STATE OF COLORADO

OFFICE OF THE GOVERNOR

136 State Capitol Building Denver, Colorado 80203 (303) 866 - 2471 (303) 866 - 2003 fax



April 15, 2015

Ms. Sylvia M. Burwell, Secretary U.S. Department of Health & Human Services 200 Independence Avenue, S.W. Washington, D.C. 20201

Dear Ms. Burwell:

On behalf of the Colorado Department of Health Care Policy & Financing, Colorado's single state agency responsible for administering the Medicaid and CHIP programs, the State of Colorado respectfully submits our extension application for the extension of Colorado's title XXI section 1115 demonstration project No. 21-W-00014/8. Specifically, our application requests an extension of the federal authority for Colorado to continue to receive title XXI funds for pregnant women with income from 142 percent of the federal poverty level (FPL) through 195 percent of the FPL (post-MAGI converted levels).

Thank you very much for this opportunity. Should you have any questions or concerns, please contact Gretchen Hammer, Medicaid Director at the Department of Health Care Policy & Financing, at (303) 866-3058 or gretchen.hammer@state.co.us.

Sincerely,

John W. Hickenlooper Governor of Colorado

Attachments

- Demonstration Extension Application: Colorado Adult Prenatal Coverage in CHP+ (No. 21-W-00014/8)
- Historical and Projected Expenditures
- 2014 HEDIS[®] Aggregate Report for Child Health Plan *Plus*
- 2013-2014 Child Health Plan *Plus* Technical Report
- Compliance with Special Terms and Conditions Document



DEMONSTRATION EXTENSION APPLICATION COLORADO ADULT PRENATAL COVERAGE IN CHP+ (NO. 21-W-00014/8)

Historical Narrative Summary of the Demonstration Project

On September 27, 2002, the Centers for Medicare and Medicaid (CMS) initially approved Colorado's "Adult Prenatal Coverage in CHP+" demonstration for a four-year period through September 30, 2006, permitting the State to use title XXI funds to expand coverage to uninsured pregnant women with family incomes from 133 percent to 185 percent of the federal poverty level (FPL). Subsequently, on January 24, 2006, CMS approved an amendment to the demonstration, allowing Colorado to expand eligibility for uninsured pregnant women under the demonstration from above 185 percent to 200 percent of the FPL. On September 29, 2006, CMS approved Colorado's request to renew the demonstration for a three-year period through September 30, 2009. CMS then approved Colorado's extension request, which extended the program through June 2012. On July 30, 2012, Colorado received approval to expand coverage for uninsured pregnant women from 200 percent to 250 percent of the FPL.

Section 111 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) added Section 2112(b)(1)(A) of the Social Security Act, which specifies that a state must first cover pregnant women in Medicaid to at least 185 percent of the FPL before expanding coverage to pregnant women in the Children's Health Insurance Program (CHIP). Section 111 of CHIPRA also added a provision to provide states the option to provide necessary prenatal, delivery and postpartum care to targeted, low-income, pregnant women through the title XXI State plan.

In order to comport with the intent of CHIPRA, under this renewal, Colorado submitted a Medicaid State plan amendment and got approval for transitioning pregnant women from 133 percent to 185 percent of the FPL to the Medicaid State plan and to provide the full Medicaid benefit to these women. The State has continued to receive title XXI funds for uninsured pregnant women from 133 percent to 185 percent of the FPL. In addition, the State submitted and received approval for a corresponding CHIP State plan amendment to transition pregnant women above 185 percent of the FPL to 250 percent of the FPL to the CHIP State plan. As required under Special Terms and Conditions (STCs) #17, the State transitioned coverage of pregnant women from this demonstration to the Medicaid State plan and the CHIP State plan, effective January 1, 2013.¹

Colorado's Title XXI Health Insurance Flexibility and Accountability (HIFA) demonstration has three main objectives:

- Decrease the uninsurance rate for pregnant women
- Increase prenatal and postpartum care for pregnant women enrolled in the demonstration
- Increase the number of healthy babies born to pregnant women enrolled in the demonstration

The "Quality Assurance" section of this application describes how the objectives were or were not met during the demonstration and provides an explanation regarding outcomes. The "Evaluation" section

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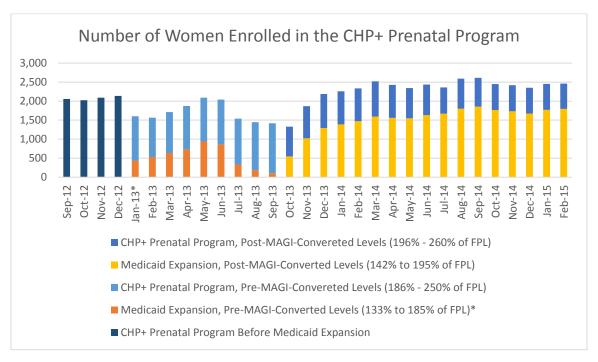
¹ The federal poverty levels listed in the Historical Summary of the Demonstration Project section are pre-MAGI-converted levels.



indicates where the outcomes data are located and describes the hypotheses and the evaluation design and activities for the extension period.

Prenatal Program

The average monthly enrollment of clients enrolled in the prenatal program during state fiscal year (SFY) 2013 (July 1, 2012 through June 30, 2013) was 1,955. Of those enrolled, the average monthly enrollment in the CHIP State plan was 1,611 and in the Medicaid State plan was 344. During SFY 2014 (July 1, 2013 through June 30, 2014), the average monthly enrollment of clients enrolled in the prenatal program was 2,009, a 2.8 percent increase over SFY 2013. Of those enrolled, the average monthly enrollment in the CHIP State plan was 952 and in the Medicaid State plan was 1,057. The following chart illustrates the monthly average of the number of uninsured pregnant women enrolled in the prenatal program. Due to Medicaid expansion effective January 1, 2013, the State started providing services under the Medicaid State plan to uninsured and insured pregnant women at 133 percent to 185 percent of the FPL, and services under the CHIP State plan to uninsured women above 185 percent of the FPL to 250 percent of the FPL. Due to this shift, the number of prenatal clients receiving CHP+ benefits declined while the number of prenatal clients receiving Medicaid benefits increased, as illustrated in the following chart.²



^{*} From January 2013 to September 2013, the estimated enrollment numbers are lower due to the classification of the FPL bracket codes.

One of the goals of the program is to improve health outcomes for low-income mothers and their babies. To achieve this goal, clients identified as pregnant receive a call to complete a prenatal risk assessment and a Patient Health Questionnaire (PHQ-9), which aims to identify community and

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² The federal poverty levels listed in the Prenatal Program section are pre-MAGI-converted levels.



educational resources that may benefit the clients, such as Women, Infants and Children (WIC), Prenatal Plus (PN+), Nurse Family Partnership (NFP), and Healthy Start. Members who are identified as high risk are enrolled in the Intensive Case Management program.

Clients also receive educational materials and information related to their current trimester and their baby's development and outbound postpartum calls to screen for postpartum depression and address any concerns. The calls ensure that enrollment has been set up for the newborn and the mother is seeking postpartum care.

Extension Request

Colorado requests an extension to the demonstration from August 1, 2015, through July 31, 2018. Specifically, the State requests an extension of the federal authority for Colorado to continue to receive title XXI funds for uninsured pregnant women with income from 142 percent of the FPL to 195 percent of the FPL. Title XIX funds will continue to be used for pregnant women in this income range who are insured. During this timeframe, Colorado will continue to reach out to, enroll and provide prenatal and postpartum care to eligible pregnant women from 142 percent of the FPL to 260 percent of the FPL to achieve the goals and objectives of this program.³

Under this demonstration, fee-for-service and managed care delivery systems will cover the pregnant women. Cost sharing is not applied to this population for any type of service.

Waiver and Expenditure Authority

The specific waiver requested is "CHIP Secondary Payer to Medicaid rules" at Section 2105(c)(6)(B) of the Social Security Act. Colorado is requesting the same expenditure authority as approved in the current demonstration. Annual expenditures that apply to the Demonstration are provided in the Historical and Projected Expenditures document.

Because Colorado received approval for increasing the income limit for uninsured and insured pregnant women from 133 percent of the FPL to 185 percent of the FPL under the Medicaid State plan and expanding the income eligibility level for uninsured pregnant women to 250 percent of the FPL under the CHP+ State plan, Colorado no longer needs a waiver to provide prenatal and postpartum services to these women.⁴

Quality Assurance

The Department contracted with Health Services Advisory Group, Inc. (HSAG) as the external quality review organization (EQRO) to evaluate the timeliness and adequacy of prenatal and postpartum care for eligible pregnant women from above 195 percent of the FPL to 260 percent of the FPL. Colorado Access, contractor for the state managed care network, provided data to the State to determine the impact of prenatal care on birth outcomes for women in the CHP+ State plan. The major findings that occurred in SFY 2013 and SFY 2014 for these prenatal women include:

³ The federal poverty levels listed in the Extension Request section are post-MAGI-converted levels.

⁴ The federal poverty levels listed in the Waiver and Expenditure Authority section are pre-MAGI-converted levels.



- The timeliness of prenatal care increased by 6.33 percentage points to 78.59 percent from SFY 2012 to SFY 2013; it then decreased by 7.79 percentage points to 70.80 percent from SFY 2013 to SFY 2014.
- Postpartum care was maintained at the same level at 67.88 percent in SFY 2012 and SFY 2013; it then decreased by 4.62 percentage points to 63.26 percent from SFY 2013 to SFY 2014.
- The percentage of babies born with low birth weights (less than 2500 grams) to women in the prenatal program in the CHP+ State plan increased by 13.89 percentage points, from 8.05 percent in SFY 2013 to 21.94 percent in SFY 2014 (through the third quarter of SFY 2014; fourth quarter outcomes are not yet available).⁵

From SFY 2013 to SFY 2014, there was a decline in overall outcomes for the prenatal women in the CHP+ State plan. The Department believes that the decline was in part due to (1) the shift of prenatal women at 142 percent to 195 percent of the FPL from the CHP+ State plan to the Medicaid State plan and (2) the expansion of eligible prenatal women to 260 percent of the FPL. Because of Medicaid expansion, most of the prenatal women who were being served in the CHP+ State plan were moved to the Medicaid State plan. Consequently, most of the prenatal women in the CHP+ State plan in SFY 2014 were newly eligible. Accordingly, the Department had to implement additional outreach efforts, educate this new population and service providers about the program and the expanded eligibility levels, inform them about their potential eligibility, and then enroll them in the program if eligible. As a result of this start-up phase, newly eligible prenatal women may have enrolled in the program later in their pregnancy, causing an initial dip in outcomes. The Department is monitoring these performance outcomes and working with Colorado Access to make sure that these measures improve.

Financial Data

Historical and projected expenditures and financial analysis are provided in the Historical and Projected Expenditures spreadsheet as a separate document. This document also shows the projected number of eligible members per month, which is anticipated to grow each year.

Evaluation

The evaluation reports produced by HSAG, including the 2014 HEDIS® Aggregate Report for Child Health Plan *Plus* and the 2013-2014 Child Health Plan *Plus* Technical Report, show the results regarding the timeliness of prenatal care and postpartum care. The reports are provided as separate documents, and outcomes can be found on the following pages of the reports.

2014 HEDIS Aggregate Report for Child Health Plan Plus

- Table 1-1 Colorado CHP+ Statewide Weighted Averages, pg. 1-4
- Access to Care bullet, pg. 1-5
- Access to Care section, pg. 3-25 3-27
- Table 3-4 Individual Access to Care Performance Summary by Measure, pg. 3-31
- Table A-11 Prenatal and Postpartum Care, pg. A-11

⁵ SFY 2013 includes data from quarters 1, 2, 3 and 4; SFY 2014 includes data from quarters 1, 2 and 3. Data from SFY 2014 quarter 4 are not yet available.



• Table B-6 = State Managed Care Network Trend Table, pg. B-17

2013-2014 Child Health Plan Plus Technical Report

- Quality section, pg. 1-4
- Timeliness section, pg. 1-5
- Access section, pg. 1-5 1-6
- Strengths section, pg. 3-15
- Table 3-15 HEDIS 2014 Performance Measures, pg. 3-19
- Performance Measures, Strengths, Recommendations and Summary of Assessment Related to Quality, Timeliness, and Access sections, pg. 3-40 – 3-41
- Table 3-27 Statewide Review Audit Results for HEDIS 2014 Performance Measures, pg. 3-42
- Quality, Timeliness and Access sections, pg. 3-43 3-44
- Validation of Performance Measures, pg. 4-9
- Table E-3 2013 2014 Performance Measure Results for each HMO and Statewide Average, pg. E-3

Objectives, Hypotheses and Evaluation Activities During the Extension Period

During the extension period, the following objectives of the demonstration will remain the same:

- Objective 1: Increase prenatal and postpartum care for pregnant women enrolled in the demonstration
- Objective 2: Increase the number of healthy babies born to pregnant women enrolled in the demonstration

To know if Colorado is achieving these objectives, the State will evaluate the following:

- Hypothesis 1: Prenatal and postpartum care for the pregnant women from 142 percent of the FPL to 195 percent of the FPL will be better than the prenatal and postpartum care for the pregnant women in the Medicaid population as a whole.
 - Methodology: Colorado will use claims data, birth certificate data and HEDIS data to measure prenatal and postpartum care for the women in the demonstration program as well as for the pregnant women in Medicaid as a whole.
- Hypothesis 2: Prenatal and postpartum care for the prenatal women from 142 percent of the FPL to 195 percent of the FPL will align closely with the prenatal and postpartum care for prenatal women from 143 percent of FPL to 260 percent of FPL.
 - Methodology: Colorado will use claims data, birth certificate data and HEDIS data to measure prenatal and postpartum care for the women in the demonstration program as well as for the pregnant women in the CHP+ State plan.



