizations performed detailed evaluations of the 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 2016 FAR
Supplemental Data Validation—If the health plan used any supplemental data for reporting, the HEDIS compliance auditor must validate the supplemental data according to NCQA guidelines. HSAG verified that the NCQA-required processes were followed to validate the supplemental databases.	HEDIS 2016 FAR
Convenience Sample Validation—Per NCQA guidelines, the HEDIS auditor reviews a small number of processed medical records to uncover potential problems that may require corrective action early in the medical record review (MRR) process. A convenience sample must be prepared unless the auditor determines that a health plan is exempt. NCQA allows organizations to be exempt from the convenience sample if they participated in a HEDIS audit the previous year and passed MRR validation, if the current MRR process has not changed significantly from the previous year, and if the health plan did not report hybrid measures that the auditor determines to be at risk of inaccurate reporting. HSAG verified that the HEDIS auditors determined whether or not the health plans were required to undergo a convenience sample validation. HSAG also verified that if a convenience sample validation was not required by the HEDIS auditor the specific reasons were documented.	HEDIS 2016 FAR
Medical Record Review—The HEDIS auditors 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 auditor performed a re-review of a minimum random sample of 16 medical records for each measure group and the exclusions group to ensure the reliability and validity of the data collected.	HEDIS 2016 FAR
Interactive Data Submission System (IDSS) Review—The health plans 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 health plans. The auditor locks the IDSS so that no information can be changed. HSAG verified that the auditors completed the IDSS review process. In a situation where the health plans did not submit the rates via IDSS, HSAG validated the accuracy of the rates submitted by the health plans in a State-specified reporting template.	HEDIS 2016 IDSS

Table B-2 identifies the key validation elements reviewed by HSAG. HSAG identified whether or not each health plan was compliant with the key elements as described by the licensed HEDIS auditor organization in the FAR and the IDSS. As presented in Table B-2, a check mark symbol indicates that the licensed organization conducted the corresponding audit activity according to the HEDIS methodology. Some activities were conducted by other companies, such as NCQA-certified software or survey vendors, which contracted with the health plans. In these instances, the name of the company which performed the required task is listed.

Table B-2—Validation Activities

	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP
Licensed HEDIS Auditor 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.	SPH Analytics (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	✓	✓	✓	✓	✓

The preceding table indicates that audits conducted for the health plans included all required validation activities. The health plans used NCQA-licensed organizations to perform the HEDIS audits. In addition, all health plans 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 HEDIS auditor organization, indicating that the code was within the HEDIS 2016 technical specifications.

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.

Aggregation, Analysis, and How Conclusions Were Drawn

The following process describes the standard practice for HEDIS audits regardless of the auditing firm. The health plans submitted the FARs 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.

Hybrid Measure Rates for HEDIS 2016

Table B-3 presents the HEDIS 2016 hybrid measure rates reported by the health plans, with the exception of Kaiser, which only reported its HEDIS 2016 rates administratively. Health plans' administrative rates for these measures are presented in the main body of this report. RMHP's rates for all hybrid measures were deemed invalid by the health plan and, as such, are denoted as *Biased Rate (BR)* throughout this report.

Table B-3—Health Plan-Specific HEDIS 2016 Hybrid Measure Rates

Performance Measures	Colorado Access	Colorado Choice	DHMP
Childhood Immunization Status			
Combination 2	68.86%	22.22%	85.04%
Combination 3	65.21%	22.22%	83.46%
Combination 4	58.64%	20.37%	82.68%
Combination 5	57.18%	11.11%	78.74%
Combination 6	41.61%	12.96%	62.99%
Combination 7	52.07%	11.11%	77.95%
Combination 8	39.17%	12.96%	62.20%
Combination 9	37.71%	7.41%	60.63%
Combination 10	36.01%	7.41%	59.84%
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	71.43%	19.05%	87.50%
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	3.21%	NA	4.00%
Six or More Visits	66.79%	NA	46.00%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.11%	45.56%	61.17%
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	50.85%	31.01%	48.42%

*Lower rates indicate better performance for this measure.

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 one of the mandatory EQR activities under the BBA at 42 CFR 438.358, the State is required to validate the PIPs conducted by its contracted health plans. The Department contracted with HSAG to meet this validation requirement. As part of its QAPI program, each 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 member satisfaction.

