# 2013–2014 Child Health Plan *Plus* Technical Report

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

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## Purpose of Report

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

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

The Balanced Budget Act of 1997 (BBA) and The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), require states to prepare an annual technical report that describes the manner in which data from EQR activities conducted in accordance with the Code of Federal Regulations (CFR), 42 CFR 438.358, were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' health plans. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which the health plans addressed any previous recommendations. To meet this requirement, the State of Colorado Department of Health Care Policy and Financing (the Department) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare a report regarding EQR activities performed on the CHP+ contracted health maintenance organizations (HMOs).

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

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

## Scope of EQR Activities

The HMOs and the SMCN were subject to three federally mandated BBA activities and one optional activity, with the exception that the SMCN was not required to complete a performance improvement project or Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-1] surveys. As set forth in 42 CFR 438.352, these activities were:

- **Compliance monitoring evaluations.** These evaluations were designed to determine the health plans' compliance with their contract with the State and with federal managed care regulations. HSAG determined compliance through review of selected standards based on the regulations at 42CFR.438 *et seq*.
- **Validation of performance measures.** HSAG validated each of the performance measures identified by the Department to evaluate the accuracy of the performance measures reported by or on behalf of the HMOs. The validation also determined the extent to which Medicaid-specific performance measures calculated by the HMOs followed specifications established by the Department.
- **Validation of performance improvement projects (PIPs).** HSAG reviewed PIPs to ensure that the projects were designed, conducted, and reported in a methodologically sound manner.

The optional activity was:

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

## Definitions

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

### *Quality*

CMS defines quality in the final rule at 42 CFR 438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which a managed care organization (MCO) or pre-paid inpatient health plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-2]

### *Timeliness*

The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to

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

accommodate the clinical urgency of a situation."[1-3] NCQA further discusses that the intent of this standard is to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO or PIHP, such as processing expedited appeals and providing timely follow-up care.

### Access

In the preamble to the BBA Rules and Regulations,[1-4] CMS discusses access and availability of services to enrollees as the degree to which MCOs implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO.

## Overall Conclusions

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

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

**Table 1-1—Assignment of Activities to Performance Domains**

| | Quality | Timeliness | Access |
|---|---|---|---|
| **Compliance Monitoring** | | | |
| Standard I—Coverage and Authorization of Services | ✓ | ✓ | ✓ |
| Standard II—Access and Availability | | ✓ | ✓ |
| **Performance Measures** | | | |
| Childhood Immunization Status | ✓ | ✓ | |
| Well-Child Visits in the First 15 Months of Life | ✓ | ✓ | |
| Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life | ✓ | ✓ | |
| Adolescent Well-Care Visits | ✓ | ✓ | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents | ✓ | | |
| Immunization for Adolescents | ✓ | ✓ | |
| Appropriate Testing for Children with Pharyngitis | ✓ | | |
| Follow-up Care for Children Prescribed ADHD Medication | ✓ | ✓ | |

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

| Table 1-1—Assignment of Activities to Performance Domains | | | |
|---|---|---|---|
| | Quality | Timeliness | Access |
| Asthma Medication Ratio | ✓ | | |
| Prenatal Care and Postpartum Care (for SMCN population only) | ✓ | ✓ | ✓ |
| Children and Adolescents' Access to Primary Care Practitioners | | | ✓ |
| Ambulatory Care | | | ✓ |
| Inpatient Utilization—General Hospital/Acute Care | | | ✓ |
| **Performance Improvement Projects** | | | |
| All performance improvement projects | ✓ | | |
| **CAHPS** | | | |
| *Getting Needed Care* | ✓ | ✓ | |
| *Getting Care Quickly* | ✓ | ✓ | |
| *How Well Doctors Communicate* | ✓ | | |
| *Customer Service* | ✓ | | |
| *Shared Decision Making* | ✓ | | |
| *Rating of Personal Doctor* | ✓ | | |
| *Rating of Specialist Seen Most Often* | ✓ | | |
| *Rating of All Health Care* | ✓ | | |
| *Rating of Health Plan* | ✓ | | |

## Quality

All five of the HMOs as well as the SMCN had utilization management programs that described the processes the plan used to ensure consistent and appropriate authorization of services. However, all of the HMOs had required actions related to the quality domain. HSAG recommended that each of HMO review its notices of action (NOAs) to ensure member information does not exceed the 6th grade reading level to the extent possible. HSAG required that two of the HMOs make revisions to ensure that the NOAs include all required information. Furthermore, HSAG found that two of the five HMOs were mistakenly denying covered services.

Of the 23 statewide rates from the 10 quality-related performance measures, 10 reported significant rate increases from last year. These rates were from the *Childhood Immunization Status* and the *Well-Child Visits in the First 15 Months of life—6+ Visits* measures. Since the required data collection methodology for these measures was changed from administrative in FY 2012–2013 to hybrid in FY 2013–2014, the rate increases may not denote actual performance improvement. One measure (*Asthma Medication Ratio—Total*) benchmarked at the national HEDIS Medicaid 90th percentile. One indicator (*Timeliness of Prenatal Care*) reported a significant rate decline and one (*Follow-up Care for Children Prescribed ADHD Medication—Initiation*) benchmarked at or below the national HEDIS Medicaid 10th percentile. These measures presented opportunities for improvement.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the

quality domain. Four of the five validated PIPs earned a *Met* validation status, demonstrating a strong implementation of the processes required for valid and reliable PIP results.

In regard to the CAHPS results, all five of the HMOs experienced increased rates for the *Shared Decision Making* measure, with four of the five plans demonstrating substantial increases of 5.0 percentage points or higher. All other substantial rate changes were decreases. Colorado Choice experienced substantially significant decreases in four measures and DHMP experienced substantially significant decreases in five measures.

### Timeliness

Each of the five HMOs had required actions related to timeliness of utilization management decisions and/or notices of action. HSAG found that some of the health plans were still transitioning from Department of Insurance requirements to BBA managed care requirements. While all five HMOs communicated appointment availability standards to their providers, two had not communicated the standards to their members and one had not specified the appointment availability standards for appointments related to mental health and substance abuse.

Of the 18 rates from the seven timeliness-related measures, 10 reported significant rate increases from last year. These rates were from the *Childhood Immunization Status* and the *Well-Child Visits in the First 15 Months of life—6+ Visits* measures. Since the required data collection methodology for these measures was changed from administrative in FY 2012–2013 to hybrid in FY 2013–2014, the rate increases may not denote actual performance improvement. One timeliness-related measure (*Timeliness of Prenatal Care*) showed a significant rate decline and one (*Follow-up Care for Children Prescribed ADHD Medication—Initiation*) benchmarked below the national HEDIS Medicaid 10th percentile. These measures presented statewide opportunities for improvement.

HSAG assigned two of the nine CAHPS measures to the timeliness domain: *Getting Needed Care* and *Getting Care Quickly*. Three of the five HMOs experienced insignificant changes in rates (less than 5 percentage points) between FY 2012–2013 and FY 2013–2014; however, Colorado Choice experienced a decrease of 5.2 percentage points for *Getting Care Quickly* and DHMP experienced a decrease of 10.3 percentage points for *Getting Needed Care*.

### Access

HSAG found ample evidence that all five HMOs worked diligently to maintain a robust provider network. Two of the five HMOs had service areas that were State and/or federally designated as medically underserved or health provider shortage areas. In both instances, the HMO demonstrated it had contracted with all available primary care providers, federally qualified health centers, and rural health clinics. All of the HMOs had processes to monitor their network and member perceptions to ensure adequate availability of all covered services.

Of the four access-related measures, two were population-based (*Prenatal and Postpartum Care* and *Children's and Adolescents' Access to Primary Care Practitioners*) and contained a total of six rates. None of these measures reported a statistically significant improvement over the previous year. The *Timeliness of Prenatal Care* indicator under *Prenatal and Postpartum Care* showed a

statistically significant decline of 7.8 percentage points. Additionally, the two younger age groups under the *Children's and Adolescents' Access to Primary Care Practitioners* were at or below the national HEDIS Medicaid 10th percentile. For the utilization-based measures (i.e., *Ambulatory Care* and *Inpatient Utilization), Ambulatory Care—Emergency Department Visits* declined by 12 percent. Since these measures are not risk-adjusted, the statewide rates should be for information only.

## Activities

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

Appendices A, B, and D detail and describe how HSAG conducted each activity, addressing:

- Objectives for conducting the activity.
- Technical methods of data collection.
- A description of data obtained.
- Data aggregation and analysis.

Section 3 presents conclusions drawn from the data and recommendations related to health care quality, timeliness, and access for each health plan and statewide, across the health plans.

# 3. Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access

## Introduction

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

## Compliance Monitoring Site Reviews

For the FY 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing these performance areas. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. For each standard, HSAG conducted a desk review of documents sent by the health plans prior to the on-site portion of the review, conducted interviews with key health plan staff members on-site, and reviewed additional key documents on-site.

The health plan's administrative records were also reviewed to evaluate implementation of managed care regulations related to CHP+ service denials and NOAs. Using a random sampling technique, HSAG selected a sample of 15 plus an oversample of five from all applicable service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). HSAG used a standardized tool to review the records and document findings. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also calculated an overall record review score separately.

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

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

| Table 3-1—Standards containing Requirements related to Performance Domains | | | |
|---|---|---|---|
| **Standards** | **Quality** | **Timeliness** | **Access** |
| Standard I—Coverage and Authorization of Services | ✓ | ✓ | ✓ |
| Standard II—Access and Availability | | ✓ | ✓ |

## *Colorado Access*

### Findings

Table 3-2 and Table 3-3 present the number of elements for each of the two standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2013–2014.

| Table 3-2—Summary of Scores for the Standards *for* Colorado Access | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Standard** | **# of Elements** | **# of Applicable Elements** | **# *Met*** | **# *Partially Met*** | **# *Not Met*** | **# *Not Applicable*** | **Score (% of *Met* Elements)** |
| Standard I—Coverage and Authorization of Services | 34 | 34 | 30 | 4 | 0 | 0 | 88% |
| Standard II—Access and Availability | 22 | 22 | 20 | 2 | 0 | 0 | 91% |
| **Totals** | **56** | **56** | **50** | **6** | **0** | **0** | **89%*** |

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

| Table 3-3—Summary of Scores for Colorado Access' Record Review | | | | | | |
|---|---|---|---|---|---|---|
| **Record Review** | **# of Elements** | **# of Applicable Elements** | **# *Met*** | **# *Not Met*** | **# *Not Applicable*** | **Score (% of *Met* Elements)** |
| Denials | 70 | 42 | 40 | 2 | 28 | 95% |
| **Total** | **70** | **42** | **40** | **2** | **28** | **95%** |

### Strengths

Colorado Access' policies addressed each of the requirements related to coverage and authorization of services and described procedures for ensuring consistent application of utilization review criteria. Colorado Access staff members described extensive interrater reliability training and testing. The Colorado Access member handbook and the provider manual included accurate and complete information regarding how to obtain emergency, urgently needed, and poststabilization services. On-site discussion with staff members demonstrated that Colorado Access staff members had a clear understanding of poststabilization rules and requirements.

Colorado Access demonstrated a robust preventive services program for members through examples of health information and safety guidelines available on the member Web site, in member newsletters, and through interactive voice response (IVR) messages associated with CHP+ HEDIS measures and management of chronic illnesses (e.g., asthma, diabetes). Also, in order to meet the

diverse cultural needs of its members, Colorado Access developed activities directed toward specific cultural subpopulations, such as providing a single case agreement for a provider to work with a member who has unique religious beliefs, as well as working to expand the provider network in rural areas to address the farming and rural cultures.

## Recommendations

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

### Coverage and Authorization of Services

- Colorado Access was required to revise the Medication Utilization Review Procedure policy to accurately depict the standard authorization decision time frame as being within 10 calendar days from the date of the request for service (as required by Colorado regulations).
- Colorado Access was required to develop processes to ensure that physician reviewers are cognizant of the requirement that NOAs and other member-specific communication are written at the sixth-grade reading level whenever possible.
- Colorado Access was required to revise its applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination.
- Colorado Access was required to clarify the Utilization Review Determinations policy to state that an NOA is not needed if the extension is used and that, although an NOA is required when the time frames expire, this notification period includes the extension time, if used.

### Access and Availability

- Colorado Access was required to remove from the CHP+ HMO member handbook any exceptions to coverage for urgent care outside the service area.
- Colorado Access was required to notify its providers of the requirement to maintain hours of operation for CHP+ members that are no less than hours of operation for commercial members.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Colorado Access' utilization management (UM) program comprehensive and clearly described the structure and scope of the program as well as staff responsibilities, philosophies of care, and processes for authorizing care and ensuring appropriate utilization control and appropriateness of services furnished. Colorado Access also initiated member focus groups to obtain qualitative feedback and evaluation of services. This comprehensive program and input from members helps Colorado Access ensure its members receive quality health care that will increase the likelihood of desired health outcomes.

**Timeliness**: Colorado Access communicated all appointment standards to its members and providers and, in some cases, these standards were more stringent than what was required. Although HSAG identified a required corrective action related to the timeliness of authorization decisions, the

on-site review of denial records demonstrated that Colorado Access routinely responded within the required time frames.

**Access:** Colorado Access reported that it began working with the Department and with community-centered boards to enable greater access to early intervention services for children in rural areas. It also used IVR messages to communicate the importance and availability of preventive health visits to its members. Colorado Access routinely monitored grievance data, CAHPS survey results, and other outreach study results to monitor member perceptions of accessibility and adequacy of its services.

## *Colorado Choice Health Plan*

### Findings

Table 3-4 and Table 3-5 present the number of elements for each of the two standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2013–2014.

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

| Standard | # of Elements | # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|---|
| Standard I—Coverage and Authorization of Services | 34 | 34 | 24 | 9 | 1 | 0 | 71% |
| Standard II—Access and Availability | 22 | 22 | 16 | 6 | 0 | 0 | 73% |
| **Totals** | **56** | **56** | **40** | **15** | **1** | **0** | **71%*** |

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

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

| Record Review | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| Denials | 150 | 75 | 42 | 33 | 75 | 56% |
| **Total** | **150** | **75** | **42** | **33** | **75** | **56%** |

### Strengths

On-site review of denials records demonstrated that the individuals making denial decisions had the appropriate clinical expertise to do so. Demonstration of the electronic authorization system during the on-site record review also affirmed that Colorado Choice made decisions and notified its members within the required time frames.

The sample provider contract (applicable to CHP+) required that providers offer Colorado Choice CHP+ members and commercial members the same standard of care and access to services. The Network Access Plan outlined appointment scheduling standards and stated that providers are expected to meet all standards. Colorado Choice staff members reported that it conducts provider site visits at the time of contracting and at recredentialing, although NCQA guidelines no longer require on-site visits to practitioner offices unless complaint thresholds are met. The Provider Office Site Evaluation checklist included numerous criteria related to physical accessibility of provider offices for persons with disabilities.

## Recommendations

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

### Coverage and Authorization of Services

- Colorado Choice was required to ensure that its UM Program Description clearly describes processes for discharge planning, concurrent review, and on-site utilization review to the extent that they are used.
- Colorado Choice was required to revise or develop policies as follows:
  - Colorado was required to address, in either the precertification policy or other applicable policies or procedures, the continuing authorization of services and its procedures for on-site review.
  - Colorado Choice was required to develop and implement policies and procedures designed to ensure consistent application of review criteria to authorization decisions.
  - Colorado Choice was required to have and follow written policies and procedures that include a mechanism to consult with the requesting provider, when appropriate.
  - Colorado Choice was required to revise the pre-authorization policy—which described a 14-day time frame for standard pre-service authorization decisions—to state a time frame of decision and notice to the member within 10 calendar days of receiving the request for service, in compliance with 10 CCR, 2505-10, Section 8.209.
  - Colorado Choice was required to clarify any applicable policies and procedures to state that precertification requests or prior authorization is not required for emergency or urgent care services. Colorado Choice must also revise member materials, removing any qualifications to providing urgent care services.
- Colorado Choice was required to review and revise NOA templates to ensure that correct information is provided in an easy-to-understand format, and to include State fair hearing and continuation of benefits information.
- Colorado Choice was required to ensure that all NOAs—whether using a letter format for UM denials or an explanation of benefits (EOB) format for claims denials—include the required and accurate information.
- Colorado Choice was required to also develop a mechanism to ensure that NOAs are available to members in the prevalent non-English language for its service area.
- Colorado Choice was required to review its coding and claims systems and processes, making revisions as required, to ensure that services are not denied arbitrarily, and that documentation exists to indicate that authorizations and denial decisions are based on established criteria.
- To the extent that the initial presentation for emergency care meets the definition of emergency medical condition (using the prudent layperson standard), Colorado Choice must pay for the emergency treatment obtained and may not deny payment for emergency services for members who leave the emergency room against medical advice. Colorado Choice was required to revise policies, procedures and actual practices accordingly.

### Access and Availability

- Colorado Choice was required to develop policies and procedures that address the availability of emergency services 24 hours per day, seven days per week, and state that emergency services and urgently needed services are covered when members are temporarily out of the service area.
- Colorado Choice was required to develop a mechanism to communicate mental health and substance abuse scheduling guidelines to providers and all scheduling guidelines to members.
- Colorado Choice was required to develop policies and procedures that address the required elements of a preventive medicine program.
- Colorado Choice was required to ensure that the required elements are present in its policies and/or practices to promote the State's efforts for delivery of services in a culturally competent manner.
- Colorado Choice was required to develop a mechanism to monitor actual scheduling wait times. Sampling providers for this monitoring would be acceptable.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Colorado Choice had a UM program to monitor services and ensure that services provided were sufficient to achieve the purpose; however, HSAG identified several opportunities for improvement and required actions needed to ensure the plan's authorization and denial decisions are consistently based on established criteria. HSAG also identified required actions concerning Colorado Choice's policies and member information related to authorizations for emergency and urgent care.

**Timeliness**: HSAG found several deficiencies in Colorado Choice's performance as it related to the timeliness domain. Colorado Choice's NOA templates, as well as completed NOAs reviewed in the on-site denial record review, included inaccurate time frames for filing appeals. Colorado Choice also had time frames misprinted in its pre-authorization policy. Although Colorado Choice communicated many of the appointment availability standards to its providers, it did not address mental health and substance abuse appointment availability standards. Colorado Choice also did not communicate any of the appointment availability standards to its members.

**Access**: Certain regions within Colorado Choice's service area have been designated by State and/or federal agencies as medically underserved or health care provider shortage areas; however, the staff reported that Colorado Choice has contracted with all available PCPs in those areas and a majority of the specialists in each county. The staff also reported contracting with all of the federally qualified health centers and rural health centers in the service area.

## *Denver Health Medical Plan, Inc.*

### Findings

Table 3-6 and Table 3-7 present the number of elements for each of the two standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2013–2014.

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

| Standard | # of Elements | # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|---|
| Standard I—Coverage and Authorization of Services | 34 | 34 | 29 | 5 | 0 | 0 | 85% |
| Standard II—Access and Availability | 21 | 21 | 17 | 4 | 0 | 0 | 81% |
| **Totals** | **55** | **55** | **46** | **9** | **0** | **0** | **84%*** |

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

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

| Record Review | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| Denials | 33 | 15 | 13 | 2 | 18 | 87% |
| **Total** | **33** | **15** | **13** | **2** | **18** | **87%** |

### Strengths

DHMP had a comprehensive UM Program description that outlined the goals and responsibilities of the program and addressed essential requirements such as the structure of the department responsible for making authorization determinations, the clinical expertise of individuals who make determinations, and the medical management and oversight of the UM Program. Pediatric and adult guidelines described which services may be limited at Denver Health and Hospital Authority (DHHA) clinics; therefore, UM staff members may approve out-of-network providers for these services. DHMP's UM processes included extensive training and interrater reliability testing using Milliman Care Guidelines training and interrater reliability testing modules.

DHMP's Behavioral Health and Wellness Services Program description delineated preventive health services available and a continuum of care for members with alcohol and tobacco use disorders, asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, weight management issues, and depression and anxiety related to these disorders, using health coaches, disease management processes, and complex case management. The program description depicted creative and community-based programs such as interactive education and exercise classes; distribution of written materials and/or DVDs; shopping and cooking classes; and individualized telephonic follow-up coaching, counseling, and case management. The Cultural and Linguistic Appropriate Services Annual Evaluation reported numerous committees, work groups, staff

trainings, and evaluation of metrics regarding the provision of interpreters and understanding of culture with respect to health care.

## Recommendations

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

### Coverage and Authorization of Services

- DHMP was required to develop a mechanism for reviewing claim denials to ensure ease of understanding and provide clearer information to members, as well as to ensure accuracy of the information.
- DHMP was required to ensure that NOAs include each of the required elements and that they are sent within the required time frames.
- DHMP was required to revise the CHP+ member handbook to clarify that DHMP will not refuse to cover emergency care based on DHMP's notification requirements.

### Access and Availability

- DHMP reported that all providers have an "open panel," which connotes that members may have immediate assignment to a PCP and access to appointments without a wait list process. Given that DHMP's provider network (a closed system of providers within the DHHA) used a wait list-like process, DHMP was required to further define what it means by "open panel" and more accurately describe the processes for access into the DHHA clinic system.
- As the CHP+ population continues to increase, DHMP must either implement policies to provide out-of-network care when care within the network is not available timely or consider options to expand the DHMP network by expanding the DHHA provider network, or through contracts with non-DHHA providers.
- DHMP was required to develop an effective process to monitor scheduling wait times, identify barriers to complying with appointment guidelines delineated in the CHP+ managed care contracts, and take appropriate action to ensure that appointment scheduling standards are met.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality**: DHMP's policies described the regulations and standards used to perform utilization review, including processes to ensure interrater reliability. Its policies also addressed the processes for pre-service, concurrent, and post-service utilization review. HSAG found ample evidence that DHMP consistently used established criteria and a medical necessity standard to make authorization determinations.