Hypothesis 3: The babies born to women from 142 percent of the FPL to 195 percent of the FPL will have fewer incidences of low birth weights and NICU admissions than the Medicaid population as a whole.⁶

Methodology: Colorado will use claims data, birth certificate data, HEDIS data and PRAMS data to track the birth weights of newborns and length of stay and time spent in the ICU for babies born to mothers in the demonstration program as well as for the newborns born to mothers in Medicaid as a whole.

Colorado will continue to contract with Health Services Advisory Group as the EQRO to measure and evaluate the timeliness and adequacy of prenatal and postpartum care.

Compliance with Public Notice, Tribal Consultation and Consultation with Interested Parties

The State has complied with the State public notice process for applications for an extension of an existing demonstration project. On December 1, 2014, the State conducted tribal consultation pursuant to the State's consultation agreement. No issues were raised as a result of the consultation.

On February 27, 2015, and on March 1, 2015, respectively, the State published an article in the Department of Health Care Policy and Financing's (the Department's) provider bulletin and At a Glance newsletter about Colorado's intent to submit an application to extend Colorado's title XXI section 1115 demonstration project. These articles included a link to the public notice, which provided links to the demonstration extension application, listed the dates and locations of the public hearings and provided ways to submit comments and questions both electronically and by mail. The provider newsletter was distributed to approximately 11,000 providers. The At a Glance newsletter was distributed to approximately 2,400 individuals including eligibility partners, advocates and providers. Both articles were posted on the Department's website, which enables the general public to find and learn about the application and the dates of the public hearings.

On March 4, 2015, the State added a page to the Department's web site that provided information about the demonstration. The web site page included a link to the public notice, the proposed demonstration extension application, the historical and projected expenditures document, all of the application's attachments and a link to the demonstration page on the CMS website. The web site also included notice of the public hearings and provided ways to submit comments and questions both electronically and by mail. Several of the questions asked during the public hearings were specific to the information in the application and historical and projected expenditures document (the questions are listed in this section), demonstrating that the public found and reviewed the application that was posted online.

On March 5, 2015, the State published an article in the Colorado Community Health Network (CCHN) newsletter about Colorado's intent to submit an application to extend Colorado's title XXI section 1115 demonstration project. The article listed the dates and locations of the public hearings and contact information for comments. The newsletter was distributed to CCHN members including staff at federally

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⁶ If the mother loses Medicaid eligibility after the baby has been delivered, the mother and the baby are not assigned the same case number and not linked together. As a result, the outcomes will be approximate as some of the babies may not be included in the evaluation since there is no link to the mother who was in this category.



qualified Community Health Centers. The newsletter also was posted on its web site, enabling the general public, members and other organizations to find and learn about the application and public hearings.

On March 10, 2015, the public notice was announced through the Colorado State Register in accordance with the State's procedures. The public notice listed the dates and locations of the public hearings, provided ways to submit comments and questions both electronically and by mail and included links to the demonstration extension application and to the demonstration page on the CMS website. The public notice is published on the Secretary of State's web site, which is available for the general public to review at any time. In addition, individuals can subscribe to receive automatic notifications through the Secretary of State's web site of when new public notices are published. Paper copies of the public notices are also printed by LexisNexis, which are distributed to individuals who have subscribed to this service.

The public hearings were held on March 10, 2015, at Colorado Access, 10065 East Harvard Avenue, 6th Floor Conference Room, Denver, Colorado 80231 in conjunction with the CHP+ Managed Care Organization meeting, and on March 16, 2015, at the Colorado Department of Health Care Policy and Financing, 303 E. 17th Avenue, 7th Floor, Room 7B Conference Room, Denver, Colorado 80203. The public was able to call in to the March 16th meeting. The public comment period was open through April 9, 2015.

Comments and questions were received from five members of the CHP+ Managed Care Organization meeting and two individuals representing Covering Kids and Families. No issues or concerns were raised about the application by the public during the comment period. In fact, all comments fully supported the demonstration extension application. Specific questions and responses included:

- Q: Does the requested extension include the incomes from 142 percent FPL to 195 percent FPL, instead of 133 percent FPL to 185 percent FPL, because these incomes have been MAGI converted?
 - A: Yes, the incomes from 142 percent FPL to 195 percent FPL have been MAGI converted. Whenever 133 percent of FPL to 185 percent of FPL or 133 percent of FPL to 250 percent of FPL is listed, it is referring to pre-MAGI-converted levels. Whenever you see 142 percent of FPL to 195 percent of FPL or 142 percent of FPL to 260 percent of FPL, it is referring to post-MAGI-converted levels.
- Q: On page 3 of the application and on page 2 of the public notice, it states, "specifically, the State will request an extension of the federal authority to receive title XXI funds for uninsured pregnant women with income from 142 percent of the FPL to 195 percent of the FPL. Title XIX funds will continue to be used for pregnant women in this income range who are insured." Can you please explain: (1) How are the terms "insured" vs. "uninsured" being used in these situations? (2) Why are different funding sources used depending on the woman's insured status?
 - A: (1) The terms "insured" and "uninsured" are being used to describe whether or not a
 member has other forms of health insurance. (2) To qualify for CHP+, members cannot
 have other health insurance, so they are uninsured. Medicaid members, however, may
 have other forms of health insurance, so they may be insured or uninsured. The state is



requesting an extension of the federal authority to receive title XXI funds for uninsured pregnant women (women with no other health insurance) with income from 142 percent of the FPL to 195 percent of the FPL.

- Q: Because the application says that coverage for pregnant women from 133 percent FPL to 185
 percent FPL was transitioned from a demonstration to the Medicaid and CHIP State Plan, why
 does this application request a waiver rather than an amendment to the state plan?
 - A: Colorado no longer needs a waiver to provide prenatal and postpartum services to uninsured pregnant women from 133 percent of FPL to 250 percent of FPL (pre-MAGIconverted levels), but needs a waiver to continue to receive title XXI matching funds for uninsured pregnant women in the Medicaid State plan.
- Q: In budget projections, is the state anticipating that CHIP funding will be extended at the federal level with the 23 percent rate increase? If so, how will the state's budget be impacted if the 23 percent rate increase is not included in the federal CHIP funding extension?
 - A: Yes, in the budget projections, the State is anticipating that CHIP federal financing will be extended with a 23 percentage point rate increase. The total impact on the budget would be approximately \$29.1 M (roughly \$7.3 M per year) if the 23 percentage point rate increase is not included in the extension. The State, however, has been working on contingency plans if the 23 percentage point rate increase is not included as a part of the CHIP federal financing extension.

Because most of the comments received were clarification questions regarding technical aspects of the program, no substantive changes were made to the demonstration extension application based on public comments. The application was updated to reflect the most recent enrollment numbers.

COLORADO	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019 (End Sep 30, 2019)
	Federal Fiscal Year -3	Federal Fiscal Year -2	Federal Fiscal Year -1	Federal Fiscal Year	Federal Fiscal Year +1	Federal Fiscal Year +2	Federal Fiscal Year +3	Federal Fiscal Year +4
State's Allotment	\$130,419,874	\$131,840,929	\$140,521,788	\$157,511,557	\$220,280,596	\$228,732,699	\$237,509,108	\$246,622,265
Funds Carried Over From Prior Year(s)	\$110,784,885 \$241,204,750	\$116,429,415 \$248,270,244	\$108,224,229 \$248,746,047	\$97,768,837	\$92,896,534	\$73,003,293 \$201,735,003	\$43,048,786	\$15,436,649 \$262,058,014
SUBTOTAL (Allotment + Funds Carried Over) Reallocated Funds (Redistributed or Retained that are Currently Available)	\$241,204,759	\$248,270,344	\$248,746,017	\$255,280,394	\$313,177,130	\$301,735,992	\$280,557,894	\$262,058,914
TOTAL (Subtotal + Reallocated funds)	\$241,204,759	\$248,270,344	\$248,746,017	\$255,280,394	\$313,177,130	\$301,735,992	\$280,557,894	\$262,058,914
State's Enhanced FMAP Rate	65.00%	65.00%	65.00%	65.71%	88.50%	88.50%	88.50%	88.50%
COST PROJECTIONS OF APPROVED SCHIP PLAN								
Benefit Costs								
Insurance payments				*********		^	A	
Managed care per member/per month rate @ # of eligibles	\$163,316,410	\$199,029,965 \$189.87 @ 87,363 avg elig/mo	\$214,216,069 \$194.98 @ 91,593 avg elig/mo	\$222,894,912 \$175.32 @ 106,002 avg elig/mo	\$247,834,861 \$175.36 @ 117.833 avg elig/mo	\$267,515,327 \$176.52 @ 126.355 avg elig/mo	\$273,489,721 \$171.57 @ 132,903 avg elig/mo	\$274,750,602 \$165.77 @ 138,183 avg elig/mo
Fee for Service	\$0	\$19,245	\$84,806	\$111,259	\$121,993	\$128,638	\$133,315	\$136,550
Total Benefit Costs	\$163,316,410	\$199,049,210	\$214,300,875	\$223,006,171	\$247,956,854	\$267,643,965	\$273,623,036	\$274,887,152
(Offsetting beneficiary cost sharing payments) Net Benefit Costs	-\$698,183 \$162,618,227	- <mark>\$925,411</mark> \$198,123,799	- <mark>\$927,129</mark> \$213,373,746	-\$1,009,210 \$221,996,961	-\$1,064,413 \$246,892,441	-\$1,093,524 \$266,550,441	-\$1,108,478 \$272,514,558	-\$1,116,057 \$273,771,095
Net Bellett Costs	ψ102,010,22 <i>1</i>	\$130,123,733	Ψ213,373,740	Ψ221,330,301	Ψ2+0,032,4+1	Ψ200,330,441	Ψ212,314,330	Ψ213,111,033
Administration Costs								
Personnel General administration	\$820,444 \$2,369,622	\$741,849 \$2,142,621	\$760,445 \$2,196,332	\$904,287 \$2,611,779	\$891,730 \$2,575,513	\$891,730 \$2,575,513	\$891,730	\$891,730 \$2,575,513
Contractors/Brokers (e.g., enrollment contractors)	\$890,840	\$752,812	\$785,470	\$1,038,082	\$1,016,031	\$1,016,031	\$2,575,513 \$1,016,031	\$1,016,031
Claims Processing	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Outreach/marketing costs	\$550,000	\$550,000	\$550,000	\$550,000	\$550,000	\$550,000	\$550,000	\$550,000
Other Total Administration Costs	\$3,296,138 \$7,927,044	\$3,475,851 \$7,663,133	\$3,665,361 \$7,957,608	\$3,865,204 \$8,969,352	\$4,075,942.85 \$9,109,217	\$4,298,172 \$9,331,446	\$4,532,517 \$9,565,791	\$4,779,639 \$9,812,913
10% Administrative Cap	\$18,068,692	\$22,013,755	\$23,708,194	\$24,666,329	\$27,432,493	\$29,616,716	\$30,279,395	\$30,419,011
Fadaral Title VVI Ohara	A440.074.405	A400 704 705	A440.00= 005	A1E1 =01.000	#00 L 100 00 :	MOLLI COO TOO	40 th 600 t to	#0.10.00=016
Federal Title XXI Share State Share	\$110,854,426 \$59,690,845	\$133,761,506 \$72,025,426	\$143,865,380 \$77,465,974	\$151,704,282 \$79,262,031	\$224,420,801 \$31,580,857	\$241,962,580 \$33,919,307	\$247,393,148 \$34,687,201	\$248,665,812 \$34,918,195
TOTAL COSTS OF APPROVED SCHIP PLAN	\$170,545,271	\$205,786,932	\$221,331,354	\$230,966,313	\$256,001,658	\$275,881,886	\$282,080,349	\$283,584,008
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COST DDO JECTIONS OF 4445 DEMONSTRATION DRODOSAL								
COST PROJECTIONS OF 1115 DEMONSTRATION PROPOSAL Benefit Costs for Demonstration Population #1 (pregnant women 196% - 259% FPL)								
Insurance payments								
Managed care	\$21,416,796	\$4,470,580						
per member/per month rate @ # of eligibles Fee for Service	\$914.78 @ 1,951 avg elig/mo	\$1,029.14 @ 362 avg elig/mo			+			
Total Benefit Costs for Waiver Population #1	\$21,416,796	\$4,470,580	\$0	\$0	\$0	\$0	\$0	\$0
Benefit Costs for Demonstration Population #2 (pregnant women 142% - 195% FPL)								
Insurance payments Managed care	\$0	\$5,197,392	\$10,938,325	\$16,248,781	\$17,795,861	\$18,893,477	\$20,027,182	\$21,203,410
per member/per month rate @ # of eligibles	φυ	\$829.83 @ 522 avg elig/mo	\$754.95 @ 1,231 avg elig/mo	\$754.95 @ 1,794 avg elig/mo	: , ,	\$730.78 @ 2,155 avg elig/mo		\$690.64 @ 2,559 avg elig/mo
Fee for Service		\$659	\$2,905	\$3,811	\$4,179	\$4,406	\$4,566	\$4,677
Total Benefit Costs for Waiver Population #2 Benefit Costs for Demonstration Population #3	\$0	\$5,198,051	\$10,941,230	\$16,252,592	\$17,800,040	\$18,897,883	\$20,031,748	\$21,208,087
Insurance payments								
Managed care								
Managed care per member/per month rate @ # of eligibles								
Managed care per member/per month rate @ # of eligibles Fee for Service								
Managed care per member/per month rate @ # of eligibles								
Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #3 Benefit Costs for Demonstration Population #4 Insurance payments								
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Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #3 Benefit Costs for Demonstration Population #4 Insurance payments Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #4	\$21.416.796	\$9.668.631	\$10.941.230	\$16.252.592	\$17.800.040	\$18.897.883	\$20.031.748	\$21.208.087
Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #3 Benefit Costs for Demonstration Population #4 Insurance payments Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #4 Total Benefit Costs (Offsetting beneficiary cost sharing payments) * Premium Payments will be net of cost sharing	\$21,416,796	\$9,668,631	\$10,941,230	\$16,252,592	\$17,800,040	\$18,897,883	\$20,031,748	\$21,208,087
Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #3 Benefit Costs for Demonstration Population #4 Insurance payments Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #4 Total Benefit Costs	\$21,416,796 \$21,416,796	\$9,668,631 \$9,668,631	\$10,941,230 \$10,941,230	\$16,252,592 \$16,252,592	\$17,800,040 \$17,800,040	\$18,897,883	\$20,031,748 \$20,031,748	\$21,208,087 \$21,208,087
Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #3 Benefit Costs for Demonstration Population #4 Insurance payments Managed care per member/per month rate @ # of eligibles Fee for Service Total Benefit Costs for Waiver Population #4 Total Benefit Costs for Waiver Population #4 Total Benefit Costs (Offsetting beneficiary cost sharing payments) * Premium Payments will be net of cost sharing Net Benefit Costs			-					
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2014 HEDIS® AGGREGATE REPORT for Child Health Plan Plus

