CHP+

Child Health Plan *Plus*

2016–2017 External Quality Review Technical Report for Child Health Plan *Plus*

December 2017

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

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1. Executive Summary

Report Purpose and Overview

States with Child Health Plan *Plus* (CHP+) program delivery systems that include managed care entities (MCEs) are required to annually provide an assessment of the MCEs' performance related to the quality of, timeliness of, and access to care and services provided by each MCE (42 CFR 438.364).

To meet this requirement, Colorado's Department of Health Care Policy and Financing (the Department) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and to produce this external quality review (EQR) annual technical report. The Department administers and oversees the CHP+ program (Colorado's implementation of the Children's Health Insurance Program [CHIP]). The managed care organizations (MCOs) that deliver CHP+ services in Colorado are listed in Table 1-1.

Table 1-1—Colorado CHP+ MCOs

CHP+ MCOs	Services Provided
Colorado Access	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Colorado Choice Health Plans (Colorado Choice)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Denver Health Medical Plan, Inc. (DHMP)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Kaiser Permanente Colorado (Kaiser)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Rocky Mountain Health Plans (RMHP)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.

Scope of EQR Activities

The CHP+ MCOs were subject to the three mandatory EQR activities and one optional activity. As set forth in 42 CFR 438.352, the three mandatory activities were:

- **Monitoring for compliance with federal healthcare regulations (compliance monitoring).** Compliance monitoring was designed to determine the health plans' compliance with their contracts with the State and with State and federal managed care regulations. HSAG determined compliance through review of two standard areas developed based on federal managed care regulations and contract requirements.
- **Validation of performance measures.** To assess the accuracy of the performance measures reported by or on behalf of the MCOs, HSAG validated each of the performance measures identified by the Department. The validation also determined the extent to which Medicaid-specific performance measures calculated by the MCOs followed specifications established by the Department.
- **Validation of performance improvement projects (PIPs).** HSAG reviewed PIPs to ensure that the projects were each designed, conducted, and reported in a methodologically sound manner.

The optional activity was:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS).** HSAG conducted surveys and reported results for all CHP+ health plans on behalf of the Department.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the CHP+ MCOs in each of the domains of quality of, timeliness of, and access to care and services.

Quality

The 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."[1-1]

[1-1] 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."[1-2] 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—e.g., processing appeals and providing timely care. In the final 2016 federal 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)."[1-3]

Statewide Summary of Findings and Conclusions

Strengths

All CHP+ health plans demonstrated implementation of policies, procedures, and processes to manage utilization and access to needed healthcare services in compliance with federal and State requirements for making authorization decisions and timely and accurate notification of members. All plans provided documentation of processes designed to ensure an adequate network of providers to meet member needs in culturally competent and timely manners, offered provider training regarding diverse populations, and monitored access standards. DHMP had made significant changes to expand access to primary and urgent care.

All health plans developed methodologically sound PIPs that allowed implementation of interventions to overcome identified barriers. All plans targeted interventions and performance measures to address opportunities for improvement in the quality and access domains. All PIP topics related to transition processes—two related to transitioning out of the health plan, two related to transitioning to behavioral

[1-2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

health services, and one related to transition to primary care from more acute settings of care. Of these, two projects targeted members with asthma.

Within the quality domain, CHP+ health plans ranked at or above the national Medicaid 75th percentile on performance measures, indicating areas of strength as follow:

- All health plans and statewide for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure (for this measure, a lower rate indicates better performance).
- Three health plans and statewide for the *Appropriate Testing for Children With Pharyngitis* measure.
- Two health plans for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure.
- Two health plans and statewide for the *Asthma Medication Ratio—Total* measure indicator.
- Several health plans ranked at or above the national 75th percentile for one or more additional measures, including those related to immunization rates.

Member and family perceptions regarding quality of care and services increased either substantially or slightly for two or more health plans for each of the member satisfaction measures. *Rating of Personal Doctor, Rating of All Health Care,* and *Rating of Health Plan* rates increased for four of five health plans. Three of five plans' ratings improved for *Customer Service*, *Shared Decision Making*, *How Well Doctors Communicate,* and *Rating of Specialist Seen*. *Getting Care Quickly* and *Getting Needed Care,* indicators of timeliness, experienced slight increases in three health plans. One health plan experienced either substantial or slight increases in eight of the nine ratings. Statewide member satisfaction measures regarding quality and timeliness were trending upward.

Opportunities for Improvement

While all plans demonstrated strength in their overall utilization management (UM) programs, individual elements of noncompliance unique to an individual plan were noted. Two health plans had policy and procedure issues related to defining authorization and notification time frames for some, but not all, types of authorizations. Two health plans needed to ensure that automated claims processes related to claims denials were linked to UM processes and requirements. Two health plans struggled with access and provider network adequacy—one of which was located in a rural and frontier region of the state, and one which had implemented significant improvements but needed to continue efforts to improve timely access. One of these two plans was also required to: improve communication of access standards to providers, implement monitoring of access standards, and improve cultural competency training.

The most common HSAG recommendations for progressing each health plan's selected PIP included:

- Evaluating and re-evaluating barriers and developing new interventions as needed.
- Evaluating the effectiveness of each individual intervention.
- Using data-driven decisions to revise interventions.
- Improving documentation of PIP processes.

Numerous performance measures of quality and access to care for children and adolescents fell below the national Medicaid 25th percentile or decreased by more than five percentage points, indicating areas for improvement as follows:

- Four health plans for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators.
- All health plans for at least one of the *Children and Adolescents' Access to Primary Care Practitioners* measure indicators.
- Three health plans for the *Chlamydia Screening in Women—Total* measure.
- Three health plans for at least one of the *Childhood Immunization Status* measure indicators.
- Two health plans for at least one of the *Immunizations for Adolescents* measure indicators.
- One health plan for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure.
- For well-child visits, three of the health plans experienced ratings lower than the Medicaid 25th percentiles for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure; two for the *Well-Child Visits in the First 15 Months of Life* measure indicators; and one for the *Adolescent Well-Care Visits* measure.
- Individual health plans experienced low ratings on one or more additional measures.

Again, because all HEDIS measures were reported using the administrative methodology, caution should be exercised when comparing MCO rates to benchmarks that were established using administrative and/or medical record review data.

While three of the five health plans experienced no substantial decrease in member satisfaction ratings, *Shared Decision Making, Customer Service*, and *Rating of Specialist* decreased either substantially or slightly in two health plans each. The remainder of the measures decreased only slightly in individual plans. *Getting Care Quickly* and *Getting Needed Care*, measures of timeliness, decreased slightly in two health plans.

Statewide Recommendations

Related to timeliness, the Department should ensure that CHP+ contracts clearly outline the required time frames for authorization and notification of members for all types of authorizations, as defined in federal regulations.

Ratings of member satisfaction related to quality and timeliness of care were mixed across the five CHP+ plans, with most plans experiencing increases and some plans experiencing decreases. Statewide, measures trended upward. Therefore, the Department should recommend that individual health plans develop mechanisms to further explore factors contributing to individual measures which decreased substantially and target quality improvement initiatives to improve performance within each health plan, as applicable.

HSAG recommends the Department consider identifying two or more priorities from the recommendations following for either statewide PIPs or recommended quality initiatives, to be conducted by each MCO to address performance measures related to quality and access:

- Conduct a statewide network study to determine network adequacy for access to primary care for infants, children, and adolescents.
- Develop a focus workgroup with members and providers to further explore the root causes for poor performance in well-child visits and adolescent well-care visits, with particular emphasis on children 3 to 6 years of age.
- Conduct a focus study to determine root causes of poor performance in documentation of immunizations for children and adolescents; then, implement strategies to improve performance.
- Consider conducting performance measure calculation using the hybrid methodology for specific measures such as BMI-related measures.
- Conduct a focus study or provider workgroup to examine best practices related to performing chlamydia screening in young women, determine root causes of poor performance in this indicator of quality care, and implement appropriate quality improvement initiatives.
- Consider provider incentive programs, implemented through the health plans, to improve performance in priority quality of care indicators.

2. Introduction

How This Report Is Organized

Section 1 describes the purpose and overview of this EQR annual technical report; authority under which it must be provided; and a brief overview of Colorado's CHP+ healthcare delivery system, its MCOs, and the EQR activities conducted during the year under review. This section also includes a statewide summary assessment of the quality of, timeliness of, and access to care and services provided by the CHP+ managed care delivery system as a whole.

Section 2 provides an overview of the methodology for each of the EQR activities performed and how conclusions were drawn to make an assessment regarding the quality of, timeliness of, and access to care and services for inclusion in this report.

Section 3 provides summary level results for each of the EQR activities performed for CHP+ MCOs. This information is presented by MCO and provides an activity-specific assessment related to the quality of, timeliness of, and access to care and services regarding each MCO.

Section 4 includes statewide comparative results organized by EQR activity. Comparison tables include summary results for each MCO and statewide averages. This section also identifies trends and commonalities to provide statewide conclusions and recommendations revealed through the conducting of each EQR activity.

Section 5 provides, for each EQR activity, an MCO-specific assessment of the extent to which the CHP+ MCOs were able to follow up on and complete any recommendations or corrective actions required as a result of the prior year's EQR activity.

Methodology

Assessment of Compliance With Managed Care Regulations

For the FY 2016–2017 site review process, the Department requested a review of two areas of performance based on federal healthcare regulations. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG developed a strategy and monitoring tools to review compliance with these standards and managed care contract requirements related to each standard. HSAG also reviewed the health plans' administrative records to evaluate compliance related to denials of service and notices of action (NOAs).

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The objective of each site review was to provide meaningful information to the Department and the health plans regarding:

- The health plans' compliance with federal managed care regulations and contract requirements in the areas selected for review.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the health plans into compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- The quality of, timeliness of, and access to care and services furnished by the health plans, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the health plans' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

For the health plans, HSAG performed 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.[2-1] Table 2-1 describes the five protocol activities and the specific tasks that HSAG performed to complete the compliance monitoring of these protocol activities.

Table 2-1—Protocol Activities Performed for Compliance Monitoring

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care 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.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2017.

For this step,	HSAG completed the following activities:
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) 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 the health plans' records for all denials that occurred between January 1, 2016, and December 31, 2016. 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 federal managed care. • 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 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.

For this step,	HSAG completed the following activities:
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the site review report to the health plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report. • HSAG distributed the final report to the health plan and the Department.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Internal or committee management/monitoring reports
- Topic-specific quarterly reports submitted to the Department
- 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

How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ MCOs, HSAG assigned each of the components reviewed for compliance monitoring to one or more of those domains. Each standard may involve assessment of more than one domain due to the combination of individual requirements in each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality of, timeliness of, or access to care and services provided by the MCOs. Table 2-2 depicts assignment of the standards to the domains.

Table 2-2—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standards	Quality	Timeliness	Access
Standard I—Coverage and Authorization of Services	X	X	
Standard II—Access and Availability		X	X

Performance Measure Validation

Objectives

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

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

Technical Methods of Data Collection

The Department required that each health plan 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,[2-2] 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 information system (IS) compliance standards and had the ability to report HEDIS data accurately.

The following processes/activities constitute the standard practice for HEDIS audits regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5.*[2-3]

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.
- Detailed review of the health plan's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- On-site meetings at the health plan's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.

[2-2] 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2017.

[2-3] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS measures.
- Reabstraction of a sample of medical records selected by the auditors, with a comparison of results to the health plan's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the health plan's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS 2017 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) completed by the health plan and/or its contractor.

The health plans were responsible for obtaining their respective HEDIS FARs. The auditor's responsibility was to express an opinion on the health plan's performance based on the auditor's examination, using procedures that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the health plans, it did review the audit reports produced by the other licensed audit organizations. All licensed organizations followed NCQA's methodology in conducting their HEDIS Compliance Audits.

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 2-3 outlines those activities of the audit steps reviewed by HSAG, along with the corresponding source data.

Table 2-3—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 2017 FAR

Data Reviewed	Source of Data
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 2017 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 2017 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 2017 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 2017 FAR
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 2017 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 2017 FAR

Data Reviewed	Source of Data
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 2017 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 2017 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 data submission template created by HSAG.	HEDIS 2017 IDSS

Table 2-4 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 2-4, 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 2-4—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	Centauri Health Solutions	Altegra Health	Verscend	None used	Inovalon
Source Code/Certified Measure Review	✓	✓	✓	✓	✓
Survey Vendor	Centauri Health Solutions	SPH Analytics (for marketplace)	Morpace Inc. (product line not specified)	DSS Research (for all product lines)	Center for the Study of Services (CSS) (all product lines)
CAHPS Sample Frame Validation	✓	✓	✓	✓	✓
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 for the core set of measures was reviewed and subsequently approved by the licensed HEDIS auditor organization, indicating that the code for each selected measure was within the HEDIS 2017 technical specifications.

HSAG summarized the results from Table 2-4 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.

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 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 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support Measure Reporting Integrity

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

In the measure results tables presented in Section 3, HEDIS 2016 and HEDIS 2017 measure rates are presented for measures deemed *Reportable* (*R*) by the NCQA-licensed audit organization according to NCQA standards. With regard to the final measure rates for HEDIS 2016 and HEDIS 2017, a measure result of *Small Denominator* (*NA*) indicates that the health plan followed the specifications but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate* (*BR*) indicates that the calculated rate was materially biased and therefore is not presented in this report. A measure result of *Not Reported* (*NR*) indicates that the health plan chose not to report the measure.

The health plans' 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 performance measure results tables, 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. However, caution should be exercised when interpreting results of the significance testing, given that statistically significant changes may not necessarily be clinically significant.

Measure results for HEDIS 2017 were compared to NCQA's Quality Compass national Medicaid MCO percentiles for HEDIS 2016 and are denoted in the measure results tables using the percentile rankings defined in Table 2-5. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure were compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid MCO percentiles for HEDIS 2016 since benchmarks for this measure are not published in Quality Compass.

Table 2-5—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

In the performance measure results tables, an em dash (—) indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined, either because the HEDIS 2017 measure rate was not reportable or because the measure did not have an applicable benchmark.

According to the Department's guidance, all measure rates presented in this report for the health plans are based on administrative data only.

All HEDIS 2017 measures were reported using the administrative methodology per the Department's direction; therefore, the following items should be taken into consideration when reviewing HEDIS measure results:

- Health plans capable of obtaining supplemental data or capturing more complete data will generally report higher rates when using the administrative methodology. As a result, the HEDIS measure rates presented in this report may be more representative of data completeness than of measure performance for measures that can be reported using the hybrid methodology. This should also be considered when comparing measures reported in prior years using the hybrid methodology. Table 2-6 presents the measures in this report that could be reported using the hybrid methodology.

Table 2-6—HEDIS Measures that Can Be Reported Using the Hybrid Methodology

HEDIS Measures
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
Prenatal and Postpartum Care

- National HEDIS percentiles are not available for the CHIP population; therefore, comparison of the CHP+ health plans' rates to Medicaid percentiles should be interpreted with caution.
- Caution should be exercised when comparing administrative measure results to national benchmarks, which were established using administrative and/or medical record review data.

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ health plans, HSAG assigned each of the components reviewed for performance measure validation (PMV) to one or more of these three domains. This assignment to domains is depicted in Table 2-7.

Table 2-7—Assignment of Activities to Performance Domains

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			✓

** CHP+ State Managed Care Network (SMCN) was only required to report one measure, Prenatal and Postpartum Care (PPC).*

Validation of Performance Improvement Projects

Objectives

As part of its quality assessment and performance improvement (QAPI) program, each health plan was required by the Department to conduct PIPs in accordance with 42 CFR 438.240. The purpose of conducting 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 health plan's ability to:

- Measure performance using objective quality indicators.
- Implement systematic interventions to achieve improvement in performance.
- Evaluate effectiveness of the interventions.
- Plan and initiate activities for increasing or sustaining improvement.

Technical Methods of Data Collection

The methodology used to validate PIPs started after September 2012 was based on CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-4] Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, which each health plan completed and submitted to HSAG for review and validation. The PIP Summary Forms 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
- 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

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2017.

- Activity VII. Data Analysis and Interpretation of Results
- Activity VIII. Implement Intervention and Improvement Strategies
- Activity IX. Real Improvement
- Activity X. Sustained Improvement

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the 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.

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 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.

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ MCOs, HSAG assigned each of the components reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Additionally, all of the CHP+ PIPs focused on ensuring a timely transition of care from one setting of care to another. Consequently, all PIPs were also assigned to the timeliness domain. Finally, improving a timely transition of care from one setting to another required adequate access to providers; therefore, all PIPs were assigned to the access domain. This assignment to domains is shown in Table 2-8.

Table 2-8—Assignment of PIPs to the Quality, Timeliness, and Access to Care Domains

MCO	Performance Improvement Project	Quality	Timeliness	Access
Colorado Access	*Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan*	X	X	X
Colorado Choice	*Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider*	X	X	X
DHMP	*Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*	X	X	X
Kaiser	*Access and Transition to Behavioral Health Services*	X	X	X
RMHP	*CHP+ Members With Asthma Transitioning Out of Plan Coverage*	X	X	X

Consumer Assessment of Healthcare Providers and Systems

Objectives

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

Technical Methods of Data Collection and Analysis

The technical method of data collection occurred 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 assess member 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 instruments and the comparability of the resulting data. HSAG aggregated 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 to address 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," and "Always;" or (2) "No" and "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 the results.

How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ health plans, HSAG assigned each of the components reviewed for CAHPS to one or more of these three domains. This assignment to the domains is depicted in Table 2-9.

Table 2-9—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

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	✓		

3. Evaluation of Colorado's CHP+ Health Plans

Colorado Access

Monitoring for Compliance With Managed Care Regulations

Table 3-1 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 2016–2017.