**Timeliness**: DHMP's Drug Authorizations and Utilization Review policy listed the correct time frames for authorization decisions; however, it stated that following the authorization decision, the NOA would be sent within three working days of making the decision. The NOA must also be sent within the required time frames. Also, HSAG found that one of the three records reviewed included

information based on the Department of Insurance requirements rather than the current CHP+ contract requirements. During FY 2013–2014, HSAG conducted a focus group in the Denver community of providers and referral sources to further investigate timely access to services. While few issues identified during this process were found to be clearly related the DHMP's CHP+ population, DHMP was asked to further evaluate its own processes for timely access to care for all populations served by the DHHA provider system of care.

**Access**: DHMP's Strategic Access Report stated that 99.77 percent of CHP+ members are within 30 miles of a DHHA (the provider network for DHMP) clinic. The report also noted that there are 54 bus stops within a quarter mile of a DHHA clinic, with some actually on DHHA property. Although access to care issues are complex, it was clear that DHMP had valuable studies and interventions planned that will serve it well in the coming year.

## *Kaiser Permanente Colorado*

### Findings

Table 3-8 and Table 3-9 present the number of elements for each of the two standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2013–2014.

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

| Standard | # of Elements | # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|---|
| Standard I—Coverage and Authorization of Services | 34 | 34 | 31 | 3 | 0 | 0 | 91% |
| Standard II—Access and Availability | 22 | 22 | 21 | 1 | 0 | 0 | 95% |
| **Totals** | **56** | **56** | **52** | **4** | **0** | **0** | **93%*** |

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

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

| Record Review | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| Denials | 150 | 78 | 48 | 30 | 72 | 62% |
| **Total** | **150** | **78** | **48** | **30** | **72** | **62%** |

### Strengths

Kaiser's electronic system, used to manage requests for services and authorizations, demonstrated the processes for making authorization decisions, tracking dates, and assigning cases to reviewers with the appropriate expertise based on the service request. The system also demonstrated Kaiser's processes to ensure that authorizations are made within the required time frames, and it documented

the criteria used for making UR determinations. The authorization system was linked electronically to the electronic medical record (EMR) allowing medical reviewers to search for diagnoses and conditions of record that would justify the service request under review. Kaiser's policies and procedures, as well as member information regarding emergency services and poststabilization services, adequately described processes in compliance with federal regulations. The member resource guide notified members that emergency services are available in- or out-of-network without preauthorization.

Kaiser had detailed tracking and monitoring mechanisms to ensure that appointments are offered within the required scheduling time frames. For appointments with internal providers, Kaiser uses centralized scheduling. External/contracted providers are informed of scheduling requirements via Kaiser's affiliated provider manual. Kaiser staff members reported that members who have Internet access may make their own appointments online and therefore remain in control of their own timing of access.

## Recommendations

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

### Coverage and Authorization of Services

- Kaiser was required to ensure that the appeal rights information that accompanies the EOB is accurate and applicable to the CHP+ population, and that the EOB reason language is clarified or that the EOB is accompanied by an NOA that includes the required information in easy-to-understand language. Kaiser was also required to ensure that NOAs (whether using an NOA format or an EOB format) include accurate time frames.
- Kaiser was required to ensure that NOAs for pre-service decisions are sent within 10 calendar days of the date of the request for services.

### Access and Availability

- Kaiser was required to develop a mechanism to inform CHP+ members of scheduling guidelines.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality**: Kaiser performed well in the quality domain. Its policies and procedures related to coverage and authorization of services were comprehensive. Kaiser's staff demonstrated a robust UM program that was well-monitored to ensure consistent and appropriate implementation of services. Kaiser provided ample evidence of monitoring provider and member perceptions of health care.

**Timeliness**: On-site review of denials records showed that Kaiser was still operating under Department of Insurance regulations for its CHP+ population and had not yet implemented the CHIPRA/BBA-mandated time frames related to authorization decisions. Kaiser staff members

stated that implementation was planned for January 2014. Also, while Kaiser provided its staff with scheduling guidelines and had tracking and monitoring mechanisms to ensure adherence to the requirements, it had not informed its CHP+ members of these guidelines.

**Access**: Kaiser demonstrated it had a robust provider network that included primary and specialty provider types, as required. Its policies described the processes for allowing members to seek second opinions and for allowing access to out-of-network services when the services were not available within Kaiser's network. Kaiser's member communications informed members about their rights related to direct access to specialists. Kaiser used its EMR system to monitor the provision of preventive care and notified members when preventive care services such as well-child checks and immunizations were due.

## *Rocky Mountain Health Plans*

### Findings

Table 3-10 and Table 3-11 present the number of elements for each of the two standards and record review; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year, FY 2013–2014.

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

| Standard | # of Elements | # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|---|
| Standard I—Coverage and Authorization of Services | 34 | 34 | 29 | 5 | 0 | 0 | 85% |
| Standard II—Access and Availability | 22 | 22 | 19 | 2 | 1 | 0 | 86% |
| **Totals** | **56** | **56** | **48** | **7** | **1** | **0** | **86%*** |

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

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

| Record Review | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| Denials | 101 | 51 | 36 | 15 | 50 | 71% |
| **Total** | **101** | **51** | **36** | **15** | **50** | **71%** |

### Strengths

RMHP staff members described and demonstrated the processes to ensure that professionals with the appropriate expertise make authorization or denial decisions. Staff members also described medical management oversight of medical, pharmacy, and behavioral health preauthorization determinations. Staff members demonstrated a new pilot program by which physicians may obtain on-line access to the UM authorization system, enter the data required, and obtain immediate authorization. This program is intended to expedite authorizations and significantly improve both

provider and member satisfaction in obtaining services. Staff members also described on-site hospitalization concurrent reviews. Staff members review hospitalizations in an ongoing manner, working with hospital discharge planners and the treating physician to determine the most appropriate length of stay. In addition, staff members reported that readmissions are tracked to evaluate appropriateness of care.

RMHP established a network of providers that includes contracts with nearly all available providers in the service area. In addition, RMHP consolidated all lines of business, including Medicaid and CHP+, into one provider contract, thereby simplifying requirements for providers. All participating providers were required to participate in serving all RMHP contracted populations.

RMHP determined that the culture of poverty is the most prevalent cultural concern impacting the health and health care of populations in the RMHP service area. Therefore, RMHP implemented the Bridges out of Poverty training program, which addresses the attitudes, communication styles, and behaviors associated with poverty and that can affect health care services to members. The training program has been extended to network provider offices. RMHP staff members reported that the program has been enthusiastically embraced by providers and their staffs. The Bridges out of Poverty program has significantly enhanced RMHP's comprehensive efforts to promote the delivery of services in a culturally competent manner.

## Recommendations

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

### Coverage and Authorization of Services

- RMHP was required to revise the preauthorization policy to clarify that all standard and expedited authorization decisions will be made within the required time frames from the date of the request for service, unless extended.
- RMHP was required to revise the CHP+ member handbook to remove the statement that RMHP may deny payment of emergency claims for untimely filing.
- In order to address issues identified during the on-site record review, RMHP was required to:
  - Evaluate the claims payment configuration against the CHP+ benefit package and the State's configuration to ensure covered benefits are paid correctly.
  - Audit 100 percent of CHP+ behavioral health claims denials up to 411 claims (whichever number is lower) for consistency of determinations based on the CHP+ contract and benefit package.
  - Ensure that members are not held liable for untimely filed claims.
  - Ensure that unavoidable clinical language used in denial letters is kept to a minimum and is explained to the member wherever possible (striving for 6th grade reading level).
  - Evaluate the letters being used for denials of new requests as well as for claims denials to ensure that all NOAs (denials) include each of the requirements.

**Access and Availability**

- RMHP was required to implement an effective mechanism that monitors providers regularly to determine compliance with scheduling standards, and to take appropriate corrective action.
- While RMHP's Bridges Out of Poverty program represented a clear strength related to cultural competency, RMHP was required to develop policies and procedures to address cultural characteristics broader than linguistics and characteristics identified in the Bridges Out of Poverty program, such as providing programs and services that incorporate the beliefs, attitudes, and practices of specific cultures, as well as outreach to specific cultures for prevention and treatment of diseases prevalent in those groups. In addition, RMHP was required to develop policies and procedures that ensure compliance with the laws applicable to persons with physical and developmental disabilities.
- RMHP was required to specifically analyze the three areas of the 2013 CAHPS results that performed below the 50th percentile, and to implement a relevant corrective action plan.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality**: RMHP implemented a variety of methods to monitor services provided to members and to ensure appropriateness of care. The covered services section of RMHP's member handbook described services related to prevention, wellness care, diagnosis and treatment, and rehabilitation. RMHP's electronic authorization system helped ensure that utilization review criteria are applied consistently; however, during the on-site record review, HSAG identified several issues that resulted in inappropriate denials of claims payment, and notifications to members that were confusing and inaccurate and that held members responsible for payment.

**Timeliness**: RMHP performed well in the timeliness domain. Physician access requirements, such as hours of operation and appointment availability standards, were communicated to providers and members. All 10 of the denial records reviewed included evidence that required time frames were met. However, RMHP's preauthorization policy did not accurately represent time frames for instances when additional information is requested.

**Access**: RMHP's policies and procedures, the provider contract, and the CHP+ access plan and analysis substantiated that the provider network was adequately configured to meet the majority of provider network requirements. Despite the fact that much of the RMHP service area is considered a primary care shortage area, staff members stated RMHP has contracted with nearly all qualified providers in the area.

## State Managed Care Network

### Findings

Colorado Access, as the administrative services organization for the Department of Health Care Policy and Financing, administers Colorado's CHP+ State Managed Care Network (SMCN). The SMCN provides services to the CHP+ population before CHP+ members enroll in the HMO of their choice, generally for a period of 30 to 45 days. In addition, the SMCN provides services to qualifying pregnant women, who remain in the network through their pregnancies and do not transition into an HMO. The majority of CHP+ enrollees are members of the SMCN for only a short transitional period. The provider network for the SMCN is statewide and often overlaps with the networks of the CHP+ HMOs in various regions, with the exception of three service areas in which no other HMO is available. Reimbursement for providers enrolled with the SMCN is via the State's fee-for-service reimbursement process. The SMCN and CHP+ HMO plans are subject to similar State CHP+ contract requirements; however, at the time of the site review, Colorado Access' SMCN contract with the Department had not been updated to require compliance with the Medicaid managed care regulations. Colorado Access demonstrated its commitment to comply with federal regulations and has been diligent in aligning its SMCN policies, procedures, and activities with its CHP+ HMO activities whenever possible.

### Strengths

Despite the small SMCN population base, most of the processes used by Colorado Access for the CHP+ HMO also were applied to the SMCN population to the extent possible. Examples included provider contracting, provider and member communications, cultural competency and preventive services programs, and monitoring activities. When the SMCN population was too small or member characteristics were too distinct to warrant SMCN-specific activities (such as analysis of specific HEDIS measures or CAHPS results), any interventions carried out for Colorado Access' CHP+ HMO members were also applied to SMCN members. In addition, the majority of the SMCN population is made up of prenatal care members, so Colorado Access focused on monitoring the prenatal care HEDIS measures and implemented process improvements specific to prenatal programs for SMCN members. Network Adequacy reports indicated that the provider networks were adequate to meet member needs, including contracting with essential community providers, nurse midwives, and nurse practitioners. Staff members stated that Colorado Access had been pursuing SMCN contracts with nurse practitioners in rural areas, and had increased services for prenatal care members.

### Recommendations

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

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Colorado Access' UM program was comprehensive and clearly described the structure and scope of the program as well as staff responsibilities, philosophies of care, processes for authorizing care and ensuring appropriate utilization control, and appropriateness of services. Although Colorado Access performed well in the quality domain, two of the SMCN denial records reviewed contained NOAs that were not easily understood due to the use of clinical or industry-specific language.

**Timeliness:** HSAG found a fairly minor discrepancy on Colorado Access' Utilization Review Procedure policy related to time frames for standard requests for medication determinations. Colorado Access communicated all appointment standards to its members and providers, as required in its contract with the Department. However, HSAG suggested that Colorado Access add mental health and substance abuse appointment requirements to its SMCN provider manual in order to comply with federal regulations.

**Access:** Colorado Access' network adequacy reports demonstrated a robust network of providers adequate to support its SMCN members. Its Evidence of Coverage handbooks informed members that preventive services are covered and they define the types of preventive services, such as routine exams, immunizations, vision and hearing screening, and health education. Colorado Access reviewed utilization trend reports, HEDIS measures, and input from member focus groups to evaluate the impact of preventive services and determine preventive health priorities.

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

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

**Table 3-12—Statewide Scores for Standards**

| Standards | FY 2013–2014 Statewide Average* |
|---|---|
| Standard I—Coverage and Authorization of Services | **84%** |
| Standard II—Access and Availability | **85%** |
| **Overall Statewide Compliance Score** | **85%*** |

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

**Table 3-13—Statewide Score for Record Review**

| Standards | FY 2013–2014 Statewide Average* |
|---|---|
| Denials | **69%** |
| **Overall Statewide Score for Record Reviews** | **69%*** |

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

**Quality:** All of the HMOs, as well as the SMCN, had UM programs that described the processes that the health plans used to ensure consistent and appropriate authorization of services. However, all five of the HMOs had required actions related to the quality domain. HSAG recommended that each of the five HMOs review its NOAs to ensure member information does not exceed the 6th grade reading level. HSAG required two of the HMOs to revise processes to ensure the NOAs include all required information. Furthermore, HSAG found that two of the five HMOs were mistakenly denying covered services.

**Timeliness:** Each of the five HMOs had required actions related to timeliness of utilization management decisions and/or notices of action. HSAG found that some of the health plans were still transitioning from the Department of Insurance requirements to the CHIPRA/BBA managed care requirements. While all five HMOs communicated appointment availability standards to their providers, two had not communicated the standards to their members, and one had not included the appointment availability standards for appointments that related to mental health and substance abuse.

**Access:** HSAG found ample evidence that all five of the HMOs worked diligently to maintain a robust provider network. Two of the five HMOs had service areas that were State and/or federally designated as medically underserved or health provider shortage areas. In both of these instances, the HMO demonstrated it had contracted with all available primary care providers, federal quality health centers and rural health clinics. All of the HMOs had processes to monitor their network and member perceptions to ensure adequate coverage of all available services.

## Validation of Performance Measures

The Department elected to use HEDIS methodology to satisfy the CMS validation of performance measure protocol requirements, which also included an assessment of information systems. For FY 2013–2014, the Department required that the HMOs report a total of 12 measures and the SMCN to report one measure. The Department allowed the health plans to use their existing auditors. Each HMO and the SMCN underwent an NCQA HEDIS Compliance Audit through an NCQA-licensed audit organization of its choice and submitted the audited results and audit statement to HSAG. For the SMCN, the Department contracted with HSAG to perform an NCQA HEDIS Compliance Audit.

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

HSAG reviewed all final audit reports and data workbooks to identify any data issues reported by the licensed organizations during their HEDIS Compliance Audit. Each of the measures reviewed by the licensed organizations received an audit result consistent with the NCQA categories listed in Table 3-14. All HMOs' and the SMCN's performance measures received an audit result of *Reportable (R)* for the current measurement cycle. In addition, all HMOs and the SMCN were fully compliant with all information system standards relevant to the scope of the performance measure validation.

**Table 3-14—HEDIS Audit Results**

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

To make overall assessments about the quality and timeliness of, and access to, care provided by the health plans, HSAG assigned each of the performance measures to one or more of the three domains, as shown in Table 3-15. Additionally, Table 3-15 shows the data collection methodology as required by the Department. An asterisk denotes a change in the data collection methodology required by the Department from last year. While some of the health plans chose to report rates

using hybrid methodology for the performance measures required to be reported administratively, per the Department's instructions, HSAG only reported administrative rates for these measures. Footnotes will be included for instances like these.

**Table 3-15—HEDIS 2014 Performance Measures**

| Performance Measures | Data Collection Methodology Required by the Department | Quality | Timeliness | Access |
|---|---|---|---|---|
| *Childhood Immunization Status* | Hybrid* | ✓ | ✓ | |
| *Well-Child Visits in the First 15 Months of Life* | Hybrid* | ✓ | ✓ | |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | Hybrid* | ✓ | ✓ | |
| *Adolescent Well-Care Visits* | Hybrid* | ✓ | ✓ | |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | Hybrid | ✓ | | |
| *Immunization for Adolescents* | Administrative | ✓ | ✓ | |
| *Appropriate Testing for Children With Pharyngitis* | Administrative | ✓ | | |
| *Follow-up Care for Children Prescribed ADHD Medication* | Administrative | ✓ | ✓ | |
| *Asthma Medication Ratio* | Administrative | ✓ | | |
| *Prenatal and Postpartum Care (for SMCN only)* | Hybrid | ✓ | ✓ | ✓ |
| *Children and Adolescents' Access to Primary Care Practitioners* | Administrative | | | ✓ |
| *Ambulatory Care* | Administrative | | | ✓ |
| *Inpatient Utilization—General Hospital/Acute Care* | Administrative | | | ✓ |

* There was a change in data collection methodology required by the Department from HEDIS 2013.

## Colorado Access

### Compliance with Information Systems (IS) Standards

Colorado Access was fully compliant with all IS standards relevant to the scope of the performance measure validation. The auditor did not identify any notable issues during the review of the standards that had any negative impact on HEDIS reporting. The auditor had no recommendations for Colorado Access related to compliance with IS standards.[3-1]

### Performance Measures

Table 3-16 shows the Colorado Access rates for HEDIS 2013 and HEDIS 2014, the percentile ranking for HEDIS 2014, and HEDIS 2014 audit results for each performance measure.

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

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Childhood Immunization Status* | | | | |
| *Combination 2* | 54.53%[2] | **72.51%** | 25th–49th | **R** |
| *Combination 3* | 52.41%[2] | **68.61%** | 25th-49th | **R** |
| *Combination 4* | 46.82%[2] | **61.31%** | 25th-49th | **R** |
| *Combination 5* | 41.43%[2] | **59.37%** | 50th-74th | **R** |
| *Combination 6* | 34.30%[2] | **49.64%** | 75th-89th | **R** |
| *Combination 7* | 37.57%[2] | **54.50%** | 50th-74th | **R** |
| *Combination 8* | 31.41%[2] | **45.50%** | 75th-89th | **R** |
| *Combination 9* | 28.13%[2] | **44.04%** | 75th-89th | **R** |
| *Combination 10* | 25.82%[2] | **41.12%** | 75th-89th | **R** |
| *Well-Child Visits in the First 15 Months of Life* | | | | |
| *Zero Visits*** | 2.14%[3] | 2.19% | 75th-89th | **R** |
| *Six or More Visits* | 13.64%[4] | **70.80%** | 50th-74th | **R** |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 63.20%[5] | **70.35%** | 25th-49th | **R** |
| *Adolescent Well-Care Visits* | 43.39%[6] | 43.80% | 25th-49th | **R** |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | | | | |
| *BMI Assessment: Total* | 63.99% | 61.56% | 50th-74th | **R** |
| *Counseling for Nutrition: Total* | 57.66% | 61.31% | 50th-74th | **R** |
| *Counseling for Physical Activity: Total* | 52.31% | 53.28% | 50th-74th | **R** |

[3-1] HEDIS Compliance Audit, Final Audit Report, Colorado Access, July 2014.

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

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Immunizations for Adolescents—Combination 1* | — | 64.96% | 25th-49th | R |
| *Appropriate Testing for Children with Pharyngitis* | — | 76.78% | 50th-74th | R |
| *Follow-up Care for Children Prescribed ADHD Medication* | | | | |
| *Initiation* | — | 0.55% | <10th | R |
| *Continuation* | — | 0.00% | <10th | R |
| *Asthma Medication Ratio—Total* | — | 77.61% | ≥90th | R |
| *Children's and Adolescents' Access to Primary Care Practitioners* | | | | |
| *Ages 12 to 24 Months* | — | 92.78% | 10th-24th | R |
| *Ages 25 Months to 6 Years* | — | 84.27% | 10th-24th | R |
| *Ages 7 to 11 Years* | — | 89.96% | 25th-49th | R |
| *Ages 12 to 19 Years* | — | 88.18% | 25th-49th | R |

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

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

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

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

[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2013. Colorado Access reported HEDIS 2013 hybrid rates of 74.70 percent, 71.05 percent, 63.99 percent, 57.66 percent, 48.18 percent, 52.55 percent, 44.53 percent, 39.66 percent, and 36.74 percent for the *Childhood Immunization Status— Combination 2* through *Combination 10* indicators, respectively.

[3] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2013. Colorado Access reported the HEDIS 2013 hybrid rate of 1.87 percent for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* indicator.

[4] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2013. Colorado Access reported the HEDIS 2013 hybrid rate of 57.22 percent for the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* indicator.

[5] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. Colorado Access reported the HEDIS 2013 hybrid rate of 66.37 percent for measure *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

[6] The Department's required data collection methodology for this measure in HEDIS 2013 was administrative. Colorado Access followed this requirement; the rate displayed here was the HMO's final rate.

## Strengths

Regarding Colorado Access' information systems and processes, the auditor noted that the HMO had made progress in ensuring the quality of the manual membership data entry and that it had effective routines to capture correct membership data. Colorado Access also shared HEDIS results

with its providers during provider support staff office visits, raising awareness about achievements and possible areas of improvement.

All of the performance measures for Colorado Access received an audit result of *Reportable (R)* for HEDIS 2014. Three measures (all indicators under *Childhood Immunization Status, Well-Child Visits for the First 15 Months—6+ Visits,* and *Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life*) reported statistically significant rate increase from the previous year. Rate increases observed for these measures may be due to a change in the data collection methodology required by the Department from administrative to hybrid and may not denote actual performance improvement. The *Asthma Medication Ratio—Total* indicator benchmarked at or above the national HEDIS Medicaid 90th percentile.

### Recommendations

Colorado Access did not have any measures showing a statistically significant rate decline. However, both indicators under the *Follow-up Care for Children Prescribed ADHD Medication* measure benchmarked below the national HEDIS Medicaid 10th percentile, presenting opportunities for improvement.