December 2014

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







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ACKNOWLEDGMENTS AND COPYRIGHTS

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Introduction

The State of Colorado offers its residents a low-cost health insurance plan for qualified children age 18 and younger and pregnant women age 19 and older through its Child Health Plan *Plus* (CHP+) program, also known as Children's Health Insurance Program (CHIP). As of February 2014, Colorado's CHP+ enrollment was 56,540 children and 866 pregnant women. The CHP+ services are coordinated through five health maintenance organizations (HMOs) and providers under the State Managed Care Network (SMCN). Medical services covered by Colorado's CHP+ program include regular check-ups; immunizations; medicinal prescriptions; prenatal care services; hospital services; and some vision, hearing, and dental services.

The CHP+ program is administered by Colorado's Department of Health Care Policy and Financing (the Department). During fiscal year (FY) 2013–2014, the Department contracted with five health plans to deliver health care services. Those health plans include Colorado Access, Colorado Choice Health Plan (Colorado Choice), Denver Health Medical Plan, Inc. (DHMP), Kaiser Permanente Colorado (Kaiser), and Rocky Mountain Health Plans (RMHP). In areas of the State with no managed care coverage, the CHP+ program offers an SMCN program via direct contracts with providers, hospitals, and ancillary services.

To evaluate the quality of health and health care provided by the CHP+ program, the Department implemented Healthcare Effectiveness Data and Information Set (HEDIS®) reporting. HEDIS is the most widely used set of performance measures in the managed care industry. The Department identified a subset of HEDIS measures that each health plan calculated and reported. Each health plan and the SMCN underwent an NCQA HEDIS Compliance AuditTM through a licensed audit organization. All final audit results were submitted to Health Services Advisory Group, Inc. (HSAG), which was contracted by the Department to provide external quality review (EQR) services.

HSAG's scope of work included calculation of a set of performance measures for the SMCN and development of a composite report, combining health plan performance measure data with SMCN data. HSAG objectively analyzed the health plans' and the SMCN's data and evaluated the program's current performance relative to national Medicaid percentiles.

HSAG examined the measures among different domains of care: Pediatric Care, Access to Care, and Use of Services. This approach to the analysis was designed to encourage consideration of the measures as a whole rather than in isolation and to think about the strategic and tactical changes required to improve overall performance.

¹⁻¹ Child Health Plan *Plus*. Available at: http://www.chpplus.org/. Accessed on: August 20, 2014.



Summary of Performance

Figure 1-1 shows the Colorado CHP+ program's performance on 11 measures with a total of 27 indicators¹⁻² compared with national HEDIS 2013 Medicaid percentiles. The bars represent the number of Colorado CHP+ weighted averages falling into each HEDIS percentile range. The percentile range showed how the Colorado CHP+ weighted average ranked nationally. For example, the Colorado CHP+ weighted average for one measure ranked at or above the 90th percentile. This means that the Colorado CHP+ program had one measure with performance in the top 10 percent of all health plans nationally.

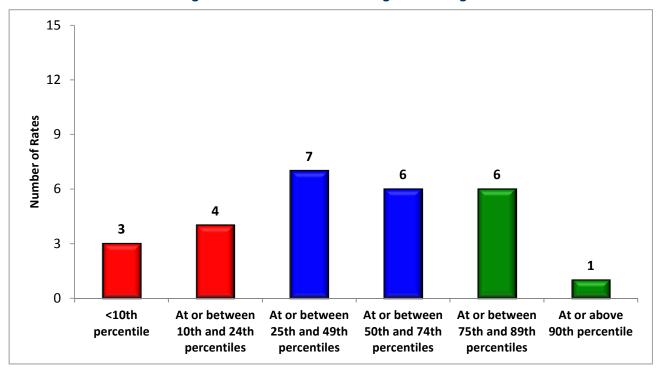


Figure 1-1—Colorado CHP+ Weighted Averages

According to Figure 1-1, 13 indicators performed within national averages (at or between the 25th and 74th percentiles), four performed at or between the 10th and 24th percentiles, and three performed below the 10th percentile. Six of the Colorado CHP+ weighted averages fell at or between the 75th and 89th percentiles, and one fell at or above the 90th percentile.

Table 1-1 presents the CHP+ statewide weighted averages for each measure from HEDIS 2012 to HEDIS 2014. The figures displayed in the comparison column reflect the percentage point difference between the HEDIS 2013 and HEDIS 2014 rates.

¹⁻² Performance measures reported in this graph include all measures in the Pediatric Care and Access to Care domains. *Ambulatory Care* and *Inpatient Utilization* are considered utilization-based measures and not performance measures; therefore, they are not included in this graph.



Table 1-1—Colorado CHP+ Statewide Weighted Averages								
HEDIS Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013– 2014	2013 National Medicaid Percentile Ranking [†]			
Pediatric Care								
Childhood Immunization Status^								
Combination 2	76.73%	58.04%	73.25%	+15.21	25th-49th			
Combination 3	74.50%	55.89%	70.33%	+14.44	25th-49th			
Combination 4	35.36%	51.43%	63.50%	+12.07	50th-74th			
Combination 5	56.16%	44.11%	58.90%	+14.79	50th-74th			
Combination 6	44.54%	36.70%	51.53%	+14.83	75th-89th			
Combination 7	27.37%	41.16%	55.43%	+14.27	50th-74th			
Combination 8	23.73%	34.73%	47.79%	+13.06	75th–89th			
Combination 9	37.01%	30.45%	44.66%	+14.21	75th-89th			
Combination 10	19.62%	28.93%	42.56%	+13.63	75th-89th			
Immunizations for Adolescents—Combination 1	_	_	66.27%	_	25th-49th			
Well-Child Visits in the First 15 Months of Life^								
Zero Visits*	4.21%	2.67%	2.16%	-0.51	75th-89th			
Six or More Visits		25.48%	67.41%	+41.93	50th-74th			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life^		61.26%	66.29%	+5.03	10th-24th			
Adolescent Well-Care Visits^	44.79%	42.09%	44.00%	+1.91	25th-49th			
Weight Assessment and Counseling for Nutrition and Physical A	Activity for	· Children/	'Adolescen	ts				
BMI Assessment: Total	57.50%	68.80%	69.59%	+0.79	50th-74th			
Nutrition Counseling: Total		62.24%	64.47%	+2.23	50th-74th			
Physical Activity Counseling: Total		56.68%	58.26%	+1.58	75th-89th			
Appropriate Testing for Children with Pharyngitis	_	_	79.09%	_	75th-89th			
Follow-up Care for Children Prescribed ADHD Medication	-	-						
Initiation	<u> </u>	_	16.78%	_	<10th			
Continuation	_	_	30.77%	_	10th-24th			
Asthma Medication Ratio—Total	_		73.78%	_	≥90th			
Note: Pates shaded in green with a green font indicate a statistically significant improvement from the prior year								

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 from the prior year.

[—] Is shown when no data were available or the measure was not reported in the HEDIS 2012 or HEDIS 2013 aggregate report.

[†] Since national HEDIS 2013 Medicaid percentiles were not available for the CHIP population, comparison of the CHP+ plans' rates and the SMCN's rates to HEDIS 2013 Medicaid percentiles, which comprised all Medicaid plans, should be interpreted with caution.

[^] Due to the Department's reporting requirement change from an administrative methodology to a hybrid methodology in HEDIS 2014, rate changes between HEDIS 2013 and HEDIS 2014 may not accurately reflect performance changes.

^{*} For the Well-Child Visits in the First 15 Months of Life—Zero Visits indicator, a lower rate indicates better performance. The 2014 percentile ranking listed is based on the original percentile values. When the percentile values are aligned to show a lower rate suggests better performance, the ranking for this indicator would be "10th–24th."



Table 1-1—Colorado CHP+ Statewide Weighted Averages								
HEDIS Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013– 2014	2013 National Medicaid Percentile Ranking [†]			
Access to Care								
Prenatal and Postpartum Care (SMCN Only)								
Timeliness of Prenatal Care	72.26%	78.59%	70.80%	-7.79	10th-24th			
Postpartum Care	67.88%	67.88%	63.26%	-4.62	25th-49th			
Children's and Adolescents' Access to Primary Care Practition	iers							
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			
Use of Services ^{††}								
Ambulatory Care: Total								
Outpatient Visits Per 1,000 MM: Total	224.09	_	214.08	_	<10th			
Emergency Department Visits Per 1,000 MM: Total	27.79	30.07	26.47	-3.60	<10th			
Inpatient Utilization—General Hospital/Acute Care: Total								
Discharges per 1,000 MM (Total Inpatient)	4.05	_	1.23	_	<10th			
Days per 1,000 MM (Total Inpatient)	12.53	_	4.16	_	<10th			
Average Length of Stay (Total Inpatient)	3.09	_	3.37	_	25th-49th			
Discharges per 1,000 MM (Medicine)	1.00	_	0.85	_	<10th			
Days per 1,000 MM (Medicine)	3.05	_	2.38	_	<10th			
Average Length of Stay (Medicine)	3.05	_	2.81	_	<10th			
Discharges per 1,000 MM (Surgery)	0.34	_	0.30	_	<10th			
Days per 1,000 MM (Surgery)	2.17	_	1.56	_	<10th			
Average Length of Stay (Surgery)	6.35	_	5.27	_	25th-49th			
Discharges per 1,000 MM (Maternity)	5.49	_	0.19	_	<10th			
Days per 1,000 MM (Maternity)	14.84	_	0.45	_	<10th			
Average Length of Stay (Maternity)	2.70	_	2.44	_	10th-24th			

For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the plan-submitted file; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Individual plan demographics should be considered when reviewing performance.



A summary of statewide performance for each domain is presented here:

- Pediatric Care—Statewide performance in the pediatric care domain showed rate increases for many measures, though some of the increases could be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology in HEDIS 2014. Significant rate increases were noted for these measures: Childhood Immunization Status (all indicators); Well-Child Visits in the First 15 Months of Life—Six or More Visits; and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. One measure (Asthma Medication Ratio—Total) benchmarked at or above the national Medicaid 90th percentile, and six additional rates benchmarked at or above the 75th percentiles. On the other hand, three measures (Well-Child Visits in the First 15 Months of Life—Zero Visits; Follow-up Care for Children Prescribed ADHD Medication [both indicators] and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life) were below the 25th percentile, suggesting opportunities for improvement.
- Access to Care—Statewide performance in this domain presents significant opportunity for improvement. None of the measures ranked at or above the national HEDIS 2013 Medicaid 50th percentile. Additionally, both indicators under *Prenatal and Postpartum Care* reported rate decreases, with the *Timeliness of Prenatal Care* indicator having a significant decrease of 7.79 percentage points.
- Use of Services—Most of the measures were newly added to the CHP+ HEDIS 2014 reporting set. The *Ambulatory Care: Total—Emergency Department Visits Per 1,000 Member Months* indicator was the only measure with the prior years' rates available. The HEDIS 2014 rate declined by 12 percent (3.6 visits).

Limitations and Considerations

- In general, health plans can choose to report certain measures using the hybrid methodology as allowed by NCQA. However, the Department has identified an acceptable methodology for each selected measure. In HEDIS 2014, the Department changed the reporting requirements from an administrative to a hybrid methodology for several 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;* and *Adolescents Well-Care Visits*). As such, trending of statewide and plan performance may not reflect true performance changes.
- Since national HEDIS 2013 Medicaid percentiles are not available for the CHIP population, comparison of the CHP+ plans' rates and the SMCN's rates to HEDIS 2013 Medicaid percentiles, which comprised all Medicaid plans, should be interpreted with caution.



Overview

This report presents the statewide and plan-specific performance on HEDIS measures selected by the Department for HEDIS 2014. Thirteen HEDIS measures with 41 unique indicators are included in this report. These measures are grouped into three domains of care for Colorado CHP+ members: Pediatric Care, Access to Care, and Use of Services. While performance is reported primarily at the measure/indicator level, grouping these measures into domains encourages health plans and the Department to consider the measures as a whole rather than in isolation and to develop the strategic and tactical changes required to improve overall performance.

Table 2-1 shows the 13 selected measures, the 41 indicators, and the corresponding domain of care. The table also identifies the Department's required data collection method. The data collection or calculation method is specified by NCQA in the *HEDIS 2013 Volume 2 Technical Specifications* (see Appendix C for a brief description).

