CHP+

Child Health Plan *Plus*

2017–2018 External Quality Review Technical Report for Child Health Plan *Plus*

November 2018

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of 2017–2018 Statewide Performance by External Quality Review Activity With Trends

Assessment of Compliance With CHIP Managed Care Regulations

In fiscal year (FY) 2017–2018, Health Services Advisory Group, Inc. (HSAG) reviewed four standards as directed by Colorado's Department of Health Care Policy and Financing (the Department) (see Section 2—Methodology). Revisions to federal Medicaid managed care regulations published May 6, 2016, were not applicable to the Children's Health Insurance Program (CHIP) managed care organizations (MCOs) until July 1, 2018; therefore, HSAG scored all regulations under review in FY 2017–2018 which were new or had revised language as *Not Applicable*. To assist the Child Health Plan *Plus* (CHP+) MCOs with changes designed to allow those MCOs to comply once regulations become effective for the CHP+ program, HSAG identified opportunities for improvement and associated recommendations based on the revised regulations in each health plan's individual site review report t. Scores, opportunities for improvement, and required actions presented in this report are based on regulations in effect for the CHP+ MCOs at the time of the 2017–2018 compliance site reviews.

For any elements scored other than *Not Applicable* in FY 2017–2018, Colorado's CHP+ health plans experienced the highest performance in Standard V—Member Information, with all five health plans demonstrating compliance with providing members information about requirements and benefits of the plan; how to use the health plan; member rights; availability of alternative formats, oral translation, and interpretation services; and how to exercise advance directives. Colorado's health plans also demonstrated strong performance in Standard VII—Provider Participation and Program Integrity. All five health plans had compliance programs that included robust mechanisms to detect and report fraud, waste, and abuse.

All elements related to subcontracts and delegation included revisions not yet applicable to CHP+ health plans; therefore, HSAG scored all requirements in Standard IX—Subcontracts and Delegation as *Not Applicable*.

Table 1-1 displays the statewide average compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 1-1—Compliance Monitoring Statewide Trended Performance for CHP+ MCOs

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	84%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	85%	93%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	82%	85%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	68%	80%
Standard V—Member Information (2014–2015, 2017–2018)**	**72%**	**95%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)**	**65%**	**84%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)**	**90%**	**90%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	86%	94%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)**	**92%**	**NA**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	76%	88%

*The 2017–2018 scores reflect overall compliance without scoring of any regulations that were new based on the May 2016 release of revised regulations or that contained revisions of the prevision rules; therefore, overall compliance scores may not be comparable to scores earned in the previous or future review cycles. In addition, for all standards, the health plans' contracts with the State may have changed since each of the previous review years and may have contributed to performance changes.
**Bold text indicates standards that HSAG reviewed during FY 2017–2018.

Colorado's CHP+ health plans demonstrated improved performance in the most recent year of review for eight of ten standards as compared to the previous year the standard was reviewed. In one standard (Standard VII—Provider Participation and Program Integrity), the statewide average remained stable at 90 percent across review cycles. Each requirement within the subcontracts and delegation standard had either new or revised elements of the requirement that were not yet applicable to the CHP+ health plans; therefore, HSAG scored the standard as *Not Applicable*.

For individual health plan scores and findings, see Section 3 of this report. For the health plan comparison of scores for 2017–2018 standards, see Section 4, Table 4-1.

Validation of Performance Measures

IS Standards Review

HSAG evaluated the health plans' information system (IS) capabilities for accurate HEDIS reporting. For the current reporting period, Colorado Access, Friday Health Plans of Colorado (FHP), Kaiser Permanente (Kaiser), and Rocky Mountain Health Plans (RMHP) were fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the health plans' licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no notable issues with negative impact on HEDIS reporting. Denver Health Medical Plan (DHMP) was fully compliant with four of the IS standards and partially compliant with two of the IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. DHMP's HEDIS auditor found that the health plan was partially compliant with IS standards 1 and 7, which impacted the *Childhood Immunization Status* measure. These concerns materially impacted DHMP's ability to report performance measure data for this measure. For the remaining health plans, HSAG determined that the data collection and reporting for the Department-selected measures followed NCQA HEDIS methodology; and the rates and audit results are valid, reliable, and accurate.

Performance Measure Results

Table 1-2 and Table 1-3 display the CHP+ statewide weighted averages for HEDIS 2016 through HEDIS 2018 along with the percentile ranking for each HEDIS 2018 rate for the high and low performing measure rates. Statewide performance measure results for HEDIS 2018 were compared to Quality Compass national Medicaid percentiles for HEDIS 2017, when available. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicator were compared to NCQA's Audit Means and Percentiles national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2017 since this indicator is not published in Quality Compass. Additionally, rates for HEDIS 2018 shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates for HEDIS 2018 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.[1-1] Additional CHP+ statewide weighted average measure rates can be found in Section 4.

[1-1] Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05. Therefore, results reporting the percentages of measures that changed significantly from HEDIS 2017 rates may be understated or overstated.

Table 1-2—Colorado CHP+ Statewide Weighted Averages—HEDIS 2018 High Performers

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	80.78%	84.35%	87.36%^	75th–89th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.29%	0.17%	0.07%	≥90th
Mental/Behavioral Health				
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	39.85%	75th–89th
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection[1]				
Appropriate Treatment for Children With Upper Respiratory Infection	92.66%	91.24%	93.84%	75th–89th
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	55.13%	49.43%	61.29%^	75th–89th
Asthma Medication Ratio				
Ages 5 to 11 Years	80.12%	85.80%	82.90%	75th–89th
Ages 12 to 18 Years	67.88%	73.72%	74.03%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 rates to prior years.
— Indicates that the measure was not required in previous technical reports.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

For the high performing measure within the Pediatric Care domain, all health plans with a reportable rate performed above the national Medicaid 50th percentile. Of note, Colorado Access and Kaiser exceeded the national Medicaid 90th percentile, demonstrating strength ensuring that providers are not overusing inappropriate treatments for members with pharyngitis.

The health plans all performed, within the Preventive Screening domain, above the national Medicaid 90th percentile for *Non-Recommended Cervical Cancer Screening in Adolescents*, indicating strength by not screening young women for cervical cancer unnecessarily.

Within the Mental/Behavioral Health domain, Colorado Access was the only health plan with a reportable rate for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total* measure indicator. Though statewide performance was above the 75th percentile, Colorado Access' rate fell below the national Medicaid 50th percentile, indicating that the health plan should work to ensure that members prescribed antipsychotics receive appropriate monitoring of blood sugar and cholesterol levels to identify potentially harmful side effects.

For the Respiratory Conditions high performing measures, most reportable rates ranked above the national Medicaid 50th percentile. For the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, FHP was the only health plan to fall below the national Medicaid 50th percentile, indicating that FHP should implement strategies to ensure that providers do not unnecessarily prescribe antibiotics for emergency department (ED) and outpatient visits related to acute respiratory infections.

Table 1-3—Colorado CHP+ Statewide Weighted Averages—HEDIS 2018 Low Performers

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	58.04%	65.30%	62.54%	10th–24th
Combination 3	56.19%	63.61%	61.05%	10th–24th
Combination 4	52.70%	61.14%	59.17%	10th–24th
Combination 5	49.22%	57.33%	53.79%	10th–24th
Well-Child Visits in the First 15 Months of Life[1]				
Six or More Visits	51.84%	48.01%	51.41%	10th–24th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.00%	66.60%	64.97%	10th–24th
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	46.61%	48.26%	**45.09%^^**	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	65.31%	16.67%	19.89%^	<10th
Counseling for Nutrition—Total	64.85%	18.14%	20.12%	<10th
Counseling for Physical Activity—Total	56.89%	14.31%	15.87%	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	92.74%	90.02%	90.65%	<10th
Ages 25 Months to 6 Years	85.21%	82.88%	80.91%	10th–24th
Ages 7 to 11 Years	88.77%	88.99%	87.49%	10th–24th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	36.62%	35.31%	33.66%	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Mental/Behavioral Health				
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	15.24%	13.02%	21.84%^	<10th
Continuation and Maintenance Phase	27.03%	20.00%	21.57%	<10th
***Use of Multiple Concurrent Antipsychotics in Children and Adolescents**[,2]*				
Total	4.65%	3.37%	5.62%	<10th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017.
[2] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 rates to prior years.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

The health plans demonstrated low performance for most measure rates within the Pediatric Care domain for HEDIS 2018, indicating that improvement efforts should be focused on ensuring that children and adolescents receive necessary well-care visits and documenting these services within administrative data sources. Of note, rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure demonstrated performance below the national Medicaid 10th percentile for all health plans except Kaiser, demonstrating that documentation of these services within administrative data sources should be improved.

For the *Children and Adolescents' Access to Primary Care Practitioners* measure indicators determined to be low performers within the Access to Care domain, all health plan rates for these three indicators fell below the national Medicaid 50th percentile, demonstrating an area of concern regarding access to care for young members. The lack of access to services may also have an impact on the quality of care received by members, as evidenced by poor performance on several measures related to preventive care and screenings.

Within the Preventive Screening domain, the *Chlamydia Screening in Women—Ages 16 to 20 Years* measure rates for all health plans fell below the national Medicaid 25th percentile, indicating that efforts should be increased to provide appropriate screenings to adolescent females.

For the measures identified as low performers within the Mental/Behavioral Health domain, only Colorado Access and RMHP had reportable rates. RMHP performed above the national Medicaid 50th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator. Conversely, Colorado Access performed below the national Medicaid 10th percentile for both the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* measures, demonstrating that the health plan should focus on ensuring appropriate monitoring for child members on medications for behavioral health conditions.

Validation of Performance Improvement Projects

Table 1-4 summarizes trends in PIP performance among the CHP+ MCOs from FY 2015–2016 to FY 2017–2018. Each CHP+ MCO conducted a PIP focusing on a topic related to transitions of care during this three-year period. During the first year listed, FY 2015–2016, no CHP+ MCOs had progressed to reporting study indicator remeasurement results; therefore, the PIP validation status was based on performance in the Design and Implementation stages of the PIP. For the FY 2016–2017 and FY 2017–2018 validation cycles, four of the five CHP+ MCOs progressed to reporting remeasurement results and were evaluated for demonstrating improvement in the Outcomes stage. One MCO, FHP, did not progress to the Outcomes stage during the three-year period and therefore was not evaluated for demonstrating statistically significant improvement in study indicator outcomes. In the Outcomes stage, HSAG evaluated the PIPs on demonstrating statistically significant improvement from baseline to the most recent remeasurement period. Demonstrating statistically significant improvement is evaluated as a critical evaluation element in HSAG's PIP validation tool; therefore, once a PIP progresses to the Outcomes stage, the PIP must demonstrate statistically significant improvement over baseline across all study indicators to receive an overall *Met* validation status.

Table 1-4—Performance Improvement Project Results for CHP+ MCOs

MCO	PIP Topic	FY 2015–2016 Validation Status	FY 2016–2017 Validation Status	FY 2017–2018 Validation Status	Number of Study Indicators Demonstrating Statistically Significant Improvement
Colorado Access	*Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan*	*Met*	*Met*	*Met*	1 of 1
DHMP	*Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*	*Met*	*Met*	*Not Met*	0 of 1
FHP	*Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider*	*Met*	*Met*	*Met*	*Not Assessed*
Kaiser	*Access and Transition to Behavioral Health Services*	*Partially Met*	*Partially Met*	*Partially Met*	1 of 2
RMHP	*CHP+ Members With Asthma Transitioning Out of Plan Coverage*	*Partially Met*	*Not Met*	*Not Met*	0 of 1

Over the three-year period, two MCOs, Colorado Access and FHP, each received an overall *Met* validation status for each of the three validation cycles. As noted above, however, FHP did not progress to the Outcomes stage of the PIP during the three-year period; and FHP's PIP was not evaluated on

demonstrating statistically significant improvement in study indicator outcomes. Colorado Access reported statistically significant improvement over baseline for the *Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan* PIP's study indicator at two remeasurement periods. One other MCO, Kaiser, reported statistically significant improvement over baseline at each remeasurement period for one study indicator but did not report significant improvement for the second indicator in the *Access and Transition to Behavioral Health Services* PIP. The remaining two MCOs, DHMP and RMHP, reported improvement in study indicator outcomes; however, the improvement was not statistically significant. A detailed discussion of validation and study indicator results for each PIP is provided in Section 3—Evaluation of Colorado's CHP+ Health Plans.

Consumer Assessment of Healthcare Providers and Systems

Table 1-5 shows the statewide average results for each CAHPS measure for FY 2015–2016 through FY 2017–2018. The statewide averages presented in Table 1-5 are derived from the combined results of the five CHP+ health plans.

Table 1-5—Question Summary Rates and Global Proportions for Statewide Average

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	85.7%	85.7%	85.5%
Getting Care Quickly	90.8%	90.2%	91.2%
How Well Doctors Communicate	96.9%	95.9%	95.8%
Customer Service	81.7%	85.7%	84.1%
Shared Decision Making	80.8%	81.1%	78.5%
Rating of Personal Doctor	73.6%	74.4%	75.7%
Rating of Specialist Seen Most Often	68.1%	70.9%	78.7%
Rating of All Health Care	67.3%	66.5%	68.1%
Rating of Health Plan	59.2%	61.0%	61.4%

Over the three-year period, the following three measures showed an upward rate trend: *Rating of Personal Doctor, Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. Conversely, the *How Well Doctors Communicate* measure showed a slight downward rate trend. The rates for the remaining measures fluctuated, either increasing or decreasing slightly over the periods.

Statewide Conclusions and Recommendations

Based on the results of the four EQR activities performed during FY 2017–2018, HSAG made the following observations about how these activities provided assessment related to the quality, timeliness of, and access to care and services:

- The compliance activities reviewed in FY 2017–2018 were evenly distributed where it concerned the standards including requirements related to the quality, timeliness of, and access to care domains. Statewide strengths were primarily related to the quality and access to care domains, while the standard that demonstrated the most opportunity for improvement (the grievance and appeal standard) was most directly related to the timeliness and access to care domains.
- All HEDIS 2018 measure rates except one (*Access to Care—Children's and Adolescents' Access to Primary Care Practitioners*) related to the quality domain. In addition, two measures (*Prenatal and Postpartum Care* and *Follow-Up Care for Children Prescribed ADHD Medication*) related to the timeliness domain and three measures (*Prenatal and Postpartum Care, Access to Care—Children's and Adolescents' Access to Primary Care Practitioners*, and *Follow-Up Care for Children Prescribed ADHD Medication*) also related to Access to Care.
- Performance improvement validation activities are designed to evaluate the quality of the health plans' processes for performance improvement. Colorado's CHP+ health plans each chose a topic related to transitions of care. Although each health plan's specific transition topic was different, each also related to the timeliness of and access to care and services. Statewide recommendations made based on PIP validation results were related to the design of future projects and transitioning to the rapid-cycle PIP approach and were, therefore, related to the quality domain.
- The CAHPS survey is designed primarily to measure perceived quality of care, with one measure also relating to timeliness of care and another also relating to access to care. There were no clear patterns noted based on CAHPS results statewide. For example, the measure rates that showed improvement in three or more health plans related only to the quality domain. In addition, measures that showed substantial decreases also related only to the quality domain. Conversely, the three measures that showed increases with only two plans as well as the measures that showed slight statewide declines in performance related to the timeliness and access domains as well as quality of care.

Following are statewide external quality review (EQR) activity specific conclusions and recommendations where applicable.

Assessment of Compliance With CHIP Managed Care Regulations

For the four standards reviewed for compliance monitoring in FY 2017–2018, CHP+ health plans' statewide performance was high, with standard scores ranging from 80 to 90 percent. HSAG cautions, however, that revised federal regulations applicable to the CHP+ program and effective July 1, 2018, were reviewed but not scored in the FY 2017–2018 review. Variations in scoring methodologies in previous and future compliance monitoring reviews may impact the comparability of statewide averages

from year to year. Both the Member Information and the Grievance and Appeal System standards included significant revisions to federal regulations, resulting in approximately 50 percent of the elements being scored *Not Applicable* for Member Information and approximately 33 percent of elements being scored *Not Applicable* for the Grievance and Appeal System standard in FY 2017–2018. All requirements in the Subcontracts and Delegation standard had been revised with the 2016 release of managed care regulations and were scored *Not Applicable* as well. Nevertheless, for requirements reviewed in FY 2017–2018 and scored anything other than *Not Applicable*, CHP+ health plans collectively demonstrated the following state-wide performance:

- The statewide average scores in two standards reviewed in FY 2017–2018 (Standard V—Member Information and Standard VII—Provider Participation and Program Integrity) demonstrated compliance scores at or above 90 percent. The Standard VI—Grievance and Appeal System statewide average score was 84 percent, demonstrating more significant opportunities for improvement in this content area. The fourth standard reviewed in FY 2017–2018 (Standard IX—Subcontracts and Delegation) was scored *Not Applicable* for each requirement due to revisions to the federal managed care regulations not yet applicable to the CHP+ program in FY 2017–2018.
- As compared to the previous compliance review that assessed the same four standards reviewed in 2017–2018, the CHP+ health plans either maintained high performance (Standard VII—Provider Participation and Program Integrity) or improved performance substantially (Standard V—Member Information with a 23-percentage-point improvement and Standard VI—Grievance and Appeal System with a 19-percentage-point improvement).

Based on the described performance, HSAG recommends that CHP+ health plans continue to incorporate and implement processes to comply with federal managed care regulations, paying particular attention to the Grievance and Appeal System and any changes articulated in the May 2016 release of revised managed care regulations (effective for CHP+ health plans as of July 1, 2018).

Validation of Performance Measures

Based on performance measure results at the statewide level, strengths were related to appropriately testing and treating members with pharyngitis in ED and outpatient visits and avoiding unnecessary screenings for cervical cancer in young women. Additionally, members with asthma and members receiving antipsychotic medications received appropriate medication management for their conditions. With statewide performance in several areas falling below the national Medicaid 25th percentile, improvement efforts need to be focused on increasing access to care for members. Once members have access to essential services with primary care practitioners, obstetricians, and gynecologists, providers can ensure that appropriate care (including childhood vaccinations, screenings for chlamydia in young women, follow-up care for young children on ADHD medications, and required well-care visits for young children and adolescents) is being provided to keep members healthy.