### Use of Services Observations

Table 3-17 shows the audit results for all the required Use of Services measures. Colorado Access reported a 6 percent decline in the *Ambulatory Care—Emergency Department Visits* indicator from last year. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2013 and 2014 may not denote improvement or decline in performance. Percentile rankings based on HEDIS 2013 rates are also for information only.

**Table 3-17—Review Audit Results for Use of Services Measures *for* Colorado Access**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Ambulatory Care: Total (Per 1,000 MM)* | | | | |
| *Outpatient Visits* | — | 239.95 | <10th | R |
| *Emergency Department Visits* | 32.93 | 30.97 | <10th | R |
| *Inpatient Utilization—General Hospital/Acute Care: Total* | | | | |
| *Discharges per 1,000 MM (total inpatient)* | — | 1.42 | <10th | R |
| *Days per 1,000 MM (total inpatient)* | — | 5.22 | <10th | R |
| *Average Length of Stay (total inpatient)* | — | 3.68 | 25th–49th | R |
| *Discharges per 1,000 MM (medicine)* | — | 0.97 | <10th | R |
| *Days per 1,000 MM (medicine)* | — | 2.85 | <10th | R |
| *Average Length of Stay (medicine)* | — | 2.93 | <10th | R |
| *Discharges per 1,000 MM (surgery)* | — | 0.33 | <10th | R |
| *Days per 1,000 MM (surgery)* | — | 2.10 | <10th | R |

**Table 3-17—Review Audit Results for Use of Services Measures *for* Colorado Access**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Average Length of Stay (surgery)* | — | 6.34 | 25th–49th | R |
| *Discharges per 1,000 MM (maternity)* | — | 0.25 | <10th | R |
| *Days per 1,000 MM (maternity)* | — | 0.61 | <10th | R |
| *Average Length of Stay (maternity)* | — | 2.44 | 10th–24th | R |

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
[1]Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Of the 21 rates from the nine quality-related measures, 11 reported significant rate increases from the previous year. These rates were from *Childhood Immunization Status, Well-Child Visits in the First 15 Months of life—6+ Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.* Since the required data collection methodology for these measures was changed from administrative to hybrid, the rate increases may not denote actual performance improvement. Although none of the measures reported significant declines in performance, both indicators under *Follow-up Care for Children Prescribed ADHD Medication* benchmarked at or below the national HEDIS Medicaid 10th percentile and presented opportunities for improvement.

**Timeliness:** Of the 16 rates from the six timeliness-related measures, 11 reported significant rate increases from last year. These rates were from *Childhood Immunization Status, Well-Child Visits in the First 15 Months of life—6+ Visits,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of Life*. Since the required data collection methodology for these measures was changed from administrative to hybrid, the rate increases may not denote actual performance improvement. Both indicators under *Follow-up Care for Children Prescribed ADHD Medication* benchmarked below the national HEDIS Medicaid 10th percentile. This measure presented opportunities for improvement.

**Access:** Of the three access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. Although none of the indicators under *Children's and Adolescents' Access to Primary Care Practitioners* benchmarked at or below the national HEDIS Medicaid 10th percentile, all were below the national HEDIS Medicaid 50th percentile, suggesting opportunities for improvement. For the utilization-based measures, *Ambulatory Care—Emergency Department Visits* declined by 6 percent. Since these measures are not risk-adjusted, Colorado Access' rates reported for these measures should be for information only.

## Colorado Choice Health Plan

### Compliance with Information Systems (IS) Standards

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

### Performance Measures

Table 3-18 shows the Colorado Choice rates for HEDIS 2013 and HEDIS 2014, the percentile ranking for HEDIS 2014, and the HEDIS 2014 audit results for each performance measure.

**Table 3-18—Review Audit Results for Performance Measures *for* Colorado Choice**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Childhood Immunization Status* | | | | |
| *Combination 2* | NA | NA | NA | NA |
| *Combination 3* | NA | NA | NA | NA |
| *Combination 4* | NA | NA | NA | NA |
| *Combination 5* | NA | NA | NA | NA |
| *Combination 6* | NA | NA | NA | NA |
| *Combination 7* | NA | NA | NA | NA |
| *Combination 8* | NA | NA | NA | NA |
| *Combination 9* | NA | NA | NA | NA |
| *Combination 10* | NA | NA | NA | NA |
| *Well-Child Visits in the First 15 Months of Life* | | | | |
| *Zero Visits*** | NA | NA | NA | NA |
| *Six or More Visits* | NA | NA | NA | NA |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 57.94%[2] | 57.98% | <10th | **R** |
| *Adolescent Well-Care Visits* | 36.33%[3] | 37.02% | <10th | **R** |

[2] HEDIS Compliance Audit, Final Audit Report, Colorado Choice, July 2014.

**Table 3-18—Review Audit Results for Performance Measures *for* Colorado Choice**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | | | | |
| *BMI Assessment: Total* | 13.90% | **39.52%** | 25th-49th | **R** |
| *Counseling for Nutrition: Total* | 11.41% | **29.94%** | <10th | **R** |
| *Counseling for Physical Activity: Total* | 15.63% | **35.93%** | 25th-49th | **R** |
| *Immunizations for Adolescents—Combination 1* | — | 25.81% | <10th | **R** |
| *Appropriate Testing for Children with Pharyngitis* | — | 57.14% | 10th-24th | **R** |
| *Follow-up Care for Children Prescribed ADHD Medication* | | | | |
| *Initiation* | — | NA | NA | NA |
| *Continuation* | — | NA | NA | NA |
| *Asthma Medication Ratio—Total* | — | NA | NA | NA |
| *Children's and Adolescents' Access to Primary Care Practitioners* | | | | |
| *Ages 12 to 24 Months* | — | NA | NA | NA |
| *Ages 25 Months to 6 Years* | — | 76.87% | <10th | **R** |
| *Ages 7 to 11 Years* | — | 88.89% | 25th-49th | **R** |
| *Ages 12 to 19 Years* | — | 91.27% | 50th-74th | **R** |

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

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

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

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

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

[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] Per the Department's required data collection methodology, the HEDIS 2013 rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. Colorado Choice's HEDIS 2013 rate was based on administrative data only and was the final reported rate.

[3] The Department's required data collection methodology for this measure in HEDIS 2013 was administrative. Colorado Choice followed this requirement; the rate displayed here was the HMO's final rate.

## Strengths

Colorado Choice had an audit result of *Reportable (R)* for all measures required for HEDIS 2014 reporting. All indicators under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* reported a statistically significant rate increase from last year. This increase may be due to a change in the data collection methodology required by the Department, from administrative to hybrid, and may not denote actual performance improvement.

## Recommendations

HSAG identified five rates that benchmarked at or below the national HEDIS Medicaid 10th percentiles: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care Visits; Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition; Immunization for Adolescents—Combination 1*; and two of the younger age groups under the *Children's and Adolescents' Access to Primary Care Practitioners* measure. These measures presented opportunities for improvement for Colorado Choice.

## Use of Services Observations

Table 3-19 shows the audit results for all the required Use of Services measures. Colorado Choice reported an 8.4 percent decline in *Ambulatory Care—Emergency Department Visits*. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2013 and 2014 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

**Table 3-19—Review Audit Results for Use of Services Measures *for* Colorado Choice**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Ambulatory Care: Total (Per 1,000 MM)* | | | | |
| *Outpatient Visits* | — | 189.86 | <10th | R |
| *Emergency Department Visits* | 20.84 | 19.09 | <10th | R |
| *Inpatient Utilization—General Hospital/Acute Care: Total* | | | | |
| *Discharges per 1,000 MM (total inpatient)* | — | 1.06 | <10th | R |
| *Days per 1,000 MM (total inpatient)* | — | 2.89 | <10th | R |
| *Average Length of Stay (total inpatient)* | — | 2.74 | <10th | R |
| *Discharges per 1,000 MM (medicine)* | — | 0.39 | <10th | R |
| *Days per 1,000 MM (medicine)* | — | 1.28 | <10th | R |
| *Average Length of Stay (medicine)* | — | 3.29 | 25th–49th | R |
| *Discharges per 1,000 MM (surgery)* | — | 0.39 | <10th | R |
| *Days per 1,000 MM (surgery)* | — | 1.28 | <10th | R |
| *Average Length of Stay (surgery)* | — | 3.29 | <10th | R |
| *Discharges per 1,000 MM (maternity)* | — | 0.23 | <10th | R |
| *Days per 1,000 MM (maternity)* | — | 0.35 | <10th | R |
| *Average Length of Stay (maternity)* | — | 1.50 | <10th | R |

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
[1]Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Of the 21 rates from the nine quality-related measures, three, all under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (14.3 percent), reported significant rate increases from last year. Although Colorado Choice did not have any measures with significant declines in performance, four quality-related rates benchmarked at or below the national HEDIS Medicaid 10th percentile. The three measures were *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—Counseling for Nutrition;* and *Immunizations for Adolescents—Combination 1*. These measures presented opportunities for improvement.

**Timeliness:** Of the 16 rates from the six timeliness-related measures, and although none had significant rate increases or declines, four were at or below the national HEDIS Medicaid 10th percentiles. These measures presented opportunities for improvement.

**Access:** Of the three access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. The rate for the *25 Months to 6 Years* age group benchmarked at or below the national HEDIS Medicaid 10th percentile, suggesting opportunities for improvement. For the utilization-based measures, *Ambulatory Care—Emergency Department Visits* declined by 8.4 percent. Since these measures are not risk-adjusted, Colorado Choice's rates reported for these measures should be for information only.

## Denver Health Medical Plan, Inc.

### Compliance With Information Systems (IS) Standards

DHMP was fully compliant with all IS standards relevant to the scope of the performance measure validation. The auditor noted that DHMP had some challenges in reporting due to a change in its claims processing system. The auditor also noted that despite the HMO's efforts, the challenges in capturing accurate membership data with timely reconciliation with the State put the overall integrity of the CHP+ reports at risk of not reporting. The final audit designations for the required measures were given a result of *Reportable (R)* by the auditor after the final rate review showing the HEDIS 2014 rates being consistent with those from previous years.

### Performance Measures

Table 3-20 shows the DHMP rates for HEDIS 2013 and HEDIS 2014, the percentile ranking for HEDIS 2014, and HEDIS 2014 audit results for each performance measure.

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

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Childhood Immunization Status* | | | | |
| *Combination 2* | 83.33%[2] | 89.33% | ≥90th | R |
| *Combination 3* | 82.35%[2] | 89.33% | ≥90th | R |
| *Combination 4* | 82.35%[2] | 89.33% | ≥90th | R |
| *Combination 5* | 64.71%[2] | 81.33% | ≥90th | R |
| *Combination 6* | 69.61%[2] | 76.00% | ≥90th | R |
| *Combination 7* | 64.71%[2] | 81.33% | ≥90th | R |
| *Combination 8* | 69.61%[2] | 76.00% | ≥90th | R |
| *Combination 9* | 56.86%[2] | 68.00% | ≥90th | R |
| *Combination 10* | 56.86%[2] | 68.00% | ≥90th | R |
| *Well-Child Visits in the First 15 Months of Life* | | | | |
| *Zero Visits*** | 0.00% | 2.22% | 75th–89th | R |
| *Six or More Visits* | 2.13% | 62.22% | 25th–49th | R |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 58.53%[3] | 67.15% | <10th | R |
| *Adolescent Well-Care Visits* | 42.00%[2] | 48.91% | 50th–74th | R |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | | | | |
| *BMI Assessment: Total* | 90.27% | 93.67% | ≥90th | R |
| *Counseling for Nutrition: Total* | 76.16% | 79.32% | ≥90th | R |
| *Counseling for Physical Activity: Total* | 63.26% | 66.67% | ≥90th | R |

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

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Immunizations for Adolescents—Combination 1* | — | 90.16% | ≥90th | R |
| *Appropriate Testing for Children with Pharyngitis* | — | 84.21% | 75th–89th | R |
| *Follow-up Care for Children Prescribed ADHD Medication* | | | | |
| *Initiation* | — | NA | NA | NA |
| *Continuation* | — | NA | NA | NA |
| *Asthma Medication Ratio—Total* | — | NA | NA | NA |
| *Children's and Adolescents' Access to Primary Care Practitioners* | | | | |
| *Ages 12 to 24 Months* | — | 86.61% | <10th | R |
| *Ages 25 Months to 6 Years* | — | 74.84% | <10th | R |
| *Ages 7 to 11 Years* | — | 84.35% | 10th–24th | R |
| *Ages 12 to 19 Years* | — | 87.68% | 25th–49th | R |

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

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

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

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

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

[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] The Department's required data collection methodology for the *Childhood Immunization Status* and *Adolescents Well-Care Visits* measures in HEDIS 2013 was administrative. DHMP followed this requirement; the rates displayed here were the HMO's final rates.

[3] Per the Department's required data collection methodology, the HEDIS 2013 rate displayed reflect administrative data only and are not the final, reported hybrid rates in the plan-submitted files. DHMP reported the HEDIS 2013 hybrid rate of 73.94 percent for measure *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

## Strengths

The auditor noted that DHMP had used its HEDIS reports to monitor overall progress toward the measures and to improve care. All of DHMP's performance measures received an audit result of *Reportable (R)* for HEDIS 2014. Five indicators reported a statistically significant rate increase from the previous year. These indicators were *Childhood Immunization Status—Combination 5* and *Combination 7; Well-Child Visits in the First 15 Months of Life—6+ Visits; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits.* Rate increases observed for these measures may be due to a change in the data collection methodology required by the Department from administrative to hybrid and may not denote actual performance improvement. Nonetheless, the *Childhood Immunization Status, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,* and *Immunizations for Adolescents—Combination 1* measures all benchmarked at or above the national HEDIS Medicaid 90th percentiles.

## Recommendations

Due to the continued challenge in capturing accurate membership data, the auditor recommended that DHMP focus on working with the Department to improve the quality of the data and the reconciliation process at the State level. DHMP did not have any measures showing a significant rate decline from the previous year. Nonetheless, DHMP should focus its improvement efforts on the two younger age groups under the *Children's and Adolescents' Access to Primary Care Practitioners* indicators. These indicators benchmarked at or below the national HEDIS Medicaid 10th percentiles. Additionally, although the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure reported a significant rate increase, the rate was below the 25th percentile, suggesting opportunities for improvement.

## Use of Services Observations

Table 3-21 shows the audit results for all the required Use of Services measures. DHMP reported a 5.7 percent decline in *Ambulatory Care—Emergency Department Visits*. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2013 and 2014 may not denote improvement or decline in performance. Percentile rankings based on HEDIS 2013 rates are also for information only.

**Table 3-21—Review Audit Results for Use of Services Measures *for* DHMP**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Ambulatory Care: Total (Per 1,000 MM)* | | | | |
| *Outpatient Visits* | — | 111.45 | <10th | R |
| *Emergency Department Visits* | 31.48 | 29.68 | <10th | R |
| *Inpatient Utilization—General Hospital/Acute Care: Total* | | | | |
| *Discharges per 1,000 MM (total inpatient)* | — | 1.01 | <10th | R |
| *Days per 1,000 MM (total inpatient)* | — | 2.72 | <10th | R |
| *Average Length of Stay (total inpatient)* | — | 2.70 | <10th | R |
| *Discharges per 1,000 MM (medicine)* | — | 0.81 | <10th | R |
| *Days per 1,000 MM (medicine)* | — | 2.17 | <10th | R |
| *Average Length of Stay (medicine)* | — | 2.68 | <10th | R |
| *Discharges per 1,000 MM (surgery)* | — | 0.17 | <10th | R |
| *Days per 1,000 MM (surgery)* | — | 0.46 | <10th | R |
| *Average Length of Stay (surgery)* | — | 2.73 | <10th | R |
| *Discharges per 1,000 MM (maternity)* | — | 0.07 | <10th | R |
| *Days per 1,000 MM (maternity)* | — | 0.20 | <10th | R |
| *Average Length of Stay (maternity)* | — | 3.00 | ≥90th | R |

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

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

[1]Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

### Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Of the 21 rates from the nine quality-related measures, five reported significant rate increases from the previous year. These rates were *Childhood Immunization Status—Combination 5* and *Combination 7;, Well-Child Visits in the First 15 Months of Life--6+ Visits; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits*. Since the required data collection methodology for these measures was changed from administrative to hybrid, the rate increases may not denote actual performance improvement. Even so, the *Childhood Immunization Status, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,* and *Immunizations for Adolescents—Combination 1* measures benchmarked at or above the national HEDIS Medicaid 90th percentiles. None of the measures reported significant declines. Only one measure (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) was below the national HEDIS Medicaid 10th percentile and presented opportunities for improvement for DHMP.

**Timeliness:** Of the 16 rates from the six timeliness-related measures, five reported significant rate increases from the previous. These rates were from the *Childhood Immunization Status—Combination 5* and Combination *7; Well-Child Visits in the First 15 Months of Life—6+ Visits; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits* measures. Nonetheless, since the required data collection methodology for these measures was changed from administrative to hybrid, the rate increases may not denote actual performance improvement. Although none of the remaining measures reported significant declines in performance, DHMP should focus its efforts to improve the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* rate, which was at or below the national HEDIS Medicaid 10th percentile.

**Access:** Of the three access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. The rates for the two younger age groups (*12 to 24 Months* and *25 Months to 6 Years*) benchmarked at or below the national HEDIS Medicaid 10$^{th}$ percentile, suggesting opportunities for improvement for DHMP. For the utilization-based measures, *Ambulatory Care—Emergency Department Visits* declined by 5.7 percent. Since these measures are not risk-adjusted, DHMP's rates reported for these measures should be for information only.

## *Kaiser Permanente Colorado*

### Compliance With Information Systems (IS) Standards

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

[3-3] HEDIS Compliance Audit, Final Audit Report, Kaiser Foundation Health Plan of Colorado, July 2014

## Performance Measures

Table 3-22 shows the Kaiser rates for HEDIS 2013 and HEDIS 2014, the percentile ranking for HEDIS 2014, and HEDIS 2014 audit results for each performance measure.

**Table 3-22—Review and Audit Results for Performance Measures *for* Kaiser**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Childhood Immunization Status* | | | | |
| *Combination 2* | 90.00%[2] | 85.29% | 75th–89th | R |
| *Combination 3* | 88.89%[2] | 84.31% | ≥90th | R |
| *Combination 4* | 88.89%[2] | 84.31% | ≥90th | R |
| *Combination 5* | 74.44%[2] | 68.63% | 75th–89th | R |
| *Combination 6* | 55.56%[2] | 59.80% | ≥90th | R |
| *Combination 7* | 74.44%[2] | 68.63% | ≥90th | R |
| *Combination 8* | 55.56%[2] | 59.80% | ≥90th | R |
| *Combination 9* | 50.00%[2] | 51.96% | ≥90th | R |
| *Combination 10* | 50.00%[2] | 51.96% | ≥90th | R |
| *Well-Child Visits in the First 15 Months of Life* | | | | |
| *Zero Visits*** | 0.00%[3] | 0.00%[3] | <10th | R |
| *Six or More Visits* | 54.35%[3] | 51.92%[3] | 10th–24th | R |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 66.35%[3] | 68.02%[3] | 25th–49th | R |
| *Adolescent Well-Care Visits* | 52.03% | 49.78% | 50th–74th | R |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | | | | |
| *BMI Assessment: Total* | 97.51% | **90.74%** | ≥90th | R |
| *Counseling for Nutrition: Total* | 100.00% | **90.74%** | ≥90th | R |
| *Counseling for Physical Activity: Total* | 100.00% | **90.74%** | ≥90th | R |
| *Immunizations for Adolescents—Combination 1* | — | 89.42% | ≥90th | R |
| *Appropriate Testing for Children with Pharyngitis* | — | 91.15% | ≥90th | R |
| *Follow-up Care for Children Prescribed ADHD Medication* | | | | |
| *Initiation* | — | 38.71% | 25th–49th | R |
| *Continuation* | — | NA | NA | NA |
| *Asthma Medication Ratio—Total* | — | NA | NA | NA |

**Table 3-22—Review and Audit Results for Performance Measures *for* Kaiser**

| Performance Measures | HEDIS Rate 2013 | HEDIS Rate 2014 | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| *Children's and Adolescents' Access to Primary Care Practitioners* | | | | |
| *Ages 12 to 24 Months* | — | 95.96% | 25th–49th | R |
| *Ages 25 Months to 6 Years* | — | 90.78% | 50th–74th | R |
| *Ages 7 to 11 Years* | — | 95.47% | ≥90th | R |
| *Ages 12 to 19 Years* | — | 95.97% | ≥90th | R |

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

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

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

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

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

[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] The Department's required data collection methodology for this measure in HEDIS 2013 was administrative. Kaiser reported using a hybrid methodology but since there was no numerator event by medical records for any indicator within this measure, the final rates reported were indeed the administrative data rates for Kaiser.

[3] The Department's required data collection methodology for these measures was administrative in HEDIS 2013 and hybrid in HEDIS 2014. For both years, Kaiser reported using the administrative-only methodology as its final rates for these measures.

## Strengths

All of Kaiser's performance measures received an audit result of *Reportable (R)* for HEDIS 2014. Although none of the HEDIS 2014 rates show any significant performance improvement from the previous year, 15 rates benchmarked at or above the national HEDIS Medicaid 90th percentiles. These rates spread across measures that include *Childhood Immunization Status, Well-Child Visits in the First 15 Months of Life—Zero Visits, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Immunizations for Adolescents—Combination 1, Appropriate Testing for Children with Pharyngitis,* and *Children's and Adolescents' Access to Primary Care Practitioners*.

## Recommendations

Although *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* benchmarked among the top 10 percent in national performance, this measure reported a statistically significant rate decline from last year.