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 performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

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

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 (CAHPS)

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 members have with their health care experiences.

Technical Methods of Data Collection

The technical method of data collection was through HSAG's 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. HSAG aggregated the data from survey respondents 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). For any case wherein 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.

Description of Data Obtained

HSAG administered the *CAHPS 5.0 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set for the CHP+ population and stratified the results by the five CHP+ health plans. HSAG followed NCQA methodology when calculating these results.

Data Aggregation, Analysis, and How Conclusions Were Drawn

HSAG calculated the results for each CHP+ health plan according to NCQA HEDIS Specifications for Survey Measures.[D-1] Overall perceptions of the quality of medical care and services received 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 to services. 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-1 shows HSAG's assignment of the CAHPS measures to these performance domains.

Table D-1—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	✓		

[D-1] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA; 2015.

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

This appendix presents tables with the detailed findings for all CHP+ health plans and for each EQR activity performed in FY 2015–2016.

Results From the Compliance Monitoring Site Reviews

Table E-1 and Table E-2 combined show the compliance summary scores and record review scores for each health plan as well as the statewide average for each standard or record review score. Statewide average scores were calculated by dividing the total number of elements *Met* across all health plans by the total number of applicable elements across all health plans. SMCN was subject to a compliance site review, but an SMCN-specific sample of records was not pulled for the record reviews. For this reason, the SMCN is not included in Table E-2.

Table E-1—Standard Scores for Each CHP+ Health Plan and Statewide Average

Standards	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	SMCN	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 (2016)	92%	50%	100%	75%	100%	100%	85%
Standard IV—Member Rights and Protections (2016)	80%	80%	100%	60%	80%	80%	80%
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 (2016)	94%	77%	98%	100%	100%	94%	94%
Standard IX—Subcontracts and Delegation (2015)	100%	60%	100%	100%	100%	—	92%
Standard X—Quality Assessment and Performance Improvement (2016)	100%	73%	93%	67%	100%	100%	88%
Overall Compliance Scores	**91%**	**65%**	**91%**	**82%**	**86%**	**94%**	**84%**

Standards presented in black were reviewed in FY 2015–2016. Standards presented in red were reviewed in FY 2014–2015. Standards presented in green were reviewed in FY 2013–2014.

Table E-2—Record Review Scores for Each CHP+ Health Plan and Statewide Average

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 (2016)	100%	89%	100%	100%	100%	98%
Recredentialing (2016)	98%	97%	100%	100%	100%	99%
Overall Record Review Scores	**92%**	**81%**	**97%**	**83%**	**94%**	**89%**

Record reviews presented in black were reviewed in FY 2015–2016. Record reviews presented in red were reviewed in FY 2014–2015. Record reviews presented in green were reviewed in FY 2013–2014.

Results From the Validation of Performance Measures

Table E-3 shows the HEDIS 2016 performance measure results for each CHP+ health plan as well as the statewide average for each performance measure. Of note, all performance measures under the Pediatric Care domain are presented as administrative-only, except *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*. Rates calculated using the hybrid methodology are listed in Appendix B, Table B-3.

Table E-3—2015–2016 Performance Measure Results for Each CHP+ Health Plan and Statewide Average[1]

Performance Measures	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average**
Pediatric Care						
Childhood Immunization Status						
Combination 2	59.54%	0.00%	70.87%	58.67%	BR	58.04%
Combination 3	57.26%	0.00%	70.08%	57.14%	BR	56.19%
Combination 4	51.74%	0.00%	70.08%	56.38%	BR	52.70%
Combination 5	49.82%	0.00%	63.78%	50.00%	BR	49.22%
Combination 6	34.09%	0.00%	50.39%	38.52%	BR	35.49%
Combination 7	46.22%	0.00%	63.78%	49.74%	BR	47.01%
Combination 8	31.33%	0.00%	50.39%	38.01%	BR	33.71%
Combination 9	30.25%	0.00%	48.03%	34.18%	BR	31.79%
Combination 10	28.45%	0.00%	48.03%	33.93%	BR	30.65%
Immunizations for Adolescents						
Combination 1 (Meningococcal, Tdap/Td)	70.25%	11.90%	77.34%	80.09%	BR	70.71%
Well-Child Visits in the First 15 Months of Life						
*Zero Visits**	3.57%	NA	7.84%	3.51%	BR	4.67%