Performance Improvement Projects

During the three-year period from FY 2015–2016 to FY 2017–2018, four of the five CHP+ health plans progressed to the PIP Outcomes stage and reported study indicator remeasurement results. In the Outcomes stage, HSAG evaluates whether a PIP has demonstrated real improvement in outcomes by achieving statistically significant improvement in study indicator results. Among those PIPs that progressed to the Outcomes stage, the PIPs conducted by two CHP+ health plans demonstrated statistically significant improvement in study indicator outcomes. One MCO reported statistically significant improvement over baseline in one study indicator and one reported statistically significant improvement over baseline in two of three study indicators. The PIPs conducted by the remaining CHP+ health plans did not demonstrate statistically significant improvement in study indicator outcomes during the three-year period. Following the FY 2017–2018 PIP validation cycle, the Department instructed the CHP+ health plans to close out the current PIPs in preparation for the initiation of new PIP topics. As part of the PIP close-out process, HSAG recommended that the CHP+ health plans synthesize knowledge gained and lessons learned through the duration of the PIPs and identify opportunities for applying PIP results in ongoing improvement efforts. For example, the plans should consider how remaining barriers can be addressed, how successful improvement strategies can be spread, and how any improvement achieved through the PIP can be sustained for the long-term.

Consumer Assessment of Healthcare Providers and Systems

Measure rates related to member and family perceptions regarding quality of care and services increased either substantially or slightly between FY 2016–2017 and FY 2017–2018 for two or more health plans related to each of the following member satisfaction measures. *Rating of Specialist Seen Most Often* increased for all five health plans. *Rating of All Health Care* increased in four of five health plans. Three of five plans' ratings increased in *Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Health Plan*. *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate* each increased in two of the five CHP+ health plans.

While four of the five CHP+ health plans experienced no substantial decrease in member satisfaction ratings, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate* each decreased slightly in three health plans. Additionally, *Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Health Plan* each decreased slightly in two health plans. The *Rating of All Health Care* rating decreased only slightly in one health plan. For the remaining measure, *Rating of Specialist Seen Most Often*, none of the CHP+ MCOs experienced a rate decrease.

2. Introduction to the Report

Report Purpose and Overview

States with CHIP healthcare delivery systems that include MCOs are required to annually provide an assessment of the MCOs' performance related to the quality of, timeliness of, and access to care and services provided by each MCO (42 CFR 438.364). The Department administers and oversees the CHP+ program (Colorado's implementation of the Children's Health Insurance Program). To meet this requirement the Department contracted with HSAG to perform the assessment and to produce this EQR annual technical report based on EQR activities that HSAG conducted with the CHP+ MCOs throughout FY 2017–2018. CHP+ MCOs in Colorado are listed in Table 2-1.

Table 2-1—Colorado CHP+ MCOs

CHP+ MCOs	Services Provided
Colorado Access	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.
Friday Health Plans of Colorado (FHP)	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.

How This Report Is Organized

Section 1 includes a high-level, statewide summary of results and statewide average information derived from conducting mandatory and optional EQRO activities in FY 2017–2018. This section also includes a summary description of relevant trends over a three-year period for each EQRO activity as applicable, with references to the section where the health plan specific results can be found where appropriate. In addition, Section 1 includes any conclusions drawn and recommendations made for statewide performance improvement, if applicable.

Section 2 provides a brief overview of Colorado's CHP+ healthcare delivery system and its managed care organizations and describes the purpose and overview of this EQR annual technical report, the authority under which it must be provided, and the EQR activities conducted during FY 2017–2018. Section 1 also provides an overview of the methodology for each EQR activity performed and how HSAG used results and data obtained to draw conclusions.

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

Section 4 includes statewide comparative results organized by EQR activity. Three-year trend tables (when applicable) include summary results for each CHP+MCO and statewide averages. This section also identifies, through presentation of results for each EQR activity, statewide trends and commonalities used to derive statewide conclusions and recommendations.

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

Scope of EQR Activities

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

- **Monitoring for compliance with federal healthcare regulations.** Compliance monitoring was designed to determine the MCOs' compliance with their contracts with the State and with State and federal managed care regulations. HSAG determined compliance through review of four 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, each MCO's licensed HEDIS auditor validated each of the performance measures selected by the Department for review. The validation also determined the extent to which performance measures calculated by the MCOs followed specifications required by the Department.
- **Validation of performance improvement projects (PIPs).** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.

The optional activity conducted for the CHP+ MCOs was:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.** 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 increases the likelihood of desired health outcomes of its enrollees through its structural and operations characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement."[2-1]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2-2] 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.

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)."[2-3]

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[2-2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.
[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

Methodology

This section describes the manner in which each activity was conducted and how the resulting data were aggregated and analyzed.

Compliance With Medicaid Managed Care Regulations (Compliance Monitoring)

For the FY 2017–2018 site review process, the Department requested a review of four areas of performance based on federal healthcare regulations. The standards chosen were Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. HSAG developed a strategy and monitoring tools to review compliance with these standards and managed care contract requirements related to each standard. HSAG also reviewed the health plans' administrative records to evaluate compliance related to member appeals and grievances.

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.[2-4] Table 2-2 describes the

[2-4] 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: Sept 19, 2018.

five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

Table 2-2—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.
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. • 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 CHP+ member appeals and grievances that occurred between July 1, 2017, and December 31, 2017. 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.

For this step,	HSAG completed the following activities:
	• HSAG reviewed a sample of administrative records to evaluate implementation of federal managed care regulations. • 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 that 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.
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
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (processing of grievances and appeals)
- 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 2-3 depicts assignment of the standards to the domains.

Table 2-3—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standards	Quality	Timeliness	Access
Standard V—Member Information	X		X
Standard VI—Grievance and Appeal System		X	X
Standard VII—Provider Participation and Program Integrity	X		X
Standard IX—Subcontracts and Delegation	X		

Validation of Performance Measures

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,[2-5] identifies key types of data that should be reviewed. NCQA HEDIS Compliance Audits meet the requirements of the

[2-5] 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/externalquality-review/index.html. Accessed on: Oct 10, 2018.

CMS protocol. Therefore, HSAG requested copies of the Final Audit Report (FAR) for each health plan and aggregated several sources of HEDIS-related data to confirm that the health plans met the HEDIS IS compliance standards and had the ability to report HEDIS data accurately.

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*.[2-6]

- 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.
  - 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.
- Re-abstraction 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 and submitting 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. Through review of each health

[2-6] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

plan's FAR, HSAG determined that 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 to confirm that only valid results were included in this report. Table 2-4 outlines HEDIS audit activities and steps reviewed by HSAG, along with the corresponding data sources.

Table 2-4—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 2018 FAR
Roadmap Review—This review provided the health plan's HEDIS compliance auditors with background information on policies, processes, and data in preparation for on-site validation activities. The health plans were required to complete the Roadmap to provide their lead auditor audit team with the necessary information to begin validation activities. HSAG looked for evidence in the final report that the licensed HEDIS auditor completed a thorough review of all components of the Roadmap.	HEDIS 2018 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 2018 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 2018 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 2018 FAR

Data Reviewed	Source of Data
CAHPS Sample Frame Validation—HSAG validated that the licensed organizations performed detailed evaluations of the source code used to access and manipulate data for CAHPS sample frames. This validation reviewed the source code to ensure that data were correctly queried in the output files, and HSAG conducted a detailed review of the survey eligibility file elements, including the healthcare organization's name, product line, product, unique member ID, and subscriber ID, as well as the member name, gender, telephone number, date of birth, mailing address, continuous enrollment history, and prescreen status code (if applicable).	HEDIS 2018 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 2018 FAR
Convenience Sample Validation—Per NCQA guidelines, the HEDIS auditor reviews a small number of processed medical records to uncover potential problems that may require corrective action early in the medical record review (MRR) process. A convenience sample must be prepared unless the auditor determines that a health plan is exempt. NCQA allows organizations to be exempt from the convenience sample if they participated in a HEDIS audit the previous year and passed MRR validation, if the current MRR process has not changed significantly from the previous year, and if the health plan did not report hybrid measures that the auditor determines to be at risk of inaccurate reporting. HSAG verified that the HEDIS auditors determined whether or not the health plans were required to undergo a convenience sample validation. HSAG also verified that if a convenience sample validation was not required by the HEDIS auditor the specific reasons were documented.	HEDIS 2018 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 2018 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 2018 IDSS

Table 2-5 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 2-5, 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 2-5—Validation Activities

	Colorado Access	DHMP	FHP	Kaiser	RMHP
Licensed HEDIS Auditor Organization	HealthcareData Company, LLC	Attest Health Care Advisors	DTS Group	DTS Group	DTS Group
Pre-On-Site Visit Call/Meeting	✓	✓	✓	✓	✓
Roadmap Review	✓	✓	✓	✓	✓
Software Vendor	Centauri Health Solutions	Verscend	Change Healthcare	None used	Inovalon
Source Code/Certified Measure Review	✓	✓	✓	✓	✓
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 2018 technical specifications.

HSAG summarized the results from Table 2-5 and determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology. Therefore, all health plan rates and audit results were determined to be valid, reliable, and accurate.

How Conclusions Were Drawn

IS Standards Review

Health plans must be able to demonstrate compliance with IS standards. Health plans' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine 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

In the measure results tables presented in Section 3, HEDIS 2016, 2017, and 2018 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, 2017, and 2018, 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.

Performance Measure Results

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. To limit the impact of this, a change will not be considered statistically significant unless the change was at least 3 percentage points. Note that statistical testing could not be performed on the utilization-based measures within the Use of Services domain given that variances were not available in the IDSS files for HSAG to use for statistical testing.

The statewide average presented in this report is a weighted average of the rates for each health plan, weighted by the eligible population for each plan. This results in a statewide average similar to an actual statewide rate because, rather than counting each health plan equally, the specific size of each plan is

taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

$$Statewide\ Average = \frac{P_1R_1 + P_2R_2}{P_1 + P_2}$$

Where P_1 = the eligible population for Health Plan 1
R_1 = the rate for Health Plan 1
P_2 = the eligible population for Health Plan 2
R_2 = the rate for Health Plan 2

Measure results for HEDIS 2018 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2017 and are denoted in the measure results tables using the percentile rankings defined in Table 2-6. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* measure were compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2017 since benchmarks for this measure are not published in Quality Compass.

Table 2-6—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 2018 measure rate was not reportable or because the measure did not have an applicable benchmark. Additionally, the following logic determined the high and low performing measure rates discussed within the results:

- High performers are measures for which the statewide average is high compared to national benchmarks and performance is trending positively. These measures are those:
  - Ranked at or above the national Medicaid 75th percentile, without a statistically significant decline in performance from HEDIS 2017.
  - Ranked between the national Medicaid 50th and 74th percentiles, with statistically significant increases from HEDIS 2017.

- Low performers are measures for which statewide performance is low compared to national percentiles or performance is toward the middle but declining over time. These measures are those:
  - Ranked below the national Medicaid 25th percentile.
  - Ranked between the national Medicaid 25th and 49th percentiles, with statistically significant decreases from HEDIS 2017.

According to the Department's guidance, all measure rates presented in this report for the health plans are based on administrative data only. The Department required that all HEDIS 2017 and 2018 measures be reported using the administrative methodology only. When reviewing HEDIS measure results, the following items should be considered:

- Health plans that were able to obtain supplemental data or capture more complete data will generally report higher rates when using the administrative methodology. As a result, the HEDIS measure rates presented in this report for measures with a hybrid option may be more representative of data completeness rather than a measure of performance for measures that can be reported using the hybrid methodology. Additionally, caution should be exercised when comparing administrative measure results to national benchmarks or to prior years' results that were established using administrative and/or medical record review data as results likely underestimate actual performance. Table 2-7 presents the measures provided in the report that could be reported using the hybrid methodology.

Table 2-7—HEDIS Measures That Can Be Reported Using the Hybrid Methodology

Hybrid 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.

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 2-8.

Table 2-8—Assignment of Activities to Performance Domains

Performance Measures	Quality	Timeliness	Access
Pediatric Care 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	✓		
Appropriate Testing for Children With Pharyngitis	✓		
Access to Care Measures			
*Prenatal and Postpartum Care**	✓	✓	✓
Children's and Adolescents' Access to Primary Care Practitioners			✓
Preventive Screening Measures			
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
Mental/Behavioral Health Measures			
Antidepressant Medication Management	✓		
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	✓		
Respiratory Conditions Measures			
Appropriate Treatment for Children With Upper Respiratory Infection	✓		
Medication Management for People With Asthma	✓		
Asthma Medication Ratio	✓		
Use of Services Measures			
Ambulatory Care (Per 1,000 Member Months)	NA	NA	NA
Inpatient Utilization—General Hospital/Acute Care	NA	NA	NA
Antibiotic Utilization	NA	NA	NA

** CHP+ State Managed Care Network (SMCN) was required to report just one measure, Prenatal and Postpartum Care (PPC).*
NA indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).

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.[2-7] 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

[2-7] 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 2-9.

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

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

HSAG administered 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 assessed 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 2-10.

Table 2-10—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	✓		

Aggregating and Analyzing Statewide Data

For each CHP+ MCO (collectively health plans), HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2017–2018. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about quality of, timeliness of, or access to care and services for each health plan independently as well as related to statewide improvement.

3. Evaluation of Colorado's CHP+ Health Plans

Colorado Access

Monitoring for Compliance With CHIP 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 2017–2018.

Table 3-1—Summary of Colorado Access Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable*	Compliance Score (% of Met Elements)
V—Member Information	24	12	12	0	0	12	100%
VI—Grievance and Appeal System	35	22	21	1	0	13	95%
VII—Provider Participation and Program Integrity	16	15	15	0	0	1	100%
IX—Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**49**	**48**	**1**	**0**	**30**	**98%****

**HSAG scored federal requirements that did not apply to CHP+ until July 1, 2018, as NA (Not Applicable).*

***The overall compliance score is calculated by summing the total number of Met elements and 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 record review score for FY 2017–2018.

Table 3-2—Summary of Colorado Access Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	60	40	40	0	20	100%
Appeals	48	45	42	3	3	93%
Totals	**108**	**85**	**82**	**3**	**23**	**96%***

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

Colorado Access: Strengths

HSAG found the policies and procedures regarding member materials to be inclusive of the requirements. HSAG reviewed member materials, including the new member packets for Colorado Access members, written in both English and Spanish. HSAG found that member materials, both printed and electronic, used simple, easy-to-understand language. Colorado Access arranged its website in a user-friendly format that allowed for intuitive use and member ease in finding important information.

Colorado Access demonstrated that existing procedures for processing grievances and appeals complied with Colorado Access' contract with the State. The member handbook and provider manuals outlined the procedures for filing grievances and appeals, including all essential time frames and information. Record reviews demonstrated 100 percent compliance with requirements for processing grievances and 93 percent compliance with requirements for processing appeals. Staff demonstrated that the appeal manager contacts all members verbally and in writing to acknowledge receipt of appeals, offer assistance, share all available pre- and post-appeal information, and ensure that each member understands his or her appeal resolution.

HSAG found that Colorado Access' policies for the selection and retention of providers were well written and clearly described methods used to identify a specific area of need and then recruit providers to fill such gaps. Colorado Access submitted policies and reports that provided evidence of a monitoring and tracking system for ensuring that no employees, providers, consultants, subcontractors, board of directors, or other applicable individuals or entities were excluded from participation in federal healthcare programs. Colorado Access documents described actions to be taken after identifying an individual or entity excluded from participation in federal programs. Colorado Access' compliance program described the organizational structure, chain of command, and compliance training that takes place upon hire and then annually thereafter. The compliance officer described educational programs and professional organizations through which she remains current and which offer training and information about corporate compliance as well as fraud, waste, and abuse topics. Colorado Access described its processes for monitoring and reporting fraud, waste, and abuse—including investigating identified compliance issues; termination of a provider when fraud allegations are confirmed; identification and recovery of overpayments; and notification of appropriate entities, including the Department.

Colorado Access subcontracted with several external entities for provision of contracted administrative services. Policies described the delegation program, accountable to the compliance officer; and addressed Colorado Access' ultimate accountability for all delegated activities, pre-delegation assessment of the subcontractor, and ongoing oversight and monitoring of delegated functions—with corrective actions and potential revocation of the subcontract if necessary. The subcontractor agreement template and existing subcontractor agreements included the provisions required by federal healthcare regulations. Colorado Access designated internal "business owners" responsible for oversight of each subcontractor, including ongoing monitoring and management of corrective actions; and provided documentation of monthly performance tracking and annual audits of delegated activities.

Colorado Access: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard VI—Grievance and Appeal System

Appeal resolution letters included with the appeal record reviews contained clinical jargon that was potentially difficult for members to understand. Colorado Access was required to:

- Ensure that appeal resolution letters to CHP+ members are written in language that may be easily understood by those members.

Colorado Access: Trended Performance for Compliance Monitoring

Table 3-3 displays Colorado Access' compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 3-3—Compliance Monitoring Trended Performance for Colorado Access

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	88%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	91%	100%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	100%	92%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	100%	80%
Standard V—Member Information (2014–2015, 2017–2018)**	**91%**	**100%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)**	**77%**	**95%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)**	**100%**	**100%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	98%	94%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)**	**100%**	**NA**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	100%	100%

**The 2017–2018 scores reflect overall compliance without scoring of any regulations that were new based on the May 2016 release of revised regulations or that contained revisions of the previous rules; therefore, overall compliance scores may not be comparable to scores earned in the previous or future review cycles. In addition, for all standards, the health plan's contract with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***Bold text indicates standards reviewed by HSAG during FY 2017–2018.*

Trending scores over the past six years indicate that Colorado Access improved performance in four of the ten standards, with the greatest improvement observed in Standard VI—Grievance and Appeal System, followed by Standard V—Member Information and Standard II—Access and Availability. In two standard areas—Provider Participation and Program Integrity and Quality Assessment and Performance Improvement, Colorado Access maintained its 100 percent compliance across review

cycles. Colorado Access experienced declines in performance for Coordination and Continuity of Care, Member Rights and Protections, and Credentialing and Recredentialing, with the largest decline being observed in Standard IV—Member Rights and Protections. HSAG cautions, however, that over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results. Overall, Colorado Access scores demonstrate strong understanding of and compliance with federal managed care regulations and State contractual requirements.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2018 HEDIS Compliance Audit Report, 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 HEDIS auditor identified no notable issues with negative impact on HEDIS reporting.

Performance Measure Results

Table 3-4 shows the performance measure results for Colorado Access for HEDIS 2016 through HEDIS 2018, along with the percentile rankings for each HEDIS 2018 rate.