## Use of Services Observations

Table 3-23 shows the audit results for all the required Use of Services measures. Kaiser reported a 56.8 percent decline in *Ambulatory Care—Emergency Department Visits*. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2013 and 2014 may not denote improvement

or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

**Table 3-23—Review Audit Results for Use of Services Measures *for* Kaiser**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Ambulatory Care: Total (Per 1,000 MM)* | | | | |
| *Outpatient Visits* | — | 163.04 | <10th | R |
| *Emergency Department Visits* | 24.73 | 10.69 | <10th | R |
| *Inpatient Utilization—General Hospital/Acute Care: Total* | | | | |
| *Discharges per 1,000 MM (total inpatient)* | — | 0.78 | <10th | R |
| *Days per 1,000 MM (total inpatient)* | — | 2.41 | <10th | R |
| *Average Length of Stay (total inpatient)* | — | 3.09 | 10th–24th | R |
| *Discharges per 1,000 MM (medicine)* | — | 0.58 | <10th | R |
| *Days per 1,000 MM (medicine)* | — | 1.73 | <10th | R |
| *Average Length of Stay (medicine)* | — | 2.98 | 10th–24th | R |
| *Discharges per 1,000 MM (surgery)* | — | 0.13 | <10th | R |
| *Days per 1,000 MM (surgery)* | — | 0.51 | <10th | R |
| *Average Length of Stay (surgery)* | — | 3.83 | <10th | R |
| *Discharges per 1,000 MM (maternity)* | — | 0.14 | <10th | R |
| *Days per 1,000 MM (maternity)* | — | 0.35 | <10th | R |
| *Average Length of Stay (maternity)* | — | 2.50 | 25th–49th | R |

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
[1]Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Of the 21 rates from the nine quality-related measures, 13 benchmarked at or above the national HEDIS Medicaid 90th percentile. The rates were from the *Childhood Immunization Status, Well-Child Visits in the First 15 Months of Life—Zero Visits, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Immunizations for Adolescents—Combination 1,* and *Appropriate Testing for Children with Pharyngitis* measures. Although none of the measures benchmarked below the national 10th percentile, opportunities for improvement existed for *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure, where the rate was below the 25th percentile, and for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, whose rates showed a significant decline from the previous year.

**Timeliness:** Of the 16 rates from the six timeliness-related measures, nine benchmarked at or above the national HEDIS Medicaid 90th percentiles. These rates were from the *Childhood Immunization Status, Well-Child Visits in the First 15 Months of life—Zero Visits,* and *Immunizations for Adolescents—Combination 1* measures. Although none of the remaining measures reported significant declines in performance or fell below the national 10th percentile, opportunities for improvement existed for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* indicators, where the rates were at or below the national HEDIS Medicaid 50th percentiles.

**Access:** Of the three access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. The rates for the two older age groups (*7 to 11 Years* and *12 to 19 Years*) benchmarked at or above the national HEDIS Medicaid 90th percentile. On the other hand, the youngest age group (*12 to 24 Months*) was below the national HEDIS Medicaid 50th percentile, suggesting opportunities for improvement. For the utilization-based measures, *Ambulatory Care—Emergency Department Visits* declined by 56.8 percent. Since these measures are not risk-adjusted, Kaiser's rates reported for these measures should be for information only.

## Rocky Mountain Health Plans

### Compliance With Information Systems (IS) Standards

RMHP was fully compliant with all IS standards relevant to the scope of the performance measure validation. The auditor did not identify any notable issues that had any negative impact on HEDIS reporting and had no recommendations for RMHP related to compliance with IS standards.[3-4]

### Performance Measures

Table 3-24 shows the RMHP rates for HEDIS 2013 and HEDIS 2014, the percentile ranking for HEDIS 2014, and HEDIS 2014 audit results for each performance measure.

**Table 3-24—Review Audit Results for Performance Measures *for* RMHP**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Childhood Immunization Status* | | | | |
| *Combination 2* | 43.15%[2] | **69.87%** | 10th–24th | **R** |
| *Combination 3* | 42.64%[2] | **67.88%** | 25th–49th | **R** |
| *Combination 4* | 36.55%[2] | **57.95%** | 25th–49th | **R** |
| *Combination 5* | 32.99%[2] | **51.66%** | 25th–49th | **R** |
| *Combination 6* | 27.41%[2] | **49.67%** | 75th–89th | **R** |
| *Combination 7* | 29.95%[2] | **49.01%** | 25th–49th | **R** |
| *Combination 8* | 25.38%[2] | **44.70%** | 50th–74th | **R** |
| *Combination 9* | 23.35%[2] | **40.40%** | 50th–74th | **R** |
| *Combination 10* | 22.34%[2] | **38.74%** | 75th–89th | **R** |
| *Well-Child Visits in the First 15 Months of Life* | | | | |
| *Zero Visits*** | 4.79%[3] | 2.67% | 75th–89th | **R** |
| *Six or More Visits* | 20.55%[4] | **69.08%** | 50th–74th | **R** |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 62.14%[5] | **55.41%** | <10th | **R** |
| *Adolescent Well-Care Visits* | 41.10%[6] | 40.40% | 10th–24th | **R** |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | | | | |
| *BMI Assessment: Total* | 74.12% | 77.92% | 75th–89th | **R** |
| *Counseling for Nutrition: Total* | 60.40% | 58.72% | 25th–49th | **R** |
| *Counseling for Physical Activity: Total* | 58.63% | 56.07% | 75th–89th | **R** |
| *Immunizations for Adolescents—Combination 1* | — | 55.13% | 10th–24th | **R** |
| *Appropriate Testing for Children with Pharyngitis* | — | 82.52% | 75th–89th | **R** |

[3-4] HEDIS Compliance Audit, Final Audit Report, Rocky Mountain Health Plans, July 2014.

**Table 3-24—Review Audit Results for Performance Measures *for* RMHP**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Follow-up Care for Children Prescribed ADHD Medication* | | | | |
| *Initiation* | — | 44.64% | 50th–74th | R |
| *Continuation* | — | NA | NA | NA |
| *Asthma Medication Ratio—Total* | — | 75.56% | ≥90th | R |
| *Children's and Adolescents' Access to Primary Care Practitioners* | | | | |
| *Ages 12 to 24 Months* | — | 88.60% | <10th | R |
| *Ages 25 Months to 6 Years* | — | 77.74% | <10th | R |
| *Ages 7 to 11 Years* | — | 86.94% | 10th–24th | R |
| *Ages 12 to 19 Years* | — | 86.55% | 25th–49th | R |

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

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

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

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

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

[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] Per the Department's required data collection methodology, the rate displayed reflects administrative data only for HEDIS 2013. RMHP reported HEDIS 2013 hybrid rates of 69.54 percent, 67.51 percent, 58.38 percent, 54.31 percent, 45.69 percent, 49.24 percent, 42.13 percent, 39.59 percent, and 37.06 percent for the *Childhood Immunization Status—Combination 2* through *Combination 10* indicators respectively.

[3] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2013. RMHP reported the HEDIS 2013 hybrid rate of 3.42 percent for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* indicator.

[4] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2013. RMHP reported the HEDIS 2013 hybrid rate of 65.75 percent for the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* indicator.

[5] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2013. RMHP reported the HEDIS 2013 hybrid rate of 66.89 percent for measure *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

[6] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. RMHP reported the HEDIS 2013 hybrid rate of 40.18 percent for the *Adolescent Well-Care Visits* measure.

## Strengths

All of RMHP's performance measures received an audit result of *Reportable (R)* for HEDIS 2014. All the indicators under *Childhood Immunization Status* and the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator reported a statistically significant increase from the previous year. Rate increases for these measures could be related to a change in data collection methodology and may not denote actual performance improvement. Additionally, the *Follow-Up Care for*

*Children Prescribed ADHD Medication—Continuation* and *Asthma Medication Ratio—Total* indicators benchmarked at or above the national HEDIS Medicaid 90th percentiles.

### Recommendations

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

### Use of Services Observations

Table 3-25 shows the audit results for all the required Use of Services measures. RMHP reported a 12.9 percent decline in *Ambulatory Care—Emergency Department Visits*. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2013 and 2014 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

**Table 3-25—Review Audit Results for Use of Services Measures *for* RMHP**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Ambulatory Care: Total (Per 1,000 MM)* | | | | |
| *Outpatient Visits* | — | 208.28 | <10th | R |
| *Emergency Department Visits* | 22.76 | 19.82 | <10th | R |
| *Inpatient Utilization—General Hospital/Acute Care: Total* | | | | |
| *Discharges per 1,000 MM (total inpatient)* | — | 0.98 | <10th | R |
| *Days per 1,000 MM (total inpatient)* | — | 2.23 | <10th | R |
| *Average Length of Stay (total inpatient)* | — | 2.28 | <10th | R |
| *Discharges per 1,000 MM (medicine)* | — | 0.64 | <10th | R |
| *Days per 1,000 MM (medicine)* | — | 1.32 | <10th | R |
| *Average Length of Stay (medicine)* | — | 2.08 | <10th | R |
| *Discharges per 1,000 MM (surgery)* | — | 0.34 | <10th | R |
| *Days per 1,000 MM (surgery)* | — | 0.89 | <10th | R |
| *Average Length of Stay (surgery)* | — | 2.64 | <10th | R |
| *Discharges per 1,000 MM (maternity)* | — | 0.02 | <10th | R |
| *Days per 1,000 MM (maternity)* | — | 0.06 | <10th | R |
| *Average Length of Stay (maternity)* | — | 3.00 | ≥90th | R |

— is shown when no data were available or the measure was not required to be reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.

| Table 3-25—Review Audit Results for Use of Services Measures *for* RMHP | | | | |
|---|---|---|---|---|
| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
| | 2013 | 2014 | | |

[1]Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Of the 21 rates from the nine quality-related measures, 10 reported significant rate increases from the previous year. These rates were from *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life—6+ Visits*. Since the required data collection methodology for these measures was changed from administrative to hybrid, the rate increases may not denote actual performance improvement. Both indicators from *Follow-up Care for Children Prescribed ADHD Medication* benchmarked at or above the national HEDIS Medicaid 90th percentiles. Opportunities for improvement existed for one measure (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*), where the rate was at or below the national HEDIS Medicaid 10th percentile.

**Timeliness:** Of the 16 rates from the six timeliness-related measures, ten reported significant rate increases from the previous year. These rates were from the *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of life—6+ Visits* measures. Since the required data collection methodology for these measures was changed from administrative to hybrid, the rate increases may not denote actual performance improvement. One measure (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*) reported a significant rate decline from the previous year and benchmarked below the national HEDIS Medicaid 10th percentile. This measure presented opportunities for improvement for RMHP.

**Access:** Of the three access-related measures, only the *Children's and Adolescents' Access to Primary Care Practitioners* measure was population-based; the remaining measures were utilization-based. The rates for the two younger age groups (*12 to 24 Months* and *25 Months to 6 Years*) benchmarked at or below the national HEDIS Medicaid 10th percentile, suggesting opportunities for improvement. For the utilization-based measures, *Ambulatory Care—Emergency Department Visits* declined by 12.9 percent. Since these measures are not risk-adjusted, RMHP's rates reported for these measures should be for information only.

## State Managed Care Network

### Compliance With Information Systems (IS) Standards

The SMCN was fully compliant with all IS standards relevant to the scope of the performance measure validation. The auditor did not identify any notable issues that had any negative impact on HEDIS reporting. Although Colorado Access, the third-party administrator for claims submitted by the SMCN providers, changed its claims processing vendor in November 2013, there was no major issue obtaining complete and accurate claims data for HEDIS 2014 reporting. Policies and program-level changes that occurred in Colorado (e.g., Medicaid expansion and eligibility changes related to the Affordable Care Act) did not appear to significantly impact the eligible populations associated with the required measure. Colorado Access continued to work diligently with the Department to address CHP+ membership data loss during the transition from the Colorado Benefits Management System to the Medicaid Management Information System.[3-5]

### Performance Measures

Table 3-26 shows the SMCN rates for HEDIS 2013 and HEDIS 2014, the percentile ranking for HEDIS 2014, and HEDIS 2014 audit results for each performance measure.

**Table 3-26—Review Audit Results for Performance Measures *for* SMCN**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] | HEDIS 2014 Audit Result |
|---|---|---|---|---|
| | 2013 | 2014 | | |
| *Prenatal and Postpartum Care* | | | | |
| *Timeliness of Prenatal Care* | 78.59% | **70.80%** | 10th–24th | **R** |
| *Postpartum Care* | 67.88% | 63.26% | 25th–49th | **R** |

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.
R is shown when the rate was reportable, according to NCQA standards.
[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

### Strengths

Although the *Prenatal and Postpartum Care* measure received an audit result of *Reportable (R)* for HEDIS 2014, none of its indicators reported a statistically significant performance improvement from the previous year or benchmarked at or above the national HEDIS Medicaid 90th percentiles.

### Recommendations

The Department should focus its efforts to improve the rates for the *Prenatal and Postpartum Care* measure. Both indicators exhibited a rate decrease from the previous year, with the *Timeliness* indicator showing a statistically significant decline. This indicator also benchmarked at or below the

[3-5] HEDIS Compliance Audit, Final Audit Report, Child Health Plan Plus, July 2014.

national HEDIS Medicaid 10th percentile. HSAG recommended that the Department investigate the reasons behind this decline.

### Summary Assessment Related to Quality, Timeliness, and Access

Although SMCN had only one measure to report for HEDIS 2014, this measure belonged to all three domains. Both indicators of the *Prenatal and Postpartum Care* measure exhibited a decline in rate from last year, although only the *Timeliness of Prenatal Care* indicator reported a statistically significant decrease in rate. The HEDIS 2014 rates for both indicators also benchmarked below the national HEDIS Medicaid 25th percentile and presented opportunities for improvement for the SMCN.

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

Table 3-27 shows the statewide weighted averages for HEDIS 2013 and HEDIS 2014, along with the percentile ranking for each performance measure.

**Table 3-27—Statewide Review Audit Results for HEDIS 2014 Performance Measures**

| Performance Measures | HEDIS Rate | | Percentile Ranking[1] |
|---|---|---|---|
| | 2013 | 2014 | |
| *Childhood Immunization Status* | | | |
| *Combination 2* | 58.04% | **73.25%** | 25th–49th |
| *Combination 3* | 55.89% | **70.33%** | 25th–49th |
| *Combination 4* | 51.43% | **63.50%** | 50th–74th |
| *Combination 5* | 44.11% | **58.90%** | 50th–74th |
| *Combination 6* | 36.70% | **51.53%** | 75th–89th |
| *Combination 7* | 41.16% | **55.43%** | 50th–74th |
| *Combination 8* | 34.73% | **47.79%** | 75th–89th |
| *Combination 9* | 30.45% | **44.66%** | 75th–89th |
| *Combination 10* | 28.93% | **42.56%** | 75th–89th |
| *Well-Child Visits in the First 15 Months of Life* | | | |
| *Zero Visits*** | 2.67% | 2.16% | 75th–89th |
| *Six or More Visits* | 25.48% | **67.41%** | 50th–74th |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 61.26% | **66.29%** | 10th–24th |
| *Adolescent Well-Care Visits* | 42.09% | 44.00% | 25th–49th |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | | | |
| *BMI Assessment: Total* | 68.80% | 69.59% | 50th–74th |
| *Counseling for Nutrition: Total* | 62.24% | 64.47% | 50th–74th |
| *Counseling for Physical Activity: Total* | 56.68% | 58.26% | 75th–89th |

| Table 3-27—Statewide Review Audit Results for HEDIS 2014 Performance Measures | | | |
|---|---|---|---|
| Performance Measures | HEDIS Rate | | Percentile Ranking[1] |
| | 2013 | 2014 | |
| *Immunizations for Adolescents—Combination 1* | — | 66.27% | 25th–49th |
| *Appropriate Testing for Children with Pharyngitis* | — | 79.09% | 75th–89th |
| *Follow-up Care for Children Prescribed ADHD Medication* | | | |
| *Initiation* | — | 16.78% | <10th |
| *Continuation* | — | 30.77% | 10th–24th |
| *Asthma Medication Ratio—Total* | — | 73.78% | ≥90th |
| *Prenatal and Postpartum Care*[2] | | | |
| *Timeliness of Prenatal Care* | 78.59% | **70.80%** | 10th–24th |
| *Postpartum Care* | 67.88% | 63.26% | 25th–49th |
| *Children's and Adolescents' Access to Primary Care Practitioners* | | | |
| *Ages 12 to 24 Months* | — | 91.36% | <10th |
| *Ages 25 Months to 6 Years* | — | 82.41% | <10th |
| *Ages 7 to 11 Years* | — | 89.16% | 25th–49th |
| *Ages 12 to 19 Years* | — | 88.60% | 25th–49th |

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.
— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
** For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).
[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.
[2] This measure was required for SMCN reporting only.

## Strengths

The statewide rates showed significant improvement for *Childhood Immunization Status*, *Well-Child Visits in the First 15 Months of Life—6+ Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Rate increases may be related to a change in the data collection methodology required by the Department from administrative to hybrid and may not denote actual performance improvement. The *Asthma Medication Ratio—Total* indicator benchmarked at or above the national HEDIS Medicaid 90th percentile.

## Recommendations

The statewide rates for the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* indicator and the two younger age groups under *Children's and Adolescents' Access to Primary Care Practitioners* benchmarked at or below the national HEDIS Medicaid 10th percentiles.

## Use of Services Observations

Table 3-28 shows the audit results for all the Use of Services measures required for all the health plans. At the statewide level, the *Ambulatory Care—Emergency Department Visits* measure declined 12 percent from last year, though the decrease was not statistically significant. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2013 and 2014 may not denote improvement or decline in performance. Percentile rankings based on HEDIS 2013 rates are also for information only.

**Table 3-28—Statewide HEDIS 2014 Rates and Percentile Rankings for Use of Services Measures**

| Measures | HEDIS Rate | | Percentile Ranking[1] |
|---|---|---|---|
| | 2013 | 2014 | |
| *Ambulatory Care: Total (Per 1,000 MM)* | | | |
| *Outpatient Visits* | — | 214.08 | <10th |
| *Emergency Department Visits* | 30.07 | 26.47 | <10th |
| *Inpatient Utilization—General Hospital/Acute Care: Total* | | | |
| *Discharges per 1,000 MM (total inpatient)* | — | 1.23 | <10th |
| *Days per 1,000 MM (total inpatient)* | — | 4.16 | <10th |
| *Average Length of Stay (total inpatient)* | — | 3.37 | 25th-49th |
| *Discharges per 1,000 MM (medicine)* | — | 0.85 | <10th |
| *Days per 1,000 MM (medicine)* | — | 2.38 | <10th |
| *Average Length of Stay (medicine)* | — | 2.81 | <10th |
| *Discharges per 1,000 MM (surgery)* | — | 0.30 | <10th |
| *Days per 1,000 MM (surgery)* | — | 1.56 | <10th |
| *Average Length of Stay (surgery)* | — | 5.27 | 25th-49th |
| *Discharges per 1,000 MM (maternity)* | — | 0.19 | <10th |
| *Days per 1,000 MM (maternity)* | — | 0.45 | <10th |
| *Average Length of Stay (maternity)* | — | 2.44 | 10th-24th |

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

[1]Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

## Summary Assessment Related to Quality, Timeliness, and Access

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

**Quality:** Of the 23 rates from the 10 quality-related measures, 11 reported significant rate increases from the previous year. These rates were from the *Childhood Immunization Status, Well-Child Visits in the First 15 Months of life—6+ Visits,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

measures. Since the required data collection methodology for these measures was changed from administrative to hybrid, the rate increases may not denote actual performance improvement. One measure (*Asthma Medication Ratio—Total*) benchmarked at the national HEDIS Medicaid 90th percentile. One indicator (*Timeliness of Prenatal Care*) reported a significant rate decline and one (*Follow-up Care for Children Prescribed ADHD Medication—Initiation*) benchmarked at or below the national HEDIS Medicaid 10th percentile. These measures presented statewide opportunities for improvement.

**Timeliness:** Of the 18 rates from the seven timeliness-related measures, 11 reported significant rate increases from the previous year. These rates were from the *Childhood Immunization Status, Well-Child Visits in the First 15 Months of life—6+ Visits,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures. Since the required data collection methodology for these measures was changed from administrative to hybrid, the rate increases may not denote actual performance improvement. One timeliness-related measure (*Timeliness of Prenatal Care*) reported a significant rate decline and one (*Follow-up Care for Children Prescribed ADHD Medication—Initiation*) benchmarked below the national HEDIS Medicaid 10th percentile. These measures presented statewide opportunities for improvement.

**Access:** Of the four access-related measures, two were population-based (*Prenatal and Postpartum Care* and *Children's and Adolescents' Access to Primary Care Practitioners*) and contained a total of six rates. None of these measures reported a statistically significant improvement from the previous year. The *Timeliness of Prenatal Care* indicator under *Prenatal and Postpartum Care* showed a statistically significant decline. Additionally, the two younger age groups under the *Children's and Adolescents' Access to Primary Care Practitioners* were at or below the national HEDIS Medicaid 10th percentile. For the utilization-based measures (i.e., *Ambulatory Care* and *Inpatient Utilization), Ambulatory Care—Emergency Department Visits* declined by 12 percent. Since these measures are not risk-adjusted, the statewide rates should be for information only.

## Validation of Performance Improvement Projects

For FY 2013–2014, HSAG validated one PIP for each of the five CHP+ HMOs. Appendix D describes how the validation of PIP activities was conducted and how the resulting data were aggregated and analyzed.

Table 3-29 lists the HMOs and their PIP study titles.

**Table 3-29—Summary of Each HMO's PIP**

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

### *Colorado Access*

#### Findings

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

Table 3-30 provides a summary of Colorado Access' PIP validation results for the FY 2013–2014 validation cycle.