Table 3-1—Summary of Colorado Access Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	34	34	32	2	0	0	94%
II—Access and Availability	14	14	14	0	0	0	100%
Totals	**48**	**48**	**46**	**2**	**0**	**0**	**96%**

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

Table 3-2 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 2016–2017.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	60	60	0	40	100%
Totals	**100**	**60**	**60**	**0**	**40**	**100%**

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

Strengths

Colorado Access had policies and procedures that described and governed its utilization management (UM) program. These policies described the process for making authorizations based on well-defined, established criteria. Colorado Access used a three-level review system that allowed only clinically qualified physician reviewers to deny services. Colorado Access provided evidence of having completed interrater reliability training to ensure consistent application of the criteria. The policies accurately described processes to notify both the member and requesting provider of all denied services, included time frames for providing notice, and delineated the content for NOAs.

Colorado Access provided several reports and documents demonstrating that it maintains and monitors a network appropriate in size and diversity to meet the needs of its CHP+ members—both current and anticipated. Policies stated that Colorado Access would arrange for members to receive services from out-of-office providers if and when covered and/or medically necessary services are not available. Colorado Access implemented an intensive three-hour cultural competency training program that all staff members were required to attend. All staff members are required to complete a less intensive, annual refresher course. Colorado Access had periodic training programs scheduled throughout 2017 that specifically addressed issues related to culture, race, ethnicity, poverty, disabilities, sexual orientation, and refugee populations.

Opportunities for Improvement and Recommendations

Colorado Access staff members stated that Colorado Access had no process to review claims denied for not having prior authorization for inpatient hospitalizations in order to determine if the admission was related to an emergency room visit and therefore poststabilization with possible circumstances under which Colorado Access was responsible to pay for the services Colorado Access was required to develop a process to ensure that UM procedures and claims payment decisions are linked to the requirements for fiscal responsibilities for post-stabilization care services not pre-approved.

Summary Assessment of Quality, Timeliness, and Access for Compliance Monitoring

Colorado Access' performance in the quality domain was strong. Staff members demonstrated that they based medical necessity decisions on established guidelines and participated in annual interrater reliability (IRR) testing to ensure consistent application of those guidelines. Policies included most required provisions. On-site record reviews demonstrated that staff members consistently implemented authorization and denial policies and procedures, as written.

Related to the timeliness domain, Colorado Access policies and procedures accurately specified the time frames for processing standard and expedited requests for authorization of services. Review of denial records on-site confirmed that Colorado Access met the required time frames in all cases reviewed.

Colorado Access produced numerous documents and reports that illustrated that it did monitor its network to ensure appropriate size and diversity to meet the needs of its members, and how it accomplished that. In the rare instances that Colorado Access was not able to provide the necessary service, it demonstrated use of single-case agreements to ensure that the member had readily available access. Additionally, policies stated that if covered and/or medically necessary services were not available within the required time frames, Colorado Access would arrange for members to receive services out of network at a cost no greater to the member than if the services were received in network.

Validation of Performance Measures

Compliance With Information Systems (IS) 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 did not identify any notable issues of negative impact on HEDIS reporting.

Pediatric Care Measure Results

Table 3-3 shows the HEDIS 2016 and HEDIS 2017 Pediatric Care measure results for Colorado Access and the percentile rankings for the HEDIS 2017 rates.

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

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
***Childhood Immunization Status*+**			
Combination 2	59.54%	65.92%^	10th–24th
Combination 3	57.26%	63.67%^	10th–24th
Combination 4	51.74%	59.71%^	10th–24th
Combination 5	49.82%	56.67%^	25th–49th
Combination 6	34.09%	38.97%^	25th–49th
Combination 7	46.22%	53.76%^	25th–49th
Combination 8	31.33%	37.12%^	25th–49th
Combination 9	30.25%	35.80%^	50th–74th
Combination 10	28.45%	34.35%^	50th–74th
***Immunizations for Adolescents*+**			
Combination 1 (Meningococcal, Tdap)	70.25%	70.39%	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	—	23.85%	—
***Well-Child Visits in the First 15 Months of Life*+**			
*Zero Visits**	3.57%	2.17%	25th–49th
Six or More Visits	61.07%	61.96%	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	69.36%	69.48%	25th–49th
***Adolescent Well-Care Visits*+**			
Adolescent Well-Care Visits	49.70%	48.88%	50th–74th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents +,1			
BMI Percentile Documentation—Total	57.91%	**3.85%^^**	<10th
Counseling for Nutrition—Total	57.66%	**2.08%^^**	<10th
Counseling for Physical Activity—Total	48.18%	**0.78%^^**	<10th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	79.59%	84.93%^	75th–89th

+ Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.
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 of <0.05.

Strengths for Pediatric Care Measures

The following rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Appropriate Testing for Children With Pharyngitis*

Opportunities for Improvement for Pediatric Care Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Childhood Immunization Status—Combinations 2–4*
- *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*

Recommendations for Pediatric Care Measures

HSAG recommends that Colorado Access analyze strategies that can be linked to improved documentation of weight assessment as well as nutrition and physical activity counseling for children and adolescents. Additionally, although rates for select combination vaccinations for immunizations for children fell below the national Medicaid 25th percentile, all the *Childhood Immunization Status* rates improved by approximately 5 percentage points or more. This presents an opportunity for Colorado Access to focus efforts on determining initial causes that led to performance improvements in this area, in an effort to improve overall documentation of immunizations. However, because the *Childhood*

Immunization Status and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures can be reported using the hybrid methodology, caution should be used when comparing Colorado Access' administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Access to Care and Preventive Screening Measure Results

Table 3-4 shows the HEDIS 2016 and HEDIS 2017 Access to Care and Preventive Screening measure results for Colorado Access and the percentile rankings for the HEDIS 2017 rates.

Table 3-4—Access to Care and Preventive Screening Measure Results for Colorado Access

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	93.65%	91.23%	10th–24th
Ages 25 Months to 6 Years	87.50%	86.24%	25th–49th
Ages 7 to 11 Years	92.85%	91.63%	50th–74th
Ages 12 to 19 Years	92.81%	92.18%	50th–74th
Preventive Screening			
Chlamydia Screening in Women			
Total	29.34%	32.72%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.31%	0.24%	≥90th

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

Strengths for Access to Care and Preventive Screening Measures

The following rate ranked at or above the national Medicaid 90th percentile, indicating an area of strength:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*
- *Chlamydia Screening in Women—Total*

Recommendations for Access to Care and Preventive Screening Measures

As a result, HSAG recommends that Colorado Access analyze strategies that can be linked to improved access to care for infants and chlamydia screenings for women.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Mental/Behavioral Health Measure Results

Table 3-5 shows the HEDIS 2016 and HEDIS 2017 Mental/Behavioral Health measure results for Colorado Access and the percentile rankings for the HEDIS 2017 rates.

Table 3-5—Mental/Behavioral Health Measure Results for Colorado Access

Measures	HEDIS 2016 Rate	HEDIS 2017 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	0.74%	0.00%	<10th
Continuation and Maintenance Phase	0.00%	0.00%	<10th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents* [1]			
Total	6.56%	4.05%	10th–24th

NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).

Strengths for Mental/Behavioral Health Measures

None of Colorado Access' reported rates showed a rate increase when compared to the previous measure year.

Opportunities for Improvement for Mental/Behavioral Health Measures

All three of Colorado Access' HEDIS 2017 reportable rates related to Mental/Behavioral Health fell below the national Medicaid 25th percentile, suggesting opportunities for improvement overall.

Recommendations for Mental/Behavioral Health Measures

HSAG recommends that Colorado Access conduct a thorough analysis of the root causes for poor performance in this area. Colorado Access is urged to uncover causal areas linked to low performance, identify the most significant areas or populations of focus for which improvement interventions could be planned, and identify strategies and interventions for better outcomes, beginning with the easiest areas for improvements (i.e., low effort/high yield).

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Respiratory Conditions Measure Results

Table 3-6 shows the HEDIS 2016 and HEDIS 2017 Respiratory Conditions measure results for Colorado Access and the percentile rankings for the HEDIS 2017 rates.

Table 3-6—Respiratory Conditions Measure Results for Colorado Access

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
***Appropriate Treatment for Children With Upper Respiratory Infection*[1]**			
Appropriate Treatment for Children With Upper Respiratory Infection	91.99%	**89.63%^^**	50th–74th
Medication Management for People With Asthma			
Medication Compliance 50%—Total[2]	45.83%	50.00%	25th–49th
Medication Compliance 75%—Total	19.44%	27.31%	25th–49th
Asthma Medication Ratio			
Total	75.00%	81.70%	≥90th

[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).
[2] Indicates that the rate was compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid MCO percentiles since benchmarks for this measure are not published in Quality Compass.
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 of <0.05.

Strengths for Respiratory Conditions Measures

The following rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Asthma Medication Ratio—Total*

Additionally, rates for *Medication Management for People With Asthma—Medication Compliance 75%—Total* and *Asthma Medication Ratio—Total* improved by 5 percentage points or more from the prior year, indicating improved care for members on asthma medications.

Opportunities for Improvement and Recommendations for Respiratory Conditions Measures

None of Colorado Access' reported rates for respiratory-related conditions were below the national 25th percentile or showed a substantial decrease when compared to the previous measure year.

Use of Services Measure Results

Table 3-7 shows the HEDIS 2016 and HEDIS 2017 Use of Services measure results for Colorado Access and the percentile rankings for the Colorado Access' HEDIS 2017 rates. Reported rates were not risk-adjusted; therefore, rate changes observed between HEDIS 2016 and HEDIS 2017 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid MCO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 3-7—Use of Services Measure Results for Colorado Access

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)			
*Emergency Department Visits**	27.35	26.48	≥90th
Outpatient Visits	227.44	224.38	<10th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.31	0.96	<10th
Days per 1,000 Member Months (Total Inpatient)	4.10	3.51	<10th
Average Length of Stay (Total Inpatient)	3.13	3.64	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.93	0.66	<10th
Days per 1,000 Member Months (Medicine)	2.30	1.91	<10th
Average Length of Stay (Medicine)	2.48	2.88	<10th
Discharges per 1,000 Member Months (Surgery)	0.33	0.26	<10th
Days per 1,000 Member Months (Surgery)	1.67	1.49	<10th
Average Length of Stay (Surgery)	5.07	5.79	10th–24th
Discharges per 1,000 Member Months (Maternity)	0.13	0.09	<10th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Days per 1,000 Member Months (Maternity)	0.30	0.22	<10th
Average Length of Stay (Maternity)	2.40	2.41†	10th–24th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.71	0.46	≥90th
Average Days Supplied per Antibiotic Script	10.67	10.94	<10th
Average Scripts PMPY for Antibiotics of Concern	0.27	0.16	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	38.39%	33.77%	≥90th

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files: differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. Rates with this symbol may also indicate that fewer than 30 discharges were reported. Exercise caution when evaluating this rate.
** For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

Rates for Colorado Access' Use of Services measures did not take into account the characteristics of the population; therefore, HSAG did 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 of Quality, Timeliness, and Access for Validation of Performance Measures

Colorado Access' performance demonstrated strength with regard to quality of care as evidenced by:

- *Appropriate Testing for Children With Pharyngitis*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Asthma Medication Ratio—Total*

Conversely, findings related to the following measures indicate areas of opportunity for Colorado Access for improved quality of, timeliness of, and access to care:

- *Childhood Immunization Status—Combinations 2–4*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*
- *Chlamydia Screening in Women—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*

Validation of Performance Improvement Projects

Findings

Table 3-8 displays the validation results for the Colorado Access PIP, *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan,* validated during FY 2016–2017. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-8 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with the MCO completing Activities I through IX.

Table 3-8—Performance Improvement Project Validation Results for Colorado Access

Stage	Activity		Percentage of Applicable Elements*		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
		Design Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
		Implementation Total	**89% (8/9)**	**11% (1/9)**	**0% (0/9)**

Stage	Activity		Percentage of Applicable Elements*		
			Met	*Partially Met*	*Not Met*
Outcomes	IX.	Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
		Outcomes Total	**100% (2/2)**	**0% (0/2)**	**0% (0/2)**
		Percentage Score of Applicable Evaluation Elements *Met*	**95% (19/20)**	**5% (1/20)**	**0% (0/20)**

**Percentage totals may not equal 100 due to rounding.*

Overall, 95 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Met*.

Table 3-9 displays baseline and Remeasurement 1 data for Colorado Access' PIP. Colorado Access' goal is to increase the percentage of eligible high-risk members who receive care management outreach within 90 days prior to their 19th birthday.

Table 3-9—Performance Improvement Project Outcomes for Colorado Access

PIP 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.	0.0%	24.5%*		*Not Assessed*

**The remeasurement rate was a statistically significant improvement over the baseline rate.*

The baseline rate of 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 75.0 percent at the first remeasurement. With a baseline rate of zero, HSAG recommended that Colorado Access ensure that a Remeasurement 1 goal of 75.0 percent is reasonable and attainable.

At the first remeasurement, the rate of high-risk members who received care management outreach within 90 days prior to their 19th birthday increased to 24.5 percent. The health plan addressed HSAG's recommendation and revised the Remeasurement 1 goal from 75.0 percent to 30.0 percent. While the Remeasurement 1 rate did not meet the MCO's revised Remeasurement 1 goal of 30.0 percent, the increase of 24.5 percentage points from baseline to Remeasurement 1 was statistically significant. The PIP will be evaluated for sustained improvement during the next validation cycle, when the MCO reports results from the second remeasurement.

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. The MCO used appropriate quality improvement tools to identify and prioritize barriers. Timely interventions were implemented, were linked to the identified barriers, and had the potential to impact study indicator outcomes. Colorado Access evaluated interventions for effectiveness and used the intervention evaluation results to guide future improvement strategies. The MCO succeeded in demonstrating statistically significant improvement in the study indicator outcomes over baseline at the first remeasurement.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the MCO's 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 the following barriers to address:

- No transition program in place.
- Inability of the MCO to follow-up with members once they lose insurance coverage.
- Options for health insurance transition are unknown to members.
- Incorrect member contact information.
- Limited resources for providers to assist members with the transition.

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

- Conducted a mailing to members 18 years of age as a reminder of the importance of having health insurance and knowing what options are available; provided the contact information for requesting assistance.
- Conducted transition-specific care management outreach within 90 days of the member losing CHP+ coverage.

- Referred members to the Access Medical Enrollment Services (AMES) program to identify eligibility for government health insurance programs.
- Partnered with primary care providers to reach high-risk members who could not be reached directly by the MCO.

Recommendations

As the PIP progresses, HSAG recommends that Colorado Access:

- Address all of HSAG's feedback regarding documentation in the PIP Summary Form as noted in points of clarification in the PIP Validation Tool.
- Ensure that the narrative interpretation of study indicator results includes all required components, including statistical testing comparing each remeasurement period to the baseline period and a comparison of the results of each remeasurement to the goal for the corresponding remeasurement period.
- For each measurement period, document the methods used to identify and prioritize barriers and attach any tools used to identify and prioritize barriers.
- Primarily deploy active, innovative interventions that have the potential to directly impact the study indicator outcomes.
- Use quality improvement science techniques such as the Plan-Do-Study-Act (PDSA) model as part of 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 and continue to use intervention evaluation results to guide decisions about future improvement strategies.
- Seek technical assistance from HSAG as needed.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-10 shows the results achieved by Colorado Access for FY 2015–2016 and FY 2016–2017.

Table 3-10—Question Summary Rates and Global Proportions for Colorado Access

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	87.1%	85.6%
Getting Care Quickly	92.3%	90.1%
How Well Doctors Communicate	97.7%	95.2%
Customer Service	81.5%	86.9%
Shared Decision Making	80.3%	83.5%+
Rating of Personal Doctor	76.3%	73.5%
Rating of Specialist Seen Most Often	68.5%+	70.2%
Rating of All Health Care	71.5%	67.2%
Rating of Health Plan	60.4%	61.4%

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.

Strengths

For Colorado Access' CHP+ population, one measure rate increased substantially:

- *Customer Service* (5.4 percentage points)

Three measures demonstrated slight increases (fewer than 5 percentage points each):

- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Opportunities for Improvement

For Colorado Access' CHP+ population, no measure rates decreased substantially.

Five measures showed slight rate decreases:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of Personal Doctor*
- *Rating of All Health Care*

Recommendations

Colorado Access experienced no substantial decrease in rates in the 2016-2017 measurement year when compared to the previous year. However, five measure rates showed slight decreases. In order to improve members' perceptions on *Getting Care Quickly* and *Getting Needed Care*, HSAG offers the following recommendations that Colorado Access should consider based on population needs and health plan resources:

- Develop a focus study or PIP to determine appointment patterns, provider hours offered, and no-show appointments.
- Consider offering provider incentives for expanding the availability of evening and weekend hours; developing open-access scheduling; or adopting alternative schedules, such as early morning hours on some days and late evening hours on others.
- Consider encouraging the use of electronic communication between providers and members when appropriate to provide care when face-to-face appointments may not be needed.
- Develop and implement a system to provide ongoing communications to inform both members and providers of timeliness access standards and where to access after-hours care.

The *How Well Doctors Communicate, Rating of Personal Doctor,* and *Rating of Health Plan* measures could be impacted by many variables, including cultural competency, a clinician's communication style, time factors influencing the length of engagement with the member, a member's perception of how well providers communicate with other providers involved with the member's treatment, or a member's willingness to engage. Colorado Access should consider the following recommendations:

- Develop provider training forums or develop procedures that encourage providers to ensure that members *understand* communications.
- Explore creative mechanisms for member engagement, such as expanding member advisory committees, developing regionally based member committees, or offering member mentorship programs.
- Utilize care coordinators to: conduct ongoing follow-up with individual members, act as provider liaisons, provide outreach to members who have frequent no-show appointments or treatment noncompliance, or provide an option as alternative clinicians.
- Offer updated and expanded cultural competency training to providers, and develop a mechanism to track provider attendance in-person or online.
- Expand the frequency and diversity of training by coordinating cultural competency trainings with other health plans.
- Query members regarding their communication preferences and consider verbal, written, phone, electronic, telehealth, or other forms of communication with members. Increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to ensure understanding of health and treatment information.

- Coordinate with community organizations to expand disease management programs and offer to children, youth, and families health education related to chronic conditions such as asthma, diabetes, and weight management.