Table 3-4—Performance Measure Results for Colorado Access

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	59.54%	65.92%	62.30%	10th–24th
Combination 3	57.26%	63.67%	60.82%	10th–24th
Combination 4	51.74%	59.71%	58.71%	10th–24th
Combination 5	49.82%	56.67%	53.96%	25th–49th
Combination 6	34.09%	38.97%	41.29%	50th–74th
Combination 7	46.22%	53.76%	52.38%	25th–49th
Combination 8	31.33%	37.12%	39.92%	50th–74th
Combination 9	30.25%	35.80%	37.59%	50th–74th
Combination 10	28.45%	34.35%	36.54%	50th–74th
Immunizations for Adolescents[1]				
Combination 1 (Meningococcal, Tdap)	70.25%	70.39%	70.24%	25th–49th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Well-Child Visits in the First 15 Months of Life[1]				
*Zero Visits**	3.57%	2.17%	1.36%	50th–74th
Six or More Visits	61.07%	61.96%	59.86%	25th–49th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.36%	69.48%	69.32%	25th–49th
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	49.70%	48.88%	48.34%	25th–49th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	57.91%	3.85%	5.25%	<10th
Counseling for Nutrition—Total	57.66%	2.08%	2.94%	<10th
Counseling for Physical Activity—Total	48.18%	0.78%	1.06%	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	79.59%	84.93%	88.07%^	≥90th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	93.65%	91.23%	94.65%^	25th–49th
Ages 25 Months to 6 Years	87.50%	86.24%	85.90%	25th–49th
Ages 7 to 11 Years	92.85%	91.63%	89.74%	25th–49th
Ages 12 to 19 Years	92.81%	92.18%	90.90%	50th–74th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	29.34%	32.72%	32.11%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.31%	0.24%	0.06%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	0.74%	0.00%	0.00%	<10th
Continuation and Maintenance Phase	0.00%	0.00%	0.00%	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	29.59%	25th–49th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents**[3]				
Total	6.56%	4.05%	6.67%	<10th
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection[3]				
Appropriate Treatment for Children With Upper Respiratory Infection	91.99%	89.63%	92.12%	50th–74th
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	51.24%	51.18%	65.41%^	75th–89th
Medication Compliance 50%—Ages 12 to 18 Years	38.95%	48.31%	55.77%	50th–74th
Medication Compliance 75%—Ages 5 to 11 Years	23.14%	27.56%	34.59%	75th–89th
Medication Compliance 75%—Ages 12 to 18 Years	14.74%	26.97%	27.88%	50th–74th
Asthma Medication Ratio				
Ages 5 to 11 Years	79.84%	87.50%	80.58%	75th–89th
Ages 12 to 18 Years	68.93%	74.74%	72.07%	75th–89th
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits**	27.35	26.48	26.36	≥90th
Outpatient Visits	227.44	224.38	221.11	<10th
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 Member Months (Total Inpatient)	1.31	0.96	0.99	<10th
Average Length of Stay (Total Inpatient)	3.13	3.64	3.74	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.93	0.66	0.67	<10th
Average Length of Stay (Medicine)	2.48	2.88	2.85	<10th
Discharges per 1,000 Member Months (Surgery)	0.33	0.26	0.28	<10th
Average Length of Stay (Surgery)	5.07	5.79	6.00	25th–49th
Discharges per 1,000 Member Months (Maternity)	0.13	0.09	0.09	<10th
Average Length of Stay (Maternity)	2.40†	2.41†	3.05†	≥90th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.71	0.46	0.42	≥90th
Average Days Supplied per Antibiotic Script	10.67	10.94	10.88	<10th
Average Scripts PMPY for Antibiotics of Concern	0.27	0.16	0.14	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	38.39%	33.77%	34.12%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017. This measure rate presented in this table is based on administrative data only.
[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.
[3] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 and 2018 rates to prior years.
— Indicates that the measure was not required in previous technical reports or that the measure could not be compared to national Medicaid percentiles because the rate was not reportable.
† 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 poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
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.
NA (Small Denominator) indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Colorado Access: Strengths

The following HEDIS 2018 measure rates were determined to be high performers (i.e., ranked at or above the national Medicaid 75th percentiles without a statistically significant decline in performance from HEDIS 2017; or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017) for Colorado Access:

- *Appropriate Testing for Children With Pharyngitis*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years* and *Medication Compliance 75%—Ages 5 to 11 Years*
- *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years*

Colorado Access: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers (i.e., fell below the national Medicaid 25th percentiles or ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017) for Colorado Access:

- *Childhood Immunization Status—Combinations 2*, *3*, and *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*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Colorado Access' performance for HEDIS 2018 demonstrates opportunities to improve in areas related to medication management for behavioral health conditions, as evidenced by the following measures performing below the national Medicaid 10th percentiles: *Follow-Up Care for Children Prescribed ADHD Medication* and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*. Colorado Access should work to ensure that this vulnerable population receive appropriate medications and that providers appropriately monitor members on medications long-term. Additionally, members may not be adequately receiving preventive care and screenings; the following measure rates fell below the national Medicaid 25th percentiles: *Childhood Immunization Status—Combinations 2*, *3*, and *4*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*; and *Chlamydia Screening in Women—Ages 16 to 20 Years*. These interventions are essential in ensuring that children are healthy and remain healthy into adulthood; therefore, Colorado Access should work to ensure that members receive these services.

Conversely, Colorado Access performed above the national Medicaid 75th percentiles for the *Asthma Medication Ratio* and *Medication Management for People With Asthma* measure rates for members ages 5 to 11 with asthma, indicating appropriate management of these members. Additionally, Colorado Access exceeded the national Medicaid 90th percentiles for *Appropriate Testing for Children With Pharyngitis* and *Non-Recommended Cervical Cancer Screening in Adolescent Females*, demonstrating strengths by ensuring that providers are not overusing inappropriate treatments for members with pharyngitis and are not screening young women unnecessarily for cervical cancer.

Validation of Performance Improvement Projects

Table 3-5 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 2017–2018. 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 *Met* scores have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-5 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all PIP validation activities. This was the fourth validation year for the PIP, with the MCO completing Activities I through X.

Table 3-5—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% (3/3)	0% (0/3)	0% (0/3)
	X.	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			**100% (4/4)**	**0% (0/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*			**95% (21/22)**	**5% (1/22)**	**0% (0/22)**

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

Overall, 95 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII and VIII), and the Outcomes stage (Activities IX and X) were validated.

Table 3-6 displays baseline, Remeasurement 1, and Remeasurement 2 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 3-6—Performance Improvement Project Outcomes for Colorado Access

PIP Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	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%*	54.3%*	*Yes*

**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 0. Colorado Access' goal is to increase the rate to 75.0 percent at Remeasurement 1. With a baseline rate of 0, HSAG recommended that Colorado Access ensure that a Remeasurement 1 goal of 75.0 percent is reasonable and attainable.

At Remeasurement 1, 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 ($p < 0.0001$). The PIP will be evaluated for sustained improvement during the next validation cycle, when the MCO reports results from Remeasurement 2.

At Remeasurement 2, the rate of high-risk members who received care management outreach within 90 days prior to their 19th birthdays increased to 54.3 percent. The Remeasurement 2 rate exceeded the goal of 30.0 percent and demonstrated statistically significant improvement over the baseline. Sustained improvement was achieved at Remeasurement 2 because the study indicator demonstrated statistically significant improvement over baseline at Remeasurement 1 and the improvement was maintained for a subsequent measurement period.

Colorado Access: Strengths

Colorado Access developed a methodologically sound project. The solid PIP design allowed the MCO to measure and monitor PIP outcomes. The MCO accurately reported and interpreted the Remeasurement 2 study indicator results. The MCO revisited the causal/barrier analysis process and provided an updated, prioritized list of barriers for the Remeasurement 2 period using a key driver diagram. Colorado Access evaluated the Remeasurement 2 interventions and used the intervention evaluation results to guide next steps for improvement strategies. The MCO reported further improvement in the study indicator rate from Remeasurement 1 to Remeasurement 2 and succeeded in demonstrating sustained improvement over baseline at Remeasurement 2.

Colorado Access: Barriers and 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 is in place.
- Options for health insurance transition are unknown to members.
- Limited health literacy exists among members and member parents/caregivers.
- Limited resources are available for providers to assist members with transitions.

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, providing t available options, and including 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.
- Developed a comprehensive curriculum to educate members under 19 years of age and to prepare them for the transition out of CHP+ coverage (planned intervention).

Colorado Access: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the CHP+ MCOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. Upon conclusion of Colorado Access' PIP, HSAG recommended the following:

- Document a thorough and complete interpretation of study indicator results to monitor and communicate progress toward meeting outcome-related goals.
- Consider spreading successful improvement strategies to other populations or other identified areas in need of improvement. Use iterative quality improvement science techniques such as the Plan-Do-Study-Act (PDSA) model, to test an intervention on a small scale, evaluate initial results, and then gradually expand to full implementation if the intervention is deemed successful.
- Develop a sustainability plan within the organization and in collaboration with any key partners to ensure that the improvement demonstrated through the PIP is maintained beyond the life of the PIP.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-7 shows the results achieved by Colorado Access for FY 2015–2016 through FY 2017–2018.

Table 3-7—Question Summary Rates and Global Proportions for Colorado Access

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	87.1%	85.6%	85.3%
Getting Care Quickly	92.3%	90.1%	92.4%
How Well Doctors Communicate	97.7%	95.2%	95.4%
Customer Service	81.5%	86.9%	83.7%
Shared Decision Making	80.3%	83.5%+	74.8%+
Rating of Personal Doctor	76.3%	73.5%	76.2%
Rating of Specialist Seen Most Often	68.5%+	70.2%+	78.9%+
Rating of All Health Care	71.5%	67.2%	69.1%
Rating of Health Plan	60.4%	61.4%	61.3%

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

Colorado Access: Strengths

For Colorado Access' CHP+ population, one measure rate increased substantially between FY 2016–2017 and FY 2017–2018.

- *Rating of Specialist Seen Most* Often (8.7 percentage points)

Four measures demonstrated slight increases between FY 2016–2017 and FY 2017–2018.

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

Colorado Access: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For Colorado Access' CHP+ population, one measure rate decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Shared Decision Making* (8.7 percentage points)

Three measures showed slight rate decreases between FY 2016–2017 and FY 2017–2018:

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

For Colorado Access' CHP+ population, one measure rate decreased substantially between FY 2015–2016 and FY 2017–2018:

- *Shared Decision Making* (5.5 percentage points)

Four measures showed slight rate decreases between FY 2015–2016 and FY 2017–2018:

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

Colorado Access experienced a substantial rate decrease for one measure in the 2017–2018 measurement year compared to the previous measure year. In addition, three measure rates showed slight decreases compared to the previous year. HSAG recommends that Colorado Access prioritize improving those measures that demonstrated substantial decreases in rates. However, to improve member perception for all measures showing declines, HSAG offers the following recommendations that Colorado Access could consider based on population needs and health plan resources. To improve members' perceptions of *Getting Needed Care*, HSAG recommends that Colorado Access consider:

- Developing a focus study or PIP to obtain data about appointment scheduling patterns, provider hours offered, and frequency of no-show appointments to determine if interventions may be appropriate.
- Offering provider incentives for expanding the availability of evening and weekend hours, developing open-access scheduling, or adopting alternative schedules such as early morning or late evening hours.
- Encouraging the use of electronic communication between providers and members when appropriate to provide care when face-to-face appointments may not be needed.
- Developing and implementing a system to provide ongoing communications to inform both members and providers of timeliness access standards and where to access after-hours care.

The *Shared Decision Making*, *Customer Service*, and *Rating of Health Plan* measures could be impacted by many variables, including member's willingness to engage, provider's cultural competency, clinician's use of communication regarding treatment recommendations or medication, or whether a member receives the perceived help needed and is treated with courtesy and respect by customer service staff. Colorado Access should consider the following recommendations:

- Conducting evaluations to assess staff members' and providers' customer service skills and develop training programs designed to address issues found related to both staff and providers.
- Developing an ongoing tracking mechanism that captures 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.
- Enhancing weekly or monthly team meetings to include evaluating performance of calls in which the content or request was difficult, and providing peer support as needed.
- Expanding the frequency and diversity of training by coordinating cultural competency trainings with other health plans.
- Querying members regarding their communication preferences and using the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increasing follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Coordinating with community organizations to enhance disease management programs; and offering to children, youth, and families health education and support related to chronic conditions such as asthma, diabetes, and weight management.

For the *Shared Decision Making* rate that experienced a substantial decrease (more than 5 percentage points) compared to the previous measurement year, HSAG recommends that the health plan implement a barrier analysis to determine the key driver of performance on this measure and whether or not specific quality improvement initiatives are needed to improve member experiences.

Denver Health Medical Plan, Inc.

Monitoring for Compliance With CHIP Managed Care Regulations

Table 3-8 presents the number of elements for each standard; the number of elements assigned a score of *Met, Partially Met, Not Met,* or *Not Applicable*; and the overall compliance score for FY 2017–2018.

Table 3-8—Summary of DHMP Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable*	Compliance Score (% of Met Elements)
V—Member Information	24	12	10	2	0	12	83%
VI—Grievance and Appeal System	35	22	20	1	1	13	91%
VII—Provider Participation and Program Integrity	16	14	11	1	2	2	79%
IX—Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**48**	**41**	**4**	**3**	**31**	**85%****

**Note: HSAG scored federal requirements that did not apply to CHP+ until July 1, 2018, as NA (Not Applicable).*

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

Table 3-9 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2017–2018.

Table 3-9—Summary of DHMP Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances*	NA	NA	NA	NA	NA	NA
Appeals	6	6	5	1	0	83%
Totals	**6**	**6**	**5**	**1**	**0**	**83%****

**NA—DHMP reported no CHP+ member grievances during the review period.*

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

DHMP: Strengths

DHMP provided new CHP+ members with website orientation videos, face-to-face orientation meetings, and member handbooks. DHMP's policies, procedures, and materials clearly stated that information is available in Spanish, that interpreter services and auxiliary aids are available, and that member information must be written at the sixth grade reading level. The CHP+ member handbook informed members of the benefits and requirements of the plan, including procedures for choosing a provider and obtaining referrals and out-of-network services, member rights, processes for filing grievances and appeals, how to obtain emergency and after-hours services, and other required information.

DHMP's grievance and appeal system included policies and procedures that addressed State and federal requirements pertaining to member grievance, appeal, and State fair hearing (SFH) processes and were compliant with requirements and time frames for receiving, acknowledging, resolving, and providing member notices regarding grievances and appeals. DHMP had provisions in place for members or their authorized representatives to request SFHs. Additionally, DHMP demonstrated an effective health information system for documenting and tracking information related to the grievance and appeal system.

DHMP demonstrated adequate mechanisms, including detailed policies and procedures, to support selection and retention of healthcare providers. Additionally, DHMP had a robust monitoring and tracking system for ensuring that no employees, providers, consultants, subcontractors, board of director members, or other applicable individuals or entities were excluded from participation in federal healthcare programs. DHMP's corporate compliance program was detailed and described the components of an effective compliance program. DHMP's compliance program included documented processes and procedures for detecting, investigating, and reporting suspected fraud, waste, and abuse (FWA), including auditing and monitoring activities. Staff training documents and other communications demonstrated that staff were adequately informed of FWA and other compliance-related activities.

DHMP's policies and subcontractor program description documents stated that DHMP maintained ultimate responsibility for all delegated activities and addressed the processes for pre-delegation assessment of all potential subcontractors, ongoing review and annual reassessment of subcontractor performance of requirements, prompt response to identified deficiencies, and reporting results to the Compliance Committee.

DHMP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard V—Member Information

DHMP's member handbook contained incorrect information and time frames related to grievances and appeals and the SFH. In addition, the handbook included information about wraparound services but did

not explain how and where to access those services, as required. DHMP was required to revise its CHP+ member handbook to:

- Include accurate time frames for filing grievances (any time) and appeals (60 days after the notice of adverse benefit determination).
- Clarify that members must exhaust the DHMP appeals process before requesting an SFH.
- Inform members how to access benefits available under the State plan but not covered by the DHMP CHP+ managed care contract.

Standard VI—Grievance and Appeal System

Appeal resolution letters reviewed during the on-site appeal file review demonstrated that the appeal resolution letter was not written so as to be easily understood by members, and some contained inaccurate information. DHMP also provided no evidence that it gave new providers and subcontractors a description of the grievance, appeal, and State fair procedures and time frames. DHMP was required to:

- Ensure that written notices of appeal resolutions use formats and language that may be easily understood by members.
- Implement mechanisms to ensure that all providers and subcontractors are provided with information about the grievance, appeal, and SFH system upon entering into contracts with DHMP.

Standard VII—Provider Participation and Program Integrity

DHMP was unable to demonstrate having reporting processes in place related to several program integrity requirements. DHMP was required to have mechanisms in place for:

- Screening all provider claims for potential fraud, waste, and abuse.
- Reporting to the Department all overpayments identified or recovered due to potential fraud.
- Notifying the Department about changes in a network provider's circumstances which could affect that provider's eligibility to participate in the managed care program.
- Ensuring that network providers report to DHMP when they have received an overpayment, return the overpayment to DHMP within 60 calendar days of its identification as such, and notify DHMP in writing of the reason for the overpayment. DHMP was also required to annually report recoveries of overpayments to the Department.
- Notifying the Department of the following: written disclosure of any prohibited affiliation, written disclosure of ownership and control, and identification within 60 calendar days of any capitation payments or other payments made for more than the amounts specified in the contract.