**Table 3-30—FY13-14 Performance Improvement Project Validation Results *for* Colorado Access**

| Study Stage | Activity | | Percent of Applicable Elements | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Design | I. | Study Topic | 100% (2/2) | 0% (0/2) | 0% (0/2) |
| | II. | Study Question | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | III. | Study Indicator | 100% (2/2) | 0% (0/2) | 0% (0/2) |
| | IV. | Study Population | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | V. | Sampling Techniques | 100% (6/6) | 0% (0/6) | 0% (0/6) |
| | VI. | Data Collection | 100% (6/6) | 0% (0/6) | 0% (0/6) |
| | | Design Total | 100% (18/18) | 0% (0/18) | 0% (0/18) |
| Implementation | VII. | Data Analysis and Interpretation | 100% (9/9) | 0% (0/9) | 0% (0/9) |
| | VIII. | Interventions and Improvement Strategies | 100% (3/3) | 0% (0/3) | 0% (0/3) |

| Table 3-30—FY13-14 Performance Improvement Project Validation Results *for* Colorado Access | | | | | |
|---|---|---|---|---|---|
| Study Stage | Activity | | Percent of Applicable Elements | | |
| | | | Met | Partially Met | Not Met |
| | | Implementation Total | 100% (12/12) | 0% (0/12) | 0% (0/12) |
| Outcomes | IX. | Real Improvement | 100% (4/4) | 0% (0/4) | 0% (0/4) |
| | X. | Sustained Improvement | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | | Outcomes Total | 100% (5/5) | 0% (0/5) | 0% (0/5) |
| **Percent Score of Applicable Evaluation Elements Met** | | | **100% Percent (35/35)** | | |

Colorado Access demonstrated strength in its study design (Activities I–VI), study implementation (Activities VII and VIII), and study outcomes (Activities IX and X) by receiving *Met* scores for all applicable evaluation elements. The health plan documented a solid study design, implemented effective improvement strategies, and achieved sustained improvement over baseline at the second remeasurement. The Colorado Access PIP received a *Met* score for 100 percent of 35 applicable evaluation elements. This was the third consecutive year that the PIP received a *Met* score for 100 percent of applicable evaluation elements.

Table 3-31 provides a summary of Colorado Access' PIP-specific outcomes for the FY 2013–2014 validation cycle.

| Table 3-31—FY13–14 Performance Improvement Project Specific Outcomes *for* Colorado Access | | | | | | |
|---|---|---|---|---|---|---|
| **PIP Topic: *Improving Weight Assessment in Children and Adolescents*** | | | | | | |
| **PIP Study Indicator** | **Baseline** | **Remeasure-ment 1** | **Remeasure-ment 2** | **Percentage Point Change** | **Statistical Significance (*p* value)** | **Sustained Improvement** |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation during the measurement year. | 23.11% | 52.55% | 63.99% | 11.44↑ | $p = 0.0009$ Statistically Significant | *Yes* |

↑ Designates an increase in the study indicator rate from the previous measurement period.

For the second remeasurement, Colorado Access reported that 63.99 percent of members 3–17 years of age had an outpatient visit with a PCP or OB/GYN, and had evidence of BMI percentile documentation during the measurement year. The rate increase of 11.44 percentage points from

52.55 percent at the first remeasurement was statistically significant ($p$ = 0.0009). The study indicator demonstrated sustained improvement over the baseline rate at Remeasurement 2.

### Strengths

Colorado Access documented a solid study design, implemented effective improvement strategies, and achieved real and sustained improvement for the second remeasurement of the *Improving Weight Assessment in Children and Adolescents* PIP. The PIP received a *Met* score for 100 percent of applicable evaluation elements in Activities I–X.

### Interventions

The interventions implemented by Colorado Access during this measurement period were concretely linked to priority barriers identified by the causal/barrier analysis. The health plan conducted exit interviews with providers at the conclusion of HEDIS site visits. The exit interviews included a standardized scorecard that summarized the findings for each provider and offered recommendations for improvement. Each provider was also given HEDIS coding information and relevant diagnosis codes for reference. Colorado Access will track the provider scorecards in a database to allow for future year-to-year comparisons. To address the second-highest priority barriers the health plan encouraged providers to adopt electronic medical records, developed a nutritional referral resource list, created a BMI screening/coding article for the provider bulletin, sent well-child reminder birthday cards to members, and sent monthly interactive voice response (IVR) automated messages to members.

Colorado Access demonstrated that the implemented interventions were evaluated to determine the impact they had on the outcomes. The annual HEDIS medical record reviews (site visits) and data abstraction performed by the Colorado Access staff yielded positive results for two consecutive years. The health plan stated that in an effort to build provider relations, the same Colorado Access staff members will visit providers annually to conduct the HEDIS medical record review. The HEDIS exit interview process/scorecard will also be continued because feedback indicated that providers appreciated these efforts. During this measurement period the health plan instituted a member focus group that reacted positively to the birthday card and IVR reminders. The health plan standardized the birthday card and IVR reminders and noted that most of the interventions will continue beyond the scope of the PIP.

### Recommendations

Based on the FY 2013–2014 validation results for the Colorado Access *Improving Weight Assessment in Children and Adolescents* PIP, in which the PIP received a *Met* score for 100 percent of applicable evaluation elements for the third consecutive year, HSAG did not identify any opportunities for improvement.

## Colorado Choice Health Plan

### Findings

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

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

**Table 3-32—FY13–14 Performance Improvement Project Validation Results *for* Colorado Choice**

| Study Stage | Activity | | Percent of Applicable Elements | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Design | I. | Study Topic | 100% (2/2) | 0% (0/2) | 0% (0/2) |
| | II. | Study Question | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | III. | Study Indicator | 100% (3/3) | 0% (0/3) | 0% (0/3) |
| | IV. | Study Population | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | V. | Sampling Techniques | Not Applicable | Not Applicable | Not Applicable |
| | VI. | Data Collection | 100% (4/4) | 0% (0/4) | 0% (0/4) |
| | | Design Total | 100% (11/11) | 0% (0/11) | 0% (0/11) |
| Implementation | VII. | Data Analysis and Interpretation | 75% (6/8) | 25% (2/8) | 0% (0/8) |
| | VIII. | Interventions and Improvement Strategies | 33% (1/3) | 67% (2/3) | 0% (0/3) |
| | | Implementation Total | 64% (7/11) | 36% (4/11) | 0% (0/11) |
| Outcomes | IX. | Real Improvement | 25% (1/4) | 0% (0/4) | 75% (3/4) |
| | X. | Sustained Improvement | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | | Outcomes Total | 40% (2/5) | 0% (0/5) | 60% (3/5) |
| **Percent Score of Applicable Evaluation Elements Met** | | | **74% Percent (20/27)** | | |

Colorado Choice documented a solid foundation in the study design stage, which is essential to producing methodologically sound results, and the PIP received a *Met* score for 100 percent of applicable evaluation elements in Activities I–IV and VI. In the Implementation stage (Activities VII and VIII), the PIP received a *Met* score for 64 percent of applicable evaluation elements. In Activity VII, two evaluation elements were scored *Partially Met* because the PIP documentation included errors in the interpretation of the Remeasurement 2 results and did not provide a comprehensive interpretation of overall success of the PIP. Two evaluation elements in Activity VIII were scored *Partially Met* because the documentation of improvement strategies did not reflect problem-solving and revision in response to the lack of improvement in the study indicator, and the interventions did not appear to be system changes likely to induce long-term change. In the outcomes stage (Activities IX and X), the PIP received a *Met* score for 40 percent of applicable evaluation elements. Three out of four evaluation elements in Activity IX received a *Not Met* score

because the study indicator did not demonstrate improvement from the first to the second remeasurement. The PIP received a *Met* score for the one evaluation element in Activity X because, although the study indicator did not improve from Remeasurement 1 to Remeasurement 2, the decline at Remeasurement 2 was not statistically significant. Overall, the PIP received a *Partially Met* validation status, with 74 percent of all applicable evaluation elements and 100 percent of critical evaluation elements receiving a *Met* score.

Table 3-33 provides a summary of Colorado Choice's PIP-specific outcomes for the FY 2013–2014 validation cycle.

**Table 3-33—FY13–14 Performance Improvement Project Specific Outcomes *for* Colorado Choice**

| PIP Topic: *Asthma in Pediatric Patients* | | | | | | |
|---|---|---|---|---|---|---|
| **PIP Study Indicator** | **Baseline** | **Remeasurement 1** | **Remeasurement 2** | **Percentage Point Change** | **Statistical Significance (*p* value)** | **Sustained Improvement** |
| The percentage of members with a primary or secondary diagnosis of asthma who have been enrolled into the CHP+ program through Colorado Choice with an ICD-9 diagnosis code of 493 between the ages of ≥ 6 years of age and ≤ 18 years of age who have received asthma education and have had an emergency department visit (CPT codes 99281, 99282, 99283, 99284 and 99285). | 11.1% | 6.1% | 7.0% | 0.9↑^ | *p* =0.7588 Not Statistically Significant | *Yes* |

↑^ Designates an increase in the study indicator rate from the previous measurement period, which was a decline in the performance for this PIP.

For the second remeasurement of the *Asthma in Pediatric Patients* PIP, 7.0 percent of eligible members had an asthma-related ED visit. The goal of this PIP was to decrease the percentage of asthma-related ED visits for children 6–18 years of age; therefore, a lower study indicator rate is better. There was an increase of 0.9 percentage points in the study indicator rate from the first to the second remeasurement. The PIP achieved sustained improvement at the second remeasurement

because the change in the study indicator rate from the first to the second remeasurement was not statistically significant.

### Strengths

Colorado Choice documented a sound study design, which is essential for producing methodologically sound results. Additionally, at the second remeasurement, the *Asthma in Pediatric Patients* PIP demonstrated sustained improvement over baseline in the rate of asthma-related ED visits among eligible members.

### Interventions

Colorado Choice documented three intervention-type categories: consumer, provider, and school. During Remeasurement 2, the health plan documented five interventions in the Activity VIII intervention table that were labeled "ongoing"; however, one intervention was simply a statement about fluctuating enrollment, while another intervention included the addition of the provider peak flow meter order form in the member educational packet. The three remaining interventions included mailing educational packets and sending correspondence to members, providers, and primary care physicians.

To address a lack of knowledge about asthma, Colorado Choice documented that it mailed educational packets to members, providers, and primary care physicians. The health plan stated that it will continue to mail an educational packet to each new member with a primary or secondary diagnosis of asthma, and to each participating provider. Colorado Choice further documented that it addressed schools' lack of knowledge about asthma action plans through correspondence to primary care physicians and members, encouraging the creation of an asthma action plan that could be shared with the member's school.

### Recommendations

Based on the FY 2013–2014 validation results for the Colorado Choice *Asthma in Pediatric Patients* PIP, HSAG offers some recommendations that can be applied going forward. The health plan should ensure that the interpretation of PIP remeasurement results includes a thorough comparison of remeasurement rates to baseline rates, including the direction and statistical significance of rate changes. The interpretation should also include a discussion of the overall success of the PIP as demonstrated by the study indicator rates at each measurement period. When developing interventions, Colorado Choice should strive to implement system changes that are likely to support long-term improvement. During each measurement period, the health plan should conduct recurring causal/barrier analyses and an ongoing evaluation of each intervention. The results of these analyses should be used to refine improvement strategies and guide decisions about continuing, revising, or discontinuing interventions in order to achieve desired outcomes.

## Denver Health Medical Plan, Inc.

### Findings

DHMP's *Improving Well Care for Children 3–6 Years* PIP focused on increasing the rates of children 3–6 years of age who completed at least one well-child visit with a primary care practitioner during the measurement period. This was the third validation year for this PIP. HSAG validated Activities I through IV and Activities VI through X, which included Remeasurement 2 data.

Table 3-34 shows DHMP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

**Table 3-34—FY13–14 Performance Improvement Project Validation Results *for* DHMP**

| Study Stage | Activity | | Percent of Applicable Elements | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Design | I. | Study Topic | 100% (2/2) | 0% (0/2) | 0% (0/2) |
| | II. | Study Question | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | III. | Study Indicator | 100% (2/2) | 0% (0/2) | 0% (0/2) |
| | IV. | Study Population | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | V. | Sampling Techniques | Not Applicable | Not Applicable | Not Applicable |
| | VI. | Data Collection | 100% (4/4) | 0% (0/4) | 0% (0/4) |
| | | Design Total | 100% (10/10) | 0% (0/10) | 0% (0/10) |
| Implementation | VII. | Data Analysis and Interpretation | 100% (8/8) | 0% (0/8) | 0% (0/8) |
| | VIII. | Interventions and Improvement Strategies | 100% (3/3) | 0% (0/3) | 0% (0/3) |
| | | Implementation Total | 100% (11/11) | 0% (0/11) | 0% (0/11) |
| Outcomes | IX. | Real Improvement | 25% (1/4) | 0% (0/4) | 75% 3/4) |
| | X. | Sustained Improvement | 0% (0/1) | 0% (0/1) | 100% (1/1) |
| | | Outcomes Total | 20% (1/5) | 0% (0/5) | 80% (4/5) |
| **Percentage Score of Applicable Evaluation Elements Met** | | | **85% Percent (22/26)** | | |

DHMP demonstrated strong performance in Activities I through IV and Activities VII through VIII, receiving a *Met* score for 100 percent of applicable evaluation elements in the study design and study implementation stages. Only one out of four evaluation elements in Activity IX received a *Met* score because the study indicator rate declined at Remeasurement 2, falling below the baseline rate.

The evaluation element in Activity X was scored *Not Met* because the improvement achieved at Remeasurement 1 was not maintained at Remeasurement 2. Overall, the PIP received a *Met* validation status, with 85 percent of all applicable evaluation elements and 100 percent of critical evaluation elements receiving a *Met* score.

Table 3–35 provides a summary of DHMP's PIP-specific outcomes for the FY 2013–2014 validation cycle.

**Table 3–35—FY13–14 Performance Improvement Project Specific Outcomes *for* DHMP**

| PIP Topic: *Improving Well Care for Children 3–6 Years* | | | | | | |
|---|---|---|---|---|---|---|
| **PIP Study Indicator** | **Baseline** | **Remeasurement 1** | **Remeasurement 2** | **Percentage Point Change** | **Statistical Significance (*p* value)** | **Sustained Improvement** |
| The percentage of children 3 to 6 years of age with at least one well-child visit with a PCP during the measurement year. | 69.3% | 73.9% | 58.5% | 15.4↓ | *P*<0.0001 Statistically Significant | *No* |

↓ Designates a decrease in the study indicator rate from the previous measurement period.

The DHMP *Improving Well Care for Children 3–6 Years* PIP had one study indicator and reported a Remeasurement 2 rate of 58.5 percent. The rate decrease of 15.4 percentage points, from 73.9 percent at the first remeasurement, was statistically significant, with a *p* value of less than 0.0001. The Remeasurement 2 rate also fell below the baseline rate of 69.3. Sustained improvement was not achieved.

## Strengths

DHMP demonstrated strength in its study design and implementation by receiving *Met* scores for all applicable evaluation elements in Activities I through IV and VI through VIII. The health plan documented a solid study design, applied sound data analysis methods, and demonstrated a thorough application of the causal/barrier analysis process.

## Interventions

DHMP noted that it determined many of the interventions implemented during Remeasurement 2 were not sufficient to address the barriers identified, and may have been negatively impacted by a lack of resources and a lack of appropriate follow-up. DHMP acknowledged that due to the decline in the outcomes, new interventions are required to improve the well-child visit rate. The health plan documented that specific, measurable, attainable, realistic, and time-oriented (SMART) objectives will be created for its new interventions.

During its Remeasurement 2 validation, DHMP recorded a total of 12 interventions. Five were identified as continued and seven were identified as new. None of the interventions documented had a calendar year 2012 (Remeasurement 2) start date. The five continued interventions included the

back-to-school incentive, the healthy heroes birthday card reminder, Saturday pediatric clinics, panel management reports, and active recall lists. DHMP documented that during the measurement year, 2.7 percent of eligible members responded to the back-to-school incentive, and the healthy heroes birthday card reminder had an average response rate of 32.6 percent. The health plan did not provide evaluation results for the Saturday pediatric clinic, panel management reports, or active recall list interventions.

In response to the decline in Remeasurement 2 rates, DHMP documented that a team of stakeholders was assembled to discuss barriers to well-child visits and develop relevant interventions for FY 2013–2014. The team included the director of quality improvement and accreditation, the program manager for the Denver Health school-based health centers (SBHCs), the CHP+ product line manager, the quality improvement pediatric intervention manager, the HEDIS project manager, and the program manager for health communities. DHMP noted that a fishbone diagram helped the team organize the barriers into domains. The following barrier domains were identified by DHMP in its fishbone diagram: member, SBHCs, data collection, continuous eligibility, provider/clinic, and demographic information collection. The data collection domain contained the most barriers (six), while the continuous eligibility and provider/clinic domains contained the least barriers (two). DHMP developed new interventions for calendar year 2014 and stated that it will implement the new interventions in a rapid-cycle Plan-Do-Study-Act (PDSA) format that it hopes will allow for the interventions to be evaluated on a consistent and ongoing basis.

### Recommendations

Based on the FY 2013–2014 validation results for the DHMP *Improving Well Care for Children 3–6 Years* PIP, HSAG offers some recommendations that can be applied going forward. The health plan should ensure that decisions to continue, revise, or discontinue interventions for the PIP can be supported by evaluation results, as part of a causal/barrier analysis process linking study indicators, barriers, and interventions. Each intervention should be accompanied by an evaluation of effectiveness and evaluation results should drive refinement of improvement strategies in order to achieve the desired outcomes.

## *Kaiser Permanente Colorado*

### Findings

The Kaiser *Asthma Care* PIP focused on improving asthma-related ED use. This was the second validation year for this PIP, and Kaiser reported Remeasurement 2 results from calendar year 2013 and completed Activities I through IV and Activities VI through X.

Table 3-36 shows Kaiser's scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

**Table 3-36—FY13–14 Performance Improvement Project Validation Results *for* Kaiser**

| Study Stage | Activity | | Percent of Applicable Elements | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Design | I. | Study Topic | 100% (2/2) | 0% (0/2) | 0% (0/2) |
| | II. | Study Question | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | III. | Study Indicator | 100% (3/3) | 0% (0/3) | 0% (0/3) |
| | IV. | Study Population | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | V. | Sampling Techniques | Not Applicable | Not Applicable | Not Applicable |
| | VI. | Data Collection | 100% (4/4) | 0% (0/4) | 0% (0/4) |
| | | Design Total | 100% (11/11) | 0% (0/11) | 0% (0/11) |
| Implementation | VII. | Data Analysis and Interpretation | 100% (8/8) | 0% (0/8) | 0% (0/8) |
| | VIII. | Interventions and Improvement Strategies | 100% (4/4) | 0% (0/4) | 0% (0/4) |
| | | Implementation Total | 100% (12/12) | 0% (0/12) | 0% (0/12) |
| Outcomes | IX. | Real Improvement | 25% (1/4) | 0% (0/4) | 75% (3/4) |
| | X. | Sustained Improvement | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | | Outcomes Total | 40% (2/5) | 0% (0/5) | 60% (3/5) |
| **Percent Score of Applicable Evaluation Elements Met** | | | **89% Percent (25/28)** | | |

Kaiser demonstrated strong performance in both the study design and study implementation stages. The health plan received a *Met* score for 100 percent of applicable evaluation elements in Activities I through VI and VII through VIII. It developed a solid foundation and implemented effective improvement strategies and data analysis processes. Only one of four evaluation elements in Activity IX received a *Met* score because the study indicator rate did not improve from the first to the second remeasurement period. The PIP received a *Met* score in Activity X because the decline from Remeasurement 1 to Remeasurement 2 was not statistically significant. Overall, the PIP received a *Met* validation status, with 89 percent of all applicable evaluation elements and 100 percent of critical evaluation elements receiving a *Met* score.

Table 3-37 provides a summary of Kaiser's PIP-specific outcomes for the FY 2013–2014 validation cycle.

| Table 3-37—FY13–14 Performance Improvement Project Specific Outcomes *for* Kaiser | | | | | | |
|---|---|---|---|---|---|---|
| **PIP Topic: *Asthma Care*** | | | | | | |
| **PIP Study Indicator** | **Baseline** | **Remeasurement 1** | **Remeasurement 2** | **Percentage Point Change** | **Statistical Significance (*p* value)** | **Sustained Improvement** |
| The percentage of CHP+ members diagnosed with asthma who have had an asthma-related ED visit. ^ | 41.7% | 13.7% | 16.1% | 2.4↑^ | *p*=0.9453 Not Statistically Significant | *Yes* |

↑^ Designates an increase in the study indicator rate from the previous measurement period, which was a decline in the performance for this PIP.

The Kaiser *Asthma Care* PIP had one study indicator and reported a Remeasurement 2 rate of 16.1 percent. The study indicator is inverse, so a decrease in the rate represents improved outcomes. The increase of 2.4 percentage points, from 13.7 percent at the first remeasurement to 16.1 percent at the second remeasurement, was not statistically significant. The Remeasurement 2 rate remained 25.6 percentage points lower (better) than the baseline rate of 41.7 percent and, because the increase from Remeasurement 1 was not statistically significant, the PIP demonstrated sustained improvement at the second remeasurement.

## Strengths

Kaiser demonstrated strength in Activities I–IV, VI–VIII and X, meeting all of the validation requirements in these areas. The health plan documented a solid study design, which is essential to producing methodologically sound results. The health plan's intervention and improvement strategies were developed through a well-documented and comprehensive quality improvement process; the health plan documented how interventions were developed, implemented, and evaluated, and it had plans for revising improvement strategies to improve outcomes.

## Interventions

For the second remeasurement period, Kaiser identified the same three high-priority barriers to improving the rate of asthma-related ED visits that were identified during the first remeasurement period. Specifically, the health plan identified three member-based priority barriers: beta agonist overuse, no use or under-use of prescribed inhaled steroid medication, and knowledge and resource-related member-based issues. The member-based issues barrier included the following secondary barriers: Members do not have a relationship with their primary care provider, members do not understand the appropriate venue for care, members are unaware of the resources available, members are not familiar with the social determinants of health, and members do not know how to effectively manage asthma at home.