Table 2-1—Colorado CHP+ HEDIS 2014 Required Measures								
	Standard HEDIS 2014 Measures	2014 Colorado CHP+ Required Measures	Data Collection Methodology					
1.	Childhood Immunization Status	1. Childhood Immunization Status—Combination 2 2. Childhood Immunization Status—Combination 3 3. Childhood Immunization Status—Combination 4 4. Childhood Immunization Status—Combination 5 5. Childhood Immunization Status—Combination 6 6. Childhood Immunization Status—Combination 7 7. Childhood Immunization Status—Combination 8 8. Childhood Immunization Status—Combination 9 9. Childhood Immunization Status—Combination 10						
2.	Well-Child Visits in the First 15 Months of Life	 10. Well-Child Visits in the First 15 Months of Life—Zero Visits 11. Well-Child Visits in the First 15 Months of Life—Six or More Visits 	Hybrid					
3.	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	12. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Hybrid					
4.	Adolescent Well-Care Visits	13. Adolescent Well-Care Visits	Hybrid					
5.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total 	Hybrid					



Table 2-1—Colorado CHP+ HEDIS 2014 Required Measures							
Standard HEDIS 2014 Measures	2014 Colorado CHP+ Required Measures	Data Collection Methodology					
6. Immunizations for Adolescents	17. Immunizations for Adolescents—Combination 1	Hybrid					
7. Appropriate Testing for Children with Pharyngitis	18. Appropriate Testing for Children with Pharyngitis	Administrative					
8. Follow-up Care for Children Prescribed ADHD Medication	19. Follow-Up Care for Children Prescribed ADHD Medication—Initiation	Administrative					
	20. Follow-Up Care for Children Prescribed ADHD Medication—Continuation						
9. Asthma Medication Ratio	21. Asthma Medication Ratio—Total	Administrative					
	Access to Care Domain						
10. Prenatal and Postpartum Care (applicable to SMCN population only)	Prenatal and Postpartum Care—Timeliness of Prenatal Care Prenatal and Postpartum Care—Postpartum Care	Hybrid					
11. Children's and Adolescents' Access to Primary Care Practitioners	 24. Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months 25. Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years 26. Children's and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years 27. Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years 	Administrative					
	Use of Services Domain						
12. Ambulatory Care	28. Ambulatory Care: Total—Outpatient Visits Per 1,000 MM—Total 29. Ambulatory Care: Total—Emergency Department (ED) Visits Per 1,000 MM—Total	Administrative					
13. Inpatient Utilization—General Hospital/Acute Care	30. Discharges per 1,000 MM (Total Inpatient) 31. Days per 1,000 MM (Total Inpatient) 32. Average Length of Stay (Total Inpatient) 33. Discharges per 1,000 MM (Medicine) 34. Days per 1,000 MM (Medicine) 35. Average Length of Stay (Medicine) 36. Discharges per 1,000 MM (Surgery) 37. Days per 1,000 MM (Surgery) 38. Average Length of Stay (Surgery) 39. Discharges per 1,000 MM (Maternity) 40. Days per 1,000 MM (Maternity) 41. Average Length of Stay (Maternity)	Administrative					



Data Sources

Plan-specific performance displayed in this report was based on data elements obtained from the Interactive Data Submission System (IDSS) files or the Excel files supplied by health plans contracted with the Department to provide CHP+ services. For statewide performance, since CHP+ members can obtain services provided by the SMCN program, HSAG collected data elements from two major sources to calculate the statewide rates: (1) HEDIS rates reported by CHP+ health plans, and (2) rates calculated for SMCN members using HEDIS measure specifications.

HEDIS Rates Reported by CHP+ Health Plans

All Colorado CHP+ health plans are required by the Department to have their HEDIS results examined and verified through an NCQA HEDIS Compliance Audit. Therefore, all rates included in this report have been verified as an unbiased estimate of the measure.

Measure Calculation—State Managed Care Network (SMCN)

HSAG's data team used the following steps to calculate the HEDIS 2014 rates for the selected HEDIS measures for the SMCN:

- Identified the necessary data elements: Based on the list of HEDIS measures selected for reporting by the Department, HSAG's data team identified the data elements necessary to generate the HEDIS measures.
- **Obtained SMCN data:** Colorado Access, an administrative services organization (ASO), processed claims, enrollment, provider, pharmacy, and other data for the SMCN as instructed by the Department. HSAG obtained all applicable data from the ASO.
- Formatted data for HEDIS measure calculation: HSAG contracted with a software vendor (IMI Health, Inc.) with full measure certification status with NCQA for calculation of the measures. HSAG prepared the data in the vendor-specified format, validated the data against the raw source data, and forwarded the files to IMI Health.
- Calculated the HEDIS measures: IMI Health calculated the selected HEDIS measures that passed NCQA's measure certification. NCQA certification ensures that the measure calculations are performed in full compliance with NCQA HEDIS technical specifications.
- Reviewed the measure results: Once the HEDIS measure results were available, HSAG staff
 reviewed the results for reasonableness and accuracy; and all rates were audited. This report
 includes those results.

The processes of collecting, storing, and transferring the data required for the measure reporting, as well as the calculated rates, underwent an NCQA HEDIS Compliance Audit; all SMCN rates included in this report have been verified as an unbiased estimate of the measure.



Calculation of Statewide Rates

Although plan rates for each measure can be obtained from the files submitted by health plans, statewide rates require specific calculation using other plan-specific data elements. For all measures, HSAG used the audited results, ²⁻¹ numerator, denominator, rate, and eligible population elements reported in the plan-submitted files to calculate the statewide rate. Because health plans vary in membership, the statewide rate for a measure is essentially the weighted average rate based on the health plan's eligible population. Weighting the rate by the health plan's eligible population size ensures that a rate for a health plan with 125,000 members, for example, has a greater impact on the overall Colorado CHP+ rate than a rate for a health plan with only 10,000 members. For health plans with rates reported as NA, their numerators, denominators, and eligible populations were included in the calculations of the statewide rate. Health plans with rates reported as NB or NR were excluded from the statewide rate calculation.

²⁻¹ Through the audit process, each measure reported by a health plan is assigned an NCQA-defined audit result. Measures can receive one of four predefined audit results: Reportable (R), Small Denominator (<30) (NA), Not Reportable (NR), and Benefit Not Offered (NB). An audit result of R indicates that the health plan complied with all HEDIS specifications to produce an unbiased, reportable rate (or rates), which can be released for public reporting. Although a health plan may have complied with all applicable specifications, the denominator identified may be considered too small to report a valid rate, and the measure would have been assigned an NA audit result. An audit result of NR indicates that the rate could not be publicly reported because the measure deviated from HEDIS specifications such that the reported rate was significantly biased, a health plan chose not to report the measure, or a health plan was not required to report the measure. An NB audit result indicates that the health plan did not offer the benefit required by the measure.



Pediatric Care

The following section provides a detailed analysis of the Colorado CHP+ health plans' and the SMCN's performance for the Pediatric Care domain. Results related to antigen-related indicators under *Childhood Immunization Status* and age-cohort indicators under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* are displayed in Appendices A (Tabular Results) and B (Trend Tables).

The Pediatric Care domain encompasses the following nine measures with a total of 21 indicators:

- Childhood Immunization Status (all individual antigens and Combination 2—Combination 10)
- Immunizations for Adolescents—Combination 1
- Well-Child Visits in the First 15 Months of Life (Zero Visits and Six or More Visits)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visits
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Total (Body Mass Index [BMI] Assessment, Nutrition Counseling, and Physical Activity Counseling)
- Appropriate Testing for Children with Pharyngitis
- Follow-up Care for Children Prescribed ADHD Medication (Initiation and Continuation)
- ◆ Asthma Medication Ratio—Total

With the exception of the *Childhood Immunization Status* measure, a graph depicting the yearly comparison of the weighted averages is presented for each of the Pediatric Care measures/indicators. Where appropriate, a horizontal bar graph compares the health plan's performance relative to the HEDIS 2014 weighted average as well as the high and low performance levels. Since national HEDIS 2013 Medicaid percentiles are not available for the CHIP population, comparison of the CHP+ plans and the SMCN's rates to the national HEDIS 2013 Medicaid HMO percentiles, which comprised all Medicaid plans, should be interpreted with caution. For most of the measures, high performance level (HPL) corresponds to the 90th percentile and the low performance level (LPL) to the 25th percentile. For inverse measures such as *Well-Child Visits in the First 15 Months of Life—Zero Visits*, the 10th percentile (rather than the 90th percentile) and the 75th percentile (rather than the 25th percentile) are considered the HPL and LPL, respectively.

For measures required to use the hybrid data collection method, the ADMIN% column presented with each horizontal bar graph displays the percentage of the rate derived from administrative data (e.g., claims data and immunization registry). This percentage describes the level of claims/encounter data completeness of a CHP+ health plan for calculating a particular measure. A low percentage suggests that the plan is relying heavily on medical records to report the rate. Conversely, a high percentage indicates that the plan's claims/encounter data are relatively complete for use in calculating the measure.



Childhood Immunization Status

Measure Definitions

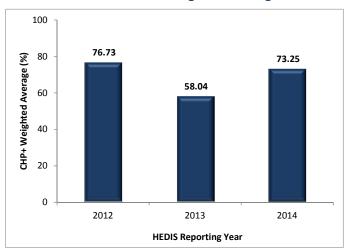
Childhood Immunization Status calculates the percentage of children who turned two years of age during the measurement year and who were identified as having the following vaccinations on or before the child's second birthday. Table 3-1 displays the different antigens associated with various combinations.

Table 3-1—Combination Vaccinations for Childhood Immunization Status										
Combination	Four DTaP	Three IPV	One MMR	Three HiB	Three Hep B	One VZV	Four PCV	One Hep A	Required RV	Two Influenza
Combination 2	✓	✓	✓	✓	✓	✓				
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 4	✓	✓	✓	✓	✓	✓	✓	✓		
Combination 5	✓	✓	✓	✓	✓	✓	✓		✓	
Combination 6	✓	✓	✓	✓	✓	✓	✓			✓
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 8	✓	✓	✓	✓	✓	✓	✓	✓		✓
Combination 9	✓	✓	✓	✓	✓	✓	✓		✓	✓
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓



Performance Results

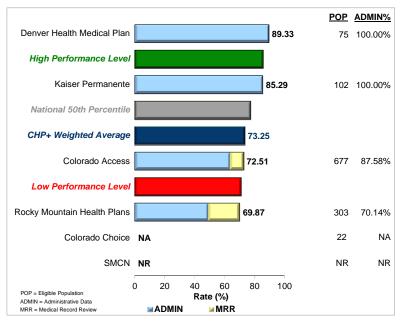
Figure 3-1—Childhood Immunization Status—Combination 2
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 2 includes four diphtheria, tetanus, and acellular pertussis (DtaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); and one chicken pox (VZV) vaccines.

The 2014 statewide rate showed a significant increase of 15.21 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

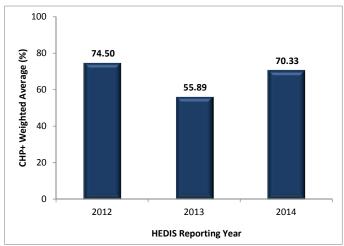
Figure 3-2—Childhood Immunization Status—Combination 2



Three of the five plans reported a valid rate for this indicator. One plan ranked above the high performance level, and one ranked below the low performance level. The CHP+ weighted average performed between the national 50th percentile and the low performance level. Plan performance varied by about 20 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 70 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



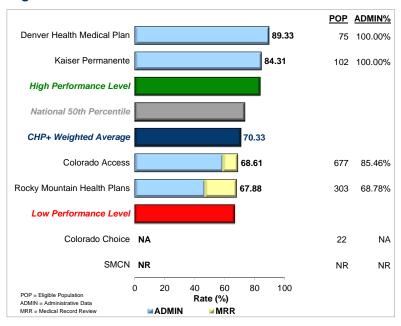
Figure 3-3—Childhood Immunization Status—Combination 3
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 3 includes four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines.

The 2014 statewide rate showed a significant increase of 14.44 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

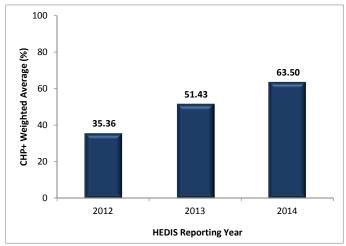
Figure 3-4—Childhood Immunization Status—Combination 3



Three of the five plans reported a valid rate for this indicator. Two plans ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average performed between the national 50th percentile and the low performance level. Plan performance varied by 21.45 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 65 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



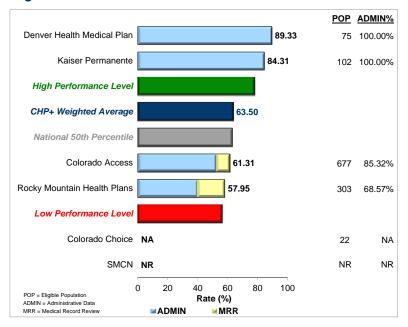
Figure 3-5—Childhood Immunization Status—Combination 4
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 4 includes four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); and one hepatitis A (HepA) vaccine.