Performance Measures	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average**
Six or More Visits	61.07%	NA	0.00%	64.91%	BR	51.84%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.36%	43.79%	59.57%	65.70%	BR	67.00%
Adolescent Well-Care Visits						
Adolescent Well-Care Visits	49.70%	30.70%	44.41%	40.56%	BR	46.61%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Assessment—Ages 3 to 11 Years	59.36%	28.10%	80.16%	98.21%	BR	66.38%
BMI Assessment—Ages 12 to 17 Years	55.63%	31.95%	74.21%	97.35%	BR	63.68%
BMI Assessment—Total	57.91%	29.68%	77.86%	97.87%	BR	65.31%
Counseling for Nutrition—Ages 3 to 11 Years	58.96%	30.17%	81.35%	96.64%	BR	65.97%
Counseling for Nutrition—Ages 12 to 17 Years	55.63%	29.59%	74.21%	94.70%	BR	63.13%
Counseling for Nutrition—Total	57.66%	29.93%	78.59%	95.87%	BR	64.85%
Counseling for Physical Activity—Ages 3 to 11 Years	45.82%	15.70%	62.30%	96.64%	BR	54.52%
Counseling for Physical Activity—Ages 12 to 17 Years	51.88%	43.20%	69.81%	94.70%	BR	60.59%
Counseling for Physical Activity—Total	48.18%	27.01%	65.21%	95.87%	BR	56.89%
Appropriate Testing for Children With Pharyngitis						
Appropriate Testing for Children With Pharyngitis	79.59%	73.85%	NA	92.18%	79.42%	80.78%
Access to Care and Preventive Screening						
Children and Adolescents' Access to Primary Care Practitioner						
Ages 12 to 24 Months	93.65%	NA	90.91%	89.88%	95.48%	92.74%
Ages 25 Months to 6 Years	87.50%	69.44%	72.65%	83.78%	86.26%	85.21%
Ages 7 to 11 Years	92.85%	80.81%	84.53%	83.85%	85.23%	88.77%
Ages 12 to 19 Years	92.81%	87.10%	86.65%	85.51%	89.01%	89.90%
Chlamydia Screening in Women						
Ages 16 to 20 Years	29.34%	NA	64.52%	58.56%	30.84%	36.62%
Total	29.34%	NA	64.52%	58.56%	30.84%	36.62%
Non-Recommended Cervical Cancer Screening in Adolescent Females*						
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.31%	2.04%	0.00%	0.00%	0.38%	0.29%

Performance Measures	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average**
Mental/Behavioral Health						
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 Phase	0.74%	NA	NA	56.67%	35.29%	15.24%
Continuation and Maintenance Phase	0.00%	NA	NA	NA	NA	27.03%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*						
Ages 1 to 5 Years	NA	NA	NA	NA	NA	NA
Ages 6 to 11 Years	NA	NA	NA	NA	NA	NA
Ages 12 to 17 Years	6.38%	NA	NA	NA	NA	4.69%
Total	6.56%	NA	NA	NA	NA	4.65%
Respiratory Conditions						
Appropriate Treatment for Children With Upper Respiratory Infection						
Appropriate Treatment for Children With Upper Respiratory Infection	91.99%	85.85%	98.03%	97.40%	93.30%	92.66%
Medication Management for People With Asthma						
Medication Compliance 50%—Ages 5 to 11 Years	51.24%	NA	NA	NA	NA	55.13%
Medication Compliance 50%—Ages 12 to 18 Years	38.95%	NA	NA	NA	NA	42.74%
Medication Compliance 50%—Total	45.83%	NA	NA	NA	NA	49.64%
Medication Compliance 75%—Ages 5 to 11 Years	23.14%	NA	NA	NA	NA	25.64%
Medication Compliance 75%—Ages 12 to 18 Years	14.74%	NA	NA	NA	NA	16.94%
Medication Compliance 75%—Total	19.44%	NA	NA	NA	NA	21.79%
Asthma Medication Ratio						
Ages 5 to 11 Years	79.84%	NA	NA	NA	NA	80.12%
Ages 12 to 18 Years	68.93%	NA	NA	NA	NA	67.88%
Total	75.00%	NA	NA	NA	NA	74.59%
Use of Services						
Ambulatory Care Visits (Per 1,000 Member Months)						
Outpatient Visits—Total	227.44	183.26	130.44	290.97	230.04	227.93