To address the three priority barriers, Kaiser implemented two new interventions and two revised interventions during the second remeasurement period. The health plan revised its intervention to

address beta agonist overuse among members, implementing the Albuterol Refill Authorization Request intervention, which used an electronic refill request system to identify members at high risk for overuse, followed by a quality check chart review and nurse intervention with the member, if necessary. To address the under-use of inhaled steroid medication, the health plan added a new member-based intervention; at-risk members were identified through weekly review of the asthma registry and received follow-up telephone calls to assess asthma status, provide education, and facilitate optimal disease management. The CHP+ Asthma ED Outreach intervention was revised from the previous weekly review of ED visits to a daily review of visits, followed by telephone outreach to all CHP+ asthma members with an identified asthma-related ED visit. To address the third member-based barrier related to social determinants of effective asthma management, Kaiser implemented a new system-based intervention, creating a Social Determinants of Health Team that can be accessed by asthma care coordinators as well as primary care and other care providers through a referral process in the EMR. The goal of this intervention was to improve access to community specialists and social workers to better address the psychosocial needs of CHP+ asthma members, potentially reducing the inappropriate use of ED services.

## Recommendations

Based on the FY 2013–2014 validation results for the Kaiser *Asthma Care* PIP, HSAG offers some recommendations that can be applied going forward. When selecting the study topic and study indicator for a PIP, Kaiser should consider the expected size of the numerator and denominator of the study indicator by looking at historical rates. The health plan should also consider the goal for improvement and whether achieving statistically significant improvement is realistic for the two remeasurement periods. Because the goal of the PIP is to achieve real improvement in two consecutive remeasurement periods, the health plan is encouraged to keep these issues in mind when developing the PIP study design.

## *Rocky Mountain Health Plans*

### Findings

RMHP reported results from the first remeasurement for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP. The PIP focused on improving the rates of documented BMI, counseling for nutrition, and counseling for physical activity. RMHP completed Activities I through IX for the FY 2013–2014 validation cycle.

Table 3-38 shows RMHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

**Table 3-38—FY13–14 Performance Improvement Project Validation Results *for* RMHP**

| Study Stage | Activity | | Percent of Applicable Elements | | |
|---|---|---|---|---|---|
| | | | Met | Partially Met | Not Met |
| Design | I. | Study Topic | 100% (2/2) | 0% (0/2) | 0% (0/2) |
| | II. | Study Question | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | III. | Study Indicator | 100% (2/2) | 0% (0/2) | 0% (0/2) |
| | IV. | Study Population | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| | V. | Sampling Techniques | 100% (6/6) | 0% (0/6) | 0% (0/6) |
| | VI. | Data Collection | 100% (5/5) | 0% (0/5) | 0% (0/5) |
| | | Design Total | 100% (17/17) | 0% (0/17) | 0% (0/17) |
| Implementation | VII. | Data Analysis and Interpretation | 89% (8/9) | 0% (0/9) | 11% (1/9) |
| | VIII. | Interventions and Improvement Strategies | 100% (4/4) | 0% (0/4) | 0% (0/4) |
| | | Implementation Total | 92% (12/13) | 0% (0/13) | 8% (1/13) |
| Outcomes | IX. | Real Improvement | 25% (1/4) | 75% (3/4) | 0% (0/4) |
| | X. | Sustained Improvement | Not Assessed | | |
| | | Outcomes Total | 25% (1/4) | 75% (3/4) | 0% (0/4) |
| **Percent Score of Applicable Evaluation Elements Met** | | | **88% Percent (30/34)** | | |

RMHP demonstrated strong performance in Activities I through VI, indicating that the plan documented a solid study design, which is essential to producing methodologically sound results. Additionally, the PIP included improvement strategies based on a sound quality improvement process, leading to a *Met* score for all evaluation elements in Activity VIII. In Activity IX, two of the three study indicators demonstrated improvement and only one study indicator demonstrated statistically significant improvement; therefore, the PIP received one *Met* score and three *Partially Met* scores for this activity. Overall, the PIP received a *Met* validation status with 88 percent of all applicable evaluation elements and 100 percent of critical evaluation elements receiving a *Met* score.

Table 3-39 provides a summary of RMHP's PIP-specific outcomes for the FY 2013–2014 validation cycle.

| Table 3-39—FY13–14 Performance Improvement Project Specific Outcomes *for* RMHP | | | | |
|---|---|---|---|---|
| **PIP Topic: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | |
| **PIP Study Indicator** | **Baseline** | **Remeasurement 1** | **Percentage Point Change** | **Statistical Significance (*p* value)** |
| Study Indicator 1: The percentage of the eligible population with BMI percentile documentation by a PCP or OB/GYN during the measurement year. | 66.7% | 74.1% | 7.4↑ | $p = 0.0165$ *Statistically Significant* |
| Study Indicator 2: The percentage of the eligible population with documentation of counseling for nutrition or referral for nutrition education during the measurement year by a PCP or OB/GYN. | 59.4% | 60.4% | 1.0↑ | $p = 0.7576$ *Not Statistically Significant* |
| Study Indicator 3: The percentage of the eligible population with documentation of counseling for physical activity or referral for physical activity during the measurement year by a PCP or OB/GYN. | 58.6% | 58.6% | *No Change* | $p = 0.9978$ *Not Statistically Significant* |

↑ Designates an increase in the study indicator rate from the previous measurement period.

The RMHP *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP had three study indicators with Remeasurement 1 rates for the current validation cycle. There was a statistically significant increase of 7.4 percentage points from baseline to Remeasurement 1 in the rate for Study Indicator 1. There was a nonstatistically significant increase of 1.0 percentage point for Study Indicator 2. The rate for Study Indicator 3 remained constant at 58.6 percent, with no change from baseline to Remeasurement 1.

## Strengths

RMHP demonstrated strength in its study design by receiving *Met* scores for all applicable evaluation elements in Activities I–VI. A solid study design allowed the health plan to progress to subsequent PIP stages. In the study implementation stage, the health plan was scored down for only one evaluation element in Activity VII because of a documentation omission, and it met all of the requirements in Activity VIII. RMHP demonstrated mixed performance in the study outcomes stage at the first remeasurement, with a statistically significant improvement in Study Indicator 1, a nonstatistically significant improvement in Study Indicator 2, and no improvement in Study Indicator 3.

## Interventions

RMHP documented the following member- and provider/practice-based barriers in its PIP submission: (1) members need reminders about the importance of preventive health visits, (2) the RMHP Web site lacks relevant electronic resources for providers and members, (3) there is a lack of electronic communications with members, (4) providers are not using EMRs to capacity, (5) provider work flows do not support BMI data collection/documentation, (6) providers lack handout materials that address nutrition and physical activity, and (7) providers need improved communication skills for addressing health and wellness concerns with members.

The RMHP interventions were appropriately linked to the identified barriers and included:

- Distributing member mailings and brochures encouraging members to have their BMI calculated during each visit.
- Continuing to focus on Beacon Program initiatives that included the formation of a group of practices (the Foundations) that follow the Beacon Program model to improve the use of EMRs.
- Creating a provider newsletter that included tips on how to accurately calculate and record BMI.
- Distributing the Patient Activation Measure interactive tool to providers.
- Posting educational materials/brochures to the RMHP Web site for providers.
- Adding member education resources to the RMHP Web site.
- Promoting the collection of member e-mail addresses to enable increased electronic communication capability.

RMHP documented that it used a PDSA cycle of improvement that included the evaluation of implemented interventions. Additionally, the health plan acknowledged that many of the interventions implemented, such as the distribution of brochures, member mailings, and provider newsletters, may have some short-term effect on the outcomes but are unlikely to have a long-lasting impact. To further address outstanding provider EMR and work flow issues, RMHP stated that it will implement interventions, such as provider collaborative education sessions and provider chart audits, aimed at producing a long-term effect on the outcomes.

## Recommendations

Based on the FY 2013–2014 validation results for the RMHP *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP, HSAG offers some recommendations that can be applied going forward. When analyzing data and interpreting results, RMHP should ensure that study indicator titles, rates, and comparisons between measurement periods are accurately and consistently documented throughout the PIP tables and narrative. At each remeasurement period, the health plan should also assess whether any factors affect the ability to compare results between measurement periods and should document the presence or absence of factors in the PIP summary form. RMHP should conduct recurring causal/barrier analyses throughout the life of the PIP and should use sound quality improvement processes to identify barriers and develop interventions. Interventions should be clearly linked to identified barriers and the study indicators; they should include primarily system changes that are likely to promote long-term change. Each intervention should be accompanied by an ongoing evaluation of effectiveness

and evaluation results should be used to guide the refinement of improvement strategies during the life of the PIP in order to optimize outcomes improvement.

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

Table 3-40 shows the health plans' overall performance based on HSAG's validation of the FY 2013–2014 PIPs that were submitted for validation.

**Table 3-40—Summary of Each HMO's PIP Validation Scores and Validation Status**

| HMO | PIP Study | % of All Elements *Met* | % of Critical Elements *Met* | Validation Status |
|---|---|---|---|---|
| Colorado Access | *Improving Weight Assessment in Children and Adolescents* | 100% | 100% | *Met* |
| Colorado Choice | *Asthma in Pediatric Patients* | 74% | 100% | *Partially Met* |
| DHMP | *Improving Well Care for Children 3–6 Years* | 85% | 100% | *Met* |
| Kaiser | *Asthma Care* | 89% | 100% | *Met* |
| RMHP | *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* | 88% | 100% | *Met* |

Overall, the validation scores and validation status of the PIPs suggests solid PIP study designs, allowing the progression to the subsequent stages of PIP implementation and outcomes. Four (80 percent) of the five PIPs reviewed by HSAG received a *Met* validation status. Additionally, all of the PIPs received a *Met* score for 100 percent of the critical evaluation elements. Colorado Choice's *Asthma in Pediatric Patients* PIP received a *Partially Met* validation status; despite receiving a *Met* score for 100 percent of the critical evaluation elements, the PIP received a *Met* score for only 74 percent of all applicable evaluation elements, falling short of the 80 percent cutoff required for a *Met* validation status.

Table 3-41 shows a comparison of the health plans' improvement results.

**Table 3-41—Statewide Summary of Improvement**

| | Colorado Access | Colorado Choice | DHMP | Kaiser | RMHP |
|---|---|---|---|---|---|
| Number of comparable rates (previous measurement to current measurement) | 1* | 1* | 1* | 1* | 3* |
| Number of rates that improved | 100% (1/1) | 0% (0/1) | 0% (0/1) | 0% (0/1) | 67% (2/3) |
| Number of rates that declined | 0% (0/1) | 100% (1/1) | 100% (1/1) | 100% (1/1) | 0% (0/3) |
| Number of rates that showed statistically significant improvement over the previous measurement period | 100% (1/1) | 0% (0/1) | 0% (0/1) | 0% (0/1) | 33% (1/3) |

| Table 3-41—Statewide Summary of Improvement | | | | | |
|---|---|---|---|---|---|
| | Colorado Access | Colorado Choice | DHMP | Kaiser | RMHP |
| Number of rates that showed statistically significant improvement over baseline | 100% (1/1) | 0% (0/1) | 0% (0/1) | 100% (1/1) | 33% (1/3) |

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

The PIPs demonstrated mixed performance in study indicator improvement for the FY 2013–2014 validation cycle. PIPs conducted by two of the HMOs, Colorado Access and RMHP, achieved improvement over the previous measurement period in some or all of their study indicator rates. These two PIPs, in addition to Kaiser's PIP, also demonstrated statistically significant improvement over baseline. RMHP documented statistically significant improvement in one of the three study indicator rates for the *Improving Weight Assessment in Children and Adolescents* PIP. Of the three study indicators in the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP, one study indicator demonstrated statistically significant improvement, one study indicator demonstrated nonstatistically significant improvement, and the remaining study indicator rate remained constant from the first to the second remeasurement. Kaiser's *Asthma Care* PIP demonstrated sustained statistically significant improvement over baseline at Remeasurement 2, although the study indicator rate did not improve from Remeasurement 1 to Remeasurement 2. The study indicator rates in Colorado Choice's *Asthma in Pediatric Patients* PIP and DHMP's *Improving Well Care for Children 3–6 Years* PIP declined and did not demonstrate improvement over the previous measurement period or over baseline.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Four of the five PIPs validated by HSAG earned a *Met* validation status, demonstrating a strong implementation of the processes required for valid and reliable PIP results.

## Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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

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

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

[3-6] Due to changes in the NCQA CAHPS national averages available for composite measures, the FY 2012–2013 rates for each composite measure were recalculated for Colorado Access, Colorado Choice, DHMP, Kaiser, RMHP, and the Statewide average. Therefore, the FY 2012–2013 CAHPS results for all composite measures presented in this section may not match previous years' report.

## Colorado Access

### Findings

Table 3-42 shows the results achieved by Colorado Access for the current year (FY 2013–2014) and the prior year (FY 2012–2013).

**Table 3-42—Question Summary Rates and Global Proportions *for* Colorado Access**

| Measure | FY 2012–2013 Rate | FY 2013–2014 Rate |
|---|---|---|
| *Getting Needed Care* | 83.0% | 81.8% |
| *Getting Care Quickly* | 87.5% | 88.0% |
| *How Well Doctors Communicate* | 93.1% | 94.9% |
| *Customer Service* | 86.2% | 81.0% |
| *Shared Decision Making* | 50.2% | 55.3% |
| *Rating of Personal Doctor* | 65.4% | 65.2% |
| *Rating of Specialist Seen Most Often* | 67.6% | 66.0%+ |
| *Rating of All Health Care* | 58.2% | 57.3% |
| *Rating of Health Plan* | 58.9% | 58.4% |

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

### Recommendations

Colorado Access demonstrated a substantial decrease in rate for one measure: *Customer Service*. In order to improve members' satisfaction with the *Customer Service* composite measure, Colorado Access' quality improvement activities should focus on evaluating call centers, on customer service training programs, and on establishing customer service performance measures.

### Summary Assessment Related to Quality, Timeliness, and Access

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

For Colorado Access, rates for three of the measures increased: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. Of these measures, one measure's rate demonstrated a substantial increase: *Shared Decision Making* (5.1 percentage points). The remaining six measures showed rate decreases; furthermore, the rate for one measure demonstrated a substantial decrease: *Customer Service* (5.2 percentage points).

## Colorado Choice

### Findings

Table 3-43 shows the results achieved by Colorado Choice for the current year (FY 2013–2014) and the prior year (FY 2012–2013).

**Table 3-43—Question Summary Rates and Global Proportions *for* Colorado Choice**

| Measure | FY 2012–2013 Rate | FY 2013–2014 Rate |
|---|---|---|
| *Getting Needed Care* | 85.9% | 89.5% |
| *Getting Care Quickly* | 95.0% | 89.8% |
| *How Well Doctors Communicate* | 94.6% | 93.2% |
| *Customer Service* | 84.3% | 74.3%+ |
| *Shared Decision Making* | 46.6% | 52.6%+ |
| *Rating of Personal Doctor* | 64.1% | 59.7% |
| *Rating of Specialist Seen Most Often* | 69.2%+ | 51.0%+ |
| *Rating of All Health Care* | 56.1% | 48.5% |
| *Rating of Health Plan* | 53.0% | 50.2% |

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

### Recommendations

Colorado Choice demonstrated a substantial decrease in rates for four measures: *Getting Care Quickly*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of all Health Care*. Colorado Choice should continue to direct quality improvement activities toward these measures.

In order to improve members' perceptions on the *Getting Care Quickly* composite measure, Colorado Choice should focus on identifying appropriate health care providers for its members, assisting providers with implementing "max-packing" strategies, language concordance programs, streamlining the referral process, and providing interactive workshops to promote health education, health literacy, and preventive health among its membership. For the *Customer Service* composite measure, quality improvement activities should focus on evaluating call centers, customer service training programs, and establishing customer service performance measures. To improve members' satisfaction on the *Rating of Specialist Seen Most Often* global rating, Colorado Choice should target planned visit management, skills training for specialists, and telemedicine. For the *Rating of All Health Care* global rating, quality improvement activities should target members' perceptions of access to care and patient and family engagement advisory councils.

## Summary Assessment Related to Quality, Timeliness, and Access

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

For Colorado Choice, rates showed an increase for two measures: *Getting Needed Care* and *Shared Decision Making*. The rate for one of these measures increased substantially: *Shared Decision Making* (6.0 percentage points). The remaining seven measures showed rate decreases; additionally, there was a substantial rate decrease for four of these measures: *Getting Care Quickly* (5.2 percentage points), *Customer Service* (10.0 percentage points), *Rating of Specialist Seen Most Often* (18.2 percentage points), and *Rating of all Health Care* (7.6 percentage points). Six measures had the lowest rates among the health plans in FY 2013-2014: *Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of all Health Care*, and *Rating of Health Plan*. One measure had the highest rate among the health plans in FY 2013–2014: *Getting Needed Care*.

## Denver Health Medical Plan

### Findings

Table 3-44 shows the results achieved by DHMP for the current year (FY 2013–2014) and the prior year (FY 2012–2013).

**Table 3-44—Question Summary Rates and Global Proportions *for* Denver Health Medical Plan**

| Measure | FY 2012–2013 Rate | FY 2013–2014 Rate |
|---|---|---|
| *Getting Needed Care* | 76.8% | 66.5% |
| *Getting Care Quickly* | 77.6% | 82.2% |
| *How Well Doctors Communicate* | 91.8% | 90.7% |
| *Customer Service* | 80.8% | 80.0% |
| *Shared Decision Making* | 59.4%+ | 59.8%+ |
| *Rating of Personal Doctor* | 78.4% | 72.4% |
| *Rating of Specialist Seen Most Often* | 80.0%+ | 68.1%+ |
| *Rating of All Health Care* | 62.0% | 56.6% |
| *Rating of Health Plan* | 63.0% | 54.5% |

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

### Recommendations

DHMP demonstrated a substantial decrease in rates for five measures: *Getting Needed Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. DHMP should continue to direct quality improvement activities toward these measures.

In order to improve members' perceptions on the *Getting Needed Care* composite measure, DHMP should focus on identifying appropriate health care providers for its members, assisting providers with implementing "max-packing" strategies, language concordance programs, streamlining the referral process, and providing interactive workshops to promote health education, health literacy, and preventive health among its membership. For the *Rating of Personal Doctor* global rating, quality improvement activities should target assisting providers with maintaining truth in office scheduling, patient-direct feedback, physician-patient communication, and improving shared decision-making. In order to improve the overall performance on the *Rating of Specialist Seen Most Often* global rating, DHMP should target planned visit management, skills training for specialists, and telemedicine. For *Rating of All Health Care*, quality improvement activities should target members' perceptions of access to care and establishing patient and family engagement advisory councils. In order to improve on the overall *Rating of Health Plan* global rating, DHMP should direct quality improvement activities on identifying alternatives to one-on-one physician visits, health plan operations, online patient portals, and promoting quality improvement initiatives.

## Summary Assessment Related to Quality, Timeliness, and Access

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

For DHMP, rates showed and increase for two measures: *Getting Care Quickly* and *Shared Decision Making Health Plan*. The remaining seven measures showed rate decreases; furthermore, rates decreased substantially for five of the seven measures: *Getting Needed Care* (10.3 percentage points), *Rating of Personal Doctor* (6.0 percentage points), *Rating of Specialist Seen Most Often* (11.9 percentage points), *Rating of All Health Care* (5.4 percentage points), and *Rating of Health Plan* (8.5 percentage points). Three measures had the lowest rates among the health plans in FY 2013–2014: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. Two measures had the highest rates among the health plans in FY 2013–2014: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*.

## *Kaiser Permanente*

### Findings

Table 3-45 shows the results achieved by Kaiser for the current year (FY 2013–2014) and the prior year (FY 2012–2013).

**Table 3-45—Question Summary Rates and Global Proportions *for* Kaiser Permanente**

| Measure | FY 2012–2013 Rate | FY 2013–2014 Rate |
|---|---|---|
| *Getting Needed Care* | 87.1% | 87.4% |
| *Getting Care Quickly* | 89.3% | 92.1% |
| *How Well Doctors Communicate* | 95.8% | 94.3% |
| *Customer Service* | 88.5% | 84.8% |
| *Shared Decision Making* | 51.0% | 60.5%+ |
| *Rating of Personal Doctor* | 76.5% | 71.6% |
| *Rating of Specialist Seen Most Often* | 68.1% | 65.8%+ |
| *Rating of All Health Care* | 65.4% | 69.5% |
| *Rating of Health Plan* | 61.6% | 63.0% |

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

Kaiser demonstrated stable ratings for FY 2013–2014, with four measures showing increased rates and five measures showing decreased rates. One measure showed a substantial increase: *Shared Decision Making,* which went from 51.0 percent to 60.5 percent. Although not substantial, *Rating of All Health Care* experienced an increase of 4.1 percentage points (from 65.4 to 69.5 percent). No measures showed a substantial decrease, although the *Rating of Personal Doctor* came close, falling by 4.9 percentage points from FY 2012–2013 to FY 2013–2014.

### Recommendations

Kaiser did not have any substantial decreases in the rates; however, four measures had a slight decrease in rates: *How Well Doctors Communicate, Customer Service*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. Kaiser should continue to direct quality improvement activities toward these measures.

In order to improve members' satisfaction on the *How Well Doctors Communicate* composite measure, Kaiser should direct quality improvement activities toward developing communication tools for patients, improving health literacy, and language barriers. For the *Customer Service* composite measure, quality improvement activities should focus on evaluating call centers, customer service training programs, and establishing customer service performance measures. To improve on the *Rating of Personal Doctor* global rating, quality improvement activities should target assisting providers with maintaining truth in office scheduling, patient-direct feedback, physician-patient communication, and improving shared decision-making. To improve members'

satisfaction on the *Rating of Specialist Seen Most Often* global rating, Kaiser should focus on planned visit management, skills training for specialists, and telemedicine.

### Summary Assessment Related to Quality, Timeliness, and Access

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

One measure showed a substantial rate increase: *Shared Decision Making* (9.5 percentage points). Four measures' rates showed slight increases: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan*. None of the measures' rates decreased substantially. Four measures had the highest rates among the health plans in FY 2013–2014: *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*.

## Rocky Mountain Health Plans

### Findings

Table 3-46 shows the results achieved by RMHP for the current year (FY 2013–2014) and the prior year (FY 2012–2013).