The 2014 statewide rate showed a significant increase of 12.07 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

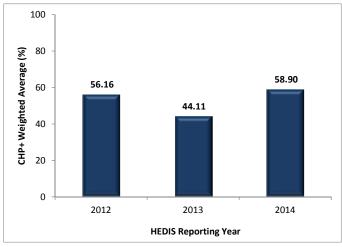
Figure 3-6—Childhood Immunization Status—Combination 4



Three of the five plans reported a valid rate for this indicator. Two plans ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average performed above the national 50th percentile. Plan performance varied by 31.38 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 65 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



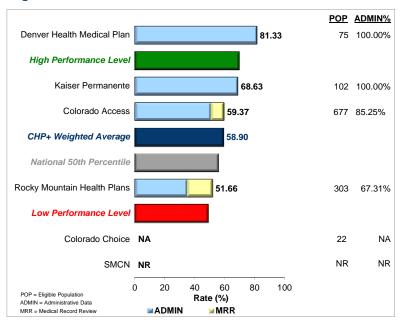
Figure 3-7—Childhood Immunization Status—Combination 5
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 5 includes four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); and two or three rotavirus (RV) vaccines.

The 2014 statewide rate showed a significant increase of 14.79 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

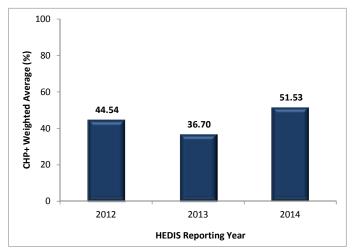
Figure 3-8—Childhood Immunization Status—Combination 5



Three of the five plans reported a valid rate for this indicator. One plan ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average and all plans except one had rates above the national 50th percentile. Plan performance varied by 29.67 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 65 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



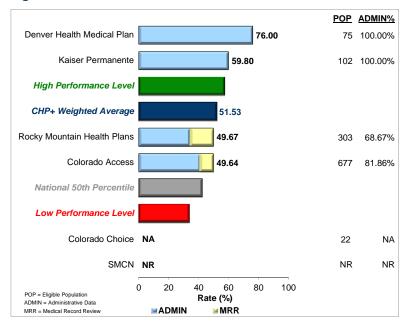
Figure 3-9—Childhood Immunization Status—Combination 6
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 6 includes four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); and two influenza (flu) vaccines.

The 2014 statewide rate showed a significant increase of 14.83 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

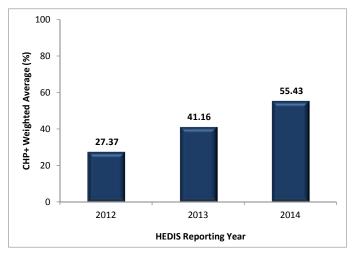
Figure 3-10—Childhood Immunization Status—Combination 6



Three of the five plans reported a valid rate for this indicator. Two plans ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average and all other plans had rates above the national 50th percentile. Plan performance varied by 26.36 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 65 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



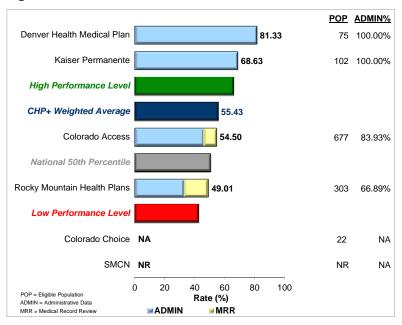
Figure 3-11—Childhood Immunization Status—Combination 7
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 7 includes four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA) vaccine; and two or three rotavirus (RV) vaccines.

The 2014 statewide rate showed a significant increase of 14.27 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

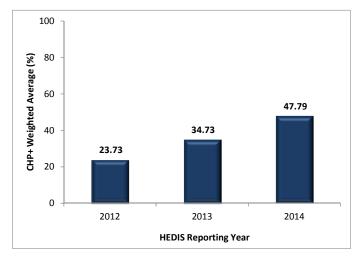
Figure 3-12—Childhood Immunization Status—Combination 7



Three of the five plans reported a valid rate for this indicator. Two plans ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average and all but one plan had rates above the national 50th percentile. Plan performance varied by 32.32 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 65 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



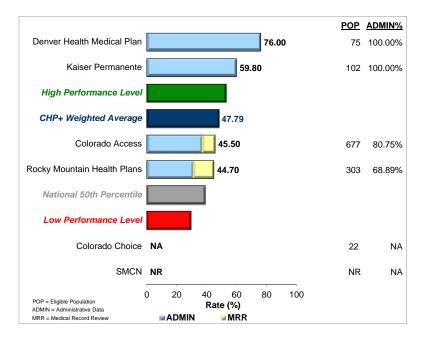
Figure 3-13—Childhood Immunization Status—Combination 8
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 8 includes four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA) vaccine; and two influenza (flu) vaccines.

The 2014 statewide rate showed a significant increase of 13.06 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

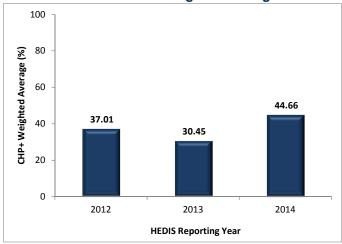
Figure 3-14—Childhood Immunization Status—Combination 8



Three of the five plans reported a valid rate for this indicator. Two plans ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average and all other plans performed had rates the national 50th percentile. Plan performance varied by 31.3 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 65 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



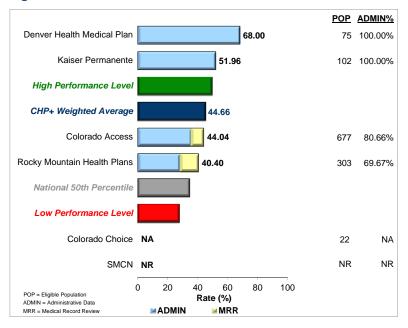
Figure 3-15—Childhood Immunization Status—Combination 9
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 9 includes four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two or three rotavirus (RV); and two influenza (flu) vaccines.

The 2014 statewide rate showed a significant increase of 14.21 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

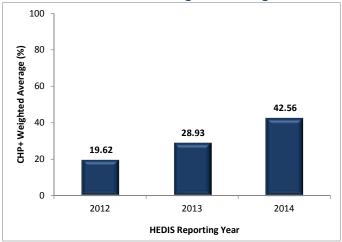
Figure 3-16—Childhood Immunization Status—Combination 9



Three of the five plans reported a valid rate for this indicator. Two plans ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average and all other plans had rates above the national 50th percentile. Plan performance varied by 27.6 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 65 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



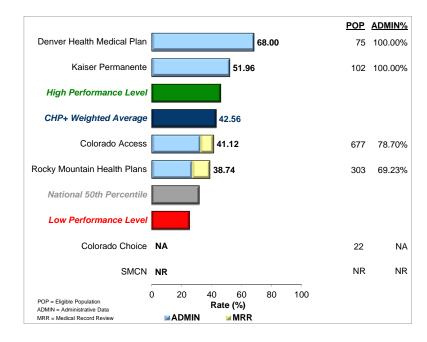
Figure 3-17—Childhood Immunization Status—Combination 10
Colorado CHP+ Weighted Averages



Rate increase from 2013 to 2014 was statistically significant. Combination 10 includes four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA) vaccine; two or three rotavirus (RV); and two influenza (flu) vaccines.

The 2014 statewide rate showed a significant increase of 13.63 percentage points from 2013. This increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

Figure 3-18—Childhood Immunization Status—Combination 10



Three of the five plans reported a valid rate for this indicator. Two plans ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average and all other plans had rates above the national 50th percentile. Plan performance varied by 29.26 percentage points. The ADMIN% column within the figure showed that all plans relied mostly on claims data (at least 65 percent) to calculate their rates, with two reporting rates exclusively from administrative data.



Immunizations for Adolescents

The *Immunizations for Adolescents* measure assesses the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate (*Combination 1*). This measure was newly added to the Department's HEDIS 2014 reporting set as a required measure for all plans except SMCN; no rate trending was performed. The HEDIS 2014 statewide rate for *Combination 1* was 66.27 percent. Figure 3-19 displays the ranking of statewide and plan rates relative to the national HEDIS 2013 Medicaid percentiles.

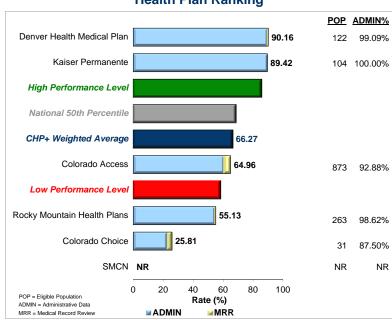


Figure 3-19—Immunizations for Adolescents—Combination 1
Health Plan Ranking

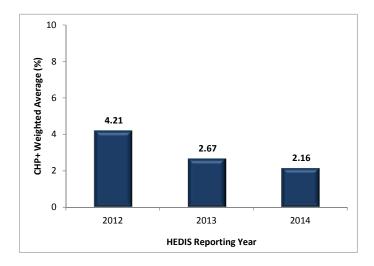
Two plans ranked above the high performance level, and two ranked below the low performance level. The CHP+ weighted average fell slightly below the national 50th percentile. Plan performance varied by 64.35 percentage points. All plans used at least 85 percent of their administrative data to calculate this indicator, which suggests that all plans had relatively complete administrative data when calculating this indicator.



Well-Child Visits in the First 15 Months of Life

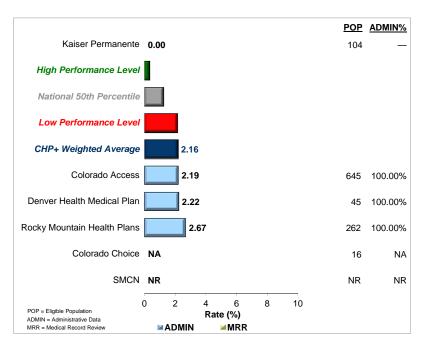
Well-Child Visits in the First 15 Months of Life calculates the percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled in the health plan from 31 days of age through 15 months of age, and who received zero, one, two, three, four, five, or six or more visits with a primary care practitioner (PCP) during their first 15 months of life. This measure was required for HEDIS 2014 reporting for all plans except SMCN. Rates for the zero and six or more visits are presented here. Rates for all other indicators are displayed in Appendices A and B.

Figure 3-20—Well-Child Visits in the First 15 Months of Life—
Zero Visits
Colorado CHP+ Weighted Averages



For this measure, a lower rate indicates better performance. The HEDIS 2014 weighted average declined slightly (0.51 percentage points) from 2013. The decline (an indication of performance improvement) was not statistically significant. Additionally, the decline may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

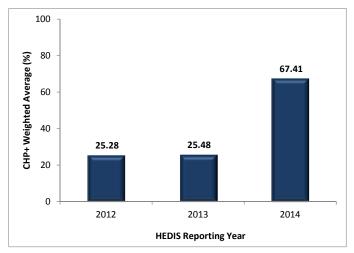
Figure 3-21—Well-Child Visits in the First 15 Months of Life
—Zero Visits



For this measure, a lower rate indicates better performance. One plan performed above the high performance level, but the rates for all other plans and the CHP+ weighted average were below the low performance level. Plan performance varied by 2.67 percentage points.

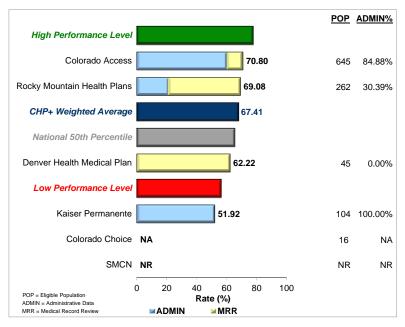


Figure 3-22—Well-Child Visits in the First 15 Months of Life
—Six or More Visits
Colorado CHP+ Weighted Averages



The HEDIS 2014 weighted average increased significantly (41.93 percentage points) from 2013. The increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

Figure 3-23—Well-Child Visits in the First 15 Months of Life
—Six or More Visits



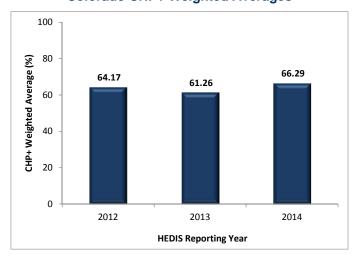
The CHP+ weighted average and two plans had rates above the national 50th percentile. One plan performed below the low performance level. Interestingly, the highest-performing plan for the zero visits indicator was the lowest-performing plan for the 6+ visits indicator. None of the plans met the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) participation goal of 80 percent. Plan performance varied by 18.88 percentage points. There was also a wide variation in the number of well-child visits identified from claims data (from 0 percent to 100 percent), which suggests that some plans had more complete claims/encounter data to calculate the rates than others.



Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

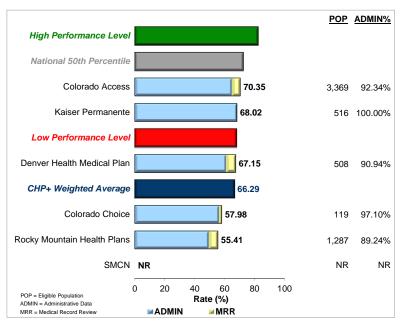
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life calculates the percentage of members who were three, four, five, or six years old during the measurement year, who were continuously enrolled during the measurement year, and who received one or more well-child visits with a PCP during the measurement year. This measure was required for HEDIS 2014 reporting for all plans except SMCN.

Figure 3-24—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Colorado CHP+ Weighted Averages



The HEDIS 2014 weighted average increased significantly (5.03 percentage points) from 2013. The increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

Figure 3-25—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



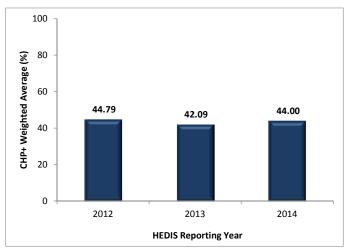
None of the plans performed at or above the national 50th percentile. Two plans ranked at or above the low performance level. The CHP+ weighted average and rates for three other plans were below the low performance level. Plan performance varied by 14.94 percentage points. All plans relied mostly on claims data (at least 85 percent) to calculate their rates. This finding suggests that, unlike the *Well-Child Visits in the First 15 Months* measure, all plans had relatively more complete administrative data to calculate this measure.