Colorado Access: Summary Assessment of 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.

For Colorado Access' CHP+ population, of the nine measures that impacted the quality domain, one measure showed a substantial rate increase when compared to the previous measure year, and three additional measure rates were slightly higher when compared to the previous measure year. No measure rates decreased substantially. The remaining five measures showed slight rate decreases when compared to the previous measure year. Colorado Access' overall results for the quality domain were mixed, and improvements can be identified.

For the *Getting Care Quickly* measure, which assessed the quality and timeliness domains, Colorado Access' measure rate for the CHP+ population showed a slight decrease, also indicating a potential downward trend.

For the *Getting Needed Care* measure, which assessed the quality and access to care domains, Colorado Access' measure rate for the CHP+ population showed a slight decrease, indicating a potential downward trend.

Colorado Choice Health Plans

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 3-11 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 2016–2017.

Table 3-11—Summary of Colorado Choice Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	34	34	31	1	2	0	91%
II—Access and Availability	14	14	11	3	0	0	79%
Totals	**48**	**48**	**42**	**4**	**2**	**0**	**88%**

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

Table 3-12 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 2016–2017.

Table 3-12—Summary of Colorado Choice Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	50	49	1	50	98%
Totals	**100**	**50**	**49**	**1**	**50**	**98%**

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

Strengths

Colorado Choice had a UM program in place to monitor services and to ensure that services provided were sufficient in amount, scope, and duration to achieve the purpose of the provided services. Policies described a three-level review process ensuring that only qualified clinicians could deny services. Colorado Choice used specialists and outside peer review services for complicated cases and appeal decisions. NOAs clearly delineated—using easy-to-understand language—the action being taken, the reason for the action, and information on the member's appeal rights.

Colorado Choice staff members described various efforts used to ensure access to care for members within its challenging underserved rural and frontier areas. Colorado Choice contracted with available PCPs in the area and most specialists in each county. Colorado Choice used single-case agreements with out-of-network providers, as necessary, and worked diligently with these providers in an effort to add

them to the network. Colorado Choice's Network Adequacy Plan delineated efforts to maintain the network of providers, standards for timely access, and information about how members can access out-of-network providers.

Opportunities for Improvement and Recommendations

Colorado Choice's UM Review Timeframes and Notification policy accurately reflected timelines for standard and expedited authorization review; however, it had no policy or process to determine which situations justified expedited review and what process would be followed to allow or deny a request for an expedited authorization. Colorado Choice was required to develop or refine and implement procedures to determine when an expedited review is warranted and how it is processed as well as procedures for extending standard and expedited authorization decisions up to 14 calendar days.

Colorado Choice staff members were able to articulate appropriate standards for timely access to care; however, the provider handbook and Network Access Plan included inaccurate information. Additionally, Colorado Choice had no mechanism to monitor providers to ensure adherence to requirements. Colorado Choice was required to amend its provider handbook and Network Access Plan to reflect appropriate timely access standards and develop a mechanism to regularly monitor provider compliance with timely access requirements.

Colorado Choice had no policy, procedure, provider training, or member communications related to its cultural competency program. Colorado Choice was also required to develop and implement policies, procedures, provider training, and member communications that describe Colorado Choice's efforts to deliver services in a culturally competent manner.

Summary Assessment of Quality, Timeliness, and Access for Compliance Monitoring

Colorado Choice demonstrated strong performance in the quality domain. Its policies and procedures delineated the criteria used to determine medical necessity, ensured that only qualified clinicians made decisions to deny services, and conducted annual interrater reliability testing to ensure consistent application of the criteria. NOAs included the required content in easy-to- understand language.

Five of Colorado Choice's six required actions were related to the timeliness standard—indicating possible misunderstanding of the federal healthcare regulations and opportunities for improvement. Colorado Choice had no policy or process to determine which situations justified expedited review and what process would be followed to allow or deny a request for an expedited authorization. Colorado Choice also had no process to extend decision time frames. Although Colorado Choice staff members were able to articulate appropriate standards for timely access to care, the provider handbook and Network Access Plan included incorrect information. Furthermore, Colorado Choice had no mechanism to regularly monitor provider compliance with timely access requirements.

Related to the access domain, Colorado Choice continues to struggle with access issues, however had processes in place to continue to positively impact this domain. Its service area is composed primarily of counties designated as medically underserved areas. Health plan staff members stated that Colorado Choice held contracts with all available primary care providers in the area and with most specialists in

each county. The Network Access Plan described efforts to maintain the provider network and included processes to allow members access to out-of-network providers as needed.

Validation of Performance Measures

Compliance With Information Systems (IS) 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 did not identify any notable issues of negative impact on HEDIS reporting.

Pediatric Care Measure Results

Table 3-13 shows the HEDIS 2016 and HEDIS 2017 Pediatric Care measure results for Colorado Choice and the percentile rankings for the HEDIS 2017 rates.

Table 3-13—Pediatric Care Measure Results for Colorado Choice

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Childhood Immunization Status[+]			
Combination 2	0.00%	4.08%	<10th
Combination 3	0.00%	4.08%	<10th
Combination 4	0.00%	2.04%	<10th
Combination 5	0.00%	0.00%	<10th
Combination 6	0.00%	2.04%	<10th
Combination 7	0.00%	0.00%	<10th
Combination 8	0.00%	0.00%	<10th
Combination 9	0.00%	0.00%	<10th
Combination 10	0.00%	0.00%	<10th
Immunizations for Adolescents[+]			
Combination 1 (Meningococcal, Tdap)	11.90%	14.81%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	—	5.56%	—
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	43.79%	42.18%	<10th
Adolescent Well-Care Visits[+]			
Adolescent Well-Care Visits	30.70%	28.92%	<10th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents+,1			
BMI Percentile Documentation—Total	29.68%	**1.53%^^**	<10th
Counseling for Nutrition—Total	29.93%	**3.44%^^**	<10th
Counseling for Physical Activity—Total	27.01%	**4.01%^^**	<10th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	73.85%	74.07%	50th–74th

+ Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
[1] Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.
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 of <0.05.

Strengths for Pediatric Care Measures

Related to the Pediatric Care Measures, Colorado Choice had no reported rates that fell above the 75th percentile or that experienced a substantial improvement when compared to the previous measure year.

Opportunities for Improvement for Pediatric Care Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Childhood Immunization Status—Combinations 2–10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *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*

Recommendations for Pediatric Care Measures

HSAG recommends that Colorado Choice analyze strategies that can be linked to improved pediatric care documentation overall, including documented immunizations for children and adolescents; well-care visits for children and adolescents; and documented weight assessments, nutrition counseling, and physical activity counseling for children and adolescents. Colorado Choice may want to consider

determining if its disease management materials and dissemination to members or providers are sufficient and enhance processes as appropriate. However, because the measures that fell below the national Medicaid 25th percentile for Colorado Choice can be reported using the hybrid methodology, caution should be exercised when comparing the health plan's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Access to Care and Preventive Screening Measure Results

Table 3-14 shows the HEDIS 2016 and HEDIS 2017 Access to Care and Preventive Screening measure results for Colorado Choice and the percentile rankings for the HEDIS 2017 rates.

Table 3-14—Access to Care and Preventive Screening Measure Results for Colorado Choice

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	NA	79.41%	<10th
Ages 25 Months to 6 Years	69.44%	65.12%	<10th
Ages 7 to 11 Years	80.81%	72.61%	<10th
Ages 12 to 19 Years	87.10%	**76.50%^^**	<10th
Preventive Screening			
Chlamydia Screening in Women			
Total	NA	NA	—
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	2.04%	0.00%	≥90th

— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
** For this indicator, a lower rate indicates better performance.*
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 of <0.05.

Strengths for Access to Care and Preventive Screening Measures

The following rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years,* and *Ages 12 to 19 Years*

Recommendations for Access to Care and Preventive Screening Measures

Additionally, Colorado Choice's rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years*, and *Ages 12 to 19 Years* declined by 5 or more percentage points from the prior year. As a result, HSAG recommends that Colorado Choice conduct a thorough analysis of the root causes for poor performance in the area of primary care for children and adolescents. Colorado Choice is urged to uncover causal areas linked to low performance, identify the most significant areas or populations of focus for which improvement interventions could be planned, and identify strategies and interventions that are anticipated to provide the highest initial impact to the rates.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Mental/Behavioral Health Measure Results

Table 3-15 shows the HEDIS 2016 and HEDIS 2017 Mental/Behavioral Health measure results for Colorado Choice and the percentile rankings for the HEDIS 2017 rates.

Table 3-15—Mental/Behavioral Health Measure Results for Colorado Choice

Measures	HEDIS 2016 Rate	HEDIS 2017 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	NA	—

NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

Strengths, Opportunities for Improvement, and Recommendations for Mental/Behavioral Health Measures

The denominators for Colorado Choice's mental/behavioral health-related measures were too small to report valid rates.

Respiratory Conditions Measure Results

Table 3-16 shows the HEDIS 2016 and HEDIS 2017 Respiratory Conditions measure results for Colorado Choice and the percentile rankings for the HEDIS 2017 rates.

Table 3-16—Respiratory Conditions Measure Results for Colorado Choice

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Appropriate Treatment for Children With Upper Respiratory Infection[1]			
Appropriate Treatment for Children With Upper Respiratory Infection	85.85%	83.72%	10th–24th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	NA	NA	—
Medication Compliance 75%—Total	NA	NA	—
Asthma Medication Ratio			
Total	NA	NA	—

[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

Strengths, Opportunities for Improvement, and Recommendations for Respiratory Conditions Measures

Only one measure related to respiratory conditions, *Appropriate Treatment for Children With Upper Respiratory Infection*, was reportable for Colorado Choice for HEDIS 2017. The rate for this measure fell below the national Medicaid 25th percentile, indicating an opportunity for improved care for children with an URI. The Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Use of Services Measure Results

Table 3-17 shows the HEDIS 2016 and HEDIS 2017 Use of Services measure results for Colorado Choice and the percentile rankings for Colorado Choice's HEDIS 2017 rates. Reported rates were not risk-adjusted; therefore, rate changes observed between HEDIS 2016 and HEDIS 2017 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid MCO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 3-17—Use of Services Measure Results for Colorado Choice

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)			
*Emergency Department Visits**	17.94	15.26	≥90th
Outpatient Visits	183.26	176.00	<10th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.52	0.81	<10th
Days per 1,000 Member Months (Total Inpatient)	3.74	2.06	<10th
Average Length of Stay (Total Inpatient)	2.46†	2.56†	<10th
Discharges per 1,000 Member Months (Medicine)	1.30	0.54	<10th
Days per 1,000 Member Months (Medicine)	3.25	1.21	<10th
Average Length of Stay (Medicine)	2.50†	2.25†	<10th
Discharges per 1,000 Member Months (Surgery)	0.16	0.27	<10th
Days per 1,000 Member Months (Surgery)	0.43	0.85	<10th
Average Length of Stay (Surgery)	2.67†	3.17†	<10th
Discharges per 1,000 Member Months (Maternity)	0.11	0.00	<10th
Days per 1,000 Member Months (Maternity)	0.11	0.00	<10th
Average Length of Stay (Maternity)	1.00†	~	—
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.59	0.50	≥90th
Average Days Supplied per Antibiotic Script	10.36	12.39	<10th
Average Scripts PMPY for Antibiotics of Concern	0.25	0.20	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	42.20%	39.01%	50th–74th

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files: differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. Rates with this symbol may also indicate that fewer than 30 discharges were reported. Exercise caution when evaluating this rate.
** For this indicator, a lower rate indicates better performance.*
~ Indicates that this rate was based on zero discharges; therefore, the average length of stay is not presented in this report.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

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 of Quality, Timeliness, and Access for Validation of Performance Measures

Most of Colorado Choice's reportable measure rates ranked below the national 10th percentile, including:

- *Childhood Immunization Status—Combinations 2–10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years,* and *Ages 12 to 19 Years*

Caution should be used when interpreting results for rates that could be reported using the hybrid methodology.

Although Colorado Choice performed well with regard to the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure, this rate should be examined and evaluated within the context that a higher performance is related to the absence of services and compare that finding to the low rates in other measures. This rate may or may not indicate positive performance.

Validation of Performance Improvement Projects

Findings

Table 3-18 displays the validation results for the Colorado Choice PIP, *Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider,* validated during FY 2016–2017. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-18 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a

score for each stage and an overall score across all activities. This was the third validation year for the PIP, with HSAG validating Activities I through VIII.

Table 3-18—Performance Improvement Project Validation Results for Colorado Choice

Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (2/2)	0% (0/2)	0% (0/2)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			***Not Assessed***	***Not Assessed***	***Not Assessed***
Percentage Score of Applicable Evaluation Elements *Met*			**100% (17/17)**	**0% (0/17)**	**0% (0/17)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Met*.

Table 3-19 displays remeasurement data for Colorado Choice's PIP. Colorado Choice's goal is to increase to 5 percent the percentage of members 12 to 17 years of age who have a follow-up visit with a behavioral health provider within 30 days of a positive depressive disorder screening with a primary care provider.

Table 3-19—Performance Improvement Project Outcomes for Colorado Choice

PIP Study Indicator	Baseline Period (07/01/2014–06/30/2015)	Remeasurement 1 (07/01/2015–06/30/2016)	Remeasurement 2 (07/01/2016–06/31/2017)	Sustained Improvement
The percentage of adolescents 12–17 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%	NR		*Not Assessed*

NR = Not Reportable

The baseline rate for members 12 to 17 years of age who had a follow-up visit with a behavioral health provider within 30 days of a positive depressive disorder screening with a primary care provider was zero (0/1). The denominator size was only one member. The health plan's goal was 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.

For Remeasurement 1, the eligible population did not increase, and the numerator and denominator were again zero, making the rate *Not Reportable (NR)* for this measurement period. The goal remains at 5 percent.

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. The health plan completed a causal/barrier analysis, identified and prioritized barriers, and implemented interventions logically linked to the barriers and which have the potential to impact indicator outcomes. Colorado Choice also has processes in place to evaluate the effectiveness of each intervention.

Barriers/Interventions

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

For the *Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider* PIP**,** Colorado Choice determined it necessary to better understand what processes, if any, the primary care providers had in place to screen for depressive disorders and for referring members to a behavioral health provider. To do this, Colorado Choice developed a telephonic survey which included the following survey questions for providers:

- Are evidenced-based depression screenings being utilized for adolescents at their evaluation and management visits?
- If so, what is the process to refer to a behavioral health provider when a positive screening is identified? If not, are there specific reasons that these evidence-based screening tools are not being used?
- Does the primary care provider have a relationship with a behavioral health provider?
- Is there a tracking mechanism in place to determine if the adolescent was seen by a behavioral health provider within 30 days of the positive screening? If so, what is the process?
- Are there any barriers referring adolescents to a behavioral health provider?

A survey was also developed for behavioral health providers that asked the following questions:

- Do you receive referrals from primary care providers for members that screened positive for depression? If so, can you see them within 30 days of the referral and how is this ensured?
- What is the intake process?
- What is the timing between the intake and first appointment?
- What is the wait time for someone with emergent needs?
- Does the behavioral health practice have clinicians integrated with the primary care setting or vice versa?

From the survey results, the following barriers were identified and prioritized:

- Not all primary care providers have a process in place for completing an adolescent depression screening.
- Primary care providers have difficulty accessing the behavioral health network.

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

- Educated the providers about using standardized depression screening tools, reimbursement rates, and correct billing codes.
- Conducted a provider survey to capture how Colorado Choice can better support providers in conducting depression screenings.
- Targeted provider contact will be made to those providers identified as a severity level 3 (providers for whom there is no screening process/tool in place and therefore no identified referral pathway).
- Continued to update the provider network regularly so that providers' needs are met.
- Uploaded the *Patient Health Questionnaire* (PHQ) screening tool to the Colorado Choice Health Plan website on the provider resources tab.

Recommendations

As the PIP progresses, HSAG recommends the following to Colorado Choice:

- Ensure that goals set will result in projected statistically significant improvement.
- Visit the causal/barrier analysis and quality improvement processes at least annually to reevaluate barriers; and develop new, active interventions as needed.
- Continue to evaluate the effectiveness of each individual intervention and report the results in the next annual submission.
- Makes data-driven decisions when revising, continuing, or discontinuing interventions.
- Reference the *PIP Completion Instructions* to ensure that all documentation requirements for each completed activity of the PIP Summary Form are addressed.
- Seek technical assistance from HSAG as needed.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-20 shows the results achieved by Colorado Choice for FY 2015–2016 and FY 2016–2017.

Table 3-20—Question Summary Rates and Global Proportions for Colorado Choice

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	90.1%	87.9%
Getting Care Quickly	90.6%	93.7%
How Well Doctors Communicate	94.4%	96.5%
Customer Service	85.2%+	76.9%+
Shared Decision Making	78.1%+	81.8%+
Rating of Personal Doctor	58.4%	66.4%
Rating of Specialist Seen Most Often	72.7%+	62.5%+
Rating of All Health Care	52.7%	54.5%
Rating of Health Plan	49.3%	46.7%

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.

Strengths

For Colorado Choice's CHP+ population, one measure increased substantially:

- *Rating of Personal Doctor* (8.0 percentage points)

Four of the measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of All Health Care*

Opportunities for Improvement

Two measure rates decreased substantially:

- *Customer Service*
- *Rating of Specialist Seen Most Often*

Two measure rates decreased slightly:

- *Getting Needed Care*
- *Rating of Health Plan*

Recommendations

Colorado Choice experienced substantial rate decreases for two measures in the 2016–2017 measurement year when compared to the previous year. In addition, two measure rates showed slight decreases. HSAG recommends that Colorado Choice prioritize improving those measures with substantial decreases in rates. However, to improve member perceptions for all measures showing a decline, HSAG offers the following recommendations for Colorado Choice to consider based on population needs and health plan resources:

To improve members' perceptions of *Customer Service* and *Rating of Health Plan*:

- Consider conducting evaluations to assess staff members' and providers' customer service skills and developing training programs designed to address issues found for both staff and providers.
- Develop an ongoing tracking mechanism that captures the reason why members called customer service and identifies the most common questions and concerns expressed by members. With this information, Colorado Choice should develop training directed at these findings to ensure that customer service representatives and reception area staff have the information and resources needed to address the most common concerns.
- Improve members' experiences by developing a comprehensive cultural competency program and written materials in alternative formats and languages and in an easy-to-understand reading level. Written materials in alternative formats and languages may be available electronically, or printed when members request hard copies.