Performance Measures	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average**
*Emergency Department Visits—Total**	27.35	17.94	22.91	14.00	20.86	23.80
Inpatient Utilization—General Hospital/Acute Care						
Discharges per 1,000 Member Months (Total Inpatient)	1.31	1.52	1.08	0.83	1.01	1.18
Days per 1,000 Member Months (Total Inpatient)	4.10	3.74	2.90	2.89	3.65	3.75
Average Length of Stay (Total Inpatient)	3.13	2.46†	2.68	3.48	3.63	3.17
Discharges per 1,000 Member Months (Medicine)	0.93	1.30	0.95	0.61	0.68	0.86
Days per 1,000 Member Months (Medicine)	2.30	3.25	2.51	2.05	2.31	2.31
Average Length of Stay (Medicine)	2.48	2.50†	2.64	3.37	3.42	2.70
Discharges per 1,000 Member Months (Surgery)	0.33	0.16	0.11	0.15	0.27	0.27
Days per 1,000 Member Months (Surgery)	1.67	0.43	0.32	0.67	1.21	1.31
Average Length of Stay (Surgery)	5.07	2.67†	3.00†	4.38†	4.42†	4.81
Discharges per 1,000 Member Months (Maternity)	0.13	0.11	0.04	0.15	0.13	0.12
Days per 1,000 Member Months (Maternity)	0.30	0.11	0.13	0.36	0.28	0.29
Average Length of Stay (Maternity)	2.40†	1.00†	3.00†	2.50†	2.20†	2.36
Antibiotic Utilization—All Ages*						
Average Scripts PMPY for Antibiotics	0.71	0.59	0.14	1.44	0.67	0.65
Average Days Supplied per Antibiotic Scripts	10.67	10.36	10.10	12.87	10.06	10.55
Average Scripts PMPY for Antibiotics of Concern	0.27	0.25	0.04	0.36	0.29	0.25
Percentage of Antibiotics of Concern of All Antibiotic Scripts	38.39%	42.20%	28.31%	25.23%	43.16%	39.06%

* For this indicator, a lower rate indicates better performance.

** Colorado CHP+ Weighted Averages were calculated using rates for Colorado Access, Colorado Choice, DHMP, Kaiser, and RMHP.

† Fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

[1] SMCN rates were deemed invalid, and therefore, were not included.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

BR (Biased Rate) indicates that RMHP's reported rate was invalid; therefore, the rate is not presented.

Table E-4 shows the health plans' overall performance based on HSAG's validation of the FY 2015–2016 PIPs submitted for validation.

Table E-4—Summary of Each HMO's PIP Validation Scores and 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 Depressive 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*	93%	100%	*Met*
Kaiser	*Access and Transition to Behavioral Health Services*	75%	63%	*Partially Met*
RMHP	*CHP+ Members With Asthma Transitioning Out of Plan Coverage*	81%	88%	*Partially Met*

Table E-5 shows each health plan's and the statewide average summary rates and global proportions for the CHP+ 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	87.1%	90.1%	65.8%	87.8%	86.1%	85.7%
Getting Care Quickly	92.3%	90.6%	76.4%	92.5%	90.2%	90.8%
How Well Doctors Communicate	97.7%	94.4%	93.6%	96.8%	96.5%	96.9%
Customer Service	81.5%	85.2%+	82.2%	84.6%	78.0%	81.7%
Shared Decision Making	80.3%	78.1%+	74.2%+	86.0%+	80.7%	80.8%
Rating of Personal Doctor	76.3%	58.4%	75.6%	72.2%	70.1%	73.6%
Rating of Specialist Seen Most Often	68.5%+	72.7%+	58.3%+	58.3%+	78.8%	68.1%
Rating of All Health Care	71.5%	52.7%	61.7%	65.0%	62.9%	67.3%
Rating of Health Plan	60.4%	49.3%	62.4%	57.0%	59.1%	59.2%

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