Adolescent Well-Care Visits

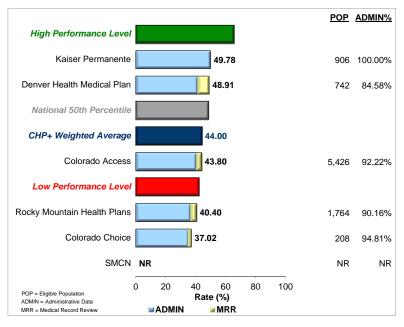
Adolescent Well-Care Visits reports the percentage of enrolled members who were 12 to 21 years of age during the measurement year, continuously enrolled during the measurement year, and had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) during the measurement year. This measure was required for HEDIS 2014 reporting for all plans except SMCN.

Figure 3-26—Adolescent Well-Care Visits
Colorado CHP+ Weighted Averages



The HEDIS 2014 weighted average increased slightly (1.91 percentage points) from 2013, though the increase was not statistically significant. The increase may be related to a change in the Department's reporting requirement from an administrative to a hybrid methodology and may not reflect true performance improvement.

Figure 3-27—Adolescent Well-Care Visits



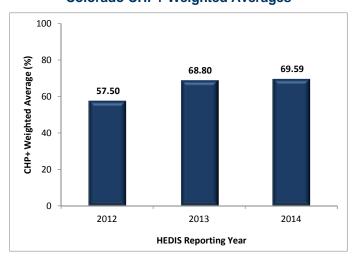
Two plans performed above the national 50th percentile, but two performed below the low performance level. The CHP+ weighted average exceeded the low performance level. None of the plans met the federal EPSDT participation goal of 80 percent. Plan performance varied by 12.76 percentage points. All plans relied mostly on claims data (at least 80 percent) to calculate their rates, which suggests that all plans had relatively complete administrative data.



Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

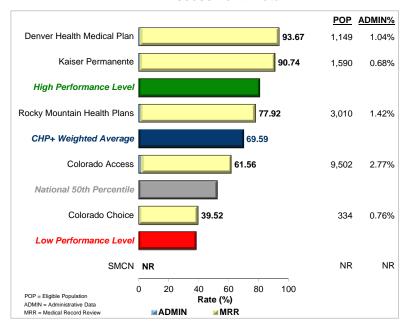
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) calculates the percentage of enrolled members between 3 and 17 years of age, who were continuously enrolled for the measurement year, had an outpatient visit with a PCP or OB/GYN, and had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year. This measure was required for HEDIS 2014 reporting for all plans except SMCN.

Figure 3-28—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
—BMI Assessment: Total
Colorado CHP+ Weighted Averages



The weighted average for the *BMI Assessment: Total* indicator has shown steady improvement over the past few years. The HEDIS 2014 rate increased 0.79 percentage point from 2013. This increase was not statistically significant.

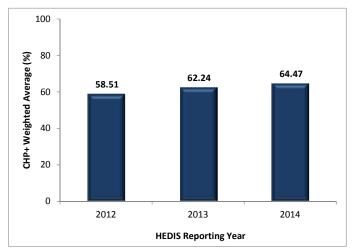
Figure 3-29—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
—BMI Assessment: Total



Two health plans performed above the high performance level, and none performed below the low performance level. The CHP+ weighted average ranked between the high performance level and the national 50th percentile. Plan performance varied by 54.15 percentage points. All plans relied almost exclusively on medical records when calculating their rates, suggesting incomplete claims/encounter data.

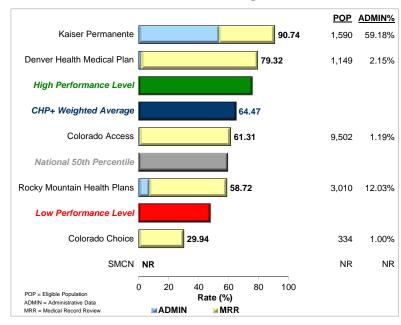


Figure 3-30—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
—Nutrition Counseling: Total
Colorado CHP+ Weighted Averages



The 2014 weighted average for the *Nutrition Counseling—Total* indicator has shown steady improvement. The rate increased by 2.23 percentage points from 2013. The increase was not statistically significant.

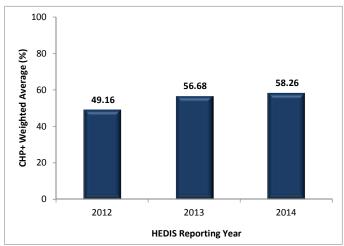
Figure 3-31—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Nutrition Counseling: Total



Two plans ranked above the high performance level, and one plan ranked below the low performance level. The CHP+ weighted average ranked between the high performance level and the national 50th percentile. Plan performance varied by 60.8 percentage points. The use of administrative data by the plans, as displayed in the ADMIN% column, varied widely (from 1 percent to 59.18 percent). This finding suggests that not all plans have complete claims/encounter data to calculate this indicator.

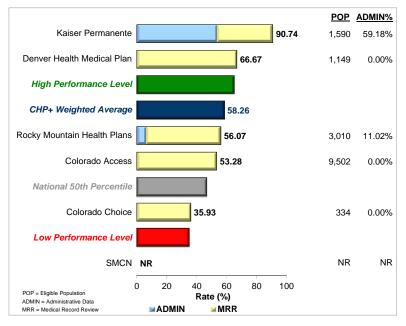


Figure 3-32—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
—Physical Activity Counseling: Total
Colorado CHP+ Weighted Averages



The 2014 weighted average for the *Physical Activity Counseling—Total* indicator has shown continuous improvement. The rate improved 1.58 percentage points from 2013. The increase was not statistically significant.

Figure 3-33—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Physical Activity Counseling: Total



Two plans ranked above the high performance level, and none ranked below the low performance level. The CHP+ weighted average ranked between the high performance level and the national 50th percentile. Plan performance varied by 54.81 percentage points. The use of administrative data by the plans, as displayed in the ADMIN% column, varied widely: three plans relied solely on medical records, while one relied more on administrative data (nearly 60 percent) to calculate the rate. This finding suggests that not all plans have complete claims/encounter data to calculate this indicator.



Appropriate Testing for Children With Pharyngitis

The Appropriate Testing for Children with Pharyngitis measure is used to calculate the percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing). This measure was newly added to the Department's HEDIS 2014 reporting set as a required measure for all plans except SMCN; no rate trending was performed. The HEDIS 2014 statewide rate was 79.09 percent. Figure 3-34 displays the ranking of statewide and plan rates relative to the national HEDIS 2013 Medicaid percentiles.

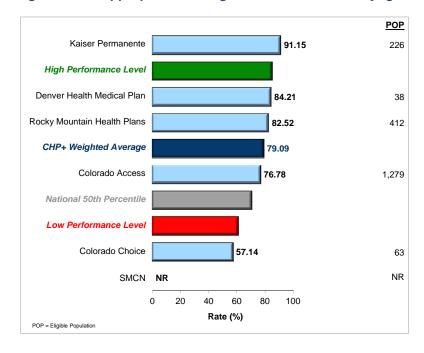


Figure 3-34—Appropriate Testing for Children with Pharyngitis

One plan ranked above the high performance level, and one ranked below the low performance level. The CHP+ weighted average ranked between the high performance level and the national 50th percentile. Plan performance varied by 34.01 percentage points.



Follow-up Care for Children Prescribed ADHD Medication

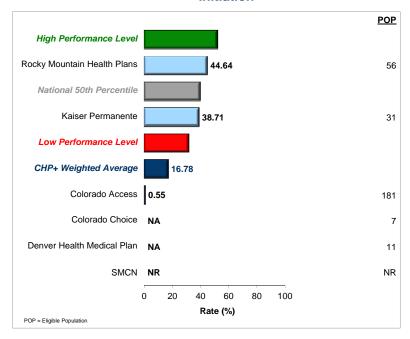
The Follow-up Care for Children Prescribed ADHD Medication measure is used to calculate the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- Initiation Phase. The percentage of eligible members who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
- Continuation and Maintenance (C&M) Phase. The percentage of eligible members who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase and had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

This measure was newly added to the Department's HEDIS 2014 reporting set as a required measure for all plans except SMCN; no rate trending was performed. The HEDIS 2014 statewide rates were 16.78 percent for the Initiation Phase and 30.77 percent for the Continuation and Maintenance Phase, respectively. Figure 3-35 and Figure 3-36 display the ranking of statewide and plan rates relative to the national HEDIS 2013 Medicaid percentiles for these indicators.

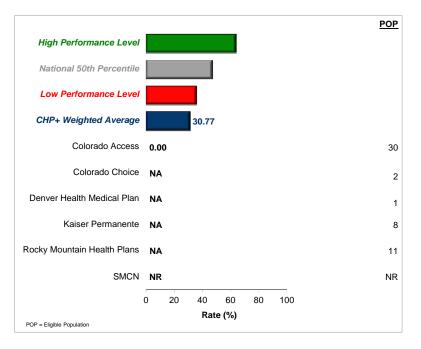


Figure 3-35—Follow-up Care for Children Prescribed ADHD Medication
—Initiation



Three plans reported a valid rate for the Initiation indicator. One plan ranked above the national 50th percentile, and another plan ranked above the low performance level. The CHP+ weighted average fell below the low performance level. Plan performance varied more than 40 percentage points (44.09 percentage points).

Figure 3-36—Follow-up Care for Children Prescribed ADHD Medication
—Continuation



For the Continuation indicator, only one plan reported a valid rate, which fell below the low performance level. The CHP+ weighted average also fell below the low performance level.



Asthma Medication Ratio

The Asthma Medication Ratio measure assesses the percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. This measure was newly added to the Department's HEDIS 2014 reporting set as a required measure for all plans except SMCN; no rate trending was performed. The HEDIS 2014 statewide rate for all ages was 73.78 percent. Figure 3-37 displays the ranking of statewide and plan rates relative to the national HEDIS 2013 Medicaid percentiles for the Asthma Medication Ratio—Total indicator.

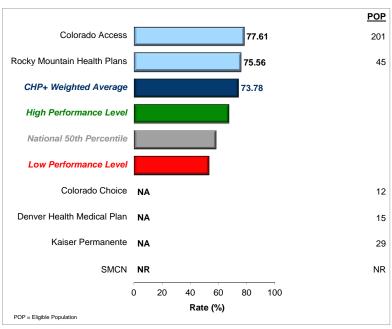


Figure 3-37—Asthma Medication Ratio—Total

Two plans reported a valid rate for the *Total* indicator and ranked above the high performance level. The CHP+ weighted average was also above the high performance level. Plan performance varied by 2.05 percentage points.



Summary of Findings

Table 3-2 presents the health plans' performance rating for each of the measures in the Pediatric Care domain. Performance ratings are assigned by comparing the plans' HEDIS 2014 rates to the HEDIS 2013 Medicaid benchmarks across five categories (from ★ representing *Poor Performance* to ★★★★ representing *Excellent Performance*). Details about the performance ratings are found in Appendix C. SMCN was not required to report any measures in this domain. Plan performance was generally weakest in measures related to well-child visits.

Table 3-2—Ped	iatric Care M	easure-Spec	ific Perform	ance Ratings	5	
Measure	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	SMCN
Childhood Immunization Status						
Combination 2	***	NA	****	****	**	NR
Combination 3	***	NA	****	****	***	NR
Combination 4	***	NA	****	****	***	NR
Combination 5	***	NA	****	****	***	NR
Combination 6	****	NA	****	****	****	NR
Combination 7	***	NA	****	****	***	NR
Combination 8	****	NA	****	****	***	NR
Combination 9	****	NA	****	****	***	NR
Combination 10	****	NA	****	****	****	NR
Immunizations for Adolescents— Combination 1	***	*	****	****	**	NR
Well-Child Visits in the First 15 Month	is of Life		<u> </u>			
Zero Visits	**	NA	**	****	**	NR
Six or More Visits	***	NA	***	**	***	NR
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	***	*	**	***	*	NR
Adolescent Well-Care Visits	***	*	***	***	**	NR
Weight Assessment and Counseling for	Nutrition an	d Physical Ac	ctivity for Chi	ldren/Adoleso	cents	<u> </u>
BMI Assessment: Total	***	***	****	****	****	NR
Nutrition Counseling: Total	***	*	****	****	***	NR
Physical Activity Counseling: Total	***	***	****	****	****	NR
Appropriate Testing for Children with Pharyngitis	***	**	****	****	****	NR
Follow-up Care for Children Prescribe	ed ADHD Me	dication				
Initiation	*	NA	NA	***	***	NR
Continuation	*	NA	NA	NA	NA	NR
Asthma Medication Ratio—Total	****	NA	NA	NA	****	NR



Table 3-3 presents a summary of the health plans' overall performance for the Pediatric Care measures.

Tabl	Table 3-3—Pediatric Care: Plan-Specific Count of Measures by Performance Ratings					
Health Plan Name	****	***	***	**	*	NA/NR/NB
Colorado Access	1	4	13	1	2	0
Colorado Choice	0	0	2	1	4	14
DHMP	13	1	2	2	0	3
Kaiser	13	2	3	1	0	2
RMHP	1	5	9	4	1	1
SMCN	0	0	0	0	0	21

Kaiser and DHMP were the top-performing CHP+ health plans in the Pediatric Care domain; both had 13 rates receiving five-star ratings (rates above the national HEDIS 2013 Medicaid 90th percentile). Colorado Choice had four rates receiving one-star ratings (rates below the national 10th percentile). Overall, performance ratings among the CHP+ health plans varied widely.