To improve the *Rating of Specialist Seen Most Often*, *Getting Needed Care,* and *Rating of Health Plan* measures:

- Colorado Choice should evaluate the adequacy of its specialist provider network and the most common referral patterns of PCPs to specialists to more specifically determine network needs.
- Due to being located in a rural region of the state, Colorado Choice should explore and implement increased options for telehealth programs to enhance availability of specialists' expertise in the region and/or encourage the use of electronic communication between providers and patients where appropriate to provide services to members when face-to-face appointments may not be needed.
- Colorado Choice should consider utilizing care coordinators to: conduct ongoing follow-up with individual members/families, act as provider liaisons, provide outreach to members who have frequent no-show appointments or treatment noncompliance, or provide an option as alternative clinicians.

- Colorado Choice should consider enhancing its single-case provider agreement process to ensure that members have a choice of specialists in or out of network.
- Colorado Choice can further enhance members' experience related to *Getting Needed Care* by disseminating accurate and consistent information to providers related to standards for timely access to care and by developing a mechanism to monitor providers' adherence.
- Colorado Choice might also want to further evaluate whether members' ratings of the specialist they see most often are related to member perceptions about *Getting Needed Care* and *Rating of Health Plan*.

For all measure rates that experienced a substantial decrease (more than 5 percentage points each) when compared to the previous measure year, the Department recommends that the health plan develop quality initiatives to improve member experience.

Colorado Choice: Summary Assessment of 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.

For Colorado Choice's CHP+ population, of the nine measures that impacted the quality domain, one measure showed a substantial rate increase when compared to the previous measure year, and four additional measure rates were slightly higher when compared to the previous measure year. Two measures' rates decreased substantially. The remaining two measures showed slight rate decreases when compared to the previous measure year. Colorado Choice's overall results for the quality domain were mixed. Rates appear to indicate that overall members' perceptions related to the care delivered by *providers* increased when compared to the previous year, while members' perceptions of the services received by *specialists* decreased substantially when compared to the previous measure year.

For the *Getting Care Quickly* measure, which assessed the quality and timeliness domains, Colorado Choice's measure rate for the CHP+ population showed a slight increase, indicating a potential upward trend.

For the *Getting Needed Care* measure, which assessed the quality and access to care domain, Colorado Choice's measure rate for the CHP+ population showed a slight decrease, indicating a potential downward trend.

Denver Health Medical Plan, Inc.

Monitoring for Compliance with Medicaid Managed Care Regulations

Table 3-21 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 2016–2017.

Table 3-21—Summary of DHMP Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	35	34	32	0	2	1	94%
II—Access and Availability	13	13	12	1	0	0	92%
Totals	**48**	**47**	**44**	**1**	**2**	**1**	**94%**

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

Table 3-22 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 2016–2017.

Table 3-22—Summary of DHMP Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	20	0	20	80	0%
Totals	**100**	**20**	**0**	**20**	**80**	**0%**

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

Strengths

DHMP did not require authorization for services delivered within the Denver Health and Hospital Authority (DHHA) network; however, staff reviewed authorization requests for all out-of-network services and for outpatient requests for durable medical equipment, consumable supplies, and home healthcare. Policies and procedures accurately addressed time frames for making authorization decisions and defined processes for determining pre-service, post-service, continued stay, expedited, and emergency services authorizations. DHMP used InterQual and Hayes Knowledge Center criteria for making medical necessity decisions and conducted interrater reliability testing for physician and non-physician staff annually.

After determining in FY 2013–2014 that its network was inadequate to meet the needs of its membership, DHMP began revising existing processes and implementing new processes as appropriate

to improve access. DHMP expanded access by opening a new clinic offering primary and urgent care and extending office hours at three other clinic locations. DHMP also expanded capacity by contracting with Walgreens Healthcare Clinic and King Soopers' Little Clinic and allowing CHP+ members to access these clinics for urgent care appointments. DHMP submitted materials that demonstrated ensuring that covered services are available 24 hours a day, 7 days a week, when medically necessary; that scheduling guidelines are communicated in writing; and that providers are monitored to ensure that they meet scheduling standards. DHMP submitted numerous documents that demonstrated its commitment to the delivery of services in a culturally competent manner, including a Certificate of Distinction in Multicultural Health Care awarded by the NCQA.

Opportunities for Improvement and Recommendations

HSAG reviewed 10 CHP+ retrospective claim denial records and found that in all 10 cases DHMP failed to provide the member with written notice. DHMP was required to develop a process to ensure that each claim denial for out-of-network services generates a written notice of action to the member.

DHMP staff members described and provided evidence to support several processes implemented in order to expand the network's capacity and to improve efficiencies. These processes remained fluid as staff determined the most effective ways for addressing the issues. While acknowledging the significant improvement made in recent years to expanding its network capacity, DHMP was required to continue expansion efforts until it can ensure all members timely access to all services covered under the contract.

Summary Assessment of Quality, Timeliness, and Access for Compliance Monitoring

Related to the quality domain, DHMP had clearly written policies and organizational procedures to ensure appropriate and consistent application of evidence-based criteria to authorization requests. On-site review of retrospective claims denials demonstrated that in all cases DHMP mailed no notice of action to members. HSAG also noted that five of the 10 records reviewed denied out-of-network services for members who had been enrolled in DHMP for one month or less. HSAG suggested that DHMP more closely align its claims adjudication decisions with the UM department authorization processes to ensure that the UM department has an opportunity to review any potential out-of-network denials to determine regulatory or policy exceptions to the denial (e.g., continuity of care or urgently needed services). DHMP must also be sure that each claim denial for out-of-network services generates a written notice to the member.

DHMP's policies and procedures accurately addressed time frames for making authorization decisions and defined processes for determining all types of service authorizations. All denials reviewed on-site represented no UM authorization processes; therefore, HSAG was unable to evaluate implementation of several requirements, including timeliness.

DHMP demonstrated substantial improvement in the access domain compared to its performance the last time HSAG reviewed these standards. Although DHMP reported appropriate provider-to-member ratios, other components used to measure adequacy (e.g., grievances, satisfaction surveys, and daily unmet demand reports) indicated that the provider network was still not adequate to ensure timely

availability of all covered services. HSAG encouraged DHMP to continue pursuing innovative ways to address capacity issues and suggested that it document these processes in writing as they are finalized.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2017 HEDIS Compliance Audit Report, DHMP 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. However, the auditor identified some notable obstacles that DHMP encountered during validation.

Although it did not have any negative impact on HEDIS reporting, the auditor noted that DHMP experienced challenges with the data extract and formatting the data to the appropriate file layout. Due to the health plan's limited information technology resources, DHMP was also unable to implement in a timely manner measure changes to file layouts and fields outlined by NCQA. The auditor recommended that DHMP's staff review measure changes and updates to the HEDIS 2018 specifications and apply these changes to file layouts and fields for the next reporting period in a timely manner.

Pediatric Care Measure Results

Table 3-23 shows the HEDIS 2016 and HEDIS 2017 Pediatric Care measures results for DHMP and the percentile rankings for the HEDIS 2017 rates.

Table 3-23—Pediatric Care Measure Results for DHMP

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Childhood Immunization Status+			
Combination 2	70.87%	73.28%	25th–49th
Combination 3	70.08%	73.28%	50th–74th
Combination 4	70.08%	73.28%	75th–89th
Combination 5	63.78%	67.24%	75th–89th
Combination 6	50.39%	53.45%	75th–89th
Combination 7	63.78%	67.24%	75th–89th
Combination 8	50.39%	53.45%	≥90th
Combination 9	48.03%	50.86%	≥90th
Combination 10	48.03%	50.86%	≥90th
Immunizations for Adolescents+			
Combination 1 (Meningococcal, Tdap)	77.34%	72.06%	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	—	27.21%	—

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Well-Child Visits in the First 15 Months of Life[+]			
*Zero Visits**	7.84%	6.78%	<10th
Six or More Visits	0.00%	6.78%	<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	59.57%	59.48%	<10th
Adolescent Well-Care Visits[+]			
Adolescent Well-Care Visits	44.41%	41.37%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[+,1]			
BMI Percentile Documentation—Total	77.86%	**7.94%^^**	<10th
Counseling for Nutrition—Total	78.59%	**1.46%^^**	<10th
Counseling for Physical Activity—Total	65.21%	**0.80%^^**	<10th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	NA	83.87%	75th–89th

[+] Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.
** For this indicator, a lower rate indicates better performance.*
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
[1] Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
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 of <0.05.

Strengths for Pediatric Care Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Childhood Immunization Status—Combinations 4–10*
- *Appropriate Testing for Children With Pharyngitis*

Opportunities for Improvement for Pediatric Care Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

- *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*

Additionally, DHMP's *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* rate decreased by more than 5 percentage points from the prior year.

Recommendations for Pediatric Care Measures

HSAG recommends that DHMP analyze strategies that can be linked to improved documentation for well-child visits; documented immunizations for adolescents; and documented weight assessments, nutrition counseling, and physical activity counseling for children and adolescents. However, because the measures for areas of improvement for DHMP can be reported using the hybrid methodology, caution should be exercised when comparing the health plan's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Access to Care and Preventive Screening Measure Results

Table 3-24 shows the HEDIS 2016 and HEDIS 2017 Access to Care and Preventive Screening measure results for DHMP and the percentile rankings for the HEDIS 2017 rates.

Table 3-24—Access to Care and Preventive Screening Measure Results for DHMP

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	90.91%	93.98%	25th–49th
Ages 25 Months to 6 Years	72.65%	71.52%	<10th
Ages 7 to 11 Years	84.53%	85.65%	10th–24th
Ages 12 to 19 Years	86.65%	85.48%	10th–24th
Preventive Screening			
Chlamydia Screening in Women			
Total	64.52%	56.06%	50th–74th
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	≥90th

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

Strengths for Access to Care and Preventive Screening Measures

The following rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years, Ages 7 to 11 Years,* and *Ages 12 to 19 Years*

Additionally, DHMP's *Chlamydia Screening in Women—Total* rate decreased by more than 5 percentage points from the prior year.

Recommendations for Access to Care and Preventive Screening Measures

HSAG recommends that DHMP analyze strategies that can be linked to improved access to care for children and adolescents and chlamydia screenings for women. Additionally, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Mental/Behavioral Health Measure Results

Table 3-25 shows the HEDIS 2016 and HEDIS 2016 Mental/Behavioral Health measure results for DHMP and the percentile rankings for the HEDIS 2017 rates.

Table 3-25—Mental/Behavioral Health Measure Results for DHMP

Measures	HEDIS 2016 Rate	HEDIS 2017 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	NA	—

NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

Strengths, Opportunities for Improvement, and Recommendations for Mental/Behavioral Health Measures

The denominators for DHMP's mental/behavioral health-related measures were too small to report valid rates.

Respiratory Conditions Measure Results

Table 3-26 shows the HEDIS 2016 and HEDIS 2017 Respiratory Conditions measure results for DHMP and the percentile rankings for the HEDIS 2017 rates.

Table 3-26—Respiratory Conditions Measure Results for DHMP

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
***Appropriate Treatment for Children With Upper Respiratory Infection*[1]**			
Appropriate Treatment for Children With Upper Respiratory Infection	98.03%	**91.40%^^**	50th–74th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	NA	NA	—
Medication Compliance 75%—Total	NA	NA	—
Asthma Medication Ratio			
Total	NA	NA	—

[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
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 of <0.05.

Strengths, Opportunities for Improvement, and Recommendations for Respiratory Conditions Measures

Only one respiratory conditions-related measure, *Appropriate Treatment for Children With Upper Respiratory Infection*, was reportable for DHMP for HEDIS 2017. The rate for this measure declined by more than 5 percentage points, indicating an opportunity for improved care for children with an URI. The Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Use of Services Measure Results

Table 3-27 shows the HEDIS 2016 and HEDIS 2017 Use of Services measure results for DHMP and the percentile rankings for DHMP's HEDIS 2017 rates. Reported rates were not risk adjusted; therefore, rate changes observed between HEDIS 2016 and HEDIS 2017 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid MCO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 3-27—Use of Services Measure Results for DHMP

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)			
*Emergency Department Visits**	22.91	18.09	≥90th
Outpatient Visits	130.44	117.49	<10th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.08	0.88	<10th
Days per 1,000 Member Months (Total Inpatient)	2.90	2.47	<10th
Average Length of Stay (Total Inpatient)	2.68	2.80	<10th
Discharges per 1,000 Member Months (Medicine)	0.95	0.65	<10th
Days per 1,000 Member Months (Medicine)	2.51	1.75	<10th
Average Length of Stay (Medicine)	2.64	2.68	<10th
Discharges per 1,000 Member Months (Surgery)	0.11	0.21	<10th
Days per 1,000 Member Months (Surgery)	0.32	0.62	<10th
Average Length of Stay (Surgery)	3.00†	2.92†	<10th
Discharges per 1,000 Member Months (Maternity)	0.04	0.03	<10th
Days per 1,000 Member Months (Maternity)	0.13	0.20	<10th
Average Length of Stay (Maternity)	3.00†	6.00†	≥90th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.14	0.13	≥90th
Average Days Supplied per Antibiotic Script	10.10	10.47	<10th
Average Scripts PMPY for Antibiotics of Concern	0.04	0.03	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	28.31%	26.07%	≥90th

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files: differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile rankings should be interpreted with caution and may not accurately reflect high or low performance. Rates with this symbol may also indicate that fewer than 30 discharges were reported. Exercise caution when evaluating this rate.
** For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

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 of Quality, Timeliness, and Access for Validation of Performance Measures

With regard to quality and timeliness of care, DHMP demonstrated areas of strength for the following measures:

- *Childhood Immunization Status—Combinations 4–10*
- *Appropriate Testing for Children With Pharyngitis*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

However, findings related to the following measures indicate areas for improved quality, timeliness, and access to care for DHMP:

- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years, Ages 7 to 11 Years,* and *Ages 12 to 19 Years*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

Many measures for areas of improvement for DHMP can be reported using the hybrid methodology; therefore, caution should be exercised when comparing the health plan's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Validation of Performance Improvement Projects

Findings

Table 3-28 displays the validation results for the DHMP PIP, *Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit,* validated during FY 2016–2017. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a

specific element. The validation results presented in Table 3-28 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This is the first year of validation for this PIP because the previous PIP topic's eligible population was very small and the baseline rate for Study Indicator 1 was 100 percent; for Study Indicator 2, the denominator was zero. During a technical assistance call with DHMP and the Department, it was decided that the DHMP would implement a new topic, which was submitted in 2016. For this first year of validation, HSAG validated Activities I through VII.

Table 3-28—Performance Improvement Project Validation Results for DHMP

Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*	*Not Assessed*	*Not Assessed*
Implementation Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			***Not Assessed***	***Not Assessed***	***Not Assessed***
Percentage Score of Applicable Evaluation Elements *Met*			**100% (12/12)**	**0% (0/12)**	**0% (0/12)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Met*.

Table 3-29 displays baseline data for DHMP's PIP. DHMP's goal is to increase the percentage of follow-up visits with a primary care practitioner within 30 days after an asthma-related emergency department visit, urgent care visit, or inpatient stay.

Table 3-29—Performance Improvement Project Outcomes for DHMP

PIP Study Indicator	Baseline Period (07/01/2015–06/30/2016)	Remeasurement 1 (07/01/2016–06/30/2017)	Remeasurement 2 (07/01/2017–06/31/2018)	Sustained Improvement
The percentage of follow-up visits with a primary care practitioner within 30 days after an asthma-related emergency department visit, urgent care visit, or inpatient stay.	0%			

DHMP's baseline rate for members 5 to 17 years of age with persistent asthma who had a follow-up visit with a primary care practitioner within 30 days of an asthma-related emergency department visit, urgent care visit, or inpatient stay was 0 percent. The numerator was zero, and the denominator was 2. Assuming a denominator of five at Remeasurement 1, the MCO set a goal of 100 percent, or five members in the numerator, to achieve projected statistically significant improvement. Although the numbers are low, DHMP staff stated that this improvement project is important because follow-up was unsuccessful for the entire CHP+ population, justifying the need for improvement in transitions of care. Improving transitions of care for children with asthma has the potential to make a significant impact to children's health in the MCO's overall population.

Strengths

DHMP designed a scientifically sound project supported by the use of key research principles. The sound study design allowed the MCO to progress to data collection. DHMP accurately reported and interpreted results of the baseline measurement period.

Barriers/Interventions

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

At the time of submission, DHMP had not implemented interventions. The MCO's quality improvement processes and interventions will be evaluated in the next annual submission.

Recommendations

As the PIP progresses, HSAG recommends the following to DHMP:

- Conduct a causal/barrier analysis using appropriate quality improvement processes, prioritize the identified barriers, and implement active interventions that are logically linked to the barriers and which have the potential to impact outcomes.
- Evaluate the effectiveness of each individual intervention and include the evaluation results in Activity VIII.
- Make data-driven decisions when revising, continuing, or discontinuing interventions.
- Seek technical assistance from HSAG as needed.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-30 shows the results achieved by DHMP for FY 2015–2016 and FY 2016–2017.

Table 3-30—Question Summary Rates and Global Proportions for DHMP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	65.8%	75.8%
Getting Care Quickly	76.4%	80.6%
How Well Doctors Communicate	93.6%	96.5%
Customer Service	82.2%	81.4%
Shared Decision Making	74.2%+	74.8%+
Rating of Personal Doctor	75.6%	80.3%
Rating of Specialist Seen Most Often	58.3%+	77.4%+
Rating of All Health Care	61.7%	67.8%
Rating of Health Plan	62.4%	67.4%

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.