DHMP: Trended Performance for Compliance Monitoring

Table 3-10 displays DHMP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 3-10—Compliance Monitoring Trended Performance for DHMP

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	85%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	81%	92%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	100%	100%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	100%	100%
Standard V—Member Information (2014–2015, 2017–2018)**	**91%**	**83%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)**	**81%**	**91%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)**	**100%**	**79%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	94%	98%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)**	**100%**	**NA**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	91%	93%

**The 2017–2018 scores reflect overall compliance without scoring of any regulations that were new based on the May 2016 release of revised regulations or that contained revisions of the previous rules; therefore, overall compliance scores may not be comparable to scores earned in the previous or future review cycles. In addition, for all standards, the health plan's contract with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***Bold text indicates standards reviewed by HSAG during FY 2017–2018.*

Trending scores over the past six years indicate that DHMP improved performance in five of the ten standards. DMHP made commendable efforts between 2014 and 2017 to improve access for its members, as demonstrated by the 11-percentage-point improvement observed in Standard II—Access and Availability. DHMP also experienced improvement in Standard I—Coverage and Authorization of Services, Standard VI—Grievance and Appeal System, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. DHMP maintained 100 percent scores in Standard III—Coordination and Continuity of Care and Standard IV—Member Rights and Protections. While performance declined slightly in Standard V—Member Information and in Standard VII—Provider Participation and Program Integrity, DHMP continues to improve its overall performance and to demonstrate strong understanding of and compliance with federal healthcare regulations and State contractual requirements. HSAG cautions, however, that over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2018 HEDIS Compliance Audit Report, DHMP was fully compliant with four of the IS standards and partially compliant with two of the IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. DHMP's HEDIS auditor found that the health plan was partially compliant with IS standards 1 and 7, which related to the *Childhood Immunization Status* measure; therefore, this materially impacted DHMP's ability to report performance measure data for this measure.

Performance Measure Results

Table 3-11 shows the performance measure results for DHMP for HEDIS 2016 through HEDIS 2018, along with the percentile rankings for each HEDIS 2018 rate.

Table 3-11—Performance Measure Results for DHMP

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	70.87%	73.28%	BR	—
Combination 3	70.08%	73.28%	BR	—
Combination 4	70.08%	73.28%	BR	—
Combination 5	63.78%	67.24%	BR	—
Combination 6	50.39%	53.45%	BR	—
Combination 7	63.78%	67.24%	BR	—
Combination 8	50.39%	53.45%	BR	—
Combination 9	48.03%	50.86%	BR	—
Combination 10	48.03%	50.86%	BR	—
Immunizations for Adolescents[1]				
Combination 1 (Meningococcal, Tdap)	77.34%	72.06%	68.81%	25th–49th
Well-Child Visits in the First 15 Months of Life[1]				
*Zero Visits**	7.84%	6.78%	NA	—
Six or More Visits	0.00%	6.78%	NA	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.57%	59.48%	**46.64%^^**	<10th
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	44.41%	41.37%	37.64%	10th-24th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	77.86%	7.94%	17.71%^	<10th
Counseling for Nutrition—Total	78.59%	1.46%	6.41%^	<10th
Counseling for Physical Activity—Total	65.21%	0.80%	1.40%	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	NA	83.87%	NA	—
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	90.91%	93.98%	**69.03%^^**	<10th
Ages 25 Months to 6 Years	72.65%	71.52%	**57.24%^^**	<10th
Ages 7 to 11 Years	84.53%	85.65%	81.33%	<10th
Ages 12 to 19 Years	86.65%	85.48%	**78.05%^^**	<10th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	64.52%	56.06%	39.74%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.00%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection[2]				
Appropriate Treatment for Children With Upper Respiratory Infection	98.03%	91.40%	100.00%^	≥90th
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits**	22.91	18.09	18.43	≥90th
Outpatient Visits	130.44	117.49	123.51	<10th
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 Member Months (Total Inpatient)	1.08	0.88	0.69	<10th
Average Length of Stay (Total Inpatient)	2.68	2.80	4.25	50th–74th
Discharges per 1,000 Member Months (Medicine)	0.95	0.65	0.49	<10th
Average Length of Stay (Medicine)	2.64	2.68	2.90	<10th
Discharges per 1,000 Member Months (Surgery)	0.11	0.21	0.18	<10th
Average Length of Stay (Surgery)	3.00†	2.92†	8.07†	75th–89th
Discharges per 1,000 Member Months (Maternity)	0.04	0.03	0.02	<10th
Average Length of Stay (Maternity)	3.00†	6.00†	2.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.14	0.13	0.09	≥90th
Average Days Supplied per Antibiotic Script	10.10	10.47	12.07	<10th
Average Scripts PMPY for Antibiotics of Concern	0.04	0.03	0.02	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	28.31%	26.07%	23.31%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017. This measure rate presented in this table is based on administrative data only.
[2] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 and 2018 rates to prior years.
— Indicates that the measure was not required in previous technical reports or that the measure could not be compared to national Medicaid percentiles because the rate was not reportable.
† 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 poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
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.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
BR (Biased Rate) indicates that the reported rate was invalid; therefore, the rate is not presented.

DHMP: Strengths

The following HEDIS 2018 measure rates were determined to be high performers (i.e., ranked at or above the national Medicaid 75th percentiles without a statistically significant decline in performance from HEDIS 2017 or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017) for DHMP:

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

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers (i.e., fell below the national Medicaid 25th percentiles or ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017) for DHMP:

- *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*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

For HEDIS 2018, DHMP demonstrated that members may have barriers accessing services to receive appropriate care, as evidenced by the measure rates for *Children and Adolescents' Access to Primary Care Practitioners* falling below the national Medicaid 10th percentile. Additionally, three of the four indicators declined significantly, with relative differences of 26.55 percent for *Ages 12 to 24 Months*, 19.97 percent for *Ages 25 Months to 6 Years*, and 8.69 percent for *Ages 12 to 19 Years*—indicating that access to care is worsening at an alarming rate. This access issue may also have an impact on the quality of care received as results related to preventive care and screenings (*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*; and *Chlamydia Screening in Women—Ages 16 to 20 Years*) reflected poor performance, falling below the national Medicaid 25th percentile. DHMP should work to ensure that members have access to care and receive these services.

Conversely, DHMP exceeded the national Medicaid 90th percentile for the following measures: *Non-Recommended Cervical Cancer Screening in Adolescent Females* and *Appropriate Treatment for Children With Upper Respiratory Infection*. The health plan demonstrated strengths by ensuring that young women were not screened unnecessarily for cervical cancer and by ensuring that providers are not overusing inappropriate treatments for respiratory infections for ED and outpatient visits.

Validation of Performance Improvement Projects

Table 3-12 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 2017–2018. 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 *Met* scores have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-12 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all PIP validation activities. This is the second 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 0. During a technical assistance call with DHMP and the Department, it was decided that DHMP would implement a new topic, which was submitted in 2016. For this second year of validation, HSAG validated Activities I through IX.

Table 3-12—Performance Improvement Project Validation Results for Denver Health Medical Plan, Inc.

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	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
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*			**95% (20/21)**	**0% (0/21)**	**5% (1/21)**

Overall, 95 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII and VIII), and the Outcomes stage (Activity IX) were validated.

Table 3-13 displays baseline and Remeasurement 1 data for DHMP's PIP. DHMP's goal is to increase the percentage of member 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 3-13—Performance Improvement Project Outcomes for Denver Health Medical Plan, Inc.

PIP Study Indicator	Baseline Period (7/1/2015–6/30/2016)	Remeasurement 1 (7/1/2016–6/30/2017)	Remeasurement 2 (7/1/2017–6/31/2018)	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%	73.9%	*Not Applicable*	*Not Assessed*

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 0, and the denominator was 2. Assuming a denominator of 5 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 feels that this improvement project is important because follow-up was unsuccessful for the entire CHP+ population, justifying the need for improvement for better transitions of care. Improving

transitions of care for children with asthma has the potential to significantly impact children's health in the MCO's overall population.

For Remeasurement 1, the rate increased to 73.9 percent. This increase was not statistically significant, as evidenced by a *p* value of 0.0933; however, the MCO did exceed its goal of 50 percent. The MCO also reported a tenfold increase in its population from baseline to Remeasurement 1.

DHMP: Strengths

DHMP designed a methodologically sound project. The sound study design allowed the MCO to progress to data collection. DHMP accurately reported and summarized the Remeasurement 1 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.

DHMP: Barriers and 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 *Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit* PIP, DHMP identified the following barriers to address:

- Lack of consistent post-discharge follow-up by patient-centered medical homes (PCMHs).
- Lack of emergency department, urgent care, and inpatient facility encounter data for Children's Hospital Colorado.

To address these barriers, DHMP implemented the following interventions:

- Created a weekly list for asthma-related concerns and admissions to DHMP's patient navigators. The list represents all members presenting to the emergency department, urgent care, or inpatient facility at Children's Hospital Colorado. The quality improvement intervention manager then filters for asthma-related diagnoses and sends the list to the Ambulatory Care Services Patient Navigation staff members for outreach.
- An outreach call is conducted to the member by the Department of Ambulatory Care Service's patient navigators within 48 hours of a member's discharge. The patient navigators assist the member with scheduling the follow-up visit with the primary care provider within 30 days of the discharge from the emergency department, urgent care, or inpatient facility.

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the CHP+ MCOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. Upon conclusion of DHMP's PIP, HSAG recommended the following:

- Consider using other quality improvement tools such as a process map or failure modes effects analysis (FMEA) to isolate barriers or gaps within processes that may not have been previously identified.
- Continue to conduct ongoing evaluations of each intervention; and make data-driven decisions regarding revising, continuing, or discontinuing interventions.
- For improvement strategies deemed successful, develop a plan for sustaining and spreading the strategies beyond the scope of the current project.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-14 shows the results achieved by DHMP for FY 2015–2016 through FY 2017–2018.

Table 3-14—Question Summary Rates and Global Proportions for DHMP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	65.8%	75.8%	83.5%
Getting Care Quickly	76.4%	80.6%	88.4%
How Well Doctors Communicate	93.6%	96.5%	95.6%
Customer Service	82.2%	81.4%	84.4%
Shared Decision Making	74.2%+	74.8%+	72.5%+
Rating of Personal Doctor	75.6%	80.3%	84.6%
Rating of Specialist Seen Most Often	58.3%+	77.4%+	84.1%+
Rating of All Health Care	61.7%	67.8%	70.2%
Rating of Health Plan	62.4%	67.4%	65.3%

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

DHMP: Strengths

For DHMP's CHP+ population, three measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Getting Needed Care* (7.7 percentage points)
- *Getting Care Quickly* (7.8 percentage points)
- *Rating of Specialist Seen Most Often* (6.7 percentage points)

Three measures demonstrated slight increases between FY 2016–2017 and FY 2017–2018:

- *Customer Service*
- *Rating of Personal Doctor*
- *Rating of All Health Care*

For DHMP's CHP+ population, five measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Getting Needed Care* (17.7 percentage points)
- *Getting Care Quickly* (12.0 percentage points)
- *Rating of Personal Doctor* (9.0 percentage points)
- *Rating of Specialist Seen Most Often* (25.8 percentage points)
- *Rating of All Health Care* (8.5 percentage points)

Three measures demonstrated slight increases between FY 2015–2016 and FY 2017–2018:

- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Health Plan*

DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For DHMP's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018.

Three measures showed slight rate decreases between FY 2016–2017 and FY 2017–2018:

- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of Health Plan*

For DHMP's CHP+ population, no measure rates decreased substantially between FY 2015–2016 and FY 2017–2018.

One measure showed a slight rate decrease between FY 2015–2016 and FY 2017–2018:

- *Shared Decision Making*

DHMP experienced no substantial rate decreases in the 2017–2018 measurement year compared to the previous year. However, three measure rates showed slight decreases compared to the previous year. HSAG offers the following recommendations for DHMP to consider based on population needs and health plan resources. To improve members' perceptions on the *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of Health Plan* measures, HSAG recommends that DHMP consider:

- Developing provider training forums or developing procedures that encourage providers to verify or ensure that members understand communications.
- Querying members regarding their communication preferences and using the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increasing follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Exploring creative mechanisms for member engagement, such as expanding member advisory committees, developing community-based member committees, or offering member mentorship programs.

Friday Health Plans of Colorado

Monitoring for Compliance With CHIP Managed Care Regulations

Table 3-15 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 2017–2018.

Table 3-15—Summary of FHP Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable*	Compliance Score (% of Met Elements)
V—Member Information	24	12	11	1	0	12	92%
VI—Grievance and Appeal System	35	22	18	4	0	13	82%
VII—Provider Participation and Program Integrity	16	15	14	1	0	1	93%
IX—Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**49**	**43**	**6**	**0**	**30**	**88%****

**Note: HSAG scored federal requirements that did not apply to CHP+ until July 1, 2018, as NA (Not Applicable).*

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

Table 3-16 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 record review score for FY 2017–2018.

Table 3-16—Summary of FHP Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	6	6	6	0	0	100%
Appeals	6	3	3	0	3	100%
Totals	**12**	**9**	**9**	**0**	**3**	**100%***

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

FHP: Strengths

FHP provided member materials upon enrollment through both its website and CHP+ member handbook to inform members of the benefits and requirements of the plan, including procedures for choosing a provider, obtaining referrals and out-of-network services, member rights, processes for filing grievances and appeals, how to obtain emergency and after-hours services, and other required information. FHP's member handbook was comprehensive and easy to navigate.

Much of the information in the CHP+ grievance and appeal procedures and member handbook was compliant with new federal regulations for CHP+ in advance of the July 1, 2018, effective date. Staff members also verbally articulated understanding of the new federal regulations related to grievances and appeals. Grievance and appeal resolution letters were written in easy-to-understand language. Staff members aided members in filing grievances, appeals, and SFH information, both in person and via phone. FHP reported only one grievance and one appeal during the review period. Both the grievance and appeal record reviews demonstrated 100 percent compliance with applicable requirements.

FHP's compliance plan expressed FHP's intent to operate within pertinent laws and delineated processes for adhering to regulations. Staff members participated in compliance training at time of hire and then annually. Prior to hiring and monthly thereafter, FHP conducted searches of federal databases to ensure that it does not employ or contract with providers, employees, or other individuals or entities excluded from participation in federal healthcare programs. FHP's compliance program included mechanisms to detect and report suspected fraud, waste, and abuse. Monitoring processes were ongoing and included a review of medical claims and utilization management (UM) processes.

FHP staff members stated that FHP delegated the following activities related to the CHP+ contract: pharmacy benefit management, specialty medical review, and comprehensive activities related to provision of vision services. FHP provided a sample delegation agreement as an example of the template agreement used with all delegates. The delegation policy outlined procedures for a pre-delegation assessment, ongoing monitoring and assessment with corrective actions when necessary, and termination for noncompliance.

FHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard V—Member Information

At the time of the on-site review, FHP did not have a fully formatted Spanish version of its member handbook available for review. FHP was required to:

- Ensure that all written information, including basic publications such as the member handbook, is available to members in Spanish.

Standard VI—Grievance and Appeal System

HSAG identified several areas of noncompliance in grievance and appeals procedures as well as related member and provider communications. FHP was required to:

- Correct written grievance and appeal procedures as well as the member handbook, to specify that FHP will inform the member in writing within two calendar days of the reason for denying an expedited appeal request and will inform the member of the right to file a grievance if the member disagrees with that decision.
- Revise grievance and appeal procedures to specify that the member may request continued benefits during an appeal within 10 days of the notice of adverse benefit determination and continued benefits during the SFH within 10 days following the adverse appeal resolution notice.
- Ensure that policies and procedures and member communications include clear, accurate information concerning the requirements for requesting continued benefits during an appeal or SFH. Remove from grievance and appeal procedures and related documents the criterion "the time period or service limits of a previously authorized service ends" as a qualification for how long benefits will continue while an appeal or SFH is pending.
- Ensure that all changes to policies, procedures, and documents are reflected in provider materials such that providers are furnished with complete and accurate information about the member grievance and appeal system.

Standard VII—Provider Participation and Program Integrity

FHP's Network Management Program Description did not include information on provider retention. FHP was required to:

- Implement written policies and procedures that address provider retention.

FHP: Trended Performance for Compliance Monitoring

During FY 2016–2017 Colorado Choice Health Plans was purchased by FHP. The service area and populations served for the Colorado CHP+ program remained consistent throughout the transition. Although FY 2017–2018 was the first year that HSAG conducted a compliance site review for FHP, HSAG presents trended information that includes site review scores for both Colorado Choice and FHP.

Table 3-17 displays FHP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 3-17—Compliance Monitoring Trended Performance for FHP

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	71%	91%
Standard II—Access and Availability (2013–2014, 2016–2017)	73%	79%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	33%	50%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	20%	80%
Standard V—Member Information (2014–2015, 2017–2018)**	**74%**	**92%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)**	**27%**	**82%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)**	**69%**	**93%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	39%	77%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)**	**60%**	**NA**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	18%	73%

**The 2017–2018 scores reflect overall compliance without scoring of any regulations that were new based on the May 2016 release of revised regulations or that contained revisions of the previous rules; therefore, overall compliance scores may not be comparable to scores earned in the previous or future review cycles. In addition, for all standards, the health plan's contract with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***Bold text indicates standards reviewed by HSAG during FY 2017–2018.*

Trending scores over the past six years indicate that FHP demonstrated improved performance in all ten standards, with the greatest improvement observed in Standard IV—Member Rights and Protections, with a 60-percentage-point increase; and in Standard VI—Grievance and Appeal System and Standard X—Quality Assessment and Performance Improvement, each improving by 55 percentage points. While these scores demonstrate FHP's commitment to improving understanding of and compliance with federal and contractual requirements, HSAG cautions that over the three-year cycle between review periods, several factors—e.g., changes in federal requirements, changes in State contract requirements, or design of compliance monitoring tools—may have impacted comparability of the compliance results.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2018 HEDIS Compliance Audit Report, FHP 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 HEDIS auditor identified no notable issues with negative impact on HEDIS reporting.

Performance Measure Results

Table 3-18 shows the performance measure results for FHP for HEDIS 2016 through HEDIS 2018, along with the percentile rankings for each HEDIS 2018 rate.