Access to Care

The following pages provide an analysis of the measures under the Access to Care domain.

The Access to Care domain encompasses the following measures:

- Prenatal and Postpartum Care (Timeline of Prenatal Care and Postpartum Care)
- Children's and Adolescents' Access to Primary Care Practitioners (Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years)

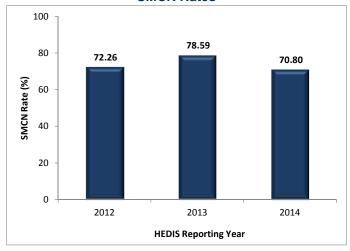
SMCN was required to report the *Prenatal and Postpartum Care* measure, and all other plans were required to report the *Children's and Adolescents' Access to Primary Care Practitioners* measure.



Timeliness of Prenatal Care

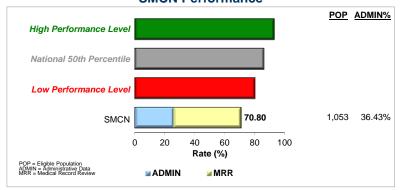
The *Timeliness of Prenatal Care* measure calculates the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery, and who received a prenatal care visit as a member of the health plan in the first trimester or within 42 days of enrollment in the health plan. For this measure, the SMCN is the only reporting plan; therefore, a weighted average was not calculated.

Figure 3-38—Prenatal and Postpartum Care
—Timeliness of Prenatal Care
SMCN Rates



The SMCN's 2014 rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* decreased significantly by 7.79 percentage points from 2013.

Figure 3-39—Prenatal and Postpartum Care
—Timeliness of Prenatal Care
SMCN Performance



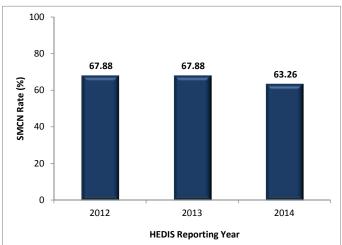
The SMCN's rate performed below the low performance level. Slightly less than two-thirds of this rate was derived from medical records.



Postpartum Care

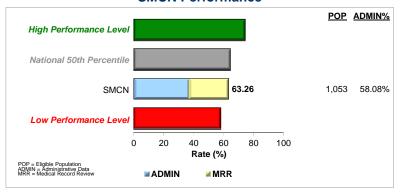
The *Postpartum Care* measure reports the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery, and who received a postpartum visit on or between 21 days and 56 days after delivery.

Figure 3-40—Prenatal and Postpartum Care—Postpartum Care
SMCN Rates



The SMCN's 2014 rate for *Prenatal and Postpartum Care—Postpartum Care* decreased 4.62 percentage points from 2013. This decline was not statistically significant.

Figure 3-41—Prenatal and Postpartum Care—Postpartum Care
SMCN Performance



The SMCN rate was slightly below the national 50th percentile. Slightly over 40 percent of the rate was based on medical records.

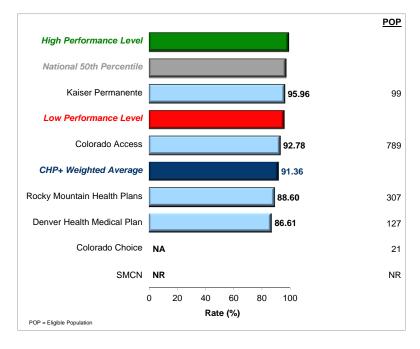


Children's and Adolescents' Access to Primary Care Practitioners

Children's and Adolescents' Access to Primary Care Practitioners calculates the percentage of children 12 to 24 months and 25 months to 6 years who had a visit with a PCP during the measurement year and children 7 to 11 years and adolescents 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year. This measure is reported in four age groups: 12 to 24 months, 25 months to 6 years, 7 to 11 years, and 12 to 19 years. This measure was added to the Department's HEDIS 2014 reporting set for all plans except SMCN; no trending was performed. The statewide rates for these age groups were 91.36 percent, 82.41 percent, 89.16 percent, and 88.60 percent, respectively. Figure 3-42 through Figure 3-45 display the ranking of statewide and plan rates relative to the national HEDIS 2013 Medicaid percentiles for each indicator.

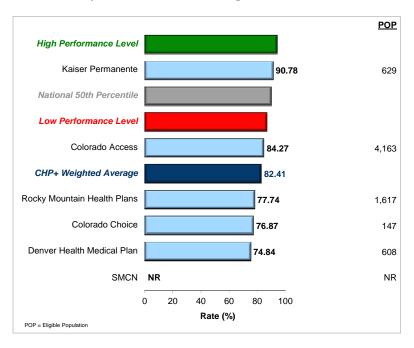


Figure 3-42—Children's and Adolescents' Access to Primary Care Practitioners: Ages 12 to 24 Months



Four plans reported a valid rate for this age group, with one plan performing above the low performance level. The CHP+ weighted average also ranked below the low performance level. Plan performance varied by 9.35 percentage points.

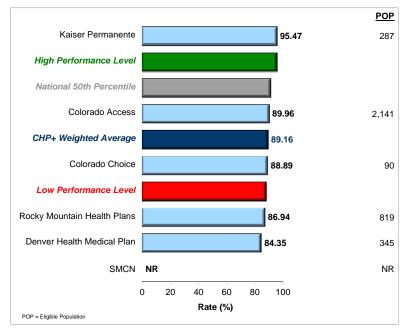
Figure 3-43—Children's and Adolescents' Access to Primary Care Practitioners: Ages 25 Months to 6 Years



One plan performed above the low performance level. The CHP+ weighted average ranked below the low performance level. Plan performance varied by 15.94 percentage points.

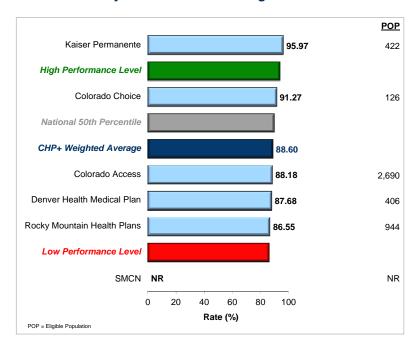


Figure 3-44—Children's and Adolescents' Access to Primary Care Practitioners: Ages 7 to 11 Years



Three plans performed above the low performance level. The CHP+ weighted average also ranked above the low performance level. Plan performance varied by 11.12 percentage points.

Figure 3-45—Children's and Adolescents' Access to Primary Care Practitioners: Ages 12 to 19 Years



Statewide and plan performance was the strongest for this age group. One plan performed above the high performance level, and another plan performed above the national 50th percentile. The CHP+ weighted average ranked slightly below the national 50th percentile. Plan performance varied by 9.42 percentage points.



Findings

Summary of Findings

Table 3-4 presents a summary of the plans' performance on the two measures under the Access to Care domain. The *Children's and Adolescents' Access to Primary Care Practitioners* measure was the only measure with more than one plan reporting the rates. For this measure, plan performance was weakest in the younger age groups (Ages 12 to 24 Months and Ages 25 Months to 6 Years).

Table 3-4—Individual Access to Care Performance Summary by Measure						
Measure	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	SMCN
Prenatal and Postpartum Care (SM	ACN Only)					
Timeliness of Prenatal Care	NR	NR	NR	NR	NR	**
Postpartum Care	NR	NR	NR	NR	NR	***
Children's and Adolescents' Acces	s to Primary	Care Practii	tioners			
Ages 12 to 24 Months	**	NA	*	***	*	NR
Ages 25 Months to 6 Years	**	*	*	***	*	NR
Ages 7 to 11 Years	***	***	**	****	**	NR
Ages 12 to 19 Years	***	***	***	****	***	NR

Table 3-5 presents a summary of the health plans' overall performance for the Access to Care measures.

Table 3-5—Access to Care Star Ratings Summary						
Health Plan Name	****	****	***	**	*	NA/NR/NB
Colorado Access	0	0	2	2	0	2
Colorado Choice	0	0	2	0	1	3
Denver Health Medical Plan	0	0	1	1	2	2
Kaiser Permanente	2	0	2	0	0	2
Rocky Mountain Health Plans	0	0	1	1	2	2
SMCN	0	0	1	1	0	4

Kaiser was the top-performing plan in this domain, with two measures receiving five-star ratings (at or above the national Medicaid HEDIS 2013 90th percentile). None of the other plans reporting rates in this domain above the 75th percentile. Denver Health Medical Plan and Rocky Mountain Health Plans both had two rates performing below the national 10th percentile.



Use of Services

For all measures in this domain, HEDIS methodology requires that the rates be derived using only the administrative method. The Use of Services domain encompasses the following measures:

- Ambulatory Care: Total (Outpatient Visits and Emergency Department Visits)
- Inpatient Utilization—General Hospital/Acute Care: Total

All plans except the SMCN were required to report these measures in HEDIS 2014. The plan's member months (MM) served as an eligible population proxy and were used to derive the weight when calculating the Colorado CHP+ weighted average. Table 3-6 displays the member months for each health plan and the CHP+ program. The largest contributions of member months came from children between 1 and 9 years of age and between 10 and 19 years of age.

	Table 3-6—Colorado CHP+ Member Months for Calendar Year 2013						
Age	Colorado Access	Colorado Choice	DHMP	Kaiser	RMHP	SMCN	Total CHP+
< 1	16,102	509	1,671	2,491	4,063	NR	24,836
1–9	245,527	8,829	33,950	44,242	66,528	NR	399,076
10–19	219,396	8,633	29,682	42,963	53,798	NR	354,472
20–44	28	0	35	0	4	NR	67
45–64	0	0	0	0	0	NR	0
65+	0	0	0	0	0	NR	0
Unknown	0	0	0	0	0	NR	0
Total	481,053	17,971	65,338	89,696	124,393	NR	778,451

Appendix A displays the utilization rates of the selected measures for each health plan and the CHP+ program.



Ambulatory Care

The *Ambulatory Care: Total* measure summarizes utilization of ambulatory care for outpatient visits and emergency department (ED) visits. Table 3-7 shows the total number of these visits per 1,000 member months (MM).

Table 3-7—Ambulatory Care: Total Visits Per 1,000 MM for Total Age Group				
		Emergency Department Visits		
Colorado Access	239.95	30.97		
Colorado Choice	189.86	19.09		
Denver Health Medical Plan	111.45	29.68		
Kaiser Permanente	163.04	10.69		
Rocky Mountain Health Plans	208.28	19.82		
SMCN	NR	NR		
2014 Colorado CHP+ Weighted Average	214.08	26.47		
2013 Colorado CHP+ Weighted Average	_	30.07		
2012 Colorado CHP+ Weighted Average	224.09	27.79		

Findings

The Ambulatory Care: Total—Emergency Department (ED) Visits Per 1,000 MM—Total indicator was the only indicator with prior years' rates available for yearly comparison. The CO CHP+ weighted average for the ED visits decreased from 2013 by 3.6 visits (12 percent). Plan visit rates varied from 10.69 visits to 30.97 visits. For outpatient visits, plan rates varied from 111.45 to 239.95 visits.

The report presents rates for measures in the Use of Services domain for informational purposes only. The rates do not indicate the quality and timeliness of, and access to, care and services. Exercise caution in connecting these data to the efficacy of the program because many factors influence these data.

HSAG recommends that health plans review their Use of Services results and identify whether a rate is higher or lower than expected. Focused analysis related to the Use of Services domain could help identify key drivers associated with the rates.

Inpatient Utilization

The Inpatient Utilization—General Hospital/Acute Care measure summarizes utilization of acute inpatient care and services in four categories: Total Inpatient, Maternity, Surgery, and Medicine. This measure was required for CHP+ HEDIS 2014 reporting for all plans except the SMCN. For



each of these categories Statewide and plan rates are presented below for all eligible ages on the following metrics:

- Discharges Per 1,000 MM
- Days Per 1,000 MM
- Average Length of Stay

Rates for specific age groups are presented in Appendix A.

Performance Results

Table 3-8 shows the total inpatient, medicine, surgery, and maternity discharges per 1,000 MM for the total age group. HEDIS 2012 weighted averages are available for comparison.

Table 3-8—Inpatient Utilization—General Hospital/Acute Care: Total Discharges Per 1,000 MM for Total Age Group					
Health Plan Name	Total Inpatient	Medicine	Surgery	Maternity	
Colorado Access	1.42	0.97	0.33	0.25	
Colorado Choice	1.06	0.39	0.39	0.23	
Denver Health Medical Plan	1.01	0.81	0.17	0.07	
Kaiser Permanente	0.78	0.58	0.13	0.14	
Rocky Mountain Health Plans	0.98	0.64	0.34	0.02	
SMCN	NR	NR	NR	NR	
2014 Colorado CHP+ Weighted Average	1.23	0.85	0.30	0.19	
2013 Colorado CHP+ Weighted Average	_	_	_	_	
2012 Colorado CHP+ Weighted Average	4.05	1.00	0.34	5.49	

Overall, the 2014 Colorado Medicaid weighted average for the four types of services showed a decline in the number of discharges from the 2012 rates. Plan rate variation in discharges was smallest in the Maternity category and largest in the Total Inpatient category.

Table 3-9 shows the total inpatient, medicine, surgery, and maternity days per 1,000 MM for the total age group. HEDIS 2012 weighted averages are available for comparison.