Strengths

For DHMP, four measure rates increased substantially:

- *Getting Needed Care* (10.0 percentage points)
- *Rating of Specialist Seen Most Often* (19.1 percentage points)
- *Rating of All Health Care* (6.1 percentage points)
- *Rating of Health Plan* (5.0 percentage points)

Four measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of Personal Doctor*

Opportunities for Improvement

For DHMP's CHP+ population, no measure rates decreased substantially. However, one measure rates showed a slight rate decrease:

- *Customer Service*

Recommendations

DHMP experienced no substantial rate decreases in the 2016–2017 measurement year when compared to the previous year. However, one measure showed a slight decrease. HSAG offers the following recommendations for DHMP to consider based on population needs and health plan resources. In order to improve members' perceptions on the *Customer Service* measure, DHMP should:

- Consider conducting evaluations to assess staff members' and providers' customer service skills and develop training programs designed to address issues found for both staff and providers.
- Develop an ongoing tracking mechanism that captures the reason why members called customer service and identifies the most common questions and concerns expressed by members. With this information, DHMP should develop training directed at those findings to ensure that customer service representatives, call center staff, and clinic-based reception area staff have the information and resources needed to address the most common concerns.
- Possibly consider weekly or monthly team meetings to evaluate performance on calls in which the content or request was difficult and provide peer support as needed.

DHMP: Summary Assessment of Quality, Timeliness, and Access

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

Of the nine measures that impacted the quality domain, four measures showed substantial increases in rates when compared to the previous measure year and four additional measure rates were slightly higher. No measure rates decreased substantially. The one remaining measure showed a slight rate decrease when compared to the previous measure year. DHMP's results for the quality domain were positive and trending substantially upward overall.

For the *Getting Care Quickly* measure, which assessed the quality and timeliness domains, DHMP demonstrated a slight increase, indicating a positive trend.

For the *Getting Needed Care* measure, which assessed the quality and access to care domain, DHMP's measure rate for the CHP+ population demonstrated a substantial increase, indicating positive results in respect to DHMP's efforts to improve access to services.

Kaiser Permanente Colorado

Monitoring for Compliance With Managed Care Regulations

Table 3-31 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 2016–2017.

Table 3-31—Summary of Kaiser Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	34	34	32	2	0	0	94%
II—Access and Availability	14	14	13	1	0	0	93%
Totals	**48**	**48**	**45**	**3**	**0**	**0**	**94%**

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

Table 3-32 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 2016–2017.

Table 3-32—Summary of Kaiser Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	54	54	54	0	0	100%
Totals	**54**	**54**	**54**	**0**	**0**	**100%**

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

Strengths

Kaiser demonstrated that it maintained a comprehensive UM program. Staff members were able to competently describe the program and communicate effectively the process of criteria-based authorization review. Kaiser's policies aligned with the process described by staff. HSAG's review of 10 denial records demonstrated full compliance with the requirements and NOAs included required content.

Kaiser provided its *Practitioner Availability and Sufficiency of Services* policy and its *Network Adequacy Report* as evidence that it maintained and monitored an appropriate and sufficient network of providers. Additionally, staff members articulated in detail how they use the policy, adequacy report, and various other monitoring methods to evaluate the member population's service area and specific needs to ensure sufficient access to and delivery of services.

Opportunities for Improvement and Recommendations

Based on findings from the site review activities, Kaiser was required to update UM policies and procedures to clearly define the medical necessity criteria outlined in the State plan and to address all notification time frames applicable to members as outlined in the requirement. Kaiser was also required to revise policies and procedures to allow members with special healthcare needs who use specialists frequently to maintain these types of specialists as PCPs or to allow such members direct access or standing referrals to specialists.

Summary Assessment of Quality, Timeliness, and Access for Compliance Monitoring

Kaiser's performance in the quality domain was mixed. HSAG noted that member materials included some terminology that exceeded the required sixth grade reading level and required that Kaiser update its definition of "medical necessity" to conform with the State's definition. However, staff members were able to articulate Kaiser's written policies and procedures, which complied with federal and State regulations.

Kaiser's policies and procedures addressed time frames for making standard and expedited UM decisions and accurately described the circumstances under which time frames can be extended. However, policies failed to address other time frame requirements applicable to CHP+ members.

Kaiser provided documents demonstrating that its network of providers was adequate to meet the needs of its members. Kaiser's policies described the processes to allow members access to out-of-network providers if in-network providers are not available. Kaiser was required to update its policies to allow members with special healthcare needs who use specialists frequently direct access or standing referrals to those specialists.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

Kaiser was fully compliant with all but one IS standard relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. Based on information in the *2017 HEDIS Compliance Audit Report*, Kaiser was not compliant with IS standard 7 (Data Integration). The auditor noted that Kaiser experienced data mapping issues and had significant challenges in producing final HEDIS rates and patient-level detail files to meet reporting and audit deadlines. Due to these issues, Kaiser was unable to produce reportable rates for several measures. However, all measures presented in this report were assigned an audit designation of *Reportable*. The auditor recommended that Kaiser implement processes to provide complete and accurate data in a timely manner for future reporting.

Pediatric Care Measure Results

Table 3-33 shows the HEDIS 2016 and HEDIS 2017 Pediatric Care measure results for Kaiser and the percentile rankings for the HEDIS 2017 rates.

Table 3-33—Pediatric Care Measure Results for Kaiser

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Childhood Immunization Status+			
Combination 2	58.67%	79.34%^	75th–89th
Combination 3	57.14%	78.93%^	75th–89th
Combination 4	56.38%	78.93%^	≥90th
Combination 5	50.00%	72.31%^	≥90th
Combination 6	38.52%	50.41%^	75th–89th
Combination 7	49.74%	72.31%^	≥90th
Combination 8	38.01%	50.41%^	75th–89th
Combination 9	34.18%	47.11%^	≥90th
Combination 10	33.93%	47.11%^	≥90th
Immunizations for Adolescents+			
Combination 1 (Meningococcal, Tdap)	80.09%	86.02%	75th–89th
Combination 2 (Meningococcal, Tdap, HPV)	—	29.66%	—
Well-Child Visits in the First 15 Months of Life+			
*Zero Visits**	3.51%	2.53%	25th–49th
Six or More Visits	64.91%	67.09%	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	65.70%	67.99%	25th–49th
Adolescent Well-Care Visits+			
Adolescent Well-Care Visits	40.56%	59.26%^	75th–89th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents+,1			
BMI Percentile Documentation—Total	97.87%	**94.10%^^**	≥90th
Counseling for Nutrition—Total	95.87%	97.18%^	≥90th
Counseling for Physical Activity—Total	95.87%	97.18%^	≥90th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	92.18%	96.58%	≥90th

+ Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.
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 of <0.05.

Strengths, Opportunities for Improvement, and Recommendations for Pediatric Care Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Childhood Immunization Status—Combinations 2–10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *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*
- *Appropriate Testing for Children With Pharyngitis*

Additionally, Kaiser's rates for *Childhood Immunization Status—Combinations 2–10*, *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, and *Adolescent Well-Care Visits* each increased by 5 percentage points or more from the prior year, indicating overall strengths with regard to documented immunizations for children and adolescents as well as well-care for adolescents.

Access to Care and Preventive Screening Measure Results

Table 3-34 shows the HEDIS 2016 and HEDIS 2017 Access to Care and Preventive Screening measure results for Kaiser and the percentile rankings for the HEDIS 2017 rates.

Table 3-34—Access to Care and Preventive Screening Measure Results for Kaiser

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	89.88%	87.43%	<10th
Ages 25 Months to 6 Years	83.78%	**79.56%^^**	<10th
Ages 7 to 11 Years	83.85%	87.93%^	25th–49th
Ages 12 to 19 Years	85.51%	87.81%	25th–49th
Preventive Screening			
Chlamydia Screening in Women			
Total	58.56%	48.46%	10th–24th
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.27%	≥90th

** 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 of <0.05.

Strengths for Access to Care and Preventive Screening Measures

The following rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*
- *Chlamydia Screening in Women—Total*

Additionally, Kaiser's rate for *Chlamydia Screening in Women—Total* decreased by more than 5 percentage points from the prior year.

Recommendations for Access to Care and Preventive Screening Measures

HSAG recommends that Kaiser analyze strategies that can be linked to improved access to care for children and chlamydia screenings for women. The Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Mental/Behavioral Health Measure Results

Table 3-35 shows the HEDIS 2016 and HEDIS 2017 Mental/Behavioral Health measure results for Kaiser and the percentile rankings for the HEDIS 2017 rates.

Table 3-35—Mental/Behavioral Health Measure Results for Kaiser

Measures	HEDIS 2016 Rate	HEDIS 2017 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	56.67%	NA	—
Continuation and Maintenance Phase	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents			
Total	NA	NA	—

NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.

— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

Strengths, Opportunities for Improvement, and Recommendations for Mental/Behavioral Health Measures

The denominators for Kaiser's mental/behavioral health-related measures for HEDIS 2017 were too small to report valid rates.

Respiratory Conditions Measure Results

Table 3-36 shows the HEDIS 2016 and HEDIS 2017 Respiratory Conditions measure results for Kaiser and the percentile rankings for the HEDIS 2017 rates.

Table 3-36—Respiratory Conditions Measure Results for Kaiser

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
***Appropriate Treatment for Children With Upper Respiratory Infection*[1]**			
Appropriate Treatment for Children With Upper Respiratory Infection	97.40%	98.91%	≥90th
Medication Management for People With Asthma			
Medication Compliance 50%—Total[2]	NA	32.26%	<10th
Medication Compliance 75%—Total	NA	12.90%	<10th
Asthma Medication Ratio			
Total	NA	80.65%	≥90th

[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).
[2] Indicates that the rate was compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid MCO percentiles since benchmarks for this measure are not published in Quality Compass.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.

Strengths for Respiratory Conditions Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Asthma Medication Ratio—Total*

Opportunities for Improvement for Respiratory Conditions Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Medication Management for People With Asthma—Medication Compliance 50%—Total and Medication Compliance 75%—Total*

Recommendations for Respiratory Conditions Measures

Although Kaiser's performance demonstrated strength in the ratio of asthma-controlling medications prescribed, HSAG recommends that the health plan analyze any potential strategies that could be linked to improvement in the percentage of members with asthma who remain on an asthma-controller medication during the treatment period. The Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Use of Services Measure Results

Table 3-37 shows the HEDIS 2016 and HEDIS 2017 Use of Services measures results for Kaiser and the percentile rankings for Kaiser's HEDIS 2017 rates. Reported rates were not risk-adjusted; therefore, rate changes observed between HEDIS 2016 and HEDIS 2017 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid MCO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 3-37—Use of Services Measure Results for Kaiser

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)			
*Emergency Department Visits**	14.00	2.98‡	≥90th
Outpatient Visits	290.97	179.23	<10th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	0.83	0.64	<10th
Days per 1,000 Member Months (Total Inpatient)	2.89	2.13	<10th
Average Length of Stay (Total Inpatient)	3.48	3.35	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.61	0.49	<10th
Days per 1,000 Member Months (Medicine)	2.05	1.48	<10th
Average Length of Stay (Medicine)	3.37	3.04	<10th
Discharges per 1,000 Member Months (Surgery)	0.15	0.15	<10th
Days per 1,000 Member Months (Surgery)	0.67	0.65	<10th
Average Length of Stay (Surgery)	4.38†	4.36†	<10th
Discharges per 1,000 Member Months (Maternity)	0.15	0.00	<10th
Days per 1,000 Member Months (Maternity)	0.36	0.00	<10th
Average Length of Stay (Maternity)	2.50†	~	—
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	1.44	0.28	≥90th
Average Days Supplied per Antibiotic Script	12.87	12.32	<10th
Average Scripts PMPY for Antibiotics of Concern	0.36	0.08	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	25.23%	28.27%	≥90th

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files: differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile rankings should be interpreted with caution and may not accurately reflect high or low performance. Rates with this symbol may also indicate that fewer than 30 discharges were reported. Exercise caution when evaluating this rate.

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

‡ Kaiser acknowledged that the reported rate for this measure may not be valid; therefore, exercise caution when interpreting these results.

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

— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

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Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

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 of Quality, Timeliness, and Access for Validation of Performance Measures

The health plan's performance demonstrated strength with regard to quality and timeliness of care as evidenced by the following measures:

- *Childhood Immunization Status—Combinations 2–10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *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*
- *Appropriate Testing for Children With Pharyngitis*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Asthma Medication Ratio—Total*

However, the following measures indicate areas of improvement for Kaiser:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*
- *Chlamydia Screening in Women—Total*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*

Validation of Performance Improvement Projects

Findings

Table 3-38 displays the validation results for the Kaiser PIP, *Access and Transition to Behavioral Health Services,* validated during FY 2016–2017. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements each receiving a *Met* score have

satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-38 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with HSAG validating Activities I through IX.

Table 3-38—Performance Improvement Project Validation Results for Kaiser

Stage	Activity		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
		Design Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	50% (3/6)	50% (3/6)	0% (0/6)
		Implementation Total	**56% (5/9)**	**44% (4/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	67% (2/3)	0% (0/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
		Outcomes Total	**33% (1/3)**	**67% (2/3)**	**0% (0/3)**
		Percentage Score of Applicable Evaluation Elements *Met*	**71% (15/21)**	**29% (6/21)**	**0% (0/21)**

Overall, 71 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Partially Met*.

Table 3-39 displays Remeasurement 1 data for Kaiser's PIP. Kaiser's goal is to increase to 25 percent at Remeasurement 1 the percentage of CHP+ members 13 through 17 years of age who were screened for depression by a primary care practitioner's (PCP's), and to 40 percent the percentage of CHP+ members 13 through17 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.

Table 3-39—Performance Improvement Project Outcomes for Kaiser

PIP 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 13–17 years of age who were screened for depression by a primary care practitioner office during the measurement year.	16.9%	35.8%*		*Not Assessed*
2. The total number of Kaiser CHP+ members 13–17 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%	33.3%		*Not Assessed*

**Indicates statistically significant improvement over the baseline.*

The first remeasurement rate for members 13 through17 years of age who were screened for depression by a primary care practitioner (Study Indicator 1) was 35.8 percent. This rate is 18.9 percentage points above the baseline and surpassed the goal of 25 percent. This improvement for Study Indicator 1 was statistically significant, as evidenced by a p value less than 0.0001.

For Kaiser's members 13 through 17 years of age who screened positive for depression by a primary care practitioner and were seen by a behavioral health practitioner within 14 days of the positive screening (Study Indicator 2), the Remeasurement 1 rate was 33.3 percent. This rate is 11.1 percentage points above the baseline; however, the goal of 40 percent was not achieved. The improvement demonstrated at Remeasurement 1 was not statistically significant, as evidenced by a p value of 0.5511.

Strengths

Kaiser 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. Kaiser calculated, reported, and interpreted its first remeasurement data accurately. For this year's validation, Kaiser progressed to reporting Remeasurement 1 data. The MCO was successful at achieving statistically significant improvement for one of two study indicators.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the MCO'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 Patient Health Questionnaire (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 a completed depression screening
- Lack of connection to a behavioral health practitioner following the visit
- Continued provider engagement and recognition of this process as a key effort in addressing depression

To address these barriers, Kaiser continued the following interventions:

- Added a PHQ-like depression screening tool for use in all well visits for adolescents 13 to 17 years of age.
- 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 process for PHQ-2 with reflexing into the PHQ-9M if the PHQ-2 was positive.
- Held a continuing education seminar on teen depression with emphasis on using the depression screening tools.
- Created a new workflow for PCPs to initiate antidepressants for the member with better communication and follow-up with the behavioral health department.

Kaiser also implemented one new intervention midway through the first remeasurement time period. Arrangements were made for cross coverage using a behavioral health medicine specialist to assist with the increased number of behavioral health referrals. This use was implemented to address the identified barrier, "increased use of screenings for depression also increased the number of requests for assistance from behavioral health."

Recommendations

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

- Revisit the causal/barrier analysis and quality improvement processes at least annually to reevaluate barriers; and develop new, active interventions as needed.
- Evaluate the effectiveness of each individual intervention and report the results in the next annual submission.
- Make data-driven decisions when revising, continuing, or discontinuing interventions.
- Reference the *PIP Completion Instructions* to ensure that all documentation requirements for each completed activity of the PIP Summary Form are addressed.
- Address all *Partially Met* and *Not Met* validation scores as well as any points of clarification associated with a *Met* validation score.
- Seek technical assistance from HSAG as needed.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-40 shows the results achieved by Kaiser for FY 2015–2016 and FY 2016–2017.

Table 3-40—Question Summary Rates and Global Proportions for Kaiser

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	87.8%	88.0%
Getting Care Quickly	92.5%	92.0%
How Well Doctors Communicate	96.8%	96.7%
Customer Service	84.6%	85.1%
Shared Decision Making	86.0%+	80.4%+
Rating of Personal Doctor	72.2%	72.9%
Rating of Specialist Seen Most Often	58.3%+	62.5%+
Rating of All Health Care	65.0%	67.5%
Rating of Health Plan	57.0%	61.0%

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.

Strengths

For Kaiser's CHP+ population, no measure rates increased substantially.

Six measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Needed Care*
- *Customer Service*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

Opportunities for Improvement

For Kaiser's CHP+ population, one measure rate decreased substantially:

- *Shared Decision Making*

Two measures showed slight rate decreases:

- *Getting Care Quickly*
- *How Well Doctors Communicate*

Recommendations

Kaiser experienced a substantial rate decrease for one measure. In addition, two measure rates showed slight decreases. HSAG offers the following recommendations for Kaiser to consider based on population needs and health plan resources.

To improve member/family perceptions of *Shared Decision Making*:

- Kaiser providers should ensure that all treatment options are discussed with members and families. To document this process, Kaiser should expedite the implementation of its FY 2015–2016 compliance monitoring corrective action plan (CAP), which required that Kaiser implement procedures to document that all members and family members are involved in a given member's treatment planning and consent to medical treatment, as required by the CHP+ contract with the Department.
- Kaiser should consider developing provider training forums or developing procedures that encourage providers to ensure that members *understand* communications with providers.
- Kaiser might also evaluate whether or not the plan's performance on the *Shared Decision Making* measure is related to the slight decrease in member/family perceptions of how well doctors communicate, and consider whether or not the automated flags and best practices programmed into the electronic record system are inadvertently diminishing interactive communications with members and families.