Table 3-18—Performance Measure Results for FHP

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	0.00%	4.08%	7.84%	<10th
Combination 3	0.00%	4.08%	5.88%	<10th
Combination 4	0.00%	2.04%	3.92%	<10th
Combination 5	0.00%	0.00%	0.00%	<10th
Combination 6	0.00%	2.04%	3.92%	<10th
Combination 7	0.00%	0.00%	0.00%	<10th
Combination 8	0.00%	0.00%	1.96%	<10th
Combination 9	0.00%	0.00%	0.00%	<10th
Combination 10	0.00%	0.00%	0.00%	<10th
Immunizations for Adolescents[1]				
Combination 1 (Meningococcal, Tdap)	11.90%	14.81%	15.94%	<10th
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	NA	NA	NA	—
Six or More Visits	NA	NA	NA	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	43.79%	42.18%	43.72%	<10th
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	30.70%	28.92%	25.05%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	29.68%	1.53%	1.69%	<10th
Counseling for Nutrition—Total	29.93%	3.44%	5.92%	<10th
Counseling for Physical Activity—Total	27.01%	4.01%	3.38%	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	73.85%	74.07%	77.55%	50th–74th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	NA	79.41%	NA	—
Ages 25 Months to 6 Years	69.44%	65.12%	65.33%	<10th
Ages 7 to 11 Years	80.81%	72.61%	73.58%	<10th
Ages 12 to 19 Years	87.10%	76.50%	80.49%	<10th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	NA	NA	13.95%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	2.04%	0.00%	0.00%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection[2]				
Appropriate Treatment for Children With Upper Respiratory Infection	85.85%	83.72%	87.72%	25th–49th
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits**	17.94	15.26	15.98	≥90th
Outpatient Visits	183.26	176.00	175.38	<10th
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 Member Months (Total Inpatient)	1.52	0.81	0.65	<10th
Average Length of Stay (Total Inpatient)	2.46†	2.56†	2.13†	<10th
Discharges per 1,000 Member Months (Medicine)	1.30	0.54	0.45	<10th
Average Length of Stay (Medicine)	2.50†	2.25†	2.36†	<10th
Discharges per 1,000 Member Months (Surgery)	0.16	0.27	0.16	<10th
Average Length of Stay (Surgery)	2.67†	3.17†	1.50†	<10th
Discharges per 1,000 Member Months (Maternity)	0.11	NA	0.08	<10th
Average Length of Stay (Maternity)	1.00†	NA	2.00†	<10th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.59	0.50	0.97	25th–49th
Average Days Supplied per Antibiotic Script	10.36	12.39	16.68	<10th
Average Scripts PMPY for Antibiotics of Concern	0.25	0.20	0.41	25th–49th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	42.20%	39.01%	41.62%	25th–49th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017. This measure rate presented in this table is based on administrative data only.
[2] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 and 2018 rates to prior years.
— Indicates that the measure was not required in previous technical reports or that the measure could not be compared to national Medicaid percentiles because the rate was not reportable.
† 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 poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
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.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.

FHP: Strengths

The following HEDIS 2018 measure rate was determined to be a high performer (i.e., ranked at or above the national Medicaid 75th percentiles without a statistically significant decline in performance from HEDIS 2017 or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017) for FHP:

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

FHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers (i.e., fell below the national Medicaid 25th percentiles or ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017) for FHP:

- *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 25 Months to 6 Years*, *Ages 7 to 11 Years*, and *Ages 12 to 19 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

FHP's performance for HEDIS 2018 demonstrated that members may face challenges accessing services to receive appropriate care, as evidenced by the reportable measure rates for *Children and Adolescents' Access to Primary Care Practitioners* falling below the national Medicaid 10th percentile. Lack of access to services may also have an impact on the performance related to several preventive care and screening measures that fell below the national Medicaid 25th percentiles: *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*; and *Chlamydia Screening in Women—Ages 16 to 20 Years*. These interventions are essential in ensuring that children are healthy and remain healthy into adulthood; therefore, FHP should work to ensure that members have access to care and receive these services.

Conversely, FHP demonstrated strength in ensuring that young women were not unnecessarily screened for cervical cancer—by exceeding the national Medicaid 90th percentile for *Non-Recommended Cervical Cancer Screening in Adolescent Females*.

Validation of Performance Improvement Projects

Table 3-19 displays the validation results for the FHP PIP, *Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider,* validated during FY 2017–2018. 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 *Met* scores have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-19 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all PIP validation activities. This was the fourth validation year for the PIP, with HSAG validating Activities I through VIII.

Table 3-19—Performance Improvement Project Validation Results for Friday Health Plans of Colorado

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)**

Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
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*. For this year's submission, the Design stage (Activities I through VI) and the Implementation stage (Activities VII and VIII) were validated.

Table 3-20 displays baseline, Remeasurement 1, and Remeasurement 2 data for FHP's PIP. FHP's goal is to increase to 10 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 3-20—Performance Improvement Project Outcomes for Friday Health Plans of Colorado

PIP Study Indicator	Baseline Period (7/1/2014–6/30/2015)	Remeasurement 1 (7/1/2015–6/30/2016)	Remeasurement 2 (7/1/2016–6/31/2017)	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	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 0 (0/1). The denominator size was one member. The MCO's goal for Remeasurement 1 was to increase the rate to 5 percent at the first remeasurement.

For Remeasurement 1, the eligible population did not increase; and the numerator and denominator were again 0, making the rate *Not Reportable (NR)* for this measurement period. The goal remained 5 percent. For Remeasurement 2, the eligible population did not increase, and the numerator and denominator were again 0, making the rate *Not Reportable (NR)* for this measurement period. The goal for the next remeasurement period is 10 percent.

FHP: Strengths

FHP developed a methodologically sound project that set the foundation for the MCO to move forward. Despite the low to nonexistent study population, FHP conducted appropriate quality improvement activities and strategies to identify problems with current provider processes and developed interventions to overcome the identified barriers. These interventions have potential to have a positive impact on the desired outcomes.

FHP: Barriers and 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, FHP determined it was 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 behavioral health providers. To do this, FHP developed and implemented a telephonic survey which included the following survey questions for providers:

1. Are evidenced-based depression screenings being used for adolescents at their evaluation and management visits?
2. 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?
3. Does the primary care provider have a relationship with a behavioral health provider?
4. 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?
5. Are there any barriers to referring adolescents to behavioral health providers?

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

1. Do you receive referrals from primary care providers for members who screened positive for depression? If so, can you see them within 30 days of the referral; and how is this ensured?
2. What is the intake process?
3. What is the timing between intake and first appointment?
4. What is the wait time for someone with emergent needs?
5. 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:

- Access to behavioral health providers.
- Lack of process for some providers for completing the adolescent depression screening.
- Primary care providers have difficulty accessing the behavioral health network.

To address these barriers, FHP implemented the following interventions:

- Developed a tool for behavioral health providers to complete that describes the specialty services they provide. This tool helps to ensure that members are matched with the right practitioner for their needed care.
- Provided to all contracted providers additional educational materials about standardized screening tools, reimbursement rate, and correct billing codes.
- Continued to update the provider network regularly so that members' needs are met.
- Provided listings and roadmaps for primary care providers to better educate them on behavioral healthcare resources in their areas.

FHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the CHP+ MCOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. Upon conclusion of FHP's PIP, HSAG recommended the following:

- 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 make data-driven decisions based on the evaluation results.
- Develop a plan to spread or sustain any improvement achieved through the PIP process.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-21 shows the results achieved by FHP for FY 2015–2016 through FY 2017–2018.

Table 3-21—Question Summary Rates and Global Proportions for FHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	90.1%	87.9%	86.1%
Getting Care Quickly	90.6%	93.7%	89.9%
How Well Doctors Communicate	94.4%	96.5%	95.3%
Customer Service	85.2%+	76.9%+	82.0%+
Shared Decision Making	78.1%+	81.8%+	84.6%+
Rating of Personal Doctor	58.4%	66.4%	62.3%
Rating of Specialist Seen Most Often	72.7%+	62.5%+	67.6%+
Rating of All Health Care	52.7%	54.5%	52.2%
Rating of Health Plan	49.3%	46.7%	47.4%

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.

FHP: Strengths

For FHP's CHP+ population, two measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Customer Service* (5.1 percentage points)
- *Rating of Specialist Seen Most Often* (5.1 percentage points)

Two measures demonstrated slight increases between FY 2016–2017 and FY 2017–2018:

- *Shared Decision Making*
- *Rating of Health Plan*

For FHP's CHP+ population, one measure rate increased substantially between FY 2015–2016 and FY 2017–2018:

- *Shared Decision Making* (6.5 percentage points)

Two measures demonstrated slight increases between FY 2015–2016 and FY 2017–2018:

- *How Well Doctors Communicate*
- *Rating of Personal Doctor*

FHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For FHP's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018.

Five measures showed slight rate decreases between FY 2016–2017 and FY 2017–2018:

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

For FHP's CHP+ population, one measure rate decreased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of Specialist Seen Most Often* (5.1 percentage points)

Five measures showed slight rate decreases between FY 2015–2016 and FY 2017–2018:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Health Plan*

FHP experienced no substantial rate decreases in the 2017–2018 measurement year compared to the previous year. In addition, five measure rates showed slight decreases compared to the previous year. HSAG offers the following recommendations for FHP to consider based on population needs and health plan resources. To improve members' perceptions on the *Getting Care Quickly* and *Getting Needed Care* measures, HSAG recommends that FHP consider:

- Developing a focus study or PIP to obtain data about appointment scheduling patterns, provider hours offered, and frequency of no-show appointments to determine if interventions may be appropriate.
- Offering provider incentives for expanding the availability of evening and weekend hours; developing open-access scheduling; or adopting alternative schedules such as early morning or late evening hours.

- Encouraging the use of electronic communication between providers and members when appropriate to provide care when face-to-face appointments may not be needed.
- Developing and implementing a system to provide ongoing communications to inform both members and providers of timeliness access standards and where to access after-hours care.

To improve the *How Well Doctors Communicate*, *Rating of Personal Doctor,* and *Rating of All Health Care* measures, FHP should:

- Develop provider training forums or procedures that encourage providers to verify or ensure that members understand communications.
- Offer updated and expanded cultural competency training to providers and use a mechanism to track provider attendance in-person or online.
- Develop member informational material and member-specific communication templates in at least Spanish (the prevalent non-English language in FHP's service area).
- Query members regarding their communication preferences, use the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth), and increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Coordinate with community organizations to enhance disease management programs; and offer to children, youth, and families health education and support related to chronic conditions such as asthma, diabetes, and weight management.

Kaiser Permanente Colorado

Monitoring for Compliance With CHIP Managed Care Regulations

Table 3-22 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 2017–2018.

Table 3-22—Summary of Kaiser Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable*	Compliance Score (% of Met Elements)
V—Member Information	24	12	12	0	0	12	100%
VI—Grievance and Appeal System	35	22	15	7	0	13	68%
VII—Provider Participation and Program Integrity	16	15	13	2	0	1	87%
IX—Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**49**	**40**	**9**	**0**	**30**	**82%****

**Note: HSAG scored federal requirements that did not apply to CHP+ until July 1, 2018, as NA (Not Applicable).*

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

Table 3-23 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 record review score for FY 2017–2018.

Table 3-23—Summary of Kaiser Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	36	24	18	6	12	75%
Appeals*	NA	NA	NA	NA	NA	NA
Totals	**36**	**24**	**18**	**6**	**12**	**75%****

**NA—Kaiser reported no CHP+ member appeals during the review period.*

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

Kaiser: Strengths

Kaiser oriented parents of new members to information regarding the benefits and requirements of the plan through member mailings, a welcome outreach call, the CHP+ Evidence of Coverage (EOC), and Kaiser's member Web portal. Members were also encouraged to contact Member Services with any questions. HSAG found that all vital member documents used easily understood language.

Kaiser's policies and procedures for appeals and grievances were extensive, descriptive, and easy to follow. Grievance and appeal decisions were made within the required time frames. Kaiser assisted members with filing grievances and appeals and involved professionals with appropriate expertise in the decision-making process. The CHP+ EOC provided members with thorough and accurate information regarding the grievance and appeal processes, and denial and appeal resolution letters included required information. The provider manual also addressed grievance and appeal procedures in compliance with requirements.

Kaiser's policies included provisions to ensure that all providers have a written agreement, that Kaiser conducts ongoing monthly monitoring of federal exclusion databases applicable to employees at all levels, and that Kaiser prohibits employing providers excluded from participation in federal healthcare programs. Kaiser's regional compliance plan and on-site discussions described responsibilities for compliance reporting and internal education and training. All Kaiser staff members undergo compliance training upon hire and annually thereafter. Staff members discussed the various methods through which administrative employees, providers, and members can report suspected fraud, waste, or abuse. HSAG found Kaiser's *Principles of Responsibility* to be a dynamic tool used for the education and onboarding of new staff members as well as for establishing a culture of compliance and integrity.

Kaiser's delegation policy thoroughly described Kaiser's mechanisms for delegation and oversight of subcontractors. The policy addressed pre-delegation assessment, periodic (at least annual) audits of delegated activities, reporting responsibilities, and required components of all delegation agreements. Kaiser's standardized letter of agreement with each delegate addressed most required components. Delegation oversight was the responsibility of the Service Quality Resource Management Committee.

Kaiser: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard VI—Grievance and Appeal System

HSAG identified several issues related to member-specific communications within the grievance and appeals system standard. HSAG also noted that the appeals policy included incomplete or inaccurate information concerning continuation of benefits during the appeal or SFH. Kaiser was required to:

- Implement mechanisms to ensure sending to each member or designated client representative (DCR) a written acknowledgement of the grievance within two working days of receipt of the grievance and a written resolution notice within 15 working days of receipt of the grievance.

- Develop a mechanism to ensure that each member who files a grievance has received a grievance resolution notice and revise its grievance resolution template letter to include the required content.
- Include in the written notice of appeal resolution (or SFH insert) that the member may be held liable for the cost of requested continued benefits if the SFH decision upholds the health plan's adverse benefit determination.
- Review and, as necessary, modify the appeal resolution template letter for CHP+ members to ensure ease of understanding for the member.
- Include in the appeals policy and the EOC that the representative of a deceased member's estate is a party to the SFH.
- Remove from the appeals policy and related documents the statement, "authorized service time period or service limits have been met" as a qualification for how long member-requested benefits will continue while the appeal or SFH is pending.

Standard VII—Provider Participation and Program Integrity

Kaiser provided no written policy describing the process for retention of providers. Kaiser also did not provide evidence of a method to verify whether billed member services were supplied by a provider. Kaiser was required to:

- Develop a written provider retention policy, or revise existing policies and procedures to include a description of Kaiser's processes to ensure provider retention.
- Define and implement a method, such as member sampling, to assess regularly whether billed member services have been supplied by a provider.

Kaiser: Trended Performance for Compliance Monitoring

Table 3-24 displays Kaiser's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 3-24—Compliance Monitoring Trended Performance for Kaiser

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	91%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	95%	93%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	89%	75%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	80%	60%
Standard V—Member Information (2014–2015, 2017–2018)**	**52%**	**100%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)**	**65%**	**68%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)**	**88%**	**87%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	100%	100%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)**	**100%**	**NA**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	100%	67%

**The 2017–2018 scores reflect overall compliance without scoring of any regulations that were new based on the May 2016 release of revised regulations or that contained revisions of the previous rules; therefore, overall compliance scores may not be comparable to scores earned in the previous or future review cycles. In addition, for all standards, the health plan's contract with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***Bold text indicates standards reviewed by HSAG during FY 2017–2018.*

Trending scores over the past six years indicate that Kaiser improved performance in three of 10 standards and maintained 100 percent compliance in one additional standard. Kaiser made commendable efforts between FY 2014–2015 and 2017–2018 to improve member information, as demonstrated by the 48-percentage-point improvement observed in Standard V—Member Information. Kaiser's performance declined slightly in Standard II—Access and Availability and Standard VII Provider Participation and Program Integrity and more substantially in Standard III—Coordination and Continuity of Care and Standard IV—Member Rights and Protections; then, saw greatest decline Standard X—Quality Assessment and Performance Improvement. HSAG cautions, however, that over the three-year cycle between review periods several factors—e.g., changes in federal requirements, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of compliance audit results.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2018 HEDIS Compliance Audit Report, Kaiser was fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no notable issues with negative impact on HEDIS reporting.

Performance Measure Results

Table 3-25 shows the performance measure results for Kaiser for HEDIS 2016 through HEDIS 2018, along with the percentile rankings for each HEDIS 2018 rate.

Table 3-25—Performance Measure Results for Kaiser

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	58.67%	79.34%	**70.85%^^**	25th–49th
Combination 3	57.14%	78.93%	**70.17%^^**	25th–49th
Combination 4	56.38%	78.93%	**69.15%^^**	50th–74th
Combination 5	50.00%	72.31%	**62.03%^^**	50th–74th
Combination 6	38.52%	50.41%	43.73%	50th–74th
Combination 7	49.74%	72.31%	**61.02%^^**	50th–74th
Combination 8	38.01%	50.41%	43.39%	50th–74th
Combination 9	34.18%	47.11%	39.32%	50th–74th
Combination 10	33.93%	47.11%	38.98%	50th–74th
Immunizations for Adolescents[1]				
Combination 1 (Meningococcal, Tdap)	80.09%	86.02%	82.30%	50th–74th
Well-Child Visits in the First 15 Months of Life[1]				
*Zero Visits**	3.51%	2.53%	2.91%	25th–49th
Six or More Visits	64.91%	67.09%	66.02%	50th–74th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.70%	67.99%	**59.35%^^**	<10th
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	40.56%	59.26%	**41.18%^^**	10th-24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	97.87%	94.10%	97.29%^	≥90th
Counseling for Nutrition—Total	95.87%	97.18%	95.57%	≥90th
Counseling for Physical Activity—Total	95.87%	97.18%	95.57%	≥90th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	92.18%	96.58%	96.37%	≥90th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	89.88%	87.43%	87.44%	<10th
Ages 25 Months to 6 Years	83.78%	79.56%	**75.76%^^**	<10th
Ages 7 to 11 Years	83.85%	87.93%	86.56%	10th-24th
Ages 12 to 19 Years	85.51%	87.81%	88.45%	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	58.56%	48.46%	41.43%	10th-24th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.27%	0.17%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	56.67%	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection[3]				
Appropriate Treatment for Children With Upper Respiratory Infection	97.40%	98.91%	99.01%	≥90th
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	46.67%	10th-24th
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	NA	23.33%	25th–49th
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	93.33%	≥90th
Ages 12 to 18 Years	NA	NA	NA	—

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits**	14.00	2.98	11.54	≥90th
Outpatient Visits	290.97	179.23	151.08	<10th
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 Member Months (Total Inpatient)	0.83	0.64	0.62	<10th
Average Length of Stay (Total Inpatient)	3.48	3.35	3.51	10th-24th
Discharges per 1,000 Member Months (Medicine)	0.61	0.49	0.46	<10th
Average Length of Stay (Medicine)	3.37	3.04	3.34	10th-24th
Discharges per 1,000 Member Months (Surgery)	0.15	0.15	0.12	<10th
Average Length of Stay (Surgery)	4.38†	4.36†	4.24†	<10th
Discharges per 1,000 Member Months (Maternity)	0.15	0.00	0.07	<10th
Average Length of Stay (Maternity)	2.50†	NA	3.20†	≥90th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	1.44	0.28	0.26	≥90th
Average Days Supplied per Antibiotic Script	12.87	12.32	12.15	<10th
Average Scripts PMPY for Antibiotics of Concern	0.36	0.08	0.05	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	25.23%	28.27%	19.57%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017. This measure rate presented in this table is based on administrative data only.
[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.
[3] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 and 2018 rates to prior years.
— Indicates that the measure was not required in previous technical reports or that the measure could not be compared to national Medicaid percentiles because the rate was not reportable.
† 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 poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
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.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.