**Table 3-46—Question Summary Rates and Global Proportions *for* Rocky Mountain Health Plans**

| Measure | FY 2012–2013 Rate | FY 2013–2014 Rate |
|---|---|---|
| *Getting Needed Care* | 87.0% | 86.3% |
| *Getting Care Quickly* | 91.9% | 93.7% |
| *How Well Doctors Communicate* | 94.4% | 95.0% |
| *Customer Service* | 84.1% | 80.7% |
| *Shared Decision Making* | 51.3% | 56.4%+ |
| *Rating of Personal Doctor* | 71.6% | 70.5% |
| *Rating of Specialist Seen Most Often* | 56.6% | 58.1%+ |
| *Rating of All Health Care* | 58.6% | 62.7% |
| *Rating of Health Plan* | 55.9% | 55.4% |

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

### Recommendations

RMHP did not have any substantial decreases in the rates; however, rates decreased slightly for four measures: *Getting Needed Care*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan*. RMHP should continue to direct quality improvement activities toward these measures.

For the *Getting Needed Care* composite measure, RMHP should focus on identifying appropriate health care providers for its members, assisting providers with implementing "max-packing" strategies, language concordance programs, streamlining the referral process, and providing interactive workshops to promote health education, health literacy, and preventive health among its membership. In order to improve members' satisfaction on the *Customer Service* composite measure, RMHP should focus on evaluating call centers, customer service training programs, and establishing customer service performance measures. For the *Rating of Personal Doctor* measure, quality improvement activities should target assisting providers with maintaining truth in office scheduling, patient-direct feedback, physician-patient communication, and improving shared decision-making. To improve members' satisfaction with the overall *Rating of Health Plan*, quality improvement activities should target identifying alternatives to one-on-one physician visits, health plan operations, online patient portals, and promoting quality improvement initiatives.

## Summary Assessment Related to Quality, Timeliness, and Access

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

One measure showed a substantial rate increase: *Shared Decision Making* (5.1 percentage points). Four measures' rates showed slight increases: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*. None of the measures' rates decreased substantially. Two measures had the highest rates among the health plans in FY 2013–2014: *Getting Care Quickly* and *How Well Doctors Communicate*.

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

## Introduction

Following EQR activities conducted in FY 2012–2013, the Department asked each health plan to address recommendations and required actions. This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations from FY 2012–2013.

## Colorado Access

### *Compliance Monitoring Site Reviews*

While Colorado Access had numerous and appropriate methods to prevent discrimination during credentialing and recredentialing processes, it did not have adequate methods for monitoring to ensure nondiscriminatory credentialing practices, as required by NCQA. Colorado Access was required to develop monitoring processes to ensure nondiscriminatory credentialing practices. The plan submitted its corrective action plan (CAP) to HSAG and the Department in May 2013, along with documents demonstrating that it had implemented the CAP. After careful review, HSAG and the Department determined that Colorado Access had successfully completed the required action.

### *Validation of Performance Measures*

During its FY 2012–2013 review, HSAG recommended that Colorado Access focus its improvement efforts on indicators that had a statistically significant decline from HEDIS 2012. These indicators were:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Well-Child Visits in the First 15 Months of Life—6+ Visits*
- *Childhood Immunization Status—Combinations 2, 3, 5, 6, and 9*

Colorado Access' HEDIS 2014 rates showed significant increases for the *Childhood Immunization Status*, *Well-Child Visits in the First 15 Months of Life—6+ Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures. Rate increases observed for these measures may be related to a change in data collection methodology from administrative to hybrid and may not denote actual performance. A comparison of the hybrid rates between HEDIS 2013 and HEDIS 2014 showed that the *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure had a statistically significant improvement but the rates for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure and the majority of the *Childhood Immunization Status* indicators did not. Most of the rates for these measures fluctuated within 5 percentage points. This finding suggests that Colorado Access might have followed up with some of HSAG's recommendations from prior year.

### Validation of Performance Improvement Projects

In FY 2012–2013, Colorado Access reported results from the first remeasurement for its *Improving Weight Assessment in Children and Adolescents* PIP. The PIP was validated through Activity IX and received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. There were no identified deficiencies or recommendations made.

### Consumer Assessment of Healthcare Providers and Systems (CAHPS)

For the comparable measures between FY 2011–2012 and FY 2012–2013, Colorado Access had no substantial decreases in rates; however, one measure experienced a rate decrease: *Rating of Personal Doctor*. HSAG recommended that Colorado Access direct quality improvement activities toward this measure. While not significant, between FY 2012–2013 and FY 2013-2014, Colorado Access experienced a further decline in the *Rating of Personal Doctor* rate.

## Colorado Choice Health Plan

### Compliance Monitoring Site Reviews

As a result of the 2012–2013 site review, **Colorado Choice** was required to create a CAP to address 49 of the 74 reviewed elements. The following is an overview of the required actions:

- Colorado Choice was required to develop policies, procedures, and processes to designate the party responsible for members' care coordination. Colorado Choice was required to implement procedures to ensure that an individual care coordination plan is developed and documented in the case management file and that it demonstrates member involvement and agreement with the plan.
- Colorado Choice was required to develop written CHP+ policies and procedures related to member rights and responsibilities.
- To be consistent with NCQA requirements, Colorado Choice was required to revise its policies and procedures related to the credentialing and recredentialing of practitioners with whom Colorado Choice has an independent relationship. Colorado Choice was also required to develop policies, procedures, and processes to assess and reassess organizational providers.
- Colorado Choice was required to designate a quality improvement oversight committee within a defined accountability structure and ensure that the committee reviews the results of ongoing quality performance measures, survey results, outcomes of focus studies, and other quality data.
- Colorado Choice was required to develop a process/procedure to adopt and disseminate clinical practice guidelines that are evidence-based, consider the needs of Colorado Choice members, address the topics required in the CHP+ managed care contract, consider the input of Colorado Choice health care professionals, and are reviewed and updated annually.
- Colorado Choice was required to define a process for the review of serious member complaints, patterns of complaints, and member survey data, and a process to develop corrective action when indicated. Colorado Choice was also required to submit evidence of committee review of

recommendations and conclusions related to member complaints, including any applicable actions taken.

Colorado Choice submitted a CAP to HSAG and the Department in April 2013. HSAG made suggestions and requested additional information before approving the plan in May 2013. Colorado Choice began to submit documents that demonstrated implementation of its plan to HSAG and the Department in August 2013. HSAG and the Department worked with Colorado Choice throughout the year, providing ongoing feedback as documents were submitted.

While Colorado Choice has completed the majority of the FY 2012–2013 required actions, one required corrective action remains outstanding. HSAG will review documents when submitted and work with Colorado Choice and the Department, providing technical assistance as required until all required actions have been completed.

### Validation of Performance Measures

During its FY 2012–2013 review, HSAG recommended that Colorado Choice focus its improvement efforts on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, where its rate fell below the national HEDIS Medicaid 10th percentile. Colorado Choice's HEDIS 2014 rate remained stable when compared to HEDIS 2013. This measure continued to perform below the national HEDIS Medicaid 10th percentile. HSAG could not ascertain whether Colorado Choice followed up with HSAG's recommendations from the prior year.

### Validation of Performance Improvement Projects

In FY 2012–2013, Colorado Choice reported results from the first remeasurement for its *Asthma in Pediatric Patients* PIP. The PIP was validated through Activity IX and received a *Met* score for 93 percent of all applicable evaluation elements and 100 percent of critical evaluation elements, and a *Met* validation status. HSAG documented a *Point of Clarification* for two evaluation elements in Activity VII because the health plan did not include an interpretation of the statistical testing results or an interpretation of the overall success of the PIP based on the first remeasurement. Colorado Choice did not address this *Point of Clarification* when it progressed to reporting results from the second remeasurement in the FY 2013–2014 PIP submission, resulting in *Partially Met* scores for these two evaluation elements during the current validation cycle. Colorado Choice also received a *Point of Clarification* for its FY 2012–2013 PIP submission because it did not document all interventions in the Activity VIII intervention table, and a *Partially Met* score for not documenting an evaluation of effectiveness for each intervention. The FY 2013–2014 PIP submission did not address either of the Activity VIII recommendations from the previous validation cycle; the Activity VIII intervention table was not updated to include the missing intervention, and the Activity VIII narrative did not document evaluations or other problem-solving techniques used to address the lack of improvement at the second remeasurement.

### Consumer Assessment of Healthcare Providers and Systems

FY 2012–2013 was the first year CAHPS surveys were conducted for Colorado Choice; therefore, improvement recommendations are limited to a comparison of the current year's FY 2013–2014

results to the previous year's FY 2012–2013 baseline results. Between FY 2012–2013 and FY 2013–2014, Colorado Choice demonstrated a substantial decrease in four measures' rates: *Getting Care Quickly*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*. HSAG recommends that Colorado Choice direct quality improvement activities toward these measures.

## Denver Health Medical Plan, Inc.

### *Compliance Monitoring Site Reviews*

As a result of the 2012–2013 site review, DHMP was required to address the following:

- Revision of the Medical Staff Bylaws or development policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA allied health professionals.
- Development or revision of documents to address notification to DHHA provider applicants regarding rights under the credentialing program.
- Development or revision of documents that describe the range of actions available to DHHA for changing the conditions of a practitioner's status based on quality reasons.
- Revision of policies to allow the public to access its clinical practice guidelines (CPGs) at no cost. DHMP was required to communicate to members the availability of CPGs and inform members how to access or request them.

DHMP submitted its CAP to HSAG and the Department in May 2013. After careful review, HSAG and the Department determined that, if the CAP were implemented as written, DHMP would achieve full compliance. DHMP submitted documentation that demonstrated it had implemented its plan, and in October 2013, HSAG and the Department determined that DHMP had successfully addressed all required actions.

### *Validation of Performance Measures*

During its FY 2012–2013 review, HSAG recommended that the HMO focus its improvement efforts on indicators that either showed significant rate decline from HEDIS 2012 or benchmarked below the national HEDIS Medicaid 10$^{th}$ percentile. These indicators were:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Adolescent Well-Care Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Well-Child Visits in the First 15 Months of Life—6+ Visits*

DHMP's HEDIS 2014 rates showed significant rate increase for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* and the *Adolescent Well-Care Visits* measures. Rate increase observed for these measures may be related to a change in data collection methodology from administrative to

hybrid and may not denote actual performance. DHMP did not use hybrid methodology for HEDIS 2013 reporting; no hybrid rates were available for comparing with the current year's rates. HSAG was not able to ascertain whether DHMP had followed up with some of HSAG's recommendations from the prior year.

### Validation of Performance Improvement Projects

For the FY 2012–2013 validation cycle, DHMP reported results from the first remeasurement for its *Improving Well Care for Children 3–6 Years* PIP, which received a *Met* score for 93 percent of all applicable evaluation elements and 100 percent of critical evaluation elements, and an overall *Met* validation status. The PIP received a *Partially Met* score in Activity VI because the statistical test type and results were not consistently or correctly documented in the data analysis plan. In Activity VIII, HSAG documented a *Point of Clarification* for two evaluation elements because the health plan did not document all interventions in the Activity VIII intervention table and the Activity VIII narrative did not document processes for monitoring evaluations. In the FY 2013–2014 submission, the health plan addressed the *Partially Met* score in Activity VI by updating the data analysis plan. In Activity VIII, DHMP updated the intervention table to include all interventions and added additional information on how interventions were monitored.

### Consumer Assessment of Healthcare Providers and Systems

Between FY 2011–2012 and FY 2012–2013, DHMP demonstrated no substantial rate decreases for the comparable measures; however, one measure—*How Well Doctors Communicate*—experienced a slight rate decrease. HSAG recommended that DHMP direct quality improvement activities toward this measure. Between FY 2012–2013 and FY 2013–2014, DHMP demonstrated a further decline in the rate for the *How Well Doctors Communicate* measure.

## Kaiser Permanente Colorado

### Compliance Monitoring Site Reviews

As a result of the FY 2012–2013 review, Kaiser was required to translate the information and concepts described in the Patient Centered Medical Home document into a written policy and procedure regarding coordination and continuity of care. Also, although Kaiser's provider and member communications informed providers and members of a member's right to review and receive a copy of his or her records, the statement did not include the right to amend or correct the records. Kaiser was required to revise its provider and member materials to include the right to amend or correct member medical records. Kaiser was also required to develop or revise applicable policies as well as member and provider materials to include the right to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

Kaiser submitted its CAP to HSAG and the Department in April 2013. In May 2013, HSAG and the Department requested additional documentation. Kaiser submitted the additional documents as they

became available. In July 2013, after careful review, HSAG and the Department determined Kaiser had successfully implemented its plan and completed all required actions.

### Validation of Performance Measures

During its FY 2012–2013 review, HSAG recommended that Kaiser focus its improvement efforts on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and the *Adolescent Well-Care Visits* measures, where the rates showed statistically significant declines from HEDIS 2012. Kaiser's HEDIS 2014 rates remained stable when compared to HEDIS 2013; there were no statistically significant changes noted. HSAG could not ascertain whether Kaiser followed up with some of HSAG's recommendations from the prior year.

### Validation of Performance Improvement Projects

In FY 2012–2013, Kaiser reported results from the first remeasurement for its *Asthma Care* PIP. The PIP was validated through Activity IX, resulting in an overall *Met* validation status, with 93 percent of all applicable evaluation elements and 100 percent of critical evaluation elements receiving a *Met* score. HSAG documented a *Point of Clarification* for one evaluation element in Activity III, recommending that the health plan revise the Remeasurement 2 goal of maintaining the Remeasurement 1 results to a goal of further improving them. The PIP also received a *Partially Met* score for one evaluation element in Activity VI and one element in Activity VII because the data analysis plan in Activity VI and the data analysis results in Activity VII both omitted a comparison of the results to the goal. In the FY 2013–2014 submission, Kaiser included results from the second remeasurement. The health plan updated the Remeasurement 2 goal to address the *Point of Clarification* in Activity III and added a comparison of the results to the goal in both the data analysis plan and the data analysis interpretation, addressing the *Partially Met* scores in Activities VI and VII.

### Consumer Assessment of Healthcare Providers and Systems

For the comparable measures between FY 2011–2012 and FY 2012–2013, Kaiser had no substantial decrease in rates; however, two measures' rates demonstrated a slight decrease: *Getting Care Quickly* and *Rating of Personal Doctor*. HSAG recommended that Kaiser direct quality improvement activities toward these measures. Between FY 2012–2013 and FY 2013–2014, Kaiser showed improvement in both of these measures' rates. These increases indicate an improvement in consumer satisfaction in these domains.

## Rocky Mountain Health Plans

### *Compliance Monitoring Site Reviews*

As a result of the 2012–2013 site review, RMHP was required to implement corrective actions related to each of the four standards reviewed: coordination and continuity of care, member rights and protections, credentialing and recredentialing, and quality assessment and performance improvement. Required actions included:

- Implementing a mechanism for initial screening of all CHP+ members upon enrollment to identify members with special health care needs.
- Revising the provider manual to clearly describe member rights applicable to the CHP+ population and to develop additional communications, such as e-mail announcements or articles for the provider newsletters, to inform providers of the changes in federal health care requirements and the resulting implications for the CHP+ population.
- Revising its CHP+ member rights policy to include all rights afforded CHP+ members by federal regulations or the CHP+ contract with the State, and ensuring that its staff, providers, and members are made aware of changes in policies or practices related to CHP+ member rights.
- Ensuring that the member handbook posted on the RMHP Web site is current and consistent with the handbooks distributed by other means.
- Improving mechanisms to ensure that organizational providers are credentialed (assessed) within the required 36-month time frame.
- Revising its annual quality improvement report to include conclusions related to the overall impact of the quality program and adopting clinical practice guidelines applicable to CHP+ members with disabilities or special health care needs, modifying its policies and processes to ensure that clinical practice guidelines are reviewed and approved annually.

RMHP submitted its CAP for the CHP+ plan to HSAG and the Department in July 2013. After requiring that RMHP make several revisions, HSAG and the Department agreed in September 2013 that, if the CAP were implemented as written, RMHP would achieve full compliance with all required actions. In October 2013, RMHP began submitting documents to HSAG and the Department to demonstrate implementation of its plan. While RMHP has completed several of the required actions, RMHP was continuing to implement corrective actions on several additional items into 2014. The requirement to adopt clinical practice guidelines for CHP+ members with disabilities remained outstanding at the time of the 2013-2014 compliance site review; however, it has subsequently been completed.

### *Validation of Performance Measures*

During its FY 2012–2013 review, HSAG recommended that RMHP focus its improvement efforts on the *Childhood Immunization Status* measure where several indicators (*Combinations 2, 3, 5, 6,* and *9*) showed significant declines from HEDIS 2012. RMHP's HEDIS 2014 rates showed statistically significant increase from HEDIS 2013, but this increase could be related to a change in

data collection methodology required by the State—from administrative in HEDIS 2013 to hybrid in HEDIS 2014. A comparison of the hybrid rates for these indicators between HEDIS 2013 and HEDIS 2014 shows that there were some rate fluctuations, but they were within 5 percentage points. HSAG could not ascertain whether RMHP followed up with some of HSAG's recommendations from the prior year.

### Validation of Performance Improvement Projects

For the FY 2012–2013 validation cycle, RMHP reported baseline results for its *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* PIP. The PIP was validated through Activity VIII, receiving a *Met* score for 100 percent of all applicable evaluation elements and an overall *Met* validation status. HSAG documented a *Point of Clarification* for one evaluation element in Activity III and one evaluation element in Activity VI, recommending that the health plan more thoroughly document the study indicator title and rationale in Activity III and expand the data analysis plan in Activity VI to apply to all measurement periods. In FY 2013–2014, RMHP progressed to reporting results from the first remeasurement and addressed both *Points of Clarification* from the previous validation cycle.

### Consumer Assessment of Healthcare Providers and Systems

For the comparable measures between FY 2011–2012 and FY 2012–2013, HSAG noted that RMHP showed a substantial decline in one measure: *Rating of Specialist Seen Most Often*. RMHP also experienced slight declines in rates for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Health Plan*. HSAG recommended that RMHP direct quality improvement activities toward these measures. Between FY 2012–2013 and FY 2013–2014, four of the five measures showed improvement: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*. These increases indicate an improvement in consumer satisfaction in these domains. Nonetheless, one of the measures continued to decline slightly: *Rating of Health Plan*.

## State Managed Care Network

### Compliance Monitoring Site Reviews

The SMCN was not required to complete a corrective action plan in FY 2012–2013.

### Validation of Performance Measures

Based on its review of SMCN's HEDIS 2013 rates, HSAG recommended that the Department focus its improvement efforts on several measures that either showed significant declines from HEDIS 2012 or benchmarked below the national HEDIS Medicaid 10th percentile. These measures include *Childhood Immunization Status (Combinations 2* and *3), Adolescent Well-Care Visits,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.* For HEDIS 2014, the Department elected to report the *Prenatal and Postpartum Care* measure only. In the Roadmap completed by the Department for HEDIS 2014, it was indicated that incentives have been offered to increase well-care visits. The Department noted that since the incentives have been in effect for several years, it did not anticipate the rates would be impacted significantly for HEDIS 2014.

### Validation of Performance Improvement Projects

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

### Consumer Assessment of Healthcare Providers and Systems

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

# Appendix A. EQR Activities—Compliance Monitoring Site Reviews

## Introduction

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

For the FY 2013–2014 site review process, the Department requested a review of two areas of performance. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG developed a strategy and monitoring tools to review compliance with federal managed care regulations and managed care contract requirements related to each of the two standards.

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plans' contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.

## Objectives

Private accreditation organizations, state licensing agencies, Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step.

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

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

## Technical Methods of Data Collection

For the health maintenance organizations (HMOs) and the State Managed Care Network (SMCN), HSAG performed the five compliance monitoring activities described in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. These activities were: establishing compliance thresholds, performing preliminary review, conducting site visits, compiling and analyzing findings, and reporting results to the Department.

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

On-site review activities included a review of additional documents, policies, and committee minutes to determine compliance with federal health care regulations and implementation of the organizations' policies. As part of Standard I—Coverage and Authorization of Services, HSAG conducted an on-site review of 15 administrative records to evaluate implementation of managed care regulations related to CHP+ service and claims denials, as well as notices of action. HSAG incorporated the results of the record reviews into the findings for the standard.

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

Table A-1 describes the tasks performed for each activity in the CMS final protocol for monitoring compliance during FY 2013–2014.

**Table A-1—Compliance Monitoring Review Activities Performed**

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

| Table A-1—Compliance Monitoring Review Activities Performed | |
|---|---|
| **For this step,** | **HSAG completed the following activities:** |
| **Activity 2:** | **Perform Preliminary Review** |
| | ◆ HSAG attended the Department's Medical Quality Improvement Committee meetings and provided group technical assistance and training, as needed.<br>◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG e-mailed the health plans a request for desk review documents, including the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the two standards and on-site activities. Thirty days prior to the review, the health plans provided documentation for the desk review, as requested.<br>◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). HSAG used a random sampling technique to select records for review during the site visit.<br>◆ 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.<br>◆ HSAG reviewed a sample of administrative records and evaluated implementation of managed care regulations related to CHP+ service denials and notices of action.<br>◆ Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original-source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.)<br>◆ At the close of the on-site portion of the site review, HSAG met with the plan's staff and Department personnel to provide an overview of preliminary findings. |
| **Activity 4:** | **Compile and Analyze Findings** |
| | ◆ HSAG used the FY 2013–2014 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities.<br>◆ HSAG analyzed the findings.<br>◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings. |

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

## Description of Data Sources

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

- Committee meeting agendas, minutes, and handouts
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Consumer handbook and informational materials
- Staff training materials and documentation of attendance
- Correspondence
- Records or files related to administrative tasks
- Interviews with key health plan staff members conducted on-site

## Data Aggregation, Analysis, and How Conclusions Were Drawn

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

The health plans' administrative records were also reviewed to evaluate implementation of managed care regulations related to CHP+ service and claims denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 15 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable health plan CHP+ service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the

required elements. The results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also calculated an overall record review score separately.

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

# Appendix B. EQR Activities—Validation of Performance Measures

## Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the validation of performance measure activities was conducted and how the resulting data were aggregated and analyzed.

## Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

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

## Technical Methods of Data Collection

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

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

## Description of Data Obtained

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

| Table B-1—Description of Data Sources Reviewed | |
|---|---|
| **Data Reviewed** | **Source of Data** |
| **Pre-on-site Visit/Meeting—**The initial conference call or meeting between the licensed organizations and the HMO or the SMCN staff. HSAG verified that key HEDIS topics such as timelines and on-site review dates were addressed by the licensed organizations. | HEDIS 2014 FAR |
| **Roadmap Review—**This review provided the licensed organizations with background information on policies, processes, and data in preparation for on-site validation activities. The HMOs and the SMCN were required to complete the Roadmap to provide the audit team with the necessary information to begin review activities. HSAG looked for evidence in the final report that the licensed organizations completed a thorough review of all components of the Roadmap. | HEDIS 2014 FAR |
| **Certified Software Review—**If an NCQA-certified software vendor was used, HSAG assessed whether all the required measures developed by the vendor were certified by NCQA. | HEDIS 2014 FAR and Measure Certification Reports |
| **Source Code Review—**HSAG ensured that the licensed organizations reviewed the programming language for calculating any HEDIS measures that did not undergo NCQA's measure certification process. Source code review is used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (to determine if rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately). | HEDIS 2014 FAR |
| **Survey Vendor—**If the HMO and SMCN used a survey vendor to perform the CAHPS surveys, HSAG verified that an NCQA-certified survey vendor was used. A certified survey vendor must be used if the HMO or SMCN performed a CAHPS survey as part of HEDIS reporting. | HEDIS 2014 FAR |
| **CAHPS Sample Frame Validation—**HSAG validated that the licensed organizations performed detailed evaluations of the computer programming (source code) used to access and manipulate data for CAHPS sample frames. This validation reviewed the source code to ensure that data were correctly queried in the output files, and HSAG conducted a detailed review of the survey eligibility file elements, including the health care organization's name, product line, product, unique member ID, and subscriber ID, as well as the member name, gender, telephone number, date of birth, mailing address, continuous enrollment history, and prescreen status code (if applicable). | HEDIS 2014 FAR |
| **Supplemental Data Validation—**If the HMO and SMCN used any supplemental data for reporting, the licensed organization was to validate the supplemental data according to NCQA's guideline. HSAG verified whether the licensed organization was following the NCQA-required approach while validating the supplemental databases. | HEDIS 2014 FAR |
| **Convenience Sample Validation—**The auditor reviews a small number of processed medical records to uncover potential problems that may require corrective action early in the MRR process. A convenience sample must be prepared unless the auditor determines that a health plan is exempt. NCQA | HEDIS 2014 FAR |

| Table B-1—Description of Data Sources Reviewed | |
|---|---|
| **Data Reviewed** | **Source of Data** |
| allows organizations to be exempt from the convenience sample if they participated in a HEDIS audit the previous year and passed MRR validation, and if the current MRR process has not changed significantly from the previous year and the organization does not report hybrid measures that the auditor determines to be at risk of inaccurate reporting. HSAG verified that the licensed organizations determined whether or not the HMOs and the SMCN were required to undergo a convenience sample validation. HSAG also verified that if a convenience sample validation was not required by a licensed organization, the specific reasons were documented. | |
| **Medical Record Review—**The licensed organizations are required to perform a more extensive validation of medical records reviewed, which is conducted late in the abstraction process. This validation ensures that the review process was executed as planned and that the results are accurate. HSAG reviewed whether or not the licensed organizations performed a re-review of a minimum random sample of 30 medical records for each of two reported measures (if applicable) to ensure the reliability and validity of the data collected. | HEDIS 2014 FAR |
| **IDSS Review—**The HMOs and the SMCN are required to complete NCQA's IDSS for the submission of audited rates to NCQA. The auditor finalizes the IDSS by completing the audit review and entering an audit result. This process verifies that the auditor validated all activities that culminated in a rate by the HMOs or the SMCN. The auditor locks the IDSS so that no information can be changed. HSAG verified that the licensed organizations completed the IDSS review process. In a situation where the HMO did not submit the rates via IDSS, HSAG validated the accuracy of the rates submitted by the HMO in a State-specified reporting template. | HEDIS 2014 IDSS |

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

**Table B-2—Validation Activities**

| | Colorado Access | Colorado Choice | DHMP | Kaiser | RMHP | SMCN |
|---|---|---|---|---|---|---|
| **Licensed Organization** | HealthcareData Company, LLC | DTS Group | HealthcareData Company, LLC | DTS Group | DTS Group | Health Services Advisory Group, Inc. (HSAG) |
| **Pre-on-site Visit Call/Meeting** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Roadmap Review** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Software Vendor** | Verisk Health, Inc. | Altegra | Verisk Health, Inc. | None | Inovalon, Inc. | IMI Health, Inc. |
| **Source Code/ Certified Measure Review** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Survey Vendor** | NA | NA | Morpace, Inc. | DSS Research | The Center for the Study of Services (CSS) | NA |
| **CAHPS Sample Frame Validation** | NA | NA | ✓ | ✓ | ✓ | NA |
| **Supplemental Data Validation** | Not indicated in FAR | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Medical Record Review** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **IDSS Review** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| NA – Not applicable; the HMO did not include this component in its HEDIS reporting. | | | | | | |

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

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

## Data Aggregation, Analysis, and How Conclusions Were Drawn

The following process describes the standard practice for HEDIS audits regardless of the auditing firm. The HMOs forwarded their final audit reports and final IDSS to the Department. HSAG reviewed and evaluated all data sources to assess health plan compliance with the HEDIS Compliance Audit Standards. The information system (IS) standards are listed as follows:

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

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

# Appendix C. EQR Activities—Validation of Performance Improvement Projects

## Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the validation of PIP activities was conducted and how the resulting data were aggregated and analyzed.

## Objectives

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

The primary objective of PIP validation was to determine each CHP+ health plan's compliance with requirements set forth in 42 CFR 438.240(b) (1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

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

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

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

## Technical Methods of Data Collection

The methodology used to validate PIPs was based on CMS guidelines as outlined in *Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, which each HMO submitted to HSAG for review and validation. The PIP Summary Form standardized the process for submitting information regarding PIPs and ensured that all CMS protocol requirements were addressed.

HSAG, with the Department's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS protocol activities:

- Activity I. Select the Study Topic(s)
- Activity II. Define the Study Question(s)
- Activity III. Select the Study Indicator(s)
- Activity IV. Use a Representative and Generalizable Study Population
- Activity V. Use Sound Sampling Techniques
- Activity VI. Reliably Collect Data
- Activity VII.* Analyze Data and Interpret Study Results
- Activity VIII.* Implement Intervention and Improvement Strategies
- Activity IX. Assess for Real Improvement
- Activity X. Assess for Sustained Improvement

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

## Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the HMOs' PIP Summary Form. This form provided detailed information about each health plan's PIP as it related to the 10 CMS protocol activities reviewed and evaluated. HSAG validates PIPs only as far as the PIP has progressed. Activities in the PIP Summary Form that have not been completed are scored *Not Assessed* by the HSAG PIP Review Team.

## Data Aggregation, Analysis, and How Conclusions Were Drawn

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. HSAG designates some of the evaluation elements that are deemed pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all of the critical elements must receive a score of *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a score of *Partially Met* or *Not Met* will result in a corresponding overall PIP validation status of *Partially Met* or *Not Met*.

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

The scoring methodology used for all PIPs is as follows:

- *Met*: All critical elements were *Met* and 80 percent to 100 percent of all critical and noncritical elements were *Met*.
- *Partially Met*: All critical elements were *Met* and 60 percent to 79 percent of all critical and noncritical elements were *Met*, or one critical element or more was *Partially Met*.
- *Not Met*: All critical elements were *Met* and less than 60 percent of all critical and noncritical elements were *Met*, or one critical element or more was *Not Met*.
- *Not Applicable (NA)*: Elements that were *NA* were removed from all scoring (including critical elements if they were not assessed).

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

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

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

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

# Appendix D. EQR Activities—Consumer Assessment of Healthcare Providers and Systems

## Introduction

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

## Objectives

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

## Technical Methods of Data Collection

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

The survey questions were categorized into nine measures of satisfaction that included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions addressing different aspects of care (e.g., getting needed care and how well doctors communicate). If 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 three categories: (1) "Never," "Sometimes," "Usually," and "Always;" (2) "Not at all," "A little," "Some," and "A lot;" or (3) "No" and "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "A lot/Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

It is important to note that the CAHPS 5.0 Medicaid Health Plan Surveys were released by the Agency for Healthcare Research and Quality (AHRQ) in 2012. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the adult and child CAHPS Health Plan Surveys in August 2012. As a result of the transition to the new surveys and changes to the *Shared Decision Making* composite measure, national data are not available for this measure and comparisons could not be performed.

## Description of Data Obtained

Table D-1 and Table D-2 present the question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for the 2014 global ratings and 2014 composite scores, respectively, for the CHP+ plans. The tables also show the program average. Measures at or above the 2013 NCQA national averages are highlighted in yellow.

**Table D-1—Question Summary Rates for Global Ratings**

| Measure of Member Satisfaction | CHP+ 2014 | | | | | |
|---|---|---|---|---|---|---|
| | Colorado Access | Colorado Choice | DHMP | Kaiser | RMHP | CHP+ Program Average |
| *Rating of Personal Doctor* | 65.2% | 59.7% | 72.4% | 71.6% | 70.5% | 68.3% |
| *Rating of Specialist Seen Most Often* | 66.0%+ | 51.0%+ | 68.1%+ | 65.8%+ | 58.1%+ | 62.3% |
| *Rating of All Health Care* | 57.3% | 48.5% | 56.6% | 69.5% | 62.7% | 59.9% |
| *Rating of Health Plan* | 58.4% | 50.2% | 54.5% | 63.0% | 55.4% | 56.9% |

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

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

Indicates a rate is at or above the 2013 NCQA CAHPS national average.

| Table D-2— Global Proportions for Composite Scores | | | | | | |
|---|---|---|---|---|---|---|
| | CHP+ 2014 | | | | | |
| Measure of Member Satisfaction | Colorado Access | Colorado Choice | DHMP | Kaiser | RMHP | CHP+ Program Average |
| *Getting Needed Care* | 81.8% | 89.5% | 66.5% | 87.4% | 86.3% | 82.8% |
| *Getting Care Quickly* | 88.0% | 89.8% | 82.2% | 92.1% | 93.7% | 89.5% |
| *How Well Doctors Communicate* | 94.9% | 93.2% | 90.7% | 94.3% | 95.0% | 94.0% |
| *Customer Service* | 81.0% | 74.3%+ | 80.0% | 84.8% | 80.7% | 80.8% |
| *Shared Decision Making* | 55.3% | 52.6%+ | 59.8%+ | 60.5%+ | 56.4%+ | 56.9% |

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

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

Due to changes to the *Shared Decision Making* composite measure, comparisons to national data could not be performed for 2014.

Indicates a rate is at or above the 2013 NCQA CAHPS national average.

## Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

| Table D-3—Assignment of CAHPS Measures to Performance Domains | | | |
|---|---|---|---|
| CAHPS Measures | Quality | Timeliness | Access |
| *Getting Needed Care* | ✓ | ✓ | |
| *Getting Care Quickly* | ✓ | ✓ | |
| *How Well Doctors Communicate* | ✓ | | |
| *Customer Service* | ✓ | | |
| *Shared Decision Making* | ✓ | | |
| *Rating of Personal Doctor* | ✓ | | |
| *Rating of Specialist Seen Most Often* | ✓ | | |
| *Rating of All Health Care* | ✓ | | |
| *Rating of Health Plan* | ✓ | | |

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

## Introduction

This appendix presents tables with the detailed findings for all CHP+ health plans and for each EQR activity performed in FY 2013–2014.

## Results from the Compliance Monitoring Site Reviews

Table E-1 and Table E-2 show the compliance summary scores and record review scores for each health plan as well as the statewide average. Statewide average scores were calculated by dividing the total number of elements that were *Met* across all plans by the total number of applicable elements across all plans. This was the second year that HSAG applied scores to HMO performance; therefore, scores are only available for the standards reviewed in 2012–2013 and 2013–2014.* SMCN was also subject to a compliance site review; however, the Department requested that the SMCN compliance review not be scored. For this reason, it is not included in Table E-1 or Table E-2.

**Table E-1—Compliance Summary Scores**

| Description of Component | CO Access | CO Choice | DHMP | Kaiser | RMHP | Statewide Average |
|---|---|---|---|---|---|---|
| Standard I—Coverage and Authorization of Services | 88% | 71% | 85% | 91% | 85% | 84% |
| Standard II—Access and Availability | 91% | 73% | 81% | 95% | 86% | 85% |
| Standard III—Coordination and Continuity of Care (2013) | 100% | 33% | 100% | 89% | 89% | 82% |
| Standard IV—Member Rights and Protections (2013) | 100% | 20% | 100% | 80% | 40% | 68% |
| Standard VIII—Credentialing and Recredentialing (2013) | 98% | 39% | 94% | 100% | 98% | 86% |
| Standard X—Quality Assessment and Performance Improvement (2013) | 100% | 34% | 91% | 100% | 73% | 76% |

Standards presented in green text were reviewed in FY 2012–2013.
Standards in black were reviewed in FY 2013–2014.

* Standards V—Member Information, VI—Grievances and Appeals, VII—Provider Participation and Program Integrity, and IX—Subcontracts and Delegation are scheduled for review in FY 2014–2015.

**Table E-2—Record Review Scores**

| Description of Component | CO Access | CO Choice | DHMP | Kaiser | RMHP | Statewide Average |
|---|---|---|---|---|---|---|
| Denials | 95% | 56% | 87% | 62% | 71% | 69% |
| Credentialing | 100% | 97% | 100% | 100% | 100% | 99% |
| Recredentialing | 100% | 91% | 100% | 100% | 100% | 98% |

## Results from the Validation of Performance Measures

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

**Table E-3—2013–2014 Performance Measure Results for each HMO and Statewide Average**

| Performance Measures | CO Access | CO Choice | DHMP | Kaiser | RMHP | SMCN | Statewide Average |
|---|---|---|---|---|---|---|---|
| *Childhood Immunization Status* | | | | | | | |
| *Combination 2* | 72.51% | NA | 89.33% | 85.29% | 69.87% | — | 73.25% |
| *Combination 3* | 68.61% | NA | 89.33% | 84.31% | 67.88% | — | 70.33% |
| *Combination 4* | 61.31% | NA | 89.33% | 84.31% | 57.95% | — | 63.50% |
| *Combination 5* | 59.37% | NA | 81.33% | 68.63% | 51.66% | — | 58.90% |
| *Combination 6* | 49.64% | NA | 76.00% | 59.80% | 49.67% | — | 51.53% |
| *Combination 7* | 54.50% | NA | 81.33% | 68.63% | 49.01% | — | 55.43% |
| *Combination 8* | 45.50% | NA | 76.00% | 59.80% | 44.70% | — | 47.79% |
| *Combination 9* | 44.04% | NA | 68.00% | 51.96% | 40.40% | — | 44.66% |
| *Combination 10* | 41.12% | NA | 68.00% | 51.96% | 38.74% | — | 42.56% |
| *Well-Child Visits in the First 15 Months of Life* | | | | | | | |
| *Zero Visits* | 2.19% | NA | 2.22% | 0.00% | 2.67% | — | 2.16% |
| *6+ Visits* | 70.80% | NA | 62.22% | 51.92% | 69.08% | — | 67.41% |
| *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* | 65.60% | 56.30% | 60.63% | 68.02% | 54.47% | — | 62.72% |
| *Adolescent Well-Care Visits* | 43.80% | 37.02% | 48.91% | 49.78% | 40.40% | — | 44.00% |
| *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | | | | | | | |
| *BMI Assessment: Total* | 61.56% | 39.52% | 93.67% | 90.74% | 77.92% | — | 69.59% |
| *Counseling for Nutrition: Total* | 61.31% | 29.94% | 79.32% | 90.74% | 58.72% | — | 64.47% |
| *Counseling for Physical Activity: Total* | 53.28% | 35.93% | 66.67% | 90.74% | 56.07% | — | 58.26% |
| *Immunizations for Adolescents—Combination 1* | 60.94% | 22.58% | 89.34% | 89.42% | 54.37% | — | 63.46% |
| *Appropriate Testing for Children with Pharyngitis* | 76.78% | 57.14% | 84.21% | 91.15% | 82.52% | — | 79.09% |
| *Follow-up Care for Children Prescribed ADHD Medication* | | | | | | | |
| *Initiation* | 0.55% | NA | NA | 38.71% | 44.64% | — | 16.78% |
| *Continuation* | 0.00% | NA | NA | NA | NA | — | 30.77% |
| *Asthma Medication Ratio—Total* | 77.61% | NA | NA | NA | 75.56% | — | 73.78% |
| *Children's and Adolescents' Access to Primary Care Practitioners* | | | | | | | |
| *Ages 12 to 24 Months* | 92.78% | NA | 86.61% | 95.96% | 88.60% | — | 91.36% |
| *Ages 25 Months to 6 Years* | 84.27% | 76.87% | 74.84% | 90.78% | 77.74% | — | 82.41% |
| *Ages 7 to 11 Years* | 89.96% | 88.89% | 84.35% | 95.47% | 86.94% | — | 89.16% |
| *Ages 12 to 19 Years* | 88.18% | 91.27% | 87.68% | 95.97% | 86.55% | — | 88.60% |

| Table E-3—2013–2014 Performance Measure Results for each HMO and Statewide Average | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Performance Measures** | **CO Access** | **CO Choice** | **DHMP** | **Kaiser** | **RMHP** | **SMCN** | **Statewide Average** |
| *Prenatal and Postpartum Care* | | | | | | | |
| *Timeliness of Prenatal Care* | — | — | — | — | — | 70.80% | 70.80% |
| *Postpartum Care* | — | — | — | — | — | 63.26% | 63.26% |
| *Ambulatory Care (per 1,000 member months)* | | | | | | | |
| *Outpatient Visits* | 239.95 | 189.86 | 111.45 | 163.04 | 208.28 | — | 214.08 |
| *Emergency Department Visits* | 30.97 | 19.09 | 29.68 | 10.69 | 19.82 | — | 26.47 |
| *Inpatient Utilization—General Hospital/Acute Care: Total* | | | | | | | |
| *Discharges per 1,000 MM (total inpatient)* | 1.42 | 1.06 | 1.01 | 0.78 | 0.98 | — | 1.23 |
| *Days per 1,000 MM (total inpatient)* | 5.22 | 2.89 | 2.72 | 2.41 | 2.23 | — | 4.16 |
| *Average Length of Stay (total inpatient)* | 3.68 | 2.74 | 2.70 | 3.09 | 2.28 | — | 3.37 |
| *Discharges per 1,000 MM (medicine)* | 0.97 | 0.39 | 0.81 | 0.58 | 0.64 | — | 0.85 |
| *Days per 1,000 MM (medicine)* | 2.85 | 1.28 | 2.17 | 1.73 | 1.32 | — | 2.38 |
| *Average Length of Stay (medicine)* | 2.93 | 3.29 | 2.68 | 2.98 | 2.08 | — | 2.81 |
| *Discharges per 1,000 MM (surgery)* | 0.33 | 0.39 | 0.17 | 0.13 | 0.34 | — | 0.30 |
| *Days per 1,000 MM (surgery)* | 2.10 | 1.28 | 0.46 | 0.51 | 0.89 | — | 1.56 |
| *Average Length of Stay (surgery)* | 6.34 | 3.29 | 2.73 | 3.83 | 2.64 | — | 5.27 |
| *Discharges per 1,000 MM (maternity)* | 0.25 | 0.23 | 0.07 | 0.14 | 0.02 | — | 0.19 |
| *Days per 1,000 MM (maternity)* | 0.61 | 0.35 | 0.20 | 0.35 | 0.06 | — | 0.45 |
| *Average Length of Stay (maternity)* | 2.44 | 1.50 | 3.00 | 2.50 | 3.00 | — | 2.44 |

— is shown when no data were available or the measure was not reported.

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

## Results from the Validation of Performance Improvement Projects

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

**Table E-4—Summary of Each HMO's PIP Validation Scores and Validation Status**

| HMO | PIP Study | % of All Elements *Met* | % of Critical Elements *Met* | Validation Status |
|---|---|---|---|---|
| Colorado Access | *Improving Weight Assessment in Children and Adolescents* | 100% | 100% | *Met* |
| Colorado Choice | *Asthma in Pediatric Patients* | 74% | 100% | *Partially Met* |
| DHMP | *Improving Well Care for Children 3–6 Years* | 85% | 100% | *Met* |
| Kaiser | *Asthma Care* | 89% | 100% | *Met* |
| RMHP | *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* | 88% | 100% | *Met* |

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

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

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

| Measure | Colorado Access | Colorado Choice | DHMP | Kaiser | RMHP | Statewide Average |
|---|---|---|---|---|---|---|
| *Getting Needed Care* | 81.8% | 89.5% | 66.5% | 87.4% | 86.3% | 82.8% |
| *Getting Care Quickly* | 88.0% | 89.8% | 82.2% | 92.1% | 93.7% | 89.5% |
| *How Well Doctors Communicate* | 94.9% | 93.2% | 90.7% | 94.3% | 95.0% | 94.0% |
| *Customer Service* | 81.0% | 74.3%+ | 80.0% | 84.8% | 80.7% | 80.8% |
| *Shared Decision Making* | 55.3% | 52.6%+ | 59.8%+ | 60.5%+ | 56.4%+ | 56.9% |
| *Rating of Personal Doctor* | 65.2% | 59.7% | 72.4% | 71.6% | 70.5% | 68.3% |
| *Rating of Specialist Seen Most Often* | 66.0%+ | 51.0%+ | 68.1%+ | 65.8%+ | 58.1%+ | 62.3% |
| *Rating of All Health Care* | 57.3% | 48.5% | 56.6% | 69.5% | 62.7% | 59.9% |
| *Rating of Health Plan* | 58.4% | 50.2% | 54.5% | 63.0% | 55.4% | 56.9% |

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