The *How Well Doctors Communicate* measure could be impacted by many variables, including cultural competency, a clinician's communication style, time factors influencing the length of engagement with the member, or a member's willingness to engage. Kaiser should consider the following recommendations:

- Use verbal, written, phone, electronic, telehealth, or other options for communication, and query members regarding their communication preferences.
- Encourage providers to re-evaluate the amount of time spent with each member to ensure that ample time is allowed for thoroughly addressing the member's concerns.
- Encourage providers to increase follow-up contacts (e.g., phone or electronic) and outreach efforts to some members to ensure understanding.
- Utilize care coordinators to: conduct ongoing follow-up with individual members/families, act as provider liaisons, provide outreach to members who have frequent no shows or treatment noncompliance, or provide an option as alternative clinicians.
- Offer communication aides during a care visit, when necessary.
- Expand disease management programs and increase provision of written materials related to specific conditions or instructions for treatment.
- Expand options for printable member information from the Kaiser website and ensure that all written clinical materials for members are written at the sixth-grade reading level and available in multiple languages whenever possible.

A decrease in rates for *Getting Care Quickly* could be an indicator of:

- Decreasing capacity in the network compared to overall demand for services; or
- Issues in the scheduling systems for provider appointments.

Kaiser should consider the following recommendations:

- Carefully monitor and evaluate provider network, considering the total number of practitioners providing services to all payor sources, provider workloads, and available capacity for children and youth at various clinic locations within the network.
- Evaluate the timeliness of access to specialists. Additionally, to more specifically determine network needs, Kaiser should evaluate the adequacy of its specialist provider network and the most common referral patterns of PCPs to specialists.
- Consider increasing telephonic or other technology-based communications with members to provide intermittent interventions, when needed, to decrease the need for formal appointments with providers.
- Evaluate scheduling mechanisms related to CHP+ timely access to appointment standards, perhaps including assessment and training of schedulers to assess the urgency of an appointment request, and provide schedulers with information to direct members to alternative sources of service, when appropriate. Kaiser should also consider further expanding use of walk-in clinics and services, and provide members and families with ongoing reminders of where to access after-hours or walk-in care.

For all measure rates that experienced a substantial decrease (more than 5 percentage points each) when compared to the previous measure year, the Department recommends that the health plan develop quality initiatives to improve member experience.

Kaiser: Summary Assessment of Quality, Timeliness, and Access for CAHPS

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

For Kaiser's CHP+ population, of the nine measures that impacted the quality domain, no measures showed a substantial increase in rates when compared to the previous measure year; however, six additional measure rates were slightly higher when compared to the previous measure year. Of the remaining three measures, one measure demonstrated a substantial decrease in rates, and two measures showed slight rate decreases when compared to the previous measure year. While results in the quality domain were mixed, Kaiser experienced a slightly upward trend overall.

For the *Getting Care Quickly* measure, which assessed the quality and timeliness domains, Kaiser's measure rate for the CHP+ population showed a slight decrease, indicating a potential downward trend.

For the *Getting Needed Care* measure, which assessed the quality and access to care domains, Kaiser's measure rate for the CHP+ population showed a slight increase, indicating a potential positive trend.

Rocky Mountain Health Plans

Monitoring for Compliance With Managed Care Regulations

Table 3-41 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 2016–2017.

Table 3-41—Summary of RMHP Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	34	34	33	1	0	0	97%
II—Access and Availability	14	14	14	0	0	0	100%
Totals	**48**	**48**	**47**	**1**	**0**	**0**	**98%**

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

Table 3-42 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 2016–2017.

Table 3-42—Summary of RMHP Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	58	56	2	42	97%
Totals	**100**	**58**	**56**	**2**	**42**	**97%**

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

Strengths

RMHP's policies and procedures described the processes and criteria used to ensure that services provided are medically necessary and appropriate, are cost-effective, and conform with the benefits of the plan. Policies described criteria used to make decisions of medical necessity, required that people with appropriate clinical expertise make decisions to deny services, and required that UM staff members participate in annual interrater reliability testing. The Preauthorization of Services policy and procedure provided staff with detailed instructions and time frames for processing both standard and expedited authorization requests and included the rules governing time frame extensions, the processes for providing notice to both the member and the requesting provider and for offering the requesting provider a peer-to-peer review. RMHP included in the member handbook, provider manual, and its Emergency Services policy and procedure definitions of "emergency medical conditions and services" consistent with both State and federal requirements. RMHP's member handbook also included an explanation of

"poststabilization services" using appropriate, easy-to-understand language. RMHP's provider manual and its internal policies and procedures were compliant with all State and federal requirements.

RMHP provided numerous documents that described its processes to maintain a network of providers adequate to meet the needs of its membership. RMHP demonstrated that it considers anticipated enrollment; expected utilization; numbers, types, and specialties of providers; physical access for members with disabilities; and the geographic location of providers in relation to members. RMHP informed members about appointment availability standards using the member handbook and newsletters and used its provider manual, provider newsletters, and website to notify providers of requirements related to hours of operation, scheduling guidelines, and standards for access to care. RMHP monitored providers' adherence to access and availability requirements through use of audits, surveys, and member grievances. In addition to mandatory, annual cultural competency training for all staff members, RMHP required that staff members who interact with members (e.g., care managers) participate in additional cultural competency training. RMHP's provider manual included a link to web-based training for which physicians may earn continuing education credit. RMHP, in collaboration with the Colorado Cross-Disability Coalition (CCDC), has provided disability competency care training for more than 200 providers and those providers' staff members.

Opportunities for Improvement and Recommendations

RMHP's policies and procedures described the process for notifying the requesting provider and member of any decision to deny payment; however, for one of the 10 denial records reviewed, RMHP failed to notify the member of the denied payment. RMHP was required to develop a process that ensures it provides members with written notice of any decision to deny payment.

Summary Assessment of Quality, Timeliness, and Access for Compliance Monitoring

RMHP demonstrated strong performance in the quality domain. Its policies and procedures described the processes and criteria used to ensure appropriate and consistent application of criteria by clinically qualified personnel.

When determining a health plan's performance in the timeliness domain, HSAG applied NCQA's definition, which states, "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation." RMHP demonstrated strong performance in the timeliness domain. RMHP's policies and procedures, provider manual, and member handbook accurately delineated the time frames for UM decisions and access to care. RMHP provided evidence that it monitored its network to ensure that providers comply with time access standards.

Using the CMS definition of "access," HSAG assessed RMHP performance based on how well RMHP demonstrated and reported on outcomes information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services). RMHP provided ample evidence that it monitored and maintained a network of providers adequate to meet the needs of its members. RMHP allowed members direct access to all in-network providers and specialists and had

procedures for allowing members access to out-of-network providers for instances when in-network services are not available.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the *2017 HEDIS Compliance Audit Report*, RMHP 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 did not identify any notable issues of negative impact on HEDIS reporting.

Pediatric Care Measure Results

Table 3-43 shows the HEDIS 2016 and HEDIS 2017 Pediatric Care measure results for RMHP and the percentile rankings for the HEDIS 2017 rates.

Table 3-43—Pediatric Care Measure Results for RMHP

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Childhood Immunization Status+			
Combination 2	BR	58.27%	<10th
Combination 3	BR	55.91%	<10th
Combination 4	BR	54.33%	10th–24th
Combination 5	BR	51.57%	10th–24th
Combination 6	BR	43.31%	50th–74th
Combination 7	BR	50.39%	25th–49th
Combination 8	BR	42.13%	50th–74th
Combination 9	BR	40.16%	50th–74th
Combination 10	BR	39.37%	50th–74th
Immunizations for Adolescents+			
Combination 1 (Meningococcal, Tdap)	BR	49.61%	<10th
Combination 2 (Meningococcal, Tdap, HPV)	—	11.33%	—
Well-Child Visits in the First 15 Months of Life+			
*Zero Visits**	BR	3.00%	25th–49th
Six or More Visits	BR	23.00%	<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	BR	63.66%	10th–24th

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Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Adolescent Well-Care Visits [+]			
Adolescent Well-Care Visits	BR	43.69%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents [+,1]			
BMI Percentile Documentation—Total	BR	4.44%	<10th
Counseling for Nutrition—Total	BR	19.04%	<10th
Counseling for Physical Activity—Total	BR	1.29%	<10th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	79.42%	78.26%	50th–74th

[+] Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.
BR (Biased Rate) indicates that RMHP's rate for this measure was not valid and, therefore, is not presented.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.

Strengths, Opportunities for Improvement, and Recommendations for Pediatric Care Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Childhood Immunization Status—Combinations 2–5*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *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*

As a result, HSAG recommends that RMHP analyze strategies that can be linked to improved documentation of well-child visits as well as improved immunizations, weight assessments, and nutrition and physical activity counseling for children and adolescents. HSAG recommends that RMHP conduct a thorough analysis of the root causes for poor performance with regard to pediatric care. RMHP is urged to uncover causal areas linked to low performance, identify the most significant areas or populations of focus for which improvement interventions could be planned, and identify strategies and interventions for better outcomes, beginning with the easiest areas for improvement (i.e., low effort/high yield). However, because the measures for areas of improvement for RMHP can be reported using the hybrid methodology, caution should be exercised when comparing the health plan's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology. For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the

health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Access to Care and Preventive Screening Measure Results

Table 3-44 shows the HEDIS 2016 and HEDIS 2017 Access to Care and Preventive Screening measure results for RMHP and the percentile rankings for the HEDIS 2017 rates.

Table 3-44—Access to Care and Preventive Screening Measure Results for RMHP

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	95.48%	91.26%	10th–24th
Ages 25 Months to 6 Years	86.26%	**82.13%^^**	10th–24th
Ages 7 to 11 Years	85.23%	86.72%	10th–24th
Ages 12 to 19 Years	89.01%	87.34%	25th–49th
Preventive Screening			
Chlamydia Screening in Women			
Total	30.84%	23.31%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.38%	0.00%	≥90th

** For this indicator, a lower rate indicates better performance.*
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 of <0.05.

Strengths for Access to Care and Preventive Screening Measures

The following rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *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*
- *Chlamydia Screening in Women—Total*

Additionally, RMHP's rate for *Chlamydia Screening in Women—Total* decreased by more than 5 percentage points from the prior year.

Recommendations for Access to Care and Preventive Screening Measures

HSAG recommends RMHP analyze strategies that can be linked to improved access to care for children and chlamydia screenings for women. The Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Mental/Behavioral Health Measure Results

Table 3-45 shows the HEDIS 2016 and HEDIS 2017 Mental/Behavioral Health measure results for RMHP and the percentile rankings for the HEDIS 2017 rates.

Table 3-45—Mental/Behavioral Health Measure Results for RMHP

Measures	HEDIS 2016 Rate	HEDIS 2017 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	35.29%	NA	—
Continuation and Maintenance Phase	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents			
Total	NA	NA	—

NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

Strengths, Opportunities for Improvement, and Recommendations for Mental/Behavioral Health Measures

The denominators for RMHP's mental/behavioral health-related measures for HEDIS 2017 were too small to report valid rates; therefore, HSAG is unable to comment upon strengths, opportunities for improvement, and recommendations.

Respiratory Conditions Measure Results

Table 3-46 shows the HEDIS 2016 and HEDIS 2017 Respiratory Conditions measure results for RMHP and the percentile rankings for the HEDIS 2017 rates.

Table 3-46—Respiratory Conditions Measure Results for RMHP

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
***Appropriate Treatment for Children With Upper Respiratory Infection*[1]**			
Appropriate Treatment for Children With Upper Respiratory Infection	93.30%	95.41%	75th–89th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	NA	NA	—
Medication Compliance 75%—Total	NA	NA	—
Asthma Medication Ratio			
Total	NA	NA	—

[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

Strengths, Opportunities for Improvement, and Recommendations for Respiratory Conditions Measures

Only one respiratory conditions related measure, *Appropriate Treatment for Children With Upper Respiratory Infection*, was reportable for RMHP for HEDIS 2017. The rate for this measure ranked at or above the national Medicaid 75th percentile, indicating strength in the area of care for children with an URI.

Use of Services Measure Results

Table 3-47 shows the HEDIS 2016 and HEDIS 2017 Use of Services measure results for RMHP and the percentile rankings for RMHP's HEDIS 2017 rates. Reported rates were not risk adjusted; therefore, rate changes observed between HEDIS 2016 and HEDIS 2017 may not necessarily be indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid MCO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 3-47—Use of Services Measure Results for RMHP

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)			
*Emergency Department Visits**	20.86	18.26	≥90th
Outpatient Visits	230.04	212.07	<10th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.01	0.73	<10th
Days per 1,000 Member Months (Total Inpatient)	3.65	2.21	<10th
Average Length of Stay (Total Inpatient)	3.63	3.01	<10th
Discharges per 1,000 Member Months (Medicine)	0.68	0.45	<10th
Days per 1,000 Member Months (Medicine)	2.31	1.16	<10th
Average Length of Stay (Medicine)	3.42	2.57	<10th
Discharges per 1,000 Member Months (Surgery)	0.27	0.27	<10th
Days per 1,000 Member Months (Surgery)	1.21	1.01	<10th
Average Length of Stay (Surgery)	4.42†	3.71	<10th
Discharges per 1,000 Member Months (Maternity)	0.13	0.02	<10th
Days per 1,000 Member Months (Maternity)	0.28	0.08	<10th
Average Length of Stay (Maternity)	2.20†	4.00†	≥90th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.67	0.40	≥90th
Average Days Supplied per Antibiotic Script	10.06	10.49	<10th
Average Scripts PMPY for Antibiotics of Concern	0.29	0.15	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	43.16%	38.64%	75th–89th

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files: differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile rankings should be interpreted with caution and may not accurately reflect high or low performance. Rates with this symbol may also indicate that fewer than 30 discharges were reported. Exercise caution when evaluating this rate.
** For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

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 of Quality, Timeliness, and Access for Validation of Performance Measures

RMHP's performance demonstrated strength with regard to quality of care as evidenced by the following measures:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

Conversely, RMHP's performance demonstrated opportunities for improvement with regard to quality of, timeliness of, and access to care and services based on the following measures:

- *Childhood Immunization Status—Combinations 2–5*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *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*
- *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*
- *Chlamydia Screening in Women—Total*

Many measures for areas of improvement for RMHP can be reported using the hybrid methodology; therefore, caution should be exercised when comparing the health plan's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Validation of Performance Improvement Projects

Findings

Table 3-48 displays the validation results for the RMHP PIP, RMHP's *CHP+ Members with Asthma Transitioning Out of Plan Coverage*, validated during FY 2016–2017. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-48 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with HSAG validating Activities I through IX.

Table 3-48—Performance Improvement Project Validation Results for RMHP

Stage	Activity		Percentage of Applicable Elements*		
			Met	***Partially Met***	***Not Met***
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (5/5)	0% (0/5)	0% (0/5)
Implementation Total			**88% (7/8)**	**13% (1/8)**	**0% (0/8)**
Outcomes	IX.	Real Improvement Achieved	67% (2/3)	0% (0/3)	33% (1/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**67% (2/3)**	**0% (0/3)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**90% (18/20)**	**5% (1/20)**	**5% (1/20)**

**Percentage totals may not equal 100 percent due to rounding.*

Overall, 90 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Not Met*.

Table 3-49 displays Remeasurement 1 data for PIP. RMHP's goal is to increase by 20 percent at the first remeasurement the percentage of CHP+ members with asthma who turn 19 years of age during the measurement year and who have at least one visit with a primary care provider (PCP). RMHP's goal for Remeasurement 2 is a 30 percent increase over the baseline.

Table 3-49—Performance Improvement Project Outcomes for RMHP

PIP 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 19 years of age during the measurement year who have at least one visit with a primary care provider.	51.7%	75%		*Not Assessed*

RMHP re-ran its baseline data, and the updated baseline rate was 51.7 percent for CHP+ members with asthma who turned 19 years of age during the measurement year and had at least one visit with a primary care provider. The first remeasurement goal was set as a 20 percent increase over baseline.

For Remeasurement 1, the rate increased to 75 percent. This was a non-statistically significant increase, as evidenced by the p value of 0.1393. The MCO exceeded its 20 percent goal of increasing the rate of CHP+ members with asthma who turned 19 years of age during the measurement year and had at least one visit with a primary care provider.

Strengths

RMHP designed a scientifically sound project supported by the use of key research principles. The sound study design allowed the MCO to progress to collecting data and implementing interventions. RMHP accurately reported and summarized the baseline and first remeasurement study indicator results and used appropriate quality improvement tools to identify and prioritize barriers. The interventions developed and implemented were logically linked to the barriers and have the potential to impact study indicator outcomes.

Barriers/Interventions

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

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

- Reaching members by telephone is difficult.
- A tracking mechanism to identify the effectiveness of outreach is lacking.
- The member needs a reminder regarding the importance of well visits.
- The member needs education about managing his or her own condition during and after transition from the CHP+ program.
- Communication with the member is not possible due to a language barrier.
- Staff members are unable to answer questions asked by a member's parent regarding coverage.

To address these barriers, RMHP implemented the following interventions:

- Attempt to reach a member three times over a one-to-two-week time period. If unable to speak directly with the member after three calls, leave voice mail.
- With the member survey, which is sent out a month prior to the member aging out of the program, include instructions on how to complete the survey. Include a self-addressed envelope requesting input on the educational information provided to the member.
- Mail to the parent or guardian of the member in the targeted population a letter is that includes educational material.
- Conduct telephone outreach to the parent or guardian of the member in the targeted population to discuss the transition out of the CHP+ program and the importance of the well-visit to the primary care provider.
- Provide the parent or guardian and the member with the customer service telephone number. This affords that any questions may be answered in the member's preferred language.