Kaiser: Strengths

The following HEDIS 2018 measure rates were determined to be high performers (i.e., ranked at or above the national Medicaid 75th percentiles without a statistically significant decline in performance from HEDIS 2017 or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017) for Kaiser:

- *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—Ages 5 to 11 Years*

Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers (i.e., fell below the national Medicaid 25th percentiles or ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017) for Kaiser:

- *Childhood Immunization Status—Combinations 2* and *3*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *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—Ages 16 to 20 Years*
- *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years*

For HEDIS 2018, Kaiser demonstrated that members may have barriers accessing services for appropriate care, as evidenced by three of four measure rates for *Children and Adolescents' Access to Primary Care Practitioners* falling below the national Medicaid 25th percentiles. This access issue may also have an impact on the quality of care received as results related to preventive care and screenings fell below the national Medicaid 25th percentile or showed significant declines in performance for the following measure rates: *Childhood Immunization Status—Combinations 2* and *3*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Adolescent Well-Care Visits*; and *Chlamydia Screening in Women—Ages 16 to 20 Years*. These interventions are essential in ensuring that children are healthy and remain healthy into adulthood; therefore, Kaiser should work to ensure that members have access to care and receive these services. Additionally, Kaiser fell below the national Medicaid 25th percentile for

Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years, indicating that asthma medication compliance for young members is lacking.

Conversely, Kaiser demonstrated strengths ensuring that providers do not provide inappropriate treatment or services to members. The health plan exceeded the national Medicaid 90th percentile for the following measures related to the appropriate treatment for children with acute respiratory conditions in the ED and outpatient settings: *Appropriate Testing for Children With Pharyngitis* and *Appropriate Treatment for Children With Upper Respiratory Infection*. Further, Kaiser performed above the national Medicaid 90th percentile for *Asthma Medication Ratio—Ages 5 to 11 Years* and *Non-Recommended Cervical Cancer Screening in Adolescent Females*, indicating that young members are receiving the appropriate medications to control their asthma and that young women are not being screened unnecessarily for cervical cancer. Additionally, the health plan excelled in providing and documenting services for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure.

Validation of Performance Improvement Projects

Table 3-26 displays the validation results for the Kaiser PIP, *Access and Transition to Behavioral Health Services*, validated during FY 2017–2018. 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 *Met* scores have satisfied the necessary technical requirements for specific elements. The validation results presented in Table 3-26 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all PIP validation activities. This was the fourth validation year for the PIP, with HSAG validating Activities I through IX.

Table 3-26—Performance Improvement Project Validation Results for Kaiser Permanente Colorado

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	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
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*			**90% (19/21)**	**10% (2/21)**	**0% (0/21)**

Overall, 90 percent of all applicable evaluation elements validated received scores of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII and VIII), and the Outcomes stage (Activity IX) were validated.

Table 3-27 displays baseline, Remeasurement 1, and Remeasurement 2 data for Kaiser's PIP. Kaiser's goals are to increase to 35 percent by Remeasurement 2 the percentage of CHP+ members ages 13 through 17 years screened for depression by a primary care practitioner's (PCP's) office and to increase to 60 percent the percentage of CHP+ members ages 13 through 17 years who screened positive for depression by a PCP's office and are seen by a behavioral health practitioner within 14 days of the positive screening.

Table 3-27—Performance Improvement Project Outcomes for Kaiser Permanente Colorado

PIP Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	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%*	38.4%*	*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	22.2%	33.3%	15.6%	*Not Assessed*

PIP Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	Sustained Improvement
and were seen by a behavioral health practitioner within 14 days of the positive screening.				

**Indicates statistically significant improvement over the baseline.*

The Remeasurement 1 rate for members 13 through 17 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.

The Remeasurement 2 rate for members 13 through 17 years of age who were screened for depression by a primary care practitioner (Study Indicator 1) increased to 38.4 percent. This rate was 21.5 percentage points above the baseline and exceeded the goal of 35 percent. This improvement for Study Indicator 1 was statistically significant, as evidenced by the *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 2 rate fell to 15.6 percent. This rate was 6.6 percentage points below the baseline and was well below the goal of 60 percent. Study Indicator 2 has not demonstrated statistically significant improvement over the baseline.

Kaiser: Strengths

Kaiser designed a methodologically sound project and performed well in the design and implementation stages, meeting all documentation requirements. Kaiser accurately reported and summarized the study indicator results and used appropriate quality improvement methods and processes to identify and prioritize barriers. The interventions implemented were logically linked to the barriers and had a positive impact on one of two study indicators.

Kaiser: Barriers and 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 the following barriers to address:

- Lack of time and simple pathways to promptly connect members who screen positive with behavioral health providers.
- Lack of awareness and maintaining engagement with the process, with large provider groups.
- Increased number of requests for assistance from behavioral health.

To address these barriers, Kaiser continued the following interventions:

- Hired and deployed a behavioral medicine specialist (BMS). Created business case to double size of BMS team.
- Developed standardized template for coding and charting.
- Continued communication regarding expectations for depression screening tool use.
- Added referral option to the primary care clinic based on BMS.
- Ensured that cross-coverage arrangements made for BMS were communicated to primary care providers.
- Held a refresher training for providers on the use of the PHQ9 tool if PHQ2 screening was positive.

Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the CHP+ MCOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. Upon conclusion of Kaiser's PIP, HSAG recommended the following:

- Continue to evaluate the effectiveness of each individual intervention and make changes as necessary.
- Develop a plan to sustain the improvement achieved through the PIP process.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-28 shows the results achieved by Kaiser for FY 2015–2016 through FY 2017–2018.

Table 3-28—Question Summary Rates and Global Proportions for Kaiser

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	87.8%	88.0%	84.5%
Getting Care Quickly	92.5%	92.0%	88.8%
How Well Doctors Communicate	96.8%	96.7%	95.7%
Customer Service	84.6%	85.1%	86.0%
Shared Decision Making	86.0%+	80.4%+	88.2%+
Rating of Personal Doctor	72.2%	72.9%	74.5%
Rating of Specialist Seen Most Often	58.3%+	62.5%+	75.7%+
Rating of All Health Care	65.0%	67.5%	68.1%
Rating of Health Plan	57.0%	61.0%	61.1%

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

Kaiser: Strengths

For Kaiser's CHP+ population, two measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Shared Decision Making* (7.8 percentage points)
- *Rating of Specialist Seen Most Often* (13.2 percentage points)

Four measures demonstrated slight increases between FY 2016–2017 and FY 2017–2018:

- *Customer Service*
- *Rating of Personal Doctor*
- *Rating of All Health Care*
- *Rating of Health Plan*

For Kaiser's CHP+ population, one measure rate increased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of Specialist Seen Most Often* (17.4 percentage points)

Five measures demonstrated slight increases between FY 2015–2016 and FY 2017–2018:

- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of All Health Care*
- *Rating of Health Plan*

Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For Kaiser's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018.

Three measures showed slight rate decreases between FY 2016–2017 and FY 2017–2018:

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

For Kaiser's CHP+ population, no measure rates decreased substantially between FY 2015–2016 and FY 2017–2018.

Three measures showed slight rate decreases between FY 2015–2016 and FY 2017–2018:

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

Kaiser experienced no substantial rate decreases in the 2017–2018 measurement year compared to the previous year. However, three measure rates showed slight decreases compared to the previous year. HSAG offers the following recommendations for Kaiser to consider based on population needs and health plan resources.

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

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

To improve member and family perceptions of these measures, HSAG recommends that Kaiser consider:

- Carefully monitoring and evaluating the 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.
- Evaluating 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 PCP-to-specialist referral patterns.
- Evaluating the effectiveness of current processes for telephonic or other technology-based communications with members which provide intermittent interventions, when needed, to decrease the need for formal appointments with providers.
- Evaluating 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 providing schedulers with CHP+ specific 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 ongoing reminders of where to access after-hours or walk-in care.

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, and members' willingness to engage. HSAG recommends that Kaiser consider the following recommendations:

- Query members regarding their communication preferences, use results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Use care coordinators to conduct ongoing follow-up with individual members and families, act as provider liaisons, provide outreach to members who have frequent no shows or treatment noncompliance, or provide some option as alternative service providers.
- Offer communication aides during a care visit, when necessary.
- Coordinate with community organizations to enhance disease management programs and offer to children, youth, and families health education and support related to chronic conditions such as asthma, diabetes, and weight management.

Rocky Mountain Health Plans

Monitoring for Compliance With CHIP Managed Care Regulations

Table 3-29 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 2017–2018.

Table 3-29—Summary of RMHP Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable*	Compliance Score (% of Met Elements)
V—Member Information	24	12	12	0	0	12	100%
VI—Grievance and Appeal System	35	22	18	0	4	13	82%
VII—Provider Participation and Program Integrity	16	14	13	1	0	2	93%
IX—Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**48**	**43**	**1**	**4**	**31**	**90%****

**Note: HSAG scored federal requirements that did not apply to CHP+ until July 1, 2018, as NA (Not Applicable).*

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

Table 3-30 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 record review score for FY 2017–2018.

Table 3-30—Summary of RMHP Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	60	33	28	5	27	85%
Appeals	30	29	24	5	1	83%
Totals	**90**	**62**	**52**	**10**	**28**	**84%***

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

RMHP: Strengths

RMHP used a variety of methods—including mailing a member handbook and welcome letter and making welcome calls—to inform members, upon enrollment, of the benefits and requirements of the plan. RMHP's CHP+ member information materials were written using easy-to-understand language and format and included required tag lines describing the availability of interpreter services and alternative formats and how to request them. Member materials repeatedly reminded members to contact customer service representatives with any questions, and the RMHP website offers the option of "chatting" with a customer service representative. The CHP+ member handbook, provider directory, and formulary drug list included the required content and were available online and upon request in both English and Spanish.

RMHP's grievance and appeal system policies and procedures addressed federal healthcare regulations and State contract requirements pertaining to member grievance, appeal, and SFH processes, time frames, and member notices. RMHP's provider contracts and provider manual informed all contracted providers and subcontractors about the grievance and appeal system. On-site record reviews demonstrated that RMHP staff making decisions about appeals and grievances have the appropriate clinical expertise and that resolution letters were member-centric and easy to understand.

RMHP provided detailed policies and procedures to support the selection and retention of healthcare providers. RMHP had a monitoring and tracking system for ensuring that no employees, providers, consultants, subcontractors, board of director members, or other applicable individuals or entities were excluded from participating in federal healthcare programs. RMHP demonstrated a satisfactory compliance program that included all required components. Additionally, RMHP demonstrated a documented compliance audit plan and an annual risk assessment of potentially high-risk program areas.

RMHP's policies and procedures described the processes for: evaluating a prospective subcontractor's ability to perform delegated activities, monitoring subcontractors' performance ongoing and annually, and requiring corrective actions for any identified deficiencies. RMHP's written agreements with its subcontractors specified the delegated activities and reporting requirements, delineated sanctions (including revocation) if the subcontractor failed to meet performance standards, and required subcontractor compliance with all applicable laws. RMHP provided evidence of collecting and reviewing ongoing reports from its subcontractors and of performing annual formal reviews. RMHP's Medical Advisory Council (MAC) conducted oversight of subcontractor performance.

RMHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard VI—Grievance and Appeal System

HSAG noted some deficiencies in sending written notices to members. RMHP was required to:

- Have mechanisms in place to send members written acknowledgment of each grievance and appeal.

- Provide written notice of resolution within 15 working days from receipt for grievances and within 10 working days from receipt for appeals.

Standard VII—Provider Participation and Program Integrity

RMHP had not implemented a method to verify whether services represented to have been delivered were received by members. RMHP was required to have a method to verify regularly, by sampling or other method(s), whether services represented to have been delivered by network providers were received by members.

RMHP: Trended Performance for Compliance Monitoring

Table 3-31 displays RMHP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 3-31—Compliance Monitoring Trended Performance for RMHP

Standard and Applicable Review Years	Previous Review	Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	85%	97%
Standard II—Access and Availability (2013–2014, 2016–2017)	86%	100%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	89%	100%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	40%	80%
Standard V—Member Information (2014–2015, 2017–2018)**	**52%**	**100%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)**	**77%**	**82%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)**	**94%**	**93%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	98%	100%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)**	**100%**	**NA**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	73%	100%

**The 2017–2018 scores reflect overall compliance without scoring of any regulations that were new based on the May 2016 release of revised regulations or that contained revisions of the previous rules; therefore, overall compliance scores may not be comparable to scores earned in the previous or future review cycles. In addition, for all standards, the health plan's contract with the State may have changed since each of the previous review years and may have contributed to performance changes.*

***Bold text indicates standards reviewed by HSAG during FY 2017–2018.*

Trending scores over the past six years indicate that RMHP improved performance in eight of ten standards. RMHP made commendable efforts to improve performance in Standard IV—Member Rights and Protections and Standard V—Member Information, as evidenced by improvement of 40 and 48 percentage points respectively. RMHP also experienced commendable improvement in Standard X—Quality Assessment and Performance Improvement, with a 27-percentage-point improvement. Standard VII experienced a 1-percentage-point decline between FY 2014–2015 and FY 2017–2018. HSAG

cautions, however, that over the three-year cycle between review periods, several factors—e.g., changes in federal requirements, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2018 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 HEDIS auditor identified no notable issues with negative impact on HEDIS reporting.

Performance Measure Results

Table 3-32 shows the performance measure results for RMHP for HEDIS 2016 through HEDIS 2018, along with the percentile rankings for each HEDIS 2018 rate.

Table 3-32—Performance Measure Results for RMHP

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	BR	58.27%	64.80%	10th-24th
Combination 3	BR	55.91%	62.40%	10th-24th
Combination 4	BR	54.33%	60.40%	10th-24th
Combination 5	BR	51.57%	54.40%	25th–49th
Combination 6	BR	43.31%	41.20%	50th–74th
Combination 7	BR	50.39%	53.20%	25th–49th
Combination 8	BR	42.13%	41.20%	50th–74th
Combination 9	BR	40.16%	36.40%	50th–74th
Combination 10	BR	39.37%	36.40%	50th–74th
Immunizations for Adolescents[1]				
Combination 1 (Meningococcal, Tdap)	BR	49.61%	60.87%^	<10th
Well-Child Visits in the First 15 Months of Life[1]				
*Zero Visits**	BR	3.00%	5.00%	10th-24th
Six or More Visits	BR	23.00%	29.00%	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	BR	63.66%	68.75%^	25th–49th
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	BR	43.69%	47.07%^	25th–49th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	BR	4.44%	4.38%	<10th
Counseling for Nutrition—Total	BR	19.04%	21.52%	<10th
Counseling for Physical Activity—Total	BR	1.29%	3.51%	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	79.42%	78.26%	80.27%	50th–74th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	95.48%	91.26%	93.48%	25th–49th
Ages 25 Months to 6 Years	86.26%	82.13%	83.49%	10th-24th
Ages 7 to 11 Years	85.23%	86.72%	86.90%	10th-24th
Ages 12 to 19 Years	89.01%	87.34%	86.82%	25th–49th
Preventive Screening				
Chlamydia Screening in Women				
Ages 16 to 20 Years	30.84%	23.31%	31.93%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.38%	0.00%	0.00%	≥90th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
Follow-Up Care for Children Prescribed ADHD Medication[2]				
Initiation Phase	35.29%	NA	47.06%	50th–74th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	NA	NA	—
Respiratory Conditions				
Appropriate Treatment for Children With Upper Respiratory Infection[3]				
Appropriate Treatment for Children With Upper Respiratory Infection	93.30%	95.41%	95.80%	75th–89th
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Asthma Medication Ratio				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits**	20.86	18.26	18.26	≥90th
Outpatient Visits	230.04	212.07	218.41	<10th
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 Member Months (Total Inpatient)	1.01	0.73	0.89	<10th
Average Length of Stay (Total Inpatient)	3.63	3.01	4.11	25th–49th
Discharges per 1,000 Member Months (Medicine)	0.68	0.45	0.59	<10th
Average Length of Stay (Medicine)	3.42	2.57	3.29	<10th
Discharges per 1,000 Member Months (Surgery)	0.27	0.27	0.28	<10th
Average Length of Stay (Surgery)	4.42†	3.71	5.91	10th-24th
Discharges per 1,000 Member Months (Maternity)	0.13	0.02	0.03	<10th
Average Length of Stay (Maternity)	2.20†	4.00†	2.50†	10th-24th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.67	0.40	0.40	≥90th
Average Days Supplied per Antibiotic Script	10.06	10.49	10.18	<10th
Average Scripts PMPY for Antibiotics of Concern	0.29	0.15	0.14	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	43.16%	38.64%	35.07%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017. This measure rate presented in this table is based on administrative data only.
[2] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.
[3] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 and 2018 rates to prior years.
— Indicates that the measure was not required in previous technical reports or that the measure could not be compared to national Medicaid percentiles because the rate was not reportable.
† 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 poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
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.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
BR (Biased Rate) indicates that the reported rate was invalid; therefore, the rate is not presented.

RMHP: Strengths

The following HEDIS 2018 measure rates were determined to be high performers (i.e., ranked at or above the national Medicaid 75th percentiles without a statistically significant decline in performance from HEDIS 2017 or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017) for RMHP:

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

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers (i.e., fell below the national Medicaid 25th percentiles or ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017) for RMHP:

- *Childhood Immunization Status—Combinations 2*, *3*, and *4*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *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*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Ages 7 to 11 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

RMHP's performance for HEDIS 2018 demonstrated that some members may face challenges accessing services to receive appropriate care, as evidenced by two of four measure rates for *Children and Adolescents' Access to Primary Care Practitioners* falling below the national Medicaid 25th percentiles. The lack of access to services may also have an impact on the performance related to several preventive care and screening measures that fell below the national Medicaid 25th percentiles: *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *Well-Child Visits in the First 15 Months of Life*; and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*. Similarly, rates for *Childhood Immunization Status—Combinations 2*, *3*, and *4* and *Chlamydia Screening in Women—Ages 16 to 20 Years* fell below the national Medicaid 25th percentiles, indicating a lack of preventive services delivered. RMHP should work to ensure that members have access to care and receive these services.