Recommendations

As the PIP progresses, HSAG recommends the following to RMHP:

- Base study indicator goals on the previous measurement period's performance, which will more likely result in projected statistically significant improvement.
- Revisit causal/barrier analysis and quality improvement processes at least annually to reevaluate barriers; and develop new, active interventions as needed.
- Continue to evaluate the effectiveness of each individual intervention, and report the results in the next annual submission.
- Make data-driven decisions when revising, continuing, or discontinuing interventions.
- Reference the *PIP Completion Instructions* to ensure that all documentation requirements for each completed activity of the PIP Summary Form are addressed.
- Seek technical assistance from HSAG as needed.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-50 shows the results achieved by RMHP for FY 2015–2016 and FY 2016–2017.

Table 3-50—Question Summary Rates and Global Proportions for RMHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	86.1%	88.2%
Getting Care Quickly	90.2%	92.5%
How Well Doctors Communicate	96.5%	97.3%
Customer Service	78.0%	86.2%+
Shared Decision Making	80.7%	76.2%+
Rating of Personal Doctor	70.1%	77.6%
Rating of Specialist Seen Most Often	78.8%	77.5%+
Rating of All Health Care	62.9%	66.6%
Rating of Health Plan	59.1%	60.6%

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.

Strengths

For RMHP's CHP+ population, two measure rates increased substantially:

- *Customer Service* (8.2 percentage points)
- *Rating of Personal Doctor* (7.5 percentage points)

Five measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*
- *Rating of Health Plan*

Opportunities for Improvement

For RMHP's CHP+ population, no measure rates decreased substantially.

Two measures showed slight rate decreases:

- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*

Recommendations

RMHP experienced no substantial decreases in rates. However, two measurement rates showed slight decreases. HSAG offers the following recommendation for RMHP to consider based on population needs and health plan resources.

In order to improve members' perceptions on the *Shared Decision Making* and *Rating of Specialist Seen Most Often* measures, RMHP should consider the following recommendations:

- Develop, adopt, or refine existing educational materials and decision aids that can be used by members' families and providers to initiate dialog and guide conversations regarding member concerns and conditions.
- Develop provider training and communications to remind providers that all members and family members should be involved in a given member's treatment planning and that member's consent to medical treatment.
- Evaluate the adequacy of its specialist provider network and the most common referral patterns of PCPs to specialists to ensure that members have an adequate choice of specialists.
- Enhance care manager follow-up protocols to increase frequency of contact with families (as prioritized by RMHP's stratification system) to determine individual member/family satisfaction with any specialists to whom the member is referred and ensure member/family understanding of the services provided or recommended.
- Enhance single-case provider agreement contracting activities to ensure that members have a choice of preferred specialists in or out of network. Additionally, to more specifically determine network needs, RMHP should evaluate the adequacy of its specialist provider network and the most common referral patterns of PCPs to specialists.
- Explore and implement alternative options for telehealth programs to enhance availability of specialist expertise in RMHP's rural and frontier regions of the Department.

RMHP: Summary Assessment of Quality, Timeliness, and Access for CAHPS

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

For RMHP's CHP+ population, of the nine measures that impacted the quality domain, two measures showed substantial increases in rates when compared to the previous measurement year, and five additional measure rates were slightly higher when compared to the previous measurement year. Of the remaining two measures, both measures showed slight rate decreases when compared to the previous

measurement year. RMHP's results for the quality domain were largely positive and trending upward overall.

For the *Getting Care Quickly* measure, which assessed the quality and timeliness domains, RMHP's measure rate for both the CHP+ population showed a slight increase, also indicating a positive trend.

For the *Getting Needed Care* measure, which assessed the quality and access to care domains, RMHP's measure rate for the CHP+ population showed a slight increase, indicating a positive trend.

4. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Monitoring for Compliance With Managed Care Regulations

Table 4-1—Statewide Results for CHP+ Managed Care MCO Standards

Description of Standards	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services (2017)	94%	91%	94%	94%	97%	94%
Standard II—Access and Availability (2017)	100%	79%	92%	93%	100%	93%
III—Coordination and Continuity of Care (2016)	92%	50%	100%	75%	100%	85%
IV—Member Rights and Protections (2016)	80%	80%	100%	60%	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%
VIII—Credentialing and Recredentialing (2016)	94%	77%	98%	100%	100%	94%
Standard IX—Subcontracts and Delegation (2015)	100%	60%	100%	100%	100%	92%
X—Quality Assessment and Performance Improvement (2016)	100%	73%	93%	67%	100%	88%

Table 4-2—Statewide Results for CHP+ Managed Care MCO Record Reviews

Record Reviews	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average
Appeals (2015)	75%	72%	67%	75%	96%	81%
Denials (2017)	100%	98%	0%	100%	97%	90%
Grievances (2015)	77%	NA*	100%	50%	97%	75%
Credentialing (2016)	100%	89%	100%	100%	100%	98%
Recredentialing (2016)	98%	97%	100%	100%	100%	99%

Statewide Conclusions and Recommendations for Compliance Monitoring

Colorado CHP+ health plan compliance with State and federal regulations continues to be strong, as evidenced by the statewide compliance score of 94 percent for Standard I—Coverage and Authorization of Services and 93 percent for Standard II—Access and Availability.

All health plans reviewed had written policies and procedures that delineated criteria used to make authorization decisions, required that qualified clinicians make decisions to deny services, and ensured that applicable staff members participate in interrater reliability testing at least annually. Staff members at all five health plans described processes to allow members with special healthcare needs direct access and/or standing referrals to specialists and females direct access to women's health specialists; however, only four of the five health plans delineated the processes in their policies and procedures.

Four of the five Colorado CHP+ health plans demonstrated robust cultural competency programs that required staff members to attend annual cultural competency training. Additionally, health plans hosted periodic trainings that focused on specific populations including aging; hearing impaired; refugee; and lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ). The health plans offered these additional trainings in person and online, and all trainings were open to staff members and providers.

While all Colorado health plans continue to demonstrate a strong understanding of federal and State regulations, HSAG noted a few areas for statewide improvement. Effective August 30, 2016, Colorado updated the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8. This update created a uniform definition of "medical necessity" to be used across all applicable Medical Assistance programs. HSAG encouraged all health plans to immediately update internal policies and procedures to reflect this combined definition.

HSAG noted that while most of the health plans' policies accurately describe time frames related to notifying members and providers about utilization management decisions, on-site record reviews showed that, in practice, several health plans struggled to meet these time frames.

Validation of Performance Measures

Statewide Results for Validation of Performance Measures

Given that the health plans varied in membership size, the statewide average rate for each measure was weighted based on the health plans' eligible populations. For the health plans with rates reported as *NA*, the numerators, denominators, and eligible populations were included in the calculations of the statewide rate. The health plan rates reported as *BR* were excluded from the statewide rate calculation.

Pediatric Care Measure Results

Table 4-3 shows the HEDIS 2016 and HEDIS 2017 statewide weighted average results for the Pediatric Care measures and the percentile rankings for the HEDIS 2017 rates.

Table 4-3—Statewide Review Audit Results for Pediatric Care Measures

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Childhood Immunization Status+			
Combination 2	58.04%	65.30%^	10th–24th
Combination 3	56.19%	63.61%^	10th–24th
Combination 4	52.70%	61.14%^	25th–49th
Combination 5	49.22%	57.33%^	25th–49th
Combination 6	35.49%	41.61%^	50th–74th
Combination 7	47.01%	55.57%^	25th–49th
Combination 8	33.71%	40.34%^	50th–74th
Combination 9	31.79%	38.50%^	50th–74th
Combination 10	30.65%	37.59%^	50th–74th
Immunizations for Adolescents+			
Combination 1 (Meningococcal, Tdap)	70.71%	67.55%	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	—	22.32%	—
Well-Child Visits in the First 15 Months of Life+			
*Zero Visits**	4.67%	3.04%	25th–49th
Six or More Visits	51.84%	48.01%	10th–24th
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	67.00%	66.60%	25th–49th
Adolescent Well-Care Visits+			
Adolescent Well-Care Visits	46.61%	48.26%^	25th–49th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[+,1]			
BMI Percentile Documentation—Total	65.31%	**16.67%^^**	<10th
Counseling for Nutrition—Total	64.85%	**18.14%^^**	<10th
Counseling for Physical Activity—Total	56.89%	**14.31%^^**	<10th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	80.78%	84.35%^	75th–89th

+ Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.
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 of <0.05.

Strengths for Pediatric Care Measures

The following statewide average rate ranked at or above the national Medicaid 75th percentile, indicating positive performance:

- *Appropriate Testing for Children With Pharyngitis*

Opportunities for Improvement for Pediatric Care Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Childhood Immunization Status—Combinations 2 and 3*
- *Well-Child Visits in the First 15 Months of Life—Six or More 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*

Additionally, rates for *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* each declined by 5 percentage points or more from the prior year.

Recommendations for Pediatric Care Measures

HSAG recommends that the CHP+ health plans analyze strategies that can be linked to improvements in documented well-child visits; documented immunizations for children; and documented weight assessments, nutrition counseling, and physical activity counseling for children and adolescents. However, because the *Childhood Immunization Status, Well-Child Visits in the First 15 Months of Life*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures can be reported using the hybrid methodology, caution should be used when comparing the statewide weighted averages to national benchmarks calculated using administrative and/or hybrid methodologies.

Access to Care and Preventive Screening Measure Results

Table 4-4 shows the HEDIS 2016 and HEDIS 2017 statewide weighted average results for the Access to Care and Preventive Screening measures and the percentile rankings for the HEDIS 2017 rates.

Table 4-4—Statewide Review Audit Results for Access to Care and Preventive Screening Measures

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Access to Care			
Prenatal and Postpartum Care[1]			
Timeliness of Prenatal Care	—[2]	57.08%	—
Postpartum Care	—[2]	42.50%	—
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	92.74%	**90.02%^^**	10th–24th
Ages 25 Months to 6 Years	85.21%	**82.88%^^**	10th–24th
Ages 7 to 11 Years	88.77%	88.99%	25th–49th
Ages 12 to 19 Years	89.90%	89.39%	50th–74th
Preventive Screening			
Chlamydia Screening in Women			
Total	36.62%	35.31%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.29%	0.17%	≥90th

[1] Rates for Prenatal and Postpartum Care were calculated using modified specifications; therefore, comparisons to national benchmarks were not performed.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
[2] Indicates that data were not available to support the calculation of the HEDIS 2016 SMCN rates according to the desired specifications. Therefore, HEDIS 2016 rates are not presented for this measure.
** For this measure, a lower rate may indicate more favorable performance.*
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 of <0.05.

Strengths for Access to Care and Preventive Screening Measures

The following statewide average rate ranked at or above the national Medicaid 75th percentile, indicating positive performance:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following statewide average rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*
- *Chlamydia Screening in Women—Total*

Recommendations for Access to Care and Preventive Screening Measures

HSAG recommends that the CHP+ health plans analyze strategies that can be linked to improved access to care for infants and children and increases in chlamydia screenings for women.

Mental/Behavioral Health Measure Results

Table 4-5 shows the HEDIS 2016 and HEDIS 2017 statewide weighted average results for the Mental/Behavioral Health measures and the percentile rankings for the HEDIS 2017 rates.

Table 4-5—Statewide Review Audit Results for Mental/Behavioral Health Measures

Measures	HEDIS 2016 Rate	HEDIS 2017 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	15.24%	13.02%	<10th
Continuation and Maintenance Phase	27.03%	20.00%	<10th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*,[1]			
Total	4.65%	3.37%	10th–24th

NA (Small Denominator) indicates that the health plan(s) followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).

Strengths, Opportunities for Improvement, and Recommendations for Mental/Behavioral Health Measures

All three of the statewide average reportable rates related to Mental/Behavioral Health rates fell below the national Medicaid 25th percentile, suggesting opportunities for improvement in this area for care for children on ADHD or antipsychotic medications.

Respiratory Conditions Measure Results

Table 4-6 shows the HEDIS 2016 and HEDIS 2017 statewide weighted average results for the Respiratory Conditions measures and the percentile rankings for the HEDIS 2017 rates.

Table 4-6—Statewide Review Audit Results for Respiratory Conditions Measures

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
***Appropriate Treatment for Children With Upper Respiratory Infection*[1]**			
Appropriate Treatment for Children With Upper Respiratory Infection	92.66%	**91.24%^^**	50th–74th
Medication Management for People With Asthma			
Medication Compliance 50%—Total[2]	49.64%	47.85%	10th–24th
Medication Compliance 75%—Total	21.79%	23.76%	10th–24th
Asthma Medication Ratio			
Total	74.59%	80.25%	≥90th

[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).
[2] Indicates that the rate was compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid MCO percentiles since benchmarks for this measure are not published in Quality Compass.
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 of <0.05.

Strengths for Respiratory Conditions Measures

The following statewide average rate ranked at or above the national Medicaid 75th percentile, indicating positive performance:

- *Asthma Medication Ratio—Total*

Additionally, this rate increased by more than 5 percentage points from the prior year, indicating improvement in this area.

Opportunities for Improvement for Respiratory Conditions Measures

The following statewide average rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Medication Management for People With Asthma—Medication Compliance 50%—Total and Medication Compliance 75%—Total*

Recommendations for Respiratory Conditions Measures

Although CHP+ health plans' performance demonstrated strength in the ratio of asthma-controlling medications prescribed, HSAG recommends that the CHP+ health plans analyze any potential strategies that could be linked to improvement in the percentage of members with asthma who remain on an asthma-controller medication during the treatment period.

Use of Services Measure Results

Table 4-7 shows the HEDIS 2016 and HEDIS 2017 statewide weighted average results for the Use of Services measures and the percentile rankings for the statewide weighted average HEDIS 2017 rates. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2016 and HEDIS 2017 may not denote actual improvement or decline in performance. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid MCO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 4-7—Statewide Review Audit Results for Use of Services Measures

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)			
*Emergency Department Visits**	23.80	20.84‡	≥90th
Outpatient Visits	227.93	205.26	<10th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	1.18	0.87	<10th
Days per 1,000 Member Months (Total Inpatient)	3.75	2.97	<10th
Average Length of Stay (Total Inpatient)	3.17	3.42	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.86	0.60	<10th
Days per 1,000 Member Months (Medicine)	2.31	1.69	<10th
Average Length of Stay (Medicine)	2.70	2.82	<10th
Discharges per 1,000 Member Months (Surgery)	0.27	0.24	<10th
Days per 1,000 Member Months (Surgery)	1.31	1.20	<10th
Average Length of Stay (Surgery)	4.81	4.97	10th–24th
Discharges per 1,000 Member Months (Maternity)	0.12	0.06	<10th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Days per 1,000 Member Months (Maternity)	0.29	0.16	<10th
Average Length of Stay (Maternity)	2.36	2.68†	50th–74th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.65	0.40	≥90th
Average Days Supplied per Antibiotic Script	10.55	11.06	<10th
Average Scripts PMPY for Antibiotics of Concern	0.25	0.13	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	39.06%	33.99%	≥90th

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the Interactive Data Submission System (IDSS) files: differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. Rates with this symbol may also indicate that fewer than 30 discharges were reported. Exercise caution when evaluating this rate.

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

‡ Kaiser acknowledged that the reported rate for this measure may not be valid; therefore, exercise caution when interpreting these results.

Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

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 statewide averages demonstrated strength with regard to quality of care as evidenced by the care for children with pharyngitis, absence of inappropriate screenings for cervical cancer for adolescent females, and ratio of asthma-controlling medications prescribed.

Conversely, findings related to documented weight assessments, nutrition counseling, and physical activity counseling for children and adolescents; documented immunizations for children; documented well-care for infants; access to care for children; screenings for chlamydia; care of children on ADHD or antipsychotic medications; and members with asthma who remain on an asthma-controller medication during the treatment period indicate areas for improved quality of, timeliness of, and access to care and services for the CHP+ health plans.

Validation of Performance Improvement Projects

Table 4-8—FY 2016–2017 PIP Validation Scores for the CHP+ MCOs

MCO	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*	95%	100%	*Met*
Colorado Choice	*Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider*	100%	100%	*Met*
DHMP	*Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*	100%	100%	*Met*
Kaiser	*Access and Transition to Behavioral Health Services*	71%	73%	*Partially Met*
RMHP	*CHP+ Members with Asthma Transitioning Out of Plan Coverage*	90%	91%	*Not Met*

Statewide Conclusions and Recommendations for Validation of PIPs

Of the five CHP+ MCOs that submitted a PIP for validation in FY 2016–2017, three MCOs each received a *Met* validation status, one MCO received a *Partially Met* validation status, and one MCO received a *Not Met* validation status. The validation status received by each PIP was driven by whether or not the PIP had progressed to the Outcomes stage and, if so, whether statistically significant improvement was demonstrated at the first remeasurement. Two of the three MCOs that each received a *Met* validation status (Colorado Choice and DHMP) were assessed through the PIP Implementation stage only and had not yet progressed to reporting Remeasurement 1 results for the Outcomes stage. Colorado Access was the only MCO that progressed to the Outcomes stage and received a *Met* validation status, having reported Remeasurement 1 study indicator results that demonstrated statistically significant improvement over the baseline results. The MCOs that received a *Partially Met* validation status (Kaiser) and a *Not Met* validation status (RMHP) had progressed to reporting Remeasurement 1 results. The Kaiser PIP demonstrated statistically significant improvement in one of two PIP study indicators, while the RMHP PIP did not demonstrate statistically significant improvement at the first remeasurement. Demonstrating statistically significant improvement over baseline is a critical evaluation element in HSAG's PIP validation process; therefore, the *Partially Met* or *Not Met* scores for this evaluation element determined the overall PIP validation status.

The PIPs will be assessed for demonstrating statistically significant improvement again during the next validation cycle. In addition, the Colorado Access PIP will be assessed for demonstrating sustained improvement during the next validation cycle. To move toward demonstrating and sustaining real improvement in the Transitions of Care PIP outcomes, the MCOs should address issues identified in

Activity VIII (Improvement Strategies) related to identification of barriers, employing active and appropriate interventions, and evaluating interventions for effectiveness. The health plans designed methodologically sound PIPs; however, most were not able to demonstrate real improvement in outcomes at the first remeasurement. The MCOs should review HSAG's feedback in the PIP validation tool and should revisit the PIP's causal/barrier analysis to determine whether or not additional barriers can be identified. After revisiting and updating the causal/barrier analyses, the health plans should prioritize the barriers and develop active interventions that are logically linked to high-priority barriers and which are likely to positively impact PIP outcomes.

As the PIPs progress, HSAG recommends that the MCOs:

- Incorporate interventions that directly address identified barriers, actively engage members and/or providers, and are likely to impact the PIP outcomes.
- Ensure that the PIP primarily incorporates interventions that actively engage members and/or providers and which are likely to impact the PIP outcomes.
- Explore resources for developing innovative interventions that have the potential to result in fundamental change and sustainable improvement. HSAG is available to provide resources that may assist in generating new ideas for interventions of greater impact.
- Evaluate the effectiveness of each implemented intervention. Obtaining evaluation results for each intervention will allow the MCO to make data-driven decisions about which interventions have the greatest impact on the study indicator and how best to direct resources to achieve optimal improvement.
- Use quality improvement science techniques such as the PDSA model to evaluate and refine its improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation if deemed successful.
- Conduct ongoing, intervention-specific evaluations of effectiveness and use evaluation results to make data-driven decisions about continuing, revising, or discontinuing interventions in order to achieve optimal improvement of the study indicator outcomes.

Consumer Assessment of Healthcare Providers and Systems Surveys

Statewide Results for CAHPS

The statewide averages presented in Table 4-9 are derived from the combined results of the five CHP+ plans. Table 4-9 shows the FY 2016–2017 plan-level and statewide average results for each CAHPS measure.

Table 4-9—Statewide Comparison of Question Summary Rates and Global Proportions

Measure	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	Statewide Average
Getting Needed Care	85.6%	87.9%	75.8%	88.0%	88.2%	85.7%
Getting Care Quickly	90.1%	93.7%	80.6%	92.0%	92.5%	90.2%
How Well Doctors Communicate	95.2%	96.5%	96.5%	96.7%	97.3%	95.9%
Customer Service	86.9%	76.9% +	81.4%	85.1%	86.2% +	85.7%
Shared Decision Making	83.5% +	81.8% +	74.8% +	80.4% +	76.2% +	81.1%
Rating of Personal Doctor	73.5%	66.4%	80.3%	72.9%	77.6%	74.4%
Rating of Specialist Seen Most Often	70.2% +	62.5% +	77.4% +	62.5% +	77.5% +	70.9%
Rating of All Health Care	67.2%	54.5%	67.8%	67.5%	66.6%	66.5%
Rating of Health Plan	61.4%	46.7%	67.4%	61.0%	60.6%	61.0%

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.

Statewide Conclusions and Recommendations for CAHPS

Member and family perceptions regarding quality of care and services increased either substantially or slightly in two or more health plans for each of the member satisfaction measures. *Rating of Personal Doctor, Rating of All Health Care,* and *Rating of Health Plan* increased in four of five health plans. Three of five plans' ratings improved in *Customer Service*, *Shared Decision Making*, *How Well Doctors Communicate,* and *Rating of Specialist Seen Most Often*. *Getting Care Quickly* and *Getting Needed Care,* indicators of timeliness, experienced slight increases in three health plans. One health plan experienced either substantial or slight increases in eight of the nine ratings. Statewide member satisfaction measures regarding quality and timeliness were trending upward.

Two of the five CHP+ health plans had no rates that were substantially lower than the statewide average. Two health plans had three or more rates substantially lower than the statewide rates, and one health plan had only one rate substantially lower than the statewide rate. For four measures, three health plans had rates lower than the statewide average—*Rating of Personal Doctor, Rating of Specialist Seen Most Often, Customer Service,* and *Shared Decision Making.* The Department may want to consider statewide initiatives or studies to further evaluate the key drivers that impact these rates.

5. Assessment of CHP+ Health Plan Follow-Up on Prior Recommendations

Colorado Access

Compliance With Managed Care Regulations

As a result of the FY 2015–2016 site review, Colorado Access was required to address one *Partially Met* element related to Coordination and Continuity of Care, one *Not Met* element for Member Rights and Protections, and three *Partially Met* elements for Credentialing and Recredentialing. Colorado Access submitted its proposed CAP to HSAG and the Department in April 2016. HSAG and the Department determined that, if implemented as written, Colorado Access would achieve full compliance with required actions. Colorado Access submitted evidence of having implemented corrective actions that addressed the elements related to Coordination and Continuity of Care and Member Rights and Protections in July 2016. Colorado Access submitted progress reports that demonstrated ongoing implementation of corrective actions related to the Credentialing and Recredentialing program in July and August 2016. HSAG and the Department determined in September 2016 that Colorado Access had fully implemented its CAP, having successfully addressed all required actions. Colorado Access had no required actions continued from FY 2015–2016.

Validation of Performance Measures

HSAG's FY 2015–2016 recommendations for Colorado Access related to improving documentation of immunizations for children, well-child visits, access to care for infants, screening for chlamydia for women, follow-up care for children prescribed ADHD medication, and care for members with asthma who remained on an asthma-controller medication during the treatment period. At the time that this report was written, Colorado Access had not provided information regarding quality initiatives addressing these performance areas. Measures regarding immunizations for children and management of people with asthma performed at higher percentile rankings; while the remaining measurement areas were identified as stable, or HSAG identified opportunities for improvement for the areas based on the HEDIS 2017 rates. As a result, HSAG recommends that Colorado Access continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these HEDIS rates in future years.

Validation of Performance Improvement Projects

Colorado Access received a *Met* score for 100 percent of applicable evaluation elements during the FY 2015–2016 validation cycle; therefore, no prior PIP recommendations for follow-up existed during the FY 2016–2017 validation cycle.

Consumer Assessment of Healthcare Providers and Systems

Between FY 2015–2016 and FY 2016–2017, Colorado Access demonstrated increases in rates for four measures. During FY 2016–2017, the rate for *Customer Service* increased by 5.4 percentage points. The remaining measures demonstrated slight rate increases. These increases may or may not indicate that Colorado Access developed improvement initiatives to positively impact member perceptions.

Colorado Choice

Compliance With Managed Care Regulations

As a result of the FY 2015–2016 site review, Colorado Choice was required to implement corrective actions for each of the four standards reviewed: Coordination and Continuity of Care, Member Rights and Protections, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement.

Colorado Choice submitted its proposed plan in June 2016. HSAG and the Department required that Colorado Choice make revisions. HSAG and the Department worked closely with Colorado Choice throughout the remainder of 2016 to monitor implementation of the Colorado Choice CAP. As of January 2017, Colorado Choice had completed two of the 20 required actions. HSAG and the Department's approval of an additional 14 required actions were pending Colorado Choice's governing board's approval of changes to policies and procedures and documentation of having trained staff members. Colorado Choice had two required actions that necessitated additional revision. HSAG and the Department determined that, during the FY 2016–2017 site review, HSAG would re-review two elements related to Standard X—Quality Assessment and Performance Improvement.

Validation of Performance Measures

For FY 2015–2016, HSAG recommended that Colorado Choice focus efforts on improving HEDIS rates for access to care for children and adolescents and care for children with a URI as well as on improving administrative documentation of services provided. At the time that this report was written, Colorado Choice had not provided information regarding quality initiatives addressing these performance areas. Similarly to the prior year, the same measurement areas were identified as opportunities for improvement based on the HEDIS 2017 rates. As a result, HSAG recommends that Colorado Choice continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these HEDIS rates in future years.

Validation of Performance Improvement Projects

Colorado Choice received a *Met* score for 100 percent of applicable evaluation elements during the FY 2015–2016 validation cycle; therefore, no prior PIP recommendations for follow-up existed during the FY 2016–2017 validation cycle.

Consumer Assessment of Healthcare Providers and Systems

Between FY 2015–2016 and FY 2016–2017, Colorado Choice demonstrated increases in rates for four measures. One measure, *Rating of Personal Doctor*, demonstrated a substantial rate increase of 8 percentage points. Colorado Choice demonstrated decreases in rates for four measures, and the rate decrease for two of the four measures was substantial (*Customer Service* and *Rating of Specialist Seen Most Often*). Colorado Choice reports encouraging members to register using the online patient portal, which should help members manage their health by consolidating member information such as medical history, medications taken, scheduled appointments, diagnosed illnesses and conditions as well as by providing a summary of medical visits. Colorado Choice reports having improved member communication and informing members of the importance of selecting a PCP to help improve the quality of care obtained. Even though Colorado Choice continued these quality improvement initiatives, the recent CAHPS scores indicate that Colorado Choice needs to continue to develop quality initiatives to prioritize and target specific measures.

Denver Health Medical Plan, Inc.

Compliance With Managed Care Regulations

As a result of the FY 2015–2016 site review, DHMP was required to address two *Partially Met* items (one related to credentialing and one related to annual review of clinical practice guidelines). DHMP submitted its proposed CAP in May 2016. HSAG and the Department met with DHMP in order to clarify requirements and provide technical assistance. DHMP submitted documents that demonstrated compliance with the proposed plan in August 2016. HSAG and the Department required one additional follow-up submission in January 2017, before determining that DHMP had adequately addressed all required actions. DHMP had no required actions continued from FY 2015–2016.

Validation of Performance Measures

HSAG's FY 2015–2016 recommendations for DHMP related to improving well-child visits, documented BMIs for children and adolescents, and access to care for children and adolescents. At the time that this report was written, DHMP had not provided information regarding quality initiatives addressing these performance areas. DHMP's FY 2016–2017 rates for documented well-child visits and access to care for children and adolescents remained consistent with the prior year. Additionally, DHMP's documentation of BMI for children and adolescents showed a decrease. However, the hybrid

data collection methodology was used to report rates for this measure for the prior year, so caution should be used when comparing FY 2015–2016 rates to FY 2016–2017 rates. As a result, HSAG recommends that DHMP continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these HEDIS rates in future years.

Validation of Performance Improvement Projects

For the FY 2015–2016 PIP validation cycle, DHMP received a *Not Met* score for one evaluation element in Activity VII (Analyze Data and Interpret Study Results) of the PIP validation tool. The health plan did not address in the PIP documentation whether or not any factors threatened the validity of the baseline data reported. For the *Not Met* score, HSAG provided feedback recommending that the health plan include documentation in the Activity VII narrative description of study indicator results addressing whether or not any factors were identified that may have impacted the validity of the study indicator results. If no factors are identified, the health plan is advised to include a statement specifying this fact. For the FY 2016–2017 PIP validation cycle, the health plan included the required documentation and received a *Met* score for this evaluation element in Activity VII.

Consumer Assessment of Healthcare Providers and Systems

During 2016, DHMP expanded access by opening a new primary and urgent care clinic and extending office hours at three clinic locations. DHMP also expanded capacity by contracting with Walgreens Healthcare Clinic and King Soopers' Little Clinic and allowing CHP+ members to access these clinics for urgent care appointments. As a result, between FY 2015–2016 and FY 2016–2017, DHMP demonstrated rate increases for eight of the nine measures and four of these increases were substantial: *Getting Needed Care* (10.0 percentage points), *Rating of Specialist Seen Most Often* (19.1 percentage points), *Rating of All Health Care* (6.1 percentage points), and *Rating of Health Plan* (5.0 percentage points). In addition, only one measure, *Customer Service*, showed a slight decrease in rate.

Kaiser Permanente Colorado

Compliance With Managed Care Regulations

As a result of the FY 2015–2016 site review, Kaiser was required to address two *Partially Met* elements and one *Not Met* element in Standard III—Coordination and Continuity of Care, one *Partially Met* element and one *Not Met* element in Standard IV—Member Rights and Protections, and five *Partially Met* elements in Standard X—Quality Assessment and Performance Improvement. Kaiser submitted its proposed CAP in June 2016. Kaiser submitted documents to demonstrate completion of the plan in July, September, November, and December 2016. As of February 2017, Kaiser had completed eight of the 10 required actions. As of March 2017, Kaiser had two outstanding FY 2015–2016 corrective actions. Kaiser must implement procedures to ensure that all CHP+ members and/or authorized family members are involved in the member's treatment planning and consent to the member's medical treatment. Kaiser

must also ensure that all documents that reference or describe member rights are revised to be inclusive of all members. HSAG and the Department will continue working with Kaiser until all required actions are adequately addressed.

Validation of Performance Measures

For FY 2015–2016, HSAG recommended that Kaiser evaluate declines in documented childhood immunizations, well-child visits, access to care for children and adolescents, and chlamydia screenings for women. At the time that this report was written, Kaiser had not provided information regarding quality initiatives addressing these performance areas. FY 2016–2017 rates for immunizations for children increased by 5 percentage points or more from the prior year for all indicators, suggesting performance improvement. Kaiser's rates for well-child visits demonstrated improvement, access to care for children and adolescents remained consistent with the prior year, and chlamydia screenings in women remained decreased from the prior year compared to the national benchmarks. As a result, HSAG recommends that Kaiser continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these HEDIS rates in future years.

Validation of Performance Improvement Projects

For the FY 2015–2016 PIP validation cycle, Kaiser received a *Partially Met* score for four evaluation elements across three PIP activities and HSAG provided recommendations for the health plan to address each *Partially Met* score. In FY 2016–2017, Kaiser addressed and incorporated the recommendations for three of the four evaluation elements that received *Partially Met* scores in FY 2015–2016.

In Activity III (Define the Study Population), Kaiser addressed HSAG's recommendations and appropriately updated the eligible population definition to include the anchor date, receiving a *Met* score for the evaluation element in Activity III. Kaiser had received a *Partially Met* score for the activity's one evaluation element during the FY 2015–2016 PIP validation cycle because the health plan did not address HSAG's recommendation from the previous year's validation tool to include the anchor date of the measurement year as part of the age criteria for inclusion in the eligible population for the PIP.

In Activity IV (Select the Study Indicators), Kaiser addressed HSAG's recommendations and corrected the denominator definition for the PIP study indicator, receiving *Met* scores for both evaluation elements in Activity IV during the FY 2016–2017 validation cycle. Kaiser had received a *Partially Met* score for one Activity IV evaluation element during the FY 2015–2016 PIP validation cycle because the health plan did not address HSAG's recommendation from the previous year's validation tool to correct the denominator definition for the PIP study indicator so that it clearly reflected that members included in the denominator had screened positive for depression with a primary care provider.

In Activity VIII (Improvement Strategies), Kaiser addressed HSAG's recommendations in FY 2016–2017 for one of the two evaluation elements that had received *Partially Met* scores during the FY 2015–2016 PIP validation cycle. Kaiser addressed HSAG's recommendations related to documentation of the causal/barrier analysis process, providing additional information on the quality improvement processes

used to identify barriers, and received a *Met* score for this evaluation element in FY 2016–2017. Kaiser did not address HSAG's recommendations related to documentation of the process used to prioritize identified barriers; therefore, the score for this evaluation element remained *Partially Met* in FY 2016–2017. In future PIP submissions, the MCO should include documentation of the process used to select high-priority barriers to be addressed by interventions. With limited resources, the MCO should use a process for prioritizing barriers and direct intervention efforts at addressing high-priority barriers. The process used for prioritizing could be based on data analysis, a failure modes and effects analysis, or assignment of risk priority numbers. The PIP documentation should clearly describe the process used.

Consumer Assessment of Healthcare Providers and Systems

Between FY 2015–2016 and FY 2016–2017, Kaiser demonstrated a substantial rate decrease for one measure, *Shared Decision Making*. In addition, two measures, *Getting Care Quickly* and *How Well Doctors Communicate*, showed slight decreases in rates. Six measures demonstrated rate increases; however, these increases were not substantial. 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 2015–2016 recommendations.

Rocky Mountain Health Plans

Compliance With Managed Care Regulations

Based on the FY 2015–2016 site review, RMHP was required to revised its policies to allow members to receive family planning services from any duly licensed provider, in or out of RMHP's network. This was the only required action for the review. RMHP submitted documents to demonstrate that it updated its policies to allow female members to obtain family planning services from any duly licensed provider, in or out of RMHP's network. HSAG and the Department reviewed the revised documents and determined that RMHP had completed the required corrective action. RMHP had no required actions continued from FY 2015–2016.

Validation of Performance Measures

HSAG's recommendations for RMHP for FY 2015–2016 included improving: access to care for children ages 7 to 11, chlamydia screenings in women, and services related to mental/behavioral health. At the time that this report was written, RMHP had not provided information regarding quality initiatives addressing these performance areas. RMHP's access to care for children ages 7 to 11 for FY 2016–2017 increased in percentile ranking from the previous year, whereas chlamydia screenings for women decreased by 5 percentage points or more from the prior year. Additionally, the denominator for the services related to the mental/behavioral health domain was too small to report valid rates. As a result, HSAG recommends that RMHP continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these HEDIS rates in future years.

Validation of Performance Improvement Projects

For the FY 2015–2016 PIP validation cycle, RMHP received a *Partially Met* score for three evaluation elements in Activity VIII (Improvement Strategies) and HSAG provided recommendations for the health plan to address each *Partially Met* score. In FY 2016–2017, RMHP addressed and incorporated the recommendations for all three evaluation elements that received *Partially Met* scores in FY 2015–2016. RMHP addressed HSAG's recommendations for the three evaluation elements by incorporating the following activities in FY 2016–2017: documenting the process used to prioritize barriers for targeting intervention efforts, providing research and evaluation data to support the interventions being conducted, and initiating interventions early enough in the measurement period to allow for an impact on study indicator results.

Consumer Assessment of Healthcare Providers and Systems

Between FY 2015–2016 and FY 2016–2017, RMHP demonstrated no substantial decreases in rates. However, two measures, *Shared Decision Making* and *Rating of Specialist Seen Most Often*, showed slight decreases in rates. Two measure rates increased substantially: *Customer Service* (8.2 percentage points) and *Rating of Personal Doctor* (7.5 percentage points). RMHP reports that its 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 2016–2017.