Conversely, RMHP exceeded the national Medicaid 75th percentiles for the following measures: *Non-Recommended Cervical Cancer Screening in Adolescent Females* and *Appropriate Treatment for Children With Upper Respiratory Infection*. The health plan demonstrated strength by ensuring that young women were not screened unnecessarily for cervical cancer and that respiratory infections noted upon ED and outpatient visits were appropriately treated.

Validation of Performance Improvement Projects

Table 3-33 displays the validation results for the RMHP PIP, RMHP's *CHP+ Members With Asthma Transitioning Out of Plan Coverage,* validated during FY 2017–2018. This table illustrates the health plan'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 *Met* scores have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-33 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all PIP validation activities. This was the fourth validation year for the PIP, with HSAG validating Activities I through IX.

Table 3-33—Performance Improvement Project Validation Results for Rocky Mountain Health Plans

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	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity		Percentage of Applicable Elements*		
			Met	*Partially Met*	*Not Met*
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**90% (19/21)**	**0% (0/21)**	**10% (2/21)**

Overall, 90 percent of all applicable evaluation elements validated received scores of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII and VIII), and the Outcomes stage (Activity IX) were validated.

Table 3-34 displays baseline, Remeasurement 1, and Remeasurement 2 data for RMHP's PIP. RMHP's goal is to increase, of CHP+ members with asthma who turned 19 years of age during the measurement year, the percentage who had at least one visit with a primary care provider.

Table 3-34—Performance Improvement Project Outcomes for Rocky Mountain Health Plans

PIP Study Indicator	Baseline Period (1/1/2014–12/31/2014)	Remeasurement 1 (1/1/2015–12/31/2015)	Remeasurement 2 (1/1/2016–12/31/2016)	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%	75.0%	73.9%	*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 75.0 percent. This was a non-statistically significant increase, as evidenced by the *p* value of 0.1393. The health plan exceeded by 10 percent its goal of

increasing, for CHP+ members with asthma who turned 19 years of age during the measurement year, the rate for those who had at least one visit with a primary care provider.

For Remeasurement 2, the rate of 73.9 percent was a slight decline from Remeasurement 1; however, improvement over baseline did occur. The improvement over baseline was not statistically significant, as evidenced by the *p* value of 0.1523. The health plan did not achieve its goal of 82.6 percent.

RMHP: Strengths

Despite the lack of statistically significant improvement, RMHP designed a methodologically sound project. The sound study design allowed the health plan to progress to the collection of data and the implementation of interventions. RMHP accurately reported and summarized the Remeasurement 2 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.

RMHP: Barriers and 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 health plan's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in improving PIP rates.

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

- Difficulty reaching members by telephone
- Lack of a tracking mechanism to identify the effectiveness of outreach
- Lack of reminder regarding the importance of well visits
- Lack of member education about managing personal condition during and after transition from the CHP+ program
- Inability to communicate with the member due to a language barrier
- Staff inability to answer questions asked by a member's parent regarding coverage

To address these barriers, RMHP implemented the following interventions:

- Customer service staff call the member and provide a warm transfer to the provider's office to schedule a visit immediately.
- Customer service staff call members and answer questions about coverage.
- Telephone outreach is made to the parent or guardian of the member in the targeted population to discuss the transition out of the CHP+ program and inform about the importance of scheduling well visit with primary care provider.

- A letter including educational material is mailed to the parent or guardian of the member in the targeted population.
- Provision of member incentive for completion of primary care visit was begun.

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the CHP+ MCOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. Upon conclusion of RMHP's PIP, HSAG recommended the following:

- Regularly review and update causal/barrier analyses and quality improvement processes to reevaluate barriers and explore innovative and impactful interventions.
- Consider using an FMEA to isolate barriers that may not have been previously identified. This quality improvement tool works well with the process map that the health plan is completing.
- Continue to conduct ongoing evaluations of each intervention; and make data-driven decisions regarding revising, continuing, or discontinuing interventions.

Consumer Assessment of Healthcare Providers and Systems

Findings

Table 3-35 shows the results achieved by RMHP for FY 2015–2016 through FY 2017–2018.

Table 3-35—Question Summary Rates and Global Proportions for RMHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	86.1%	88.2%	88.4%
Getting Care Quickly	90.2%	92.5%	91.8%
How Well Doctors Communicate	96.5%	97.3%	97.9%
Customer Service	78.0%	86.2%+	83.9%
Shared Decision Making	80.7%	76.2%+	84.2%+
Rating of Personal Doctor	70.1%	77.6%	72.8%
Rating of Specialist Seen Most Often	78.8%	77.5%+	80.5%+
Rating of All Health Care	62.9%	66.6%	67.2%
Rating of Health Plan	59.1%	60.6%	63.2%

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

RMHP: Strengths

For RMHP's CHP+ population, one measure rate increased substantially between FY 2016–2017 and FY 2017–2018:

- *Shared Decision Making* (8.0 percentage points)

Five measures demonstrated slight increases between FY 2016–2017 and FY 2017–2018:

- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For RMHP's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018.

Three measures showed slight rate decreases between FY 2016–2017 and FY 2017–2018:

- *Getting Care Quickly*
- *Customer Service*
- *Rating of Personal Doctor*

For RMHP's CHP+ population, no measure rates decreased substantially between FY 2015–2016 and FY 2017–2018.

No measures showed slight rate decreases between FY 2015–2016 and FY 2017–2018.

RMHP experienced no substantial rate decreases in the 2017–2018 measurement year compared to the previous year. However, three measurement rates showed slight decreases. HSAG offers the following for RMHP to consider based on population needs and health plan resources. To improve members' perceptions on the *Getting Care Quickly*, *Customer Service*, and *Rating of Personal Doctor* measures, HSAG recommends that RMHP:

- Offer provider incentives for expanding the availability of evening and weekend hours— develop open-access scheduling or adopt alternative schedules such as early morning or late evening hours.
- Encourage 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 communication to inform both members and providers of timeliness access standards and where to access after-hours care.

- Conduct 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 why members called Customer Service and which identifies the most common questions and concerns expressed by members. With this information, RMHP 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.

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

Monitoring for Compliance With Medicaid Managed Care Regulations

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

Description of Standard	Colorado Access	DHMP	FHP	Kaiser	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services (2016–2017)	94%	94%	91%	94%	97%	94%
Standard II—Access and Availability (2016–2017)	100%	92%	79%	93%	100%	93%
Standard III—Coordination and Continuity of Care (2015–2016)	92%	100%	50%	75%	100%	85%
Standard IV—Member Rights and Protections (2015–2016)	80%	100%	80%	60%	80%	80%
Standard V—Member Information (2017–2018)	**100%**	**83%**	**92%**	**100%**	**100%**	**95%**
Standard VI—Grievance and Appeal System (2017–2018)	**95%**	**91%**	**82%**	**68%**	**82%**	**84%**
Standard VII—Provider Participation and Program Integrity (2017–2018)	**100%**	**79%**	**93%**	**87%**	**93%**	**90%**
Standard VIII—Credentialing and Recredentialing (2015–2016)	94%	98%	77%	100%	100%	94%
Standard IX—Subcontracts and Delegation (2017–2018)	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Standard X—Quality Assessment and Performance Improvement (2015–2016)	100%	93%	73%	67%	100%	88%

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.

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

Record Reviews	Colorado Access	DHMP	FHP	Kaiser	RMHP	Statewide Average
Appeals (2017–2018)	**93%**	**83%**	**100%**	**NA**	**83%**	**90%**
Credentialing (2015–2016)	100%	100%	89%	100%	100%	98%
Denials (2016–2017)	100%	0%	98%	100%	97%	90%
Grievances (2017–2018)	**100%**	**NA**	**100%**	**75%**	**85%**	**89%**
Recredentialing (2015–2016)	98%	100%	97%	100%	100%	99%

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.
NA: DHMP reported no CHP+ member grievances and Kaiser reported no CHP+ member appeals during the review period.

Statewide Conclusions and Strengths Related to Compliance Monitoring

With respect to regulations applicable to CHP+ health plans at the time of the site reviews, HSAG found all five CHP+ health plans compliant in the following areas:

- Provided members information at time of enrollment about requirements and benefits of the plan; how to use the health plan; member rights; availability of alternative formats, oral translation, and interpretation services; and how to exercise advance directives.
- Provided members notice of significant change in benefits (30 days prior to effective date) and/or providers (within 15 days of notice).
- Defined adverse benefit determination and appeal consistent with federal regulation, allowed members and their representatives (including providers, with member's written permission) to file grievances and appeals orally or in writing, and ensured that individuals who make decisions related to grievances and appeals have appropriate expertise.
- Provided appropriate information about time frames for expedited review processes, time frames for extensions of both expedited and standard appeals, and information about members' and contractors' fiscal responsibilities for continued benefits.
- Had policies and procedures for selection of providers, and ensured that every provider signed a contract or provider agreement.
- Demonstrated robust compliance programs that included training about prevention and detection of fraud, waste, and abuse.
- Had policies and processes to prevent contracting with or hiring providers, directors, officers, partners, employees, consultants, subcontractors, or owners excluded from participation in federal programs.

Statewide Conclusions and Recommendations Related to Compliance Monitoring

With respect to regulations applicable to CHP+ health plans at the time of the site reviews, HSAG found that no two health plans had the same required action in the member information standard; however, several plans were required to address the following areas related to grievance and appeal system and provider participation and program integrity:

- Four health plans were required to ensure that they send written notice of appeal resolution within 10 days of receipt.
- Two health plans were required to send written acknowledgement for grievances and ensure that grievance resolution letters are written using easy-to-understand language.
- Two health plans were required to clarify information regarding the duration of continued benefits.
- Two health plans were required to provide information about member grievances, appeals, and State fair hearings to providers and subcontractors at the time those entities enter into a contract.

- Two health plans were required to implement written policies and procedures for the retention of providers.
- Two health plans were required to develop and implement mechanisms for promptly reporting all overpayments identified or recovered due to potential fraud; screening all provider claims for potential fraud, waste, or abuse; and notifying the Department about changes in a network provider's circumstances that could affect that provider's eligibility to participate in the Medicaid managed care program.

In addition to correcting the required actions identified, HSAG encourages the CHP+ health plans to focus efforts on addressing the suggestions for ensuring compliance with federal regulations, applicable to the CHP+ health plans beginning July 1, 2018.

Validation of Performance Measures

HSAG evaluated the health plans' information system (IS) capabilities for accurate HEDIS reporting. For the current reporting period, Colorado Access, FHP, Kaiser, and RMHP were fully compliant with all IS standards relevant to the scope of the performance measure validation performed by each health plan's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditors identified no notable issues with negative impact on HEDIS reporting. DHMP was fully compliant with four of the IS standards and partially compliant with two of the IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. DHMP's HEDIS auditor found that the health plan was partially compliant with IS standards 1 and 7, which related to the *Childhood Immunization Status* measure, and these issues materially impacted DHMP's ability to report performance measure data for this measure. For the remaining health plans, HSAG determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology and that the rates and audit results are valid, reliable, and accurate.

In Table 4-3, plan-specific and statewide weighted averages are presented for the CHP+ MCOs. Given that the MCOs 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 *Small Denominator* (*NA*), the numerators, denominators, and eligible populations were included in the calculations of the statewide rate. For health plans with rates reported as *Biased Rate (BR)*, the numerators, denominators, and eligible populations were excluded from the calculation of the statewide rate.

Table 4-3—MCO and Statewide Results

Performance Measures	Colorado Access	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Pediatric Care						
Childhood Immunization Status						
Combination 2	62.30%	BR	7.84%	70.85%	64.80%	62.54%
Combination 3	60.82%	BR	5.88%	70.17%	62.40%	61.05%
Combination 4	58.71%	BR	3.92%	69.15%	60.40%	59.17%
Combination 5	53.96%	BR	0.00%	62.03%	54.40%	53.79%
Combination 6	41.29%	BR	3.92%	43.73%	41.20%	40.51%
Combination 7	52.38%	BR	0.00%	61.02%	53.20%	52.43%
Combination 8	39.92%	BR	1.96%	43.39%	41.20%	39.53%
Combination 9	37.59%	BR	0.00%	39.32%	36.40%	36.49%
Combination 10	36.54%	BR	0.00%	38.98%	36.40%	35.77%
Immunizations for Adolescents						
Combination 1 (Meningococcal, Tdap)	70.24%	68.81%	15.94%	82.30%	60.87%	68.89%
Combination 2 (Meningococcal, Tdap, HPV)	31.71%	49.54%	5.80%	53.98%	13.71%	33.79%
Well-Child Visits in the First 15 Months of Life						
*Zero Visits**	1.36%	NA	NA	2.91%	5.00%	2.63%
Six or More Visits	59.86%	NA	NA	66.02%	29.00%	51.41%
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	69.32%	46.64%	43.72%	59.35%	68.75%	64.97%
Adolescent Well-Care Visits						
Adolescent Well-Care Visits	48.34%	37.64%	25.05%	41.18%	47.07%	45.09%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Percentile Documentation—Total	5.25%	17.71%	1.69%	97.29%	4.38%	19.89%
Counseling for Nutrition—Total	2.94%	6.41%	5.92%	95.57%	21.52%	20.12%
Counseling for Physical Activity—Total	1.06%	1.40%	3.38%	95.57%	3.51%	15.87%
Appropriate Testing for Children With Pharyngitis						
Appropriate Testing for Children With Pharyngitis	88.07%	NA	77.55%	96.37%	80.27%	87.36%
Access to Care						
Children and Adolescents' Access to Primary Care Practitioners						
Ages 12 to 24 Months	94.65%	69.03%	NA	87.44%	93.48%	90.65%
Ages 25 Months to 6 Years	85.90%	57.24%	65.33%	75.76%	83.49%	80.91%
Ages 7 to 11 Years	89.74%	81.33%	73.58%	86.56%	86.90%	87.49%
Ages 12 to 19 Years	90.90%	78.05%	80.49%	88.45%	86.82%	88.09%

Performance Measures	Colorado Access	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Prenatal and Postpartum Care^						
Timeliness of Prenatal Care	—	—	—	—	—	58.29%
Postpartum Care	—	—	—	—	—	43.42%
Preventive Screening						
Chlamydia Screening in Women						
Ages 16 to 20 Years	32.11%	39.74%	13.95%	41.43%	31.93%	33.66%
Non-Recommended Cervical Cancer Screening in Adolescent Females*						
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.06%	0.00%	0.00%	0.17%	0.00%	0.07%
Mental/Behavioral Health						
Antidepressant Medication Management						
Effective Acute Phase Treatment	NA	NA	NA	NA	NA	48.65%
Effective Continuation Phase Treatment	NA	NA	NA	NA	NA	40.54%
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	0.00%	NA	NA	NA	47.06%	21.84%
Continuation and Maintenance Phase	0.00%	NA	NA	NA	NA	21.57%
Metabolic Monitoring for Children and Adolescents on Antipsychotics						
Total	29.59%	NA	NA	NA	NA	39.85%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*						
Total	6.67%	NA	NA	NA	NA	5.62%
Respiratory Conditions						
Appropriate Treatment for Children With Upper Respiratory Infection						
Appropriate Treatment for Children With Upper Respiratory Infection	92.12%	100.00%	87.72%	99.01%	95.80%	93.84%
Medication Management for People With Asthma						
Medication Compliance 50%—Ages 5 to 11 Years	65.41%	NA	NA	46.67%	NA	61.29%
Medication Compliance 50%—Ages 12 to 18 Years	55.77%	NA	NA	NA	NA	51.75%
Medication Compliance 75%—Ages 5 to 11 Years	34.59%	NA	NA	23.33%	NA	32.26%
Medication Compliance 75%—Ages 12 to 18 Years	27.88%	NA	NA	NA	NA	24.48%
Asthma Medication Ratio						
Ages 5 to 11 Years	80.58%	NA	NA	93.33%	NA	82.90%
Ages 12 to 18 Years	72.07%	NA	NA	NA	NA	74.03%

Performance Measures	Colorado Access	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
Use of Services						
Ambulatory Care (Per 1,000 Member Months)						
*Emergency Department Visits**	26.36	18.43	15.98	11.54	18.26	21.80
Outpatient Visits	221.11	123.51	175.38	151.08	218.41	199.00
Inpatient Utilization—General Hospital/Acute Care						
Discharges per 1,000 Member Months (Total Inpatient)	0.99	0.69	0.65	0.62	0.89	0.88
Average Length of Stay (Total Inpatient)	3.74	4.25	2.13†	3.51	4.11	3.77
Discharges per 1,000 Member Months (Medicine)	0.67	0.49	0.45	0.46	0.59	0.60
Average Length of Stay (Medicine)	2.85	2.90	2.36†	3.34	3.29	2.96
Discharges per 1,000 Member Months (Surgery)	0.28	0.18	0.16	0.12	0.28	0.24
Average Length of Stay (Surgery)	6.00	8.07†	1.50†	4.24†	5.91	5.90
Discharges per 1,000 Member Months (Maternity)	0.09	0.02	0.08	0.07	0.03	0.07
Average Length of Stay (Maternity)	3.05†	2.00†	2.00†	3.20†	2.50†	2.97
Antibiotic Utilization*						
Average Scripts PMPY for Antibiotics	0.42	0.09	0.97	0.26	0.40	0.38
Average Days Supplied per Antibiotic Script	10.88	12.07	16.68	12.15	10.18	11.36
Average Scripts PMPY for Antibiotics of Concern	0.14	0.02	0.41	0.05	0.14	0.12
Percentage of Antibiotics of Concern of All Antibiotic Scripts	34.12%	23.31%	41.62%	19.57%	35.07%	33.02%

** For this indicator, a lower rate indicates better performance.*
† This symbol indicates that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
BR (Biased Rate) indicates that the reported rate was invalid; therefore, the rate is not presented.
— This symbol indicates that the health plan was not required to report this measure indicator.
^ The State Managed Care Network (SMCN) is the only CHP+ health plan required to report the Prenatal and Postpartum Care measure.

Statewide Strengths

The following HEDIS 2018 measure rates were determined to be high performers (i.e., ranked at or above the national Medicaid 75th percentile without a statistically significant decline in performance from HEDIS 2017 or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017) for the CHP+ statewide weighted average:

- *Appropriate Testing for Children With Pharyngitis*

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years*
- *Asthma Medication Ratio—Ages 5 to 11 Years* and *Ages 12 to 18 Years*

Statewide Opportunities for Improvement and Recommendations Related to MCO Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers (i.e., fell below the national Medicaid 25th percentile; or ranked between the national Medicaid 25th and 49th percentile, with statistically significant decreases from HEDIS 2017) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 2*, *3*, *4*, and *5*
- *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*
- *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*, and *Ages 7 to 11 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

At the statewide level, strengths were related to appropriately testing and treating members with pharyngitis in ED and outpatient visits and avoiding unnecessary screenings for cervical cancer in young women. Additionally, members with asthma and members on antipsychotics received appropriate medication management for their conditions. With statewide performance in several areas falling below the national Medicaid 25th percentile, improvement efforts need to be focused on increasing access to care for members. Once members have access to essential services with primary care practitioners, obstetricians, and gynecologists, providers can ensure that appropriate care is being provided to keep members healthy, including: childhood vaccinations, screenings for chlamydia in young women, follow-up care for young children on ADHD medications, and required well-care visits for young children and adolescents.

Validation of Performance Improvement Projects

Table 4-4 shows the FY 2017–2018 PIP validation results for the CHP+ MCOs.

Table 4-4—FY 2017–2018 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*
DHMP	*Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*	95%	91%	*Not Met*
FHP	*Adolescent Positive Depressive Disorder Screening and Transition to a Behavioral Health Provider*	100%	100%	*Met*
Kaiser	*Access and Transition to Behavioral Health Services*	90%	82%	*Partially Met*
RMHP	*CHP+ Members With Asthma Transitioning Out of Plan Coverage*	90%	82%	*Not Met*

Of the five CHP+ MCOs that submitted a PIP for validation in FY 2017–2018, two each received a *Met* validation status, one received a *Partially Met* validation status, and the remaining two each received a *Not Met* validation status. The percentage of evaluation elements receiving a *Met* score ranged from 90 percent to 100 percent across the five PIPs submitted by the CHP+ MCOs.

Statewide Conclusions and Recommendations for PIPs

The validation status received for each PIP was driven by whether the PIP had progressed to the Outcomes stage and whether statistically significant improvement over baseline was demonstrated by study indicator results. One of the two MCOs that each received a *Met* validation status (FHP) was assessed through the PIP Implementation stage only and had not yet progressed to reporting remeasurement 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 2 study indicator results, demonstrating statistically significant improvement over the baseline results at Remeasurement 1, and sustaining the improvement in Remeasurement 2. The MCOs that received a *Partially Met* validation status (Kaiser) or a *Not Met* validation status (DHMP and RMHP) had also progressed to reporting remeasurement results in the Outcomes stage. The Kaiser PIP demonstrated statistically significant improvement in one of two PIP study indicators, while the DHMP and RMHP PIPs did not demonstrate statistically significant improvement in study indicator outcomes. 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.

After the FY 2017–2018 PIP validation, the Colorado Department of Health Care Policy and Financing instructed the MCOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. Considering the closeout plans, HSAG recommended the following for the MCOs:

- At the conclusion of the PIP, synthesize the study indicator results and lessons learned throughout the project to provide a springboard for sustaining improvement achieved and attaining new improvements.
- If statistically significant improvement in study indicator outcomes was achieved, develop a plan to continue monitoring of outcomes and facilitate sustained improvement beyond the end of the formal PIP.
- Identify successful improvement strategies that had the greatest impact on improving outcomes, and develop a plan for ongoing implementation of those strategies.
- Explore opportunities to spread successful interventions beyond the scope of the PIP.

Consumer Assessment of Healthcare Providers and Systems Surveys

Statewide Results for CAHPS

The statewide averages presented in Table 4-5 are derived from the combined results of the five CHP+ health plans. Table 4-5 shows the FY 2017–2018 plan-level and statewide average results for each CAHPS measure.

Table 4-5—Statewide Comparison of Question Summary Rates and Global Proportions

Measure	Colorado Access	DHMP	FHP	Kaiser	RMHP	Statewide Average
Getting Needed Care	85.3%	83.5%	86.1%	84.5%	88.4%	85.5%
Getting Care Quickly	92.4%	88.4%	89.9%	88.8%	91.8%	91.2%
How Well Doctors Communicate	95.4%	95.6%	95.3%	95.7%	97.9%	95.8%
Customer Service	83.7%	84.4%	82.0%$^{+}$	86.0%	83.9%	84.1%
Shared Decision Making	74.8%$^{+}$	72.5%$^{+}$	84.6%$^{+}$	88.2%$^{+}$	84.2%$^{+}$	78.5%
Rating of Personal Doctor	76.2%	84.6%	62.3%	74.5%	72.8%	75.7%
Rating of Specialist Seen Most Often	78.9%$^{+}$	84.1%$^{+}$	67.6%$^{+}$	75.7%$^{+}$	80.5%$^{+}$	78.7%

Measure	Colorado Access	DHMP	FHP	Kaiser	RMHP	Statewide Average
Rating of All Health Care	69.1%	70.2%	52.2%	68.1%	67.2%	68.1%
Rating of Health Plan	61.3%	65.3%	47.4%	61.1%	63.2%	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.

Statewide Conclusions and Recommendations for CAHPS

Member and family perceptions regarding quality of care and services increased either substantially or slightly between FY 2016–2017 and FY 2017–2018 in two or more health plans for each member satisfaction measure. *Rating of Specialist Seen Most Often* increased in all five health plans, and in four of those substantially: Colorado Access, DHMP, FHP, and Kaiser. *Rating of All Health Care* increased in four of the five CHP+ health plans. Three of five plans' ratings improved in *Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Health Plan*. *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate* increased in two of the five health CHP+ health plans.

Three of the five CHP+ health plans—Colorado Access, Kaiser, and RMHP—had no rates substantially lower than the statewide average. One health plan, FHP, had four rates substantially lower than the statewide rates; and one health plan, DHMP, had only one rate substantially lower than the statewide rate. For one measure, *How Well Doctors Communicate,* four health plans had rates lower than the statewide average. For three measures—*Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*—three health plans had rates slightly lower than the statewide average. 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

Assessment of Compliance With Medicaid Managed Care Regulations

In FY 2016–2017, HSAG reviewed two standards: Coverage and Authorization of Services and Access and Availability. For Coverage and Authorization of Services, Colorado Access had two required actions to ensure that claims payment processes considered the financial responsibility requirements for post-stabilization services. Colorado Access had no required actions related to Access and Availability. Colorado Access submitted its initial corrective action plan proposal on August 1, 2017; and following Department approval completed implementation of all planned interventions on April 23, 2018.

Validation of Performance Measures

Last year, HSAG recommended that Colorado Access focus efforts on improving rates for the following measures: *Childhood Immunization Status—Combinations 2–4*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*; *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*; *Chlamydia Screening in Women*; *Follow-Up Care for Children Prescribed ADHD Medication*; and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*. At the time of the writing of this report, Colorado Access had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations. Colorado Access' HEDIS 2018 rate for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* demonstrated statistically significant improvement in HEDIS 2018 and improved to rank at or above the national Medicaid 25th percentile. This increase may or may not indicate that Colorado Access developed improvement initiatives to positively impact performance measure rates. All other rates remained below the national Medicaid 25th percentile and did not demonstrate significant improvements from HEDIS 2017 to HEDIS 2018. HSAG cautions that meaningful differences in HEDIS measure rates as a result of performance improvement activities may require multiple measurement periods.

Validation of Performance Improvement Projects

For the FY 2016–2017 PIP validation cycle, Colorado Access received a *Partially 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 document a complete narrative interpretation of study indicator results. For the *Partially Met* score, HSAG provided feedback recommending that the health plan ensure that the Activity VII documentation provide a narrative interpretation of study indicator results, including study indicator results from the most recent measurement period, comparing the results to the health plan's goal, and reporting statistical testing results between the most recent remeasurement and the baseline remeasurement. For the FY 2017–2018 PIP validation cycle, the health plan did not address HSAG's

previous recommendations and, therefore, again received a *Partially Met* score for the same evaluation element in Activity VII.

Consumer Assessment of Healthcare Providers and Systems

At time of the writing of this report, Colorado Access had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations; however, changes were noted in performance as follows. Between FY 2016–2017 and FY 2017–2018, Colorado Access demonstrated increases in rates for five measures. During FY 2017–2018, the rate for *Rating of Specialist Seen Most Often* increased by 8.7 percentage points since FY 2016–2017. 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.

Denver Health Medical Plan, Inc.

Assessment of Compliance With Medicaid Managed Care Regulations

For the two 2016–2017 standards—Coverage and Authorization of Services and Access and Availability—DHMP had two required actions: to improve member notices of action related to denial of claims payment and to improve coordination between utilization management (UM) decisions and claims adjudication processes. DHMP had one required action: to continue to expand its provider network to ensure sufficient access to services. DHMP submitted its initial corrective action plan proposal on December 7, 2017; and, following Department approval, completed implementation of all planned interventions on February 21, 2018.

Validation of Performance Measures

Last year, HSAG recommended that DHMP focus efforts on improving rates for the following measures: *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *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*; *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*; *Chlamydia Screening in Women*; and *Appropriate Treatment for Children With Upper Respiratory Infection*. At the time of the writing of this report, DHMP had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations; however, the following rates demonstrated statistically significant improvement in HEDIS 2018 as compared to the prior measure year: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Nutrition—Total*; and *Appropriate Treatment for Children With Upper Respiratory Infection.* Of note, the *Appropriate Treatment for Children With Upper Respiratory Infection* rate exceeded the national Medicaid 90th percentile. These increases may

or may not indicate that DHMP developed improvement initiatives to positively impact performance measure rates. Conversely, rates for the following measures demonstrated statistically significant declines in performance and fell below the national Medicaid 10th percentile: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Ages 12 to 19 Years*. HSAG cautions that meaningful differences in HEDIS measure rates as a result of performance improvement activities may require multiple measurement periods.

Validation of Performance Improvement Projects

DHMP received a *Met* score for 100 percent of applicable evaluation elements during the FY 2016–2017 validation cycle; therefore, no prior PIP recommendations for follow-up existed during the FY 2017–2018 validation cycle.

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 by allowing CHP+ members to access these clinics for urgent care appointments. As a result, between FY 2016–2017 and FY 2017–2018, DHMP demonstrated rate increases for six of the nine measures; three of these increases were substantial: *Getting Needed Care* (7.7 percentage points), *Getting Care Quickly* (7.8 percentage points), and *Rating of Specialist Seen Most Often* (6.7 percentage points).

Friday Health Plans of Colorado

Assessment of Compliance With Medicaid Managed Care Regulations

For Coverage and Authorization of Services, FHP had two required actions related to the process for extending authorization decisions and a third required action to develop procedures for processing of expedited authorization requests. For Access and Availability, FHP had two required actions related to timely access standards and a third required action to enhance procedures and communication regarding cultural competency. FHP submitted its initial corrective action plan proposal on June 2, 2017; and, following Department approval, completed implementation of all planned interventions on April 17, 2017.

Validation of Performance Measures

Last year, HSAG recommended that FHP focus efforts on improving rates for the following measures: *Childhood Immunization Status*; *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*; *Children and Adolescents' Access to Primary Care Practitioners*; and *Appropriate Treatment for Children With Upper Respiratory Infection*. At the time of the writing of this report, FHP had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations. None of FHP's HEDIS 2018 rates demonstrated statistically significant improvement or declines in performance. Of note, the *Appropriate Treatment for Children With Upper Respiratory Infection* rate increased to at or above the national Medicaid 25th percentile, with all other rates remaining below the national Medicaid 10th percentile. This increase may or may not indicate that FHP developed improvement initiatives to positively impact performance measure rates. HSAG cautions that meaningful differences in HEDIS measure rates as a result of performance improvement activities may require multiple measurement periods.

Validation of Performance Improvement Projects

FHP received a *Met* score for 100 percent of applicable evaluation elements during the FY 2016–2017 validation cycle; therefore, no prior PIP recommendations for follow-up existed during the FY 2017–2018 validation cycle.

Consumer Assessment of Healthcare Providers and Systems

At time of the writing of this report, FHP had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations; however, changes were noted in performance as follows. Between FY 2016–2017 and FY 2017–2018, FHP demonstrated increases in rates for four measures. Two measures, *Customer Service* and *Rating of Specialist Seen Most Often*, both demonstrated substantial rate increases of 5.1 percentage points. FHP demonstrated decreases in rates for five measures, but no rate decreases were substantial. These increases may or may not indicate that FHP developed improvement initiatives to positively impact member perceptions.

Kaiser Permanente Colorado

Assessment of Compliance With Medicaid Managed Care Regulations

For the Coverage and Authorization of Services standard, Kaiser had two required actions: to update its authorization policies and procedures to define "medical necessity" per State requirements and to address member notification requirements related to all types of authorization decisions. For Access and Availability, Kaiser had one required action: to develop procedures to allow members with special healthcare needs to have direct access to out-of-network specialists. Kaiser submitted its initial corrective action plan proposal on June 26, 2017; and, following Department approval, completed implementation of all planned interventions on April 24, 2018.

Validation of Performance Measures

Last year, HSAG recommended that Kaiser focus efforts on improving rates for the following measures: *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*; *Chlamydia Screening in Women*; and *Medication Management for People With Asthma*. At the time of the writing of this report, Kaiser had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations. For the measures identified as opportunities for improvement in HEDIS 2017, none of Kaiser's HEDIS 2018 rates demonstrate statistically significant improvements in performance. Conversely, the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* indicator declined significantly and continued to fall below the national Medicaid 10th percentile. HSAG cautions that meaningful differences in HEDIS measure rates as a result of performance improvement activities may require multiple measurement periods.

Validation of Performance Improvement Projects

For the FY 2016–2017 PIP validation cycle, Kaiser received a *Partially Met* score for six evaluation elements across three PIP activities; and HSAG provided recommendations for the health plan to address each *Partially Met* score. In FY 2017–2018, Kaiser addressed the recommendations for four of the six evaluation elements that received *Partially Met* scores in FY 2016–2017.

Kaiser received a *Partially Met* score for one evaluation element in Activity VII during the FY 2016–2017 PIP validation cycle because the health plan did not discuss whether any factors were identified that may have impacted the comparability of study indicator results. For the 2017–2018 validation in Activity VII (Analyze Data and Interpret Study Results), Kaiser addressed HSAG's recommendations and included a discussion of whether any factors were identified that may impact the validity or comparability of the study indicator results.

Kaiser received a *Partially Met* score for three evaluation elements in Activity VIII during the FY 2016–2017 PIP validation cycle because the health plan did not report the process used to prioritize barriers

and did not report intervention-specific evaluation results for each intervention to guide related decisions going forward. For the 2017–2018 validation in Activity VIII (Improvement Strategies), Kaiser addressed HSAG's recommendations by documenting a process for prioritizing barriers, conducting intervention-specific evaluations of effectiveness, and using evaluation results to determine next steps for each intervention.

Despite addressing HSAG's recommendations in Activities VII and VIII, Kaiser again received *Partially Met* scores for two evaluation elements in Activity IX (Real Improvement) during the FY 2017–2018 PIP validation cycle. Although the health plan documented an updated causal/barrier analysis, evaluated each intervention for effectiveness, and reported the use of evaluation results to guide next steps, only one of the two study indicators demonstrated statistically significant improvement over baseline and met the health plan's goal.

Consumer Assessment of Healthcare Providers and Systems

At time of the writing of this report, Kaiser had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations; however, changes were noted in performance as follows. Between FY 2016–2017 and FY 2017–2018, Kaiser demonstrated slight decreases in rates for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. Six measures demonstrated rate increases. Of these, two increases were substantial: *Shared Decision Making* (7.8 percentage points) and *Rating of Specialist Seen Most Often* (13.2 percentage points). These increases may or may not indicate that Kaiser developed improvement initiatives to positively impact members' perceptions.

Rocky Mountain Health Plans

Assessment of Compliance With Medicaid Managed Care Regulations

For Coverage and Authorization of Services, RMHP had one required action: to ensure that a notice of action is sent to members regarding denial of claims payments. RMHP had no required actions related to Access and Availability. RMHP submitted its initial corrective action plan proposal on June 7, 2017; and, following Department approval, completed implementation of all planned interventions on September 29, 2017.

Validation of Performance Measures

Last year, HSAG recommended that RMHP focus improvement efforts on increasing rates for 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*; *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*; and *Chlamydia Screening in Women*. At the time of the writing of this report, RMHP had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations; however, RMHP's HEDIS 2018 rate for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* demonstrated statistically significant improvement in performance. Of note, the rates for *Childhood Immunization Status—Combination 5*, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, and *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* increased to rank at or above the national Medicaid 25th percentile for HEDIS 2018. These increases may or may not indicate that RMHP developed improvement initiatives to positively impact performance measure rates. No rates demonstrated statistically significant declines in performance. HSAG cautions that meaningful differences in HEDIS measure rates as a result of performance improvement activities may require multiple measurement periods.

Validation of Performance Improvement Projects

For the FY 2016–2017 PIP validation cycle, RMHP received a *Not Met* score for one evaluation element in Activity IX (Real Improvement) of the PIP validation tool. The reported study indicator results demonstrated an improvement from baseline to Remeasurement 1, but the improvement was not statistically significant. As a result of the *Not Met* score, HSAG provided feedback recommending that the health plan revisit its causal/barrier analysis and quality improvement processes to reevaluate barriers and deploy active interventions to facilitate significant improvement during the next remeasurement period. For the FY 2017–2018 PIP validation cycle, the health plan documented an updated causal/barrier analysis and interventions logically linked to identified barriers; however, the study indicator did not demonstrate statistically significant improvement over baseline. Therefore, the evaluation element in Activity IX again received a *Not Met* score.

Consumer Assessment of Healthcare Providers and Systems

At time of the writing of this report, RMHP had not provided information regarding quality initiatives that may have been developed as a result of HSAG's FY 2016–2017 recommendations; however, changes were noted in performance as follows. Between FY 2016–2017 and FY 2017–2018, RMHP demonstrated no substantial decreases in rates. However, three measures showed slight decreases in rates—*Getting Care Quickly*, *Customer Service*, and *Rating of Personal Doctor*. One measure rate increased substantially, *Shared Decision Making* (8.0 percentage points). This increase may or may not indicate that RMHP developed improvement initiatives to positively impact member perceptions.