Table 3-9—Inpatient Utilization—General Hospital/Acute Care: Total Days Per 1,000 MM for Total Age Group					
Health Plan Name	Total Inpatient	Medicine	Surgery	Maternity	
Colorado Access	5.22	2.85	2.10	0.61	
Colorado Choice	2.89	1.28	1.28	0.35	
Denver Health Medical Plan	2.72	2.17	0.46	0.20	



Table 3-9—Inpatient Utilization—General Hospital/Acute Care: Total Days Per 1,000 MM for Total Age Group					
Health Plan Name	Total Inpatient	Medicine	Surgery	Maternity	
Kaiser Permanente	2.41	1.73	0.51	0.35	
Rocky Mountain Health Plans	2.23	1.32	0.89	0.06	
SMCN	NR	NR	NR	NR	
2014 Colorado CHP+ Weighted Average	4.16	2.38	1.56	0.45	
2013 Colorado CHP+ Weighted Average	_	_	_	_	
2012 Colorado CHP+ Weighted Average	12.53	3.05	2.17	14.84	

Overall, the 2014 Colorado Medicaid weighted average for the four types of services showed a decline in the number of days from the 2012 rates. Plan rate variation was smallest in the Maternity category and largest in the Total Inpatient category.

Table 3-10 displays the total inpatient, medicine, surgery, and maternity average length of stay for the total age group.

Table 3-10—Inpatient Utilization—General Hospital/Acute Care: Total Average Length of Stay for Total Age Group					
Health Plan Name	Total Inpatient	Medicine	Surgery	Maternity	
Colorado Access	3.68	2.93	6.34	2.44	
Colorado Choice	2.74	3.29	3.29	1.50	
Denver Health Medical Plan	2.70	2.68	2.73	3.00	
Kaiser Permanente	3.09	2.98	3.83	2.50	
Rocky Mountain Health Plans	2.28	2.08	2.64	3.00	
SMCN	NR	NR	NR	NR	
2014 Colorado CHP+ Weighted Average	3.37	2.81	5.27	2.44	
2013 Colorado CHP+ Weighted Average					
2012 Colorado CHP+ Weighted Average	3.09	3.05	6.35	2.70	

Overall, the 2014 Colorado Medicaid weighted average declined from 2012 for three of the four types of services except Total Inpatient. Plan rate variation was smallest in the Medicine category and largest in the Surgery category.



Appendix A. Tabular Results for Measures by Health Plan

Appendix A presents tables showing results for the measures by health plan. Where applicable, the results provided for each measure include the eligible population and rate for each health plan; the HEDIS 2012, HEDIS 2013, and HEDIS 2014 Colorado CHP+ weighted averages; and the national HEDIS 2013 Medicaid 50th percentile. Since national HEDIS 2013 Medicaid percentiles are not available for the CHIP population, comparison of the CHP+ plans and the SMCN's rates to HEDIS 2013 Medicaid percentiles, which comprised all Medicaid plans, should be interpreted with caution. The *Prenatal and Postpartum Care* measure was only reported by the SMCN; therefore, no weighted averages were calculated for this measure. In each table, cells with HEDIS 2014 rates or 2014 Medicaid Weighted Averages at or above the national Medicaid 50th percentile are coded in green. The following is a list of the tables and the measures presented in this appendix.

Measure	Table References
Childhood Immunization Status—Antigens	Table A-1
Childhood Immunization Status—Combinations	Table A-2
Immunizations for Adolescents—Combination 1	Table A-3
Well-Child Visits in the First 15 Months of Life	Table A-4
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Table A-5
Adolescent Well-Care Visits	Table A-6
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Table A-7
Appropriate Testing for Children with Pharyngitis	Table A-8
Follow-up Care for Children Prescribed ADHD Medication	Table A-9
Asthma Medication Ratio—Total	Table A-10
Prenatal and Postpartum Care (SMCN only)	Table A-11
Children's and Adolescents' Access to Primary Care Practitioners	Table A-12
Ambulatory Care: Total	Table A-13—Table A-14
Inpatient UtilizationGeneral Hospital/Acute Care	Table A-15—Table A-26

Following are some specific notations used for tables in this appendix.

Notation	Interpretation
_	Data elements were not relevant or data were not available in previous aggregate reports.
	Not Reportable due to one of the following:
NR	The calculated rate was materially biased.
INK	The organization chose not to report the measure.
	The organization was not required to report the measure.
NA	Indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.
	No rates were populated for cells with grey shading since these age groups for the <i>Ambulatory Care</i> measures were not appropriate for the CHP+ population.



	Table A-1—Childhood Immunization Status—Antigens^											
Health Plan Name	Eligible Population	DTaP	IPV	MMR	HiB	Hepatitis B	VZV	Pneumococcal Conjugate	Hepatitis A	Rotavirus	Influenza	
Colorado Access	677	77.86%	88.56%	86.37%	89.78%	87.10%	84.43%	77.86%	73.97%	71.05%	60.10%	
Colorado Choice	22	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Denver Health Medical Plan	75	89.33%	98.67%	93.33%	98.67%	97.33%	93.33%	93.33%	94.67%	88.00%	78.67%	
Kaiser Permanente	102	87.25%	95.10%	96.08%	94.12%	94.12%	97.06%	92.16%	96.08%	71.57%	64.71%	
Rocky Mountain Health Plans	303	74.83%	85.76%	83.77%	83.44%	85.10%	83.77%	75.83%	68.21%	64.57%	56.95%	
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	
2014 Colorado CHP+ Weighted Average	_	77.85%	88.08%	86.65%	88.35%	86.90%	85.62%	78.61%	75.27%	69.60%	60.00%	
2013 Colorado CHP+ Weighted Average		65.98%	77.41%	81.88%	78.84%	70.00%	79.64%	66.16%	70.71%	55.80%	50.36%	
2012 Colorado CHP+ Weighted Average	_	83.08%	90.96%	90.02%	91.90%	87.90%	89.08%	83.32%	37.84%	64.75%	51.35%	

[^] For the *Childhood Immunization Status* measure, the data collection methodology required by the Department was hybrid, administrative, and hybrid for HEDIS 2012, HEDIS 2013, and HEDIS 2014, respectively. Changes observed in the Colorado CHP+ Weighted Averages between these years may not reflect performance improvement or decline.



Table A	-2—Childhoo	od Immur	nization S	tatus—C	ombinati	ons^				
Health Plan Name	Eligible Population	Combo 2	Combo 3	Combo 4	Combo 5	Combo 6	Combo 7	Combo 8	Combo 9	Combo 10
Colorado Access	677	72.51%	68.61%	61.31%	59.37%	49.64%	54.50%	45.50%	44.04%	41.12%
Colorado Choice	22	NA								
Denver Health Medical Plan	75	89.33%	89.33%	89.33%	81.33%	76.00%	81.33%	76.00%	68.00%	68.00%
Kaiser Permanente	102	85.29%	84.31%	84.31%	68.63%	59.80%	68.63%	59.80%	51.96%	51.96%
Rocky Mountain Health Plans	303	69.87%	67.88%	57.95%	51.66%	49.67%	49.01%	44.70%	40.40%	38.74%
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	_	73.25%	70.33%	63.50%	58.90%	51.53%	55.43%	47.79%	44.66%	42.56%
2013 Colorado CHP+ Weighted Average	_	58.04%	55.89%	51.43%	44.11%	36.70%	41.16%	34.73%	30.45%	28.93%
2012 Colorado CHP+ Weighted Average	_	76.73%	74.50%	35.36%	56.16%	44.54%	27.37%	23.73%	37.01%	19.62%

[^] For the *Childhood Immunization Status* measure, the data collection methodology required by the Department was hybrid, administrative, and hybrid for HEDIS 2012, HEDIS 2013, and HEDIS 2014, respectively. Changes observed in the Colorado CHP+ Weighted Averages between these years may not reflect performance improvement or decline.



Table A-3—Immuniza				
Health Plan Name	Eligible Population	Meningococcal	Tdap/Td	Combination 1
Colorado Access	873	65.94%	87.59%	64.96%
Colorado Choice	31	25.81%	61.29%	25.81%
Denver Health Medical Plan	122	90.98%	91.80%	90.16%
Kaiser Permanente	104	90.38%	92.31%	89.42%
Rocky Mountain Health Plans	263	55.13%	88.97%	55.13%
SMCN	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	_	67.02%	87.99%	66.27%
2013 Colorado CHP+ Weighted Average	_	_	_	_
2012 Colorado CHP+ Weighted Average	_	_	_	_



Table A-4—Well-Child Visits in	n the First 15	Months of Life	.
Health Plan Name	Eligible Population	Zero Visits [†]	Six or More Visits
Colorado Access	645	2.19%	70.80%
Colorado Choice	16	NA	NA
Denver Health Medical Plan	45	2.22%	62.22%
Kaiser Permanente	104	0.00%	51.92%
Rocky Mountain Health Plans	262	2.67%	69.08%
SMCN	NR	NR	NR
2014 Colorado CHP+ Weighted Average	_	2.16%	67.41%
2013 Colorado CHP+ Weighted Average	_	2.67%	25.48%
2012 Colorado CHP+ Weighted Average	_	4.21%	25.28%

[†] For Well-Child Visits in the First 15 Months of Life—Zero Visits, a lower rate indicates better performance.

[^] For the *Well-Child Visits in the First 15 Months of Life* measure, the data collection methodology required by the Department was changed from administrative for HEDIS 2013 to hybrid for HEDIS 2014. Changes observed in the Colorado CHP+ Weighted Averages between these years may not reflect actual performance changes.



Table A-5—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life^									
Health Plan Name	Eligible Population	Rate							
Colorado Access	3,369	70.35%							
Colorado Choice	119	57.98%							
Denver Health Medical Plan	508	67.15%							
Kaiser Permanente	516	68.02%							
Rocky Mountain Health Plans	1,287	55.41%							
SMCN	NR	NR							
2014 Colorado CHP+ Weighted Average	_	66.29%							
2013 Colorado CHP+ Weighted Average	_	61.26%							
2012 Colorado CHP+ Weighted Average	_	64.17%							

[^] For the Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure, the data collection methodology required by the Department was changed from administrative for HEDIS 2013 to hybrid for HEDIS 2014. Changes observed in the Colorado CHP+ Weighted Averages between these years may not reflect actual performance changes.



Table A-6—Adolescent Well-Care Visits^								
Health Plan Name	Eligible Population	Rate						
Colorado Access	5,426	43.80%						
Colorado Choice	208	37.02%						
Denver Health Medical Plan	742	48.91%						
Kaiser Permanente	906	49.78%						
Rocky Mountain Health Plans	1,764	40.40%						
SMCN	NR	NR						
2014 Colorado CHP+ Weighted Average	_	44.00%						
2013 Colorado CHP+ Weighted Average	_	42.09%						
2012 Colorado CHP+ Weighted Average	_	44.79%						

[^] For the *Adolescent Well-Care Visits* measure, the data collection methodology required by the Department was changed from administrative for HEDIS 2013 to hybrid for HEDIS 2014. Changes observed in the Colorado CHP+ Weighted Averages between these years may not reflect actual performance changes.



Table A-7	Table A-7—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents											
	Ages 3–11 Years				Δ	ges 12-	17 Years		Total			
Health Plan Name	Eligible Population	ВМІ	Nutrition	Physical Activity	Eligible Population	ВМІ	Nutrition	Physical Activity	Eligible Population	ВМІ	Nutrition	Physical Activity
Colorado Access	6,107	61.76%	63.24%	50.00%	3,395	61.15%	57.55%	59.71%	9,502	61.56%	61.31%	53.28%
Colorado Choice	203	36.45%	33.50%	29.06%	131	44.27%	24.43%	46.56%	334	39.52%	29.94%	35.93%
Denver Health Medical Plan	741	93.96%	81.13%	61.13%	408	93.15%	76.03%	76.71%	1,149	93.67%	79.32%	66.67%
Kaiser Permanente	968	90.09%	90.09%	90.09%	622	92.16%	92.16%	92.16%	1,590	90.74%	90.74%	90.74%
Rocky Mountain Health Plans	1,990	78.00%	61.67%	58.33%	1,020	77.78%	52.94%	51.63%	3,010	77.92%	58.72%	56.07%
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	_	69.60%	66.24%	55.93%	_	69.60%	61.14%	62.79%	_	69.59%	64.47%	58.26%
2013 Colorado CHP+ Weighted Average		69.32%	66.53%	55.43%		67.98%	55.23%	58.75%		68.80%	62.24%	56.68%
2012 Colorado CHP+ Weighted Average		60.05%	63.34%	46.44%	_	55.69%	53.36%	54.04%		57.50%	58.51%	49.16%



Table A-8—Appropriate Testing for Children with Pharyngitis								
Health Plan Name	Eligible Population	Rate						
Colorado Access	1,279	76.78%						
Colorado Choice	63	57.14%						
Denver Health Medical Plan	38	84.21%						
Kaiser Permanente	226	91.15%						
Rocky Mountain Health Plans	412	82.52%						
SMCN	NR	NR						
2014 Colorado CHP+ Weighted Average	_	79.09%						
2013 Colorado CHP+ Weighted Average	_	_						
2012 Colorado CHP+ Weighted Average	_	_						



Table A-9—Follow-up Care for Children Prescribed ADHD Medication								
	Initiat	ion	Contin	uation				
Health Plan Name	Eligible Population	Rate	Eligible Population	nuation Rate 0.00% NA NA NA NA NA NA				
Colorado Access	181	0.55%	30	0.00%				
Colorado Choice	7	NA	2	NA				
Denver Health Medical Plan	11	NA	1	NA				
Kaiser Permanente	31	38.71%	8	NA				
Rocky Mountain Health Plans	56	44.64%	11	NA				
SMCN	NR	NR	NR	NR				
2014 Colorado CHP+ Weighted Average	_	16.78%	_	30.77%				
2013 Colorado CHP+ Weighted Average	_	_	_	_				
2012 Colorado CHP+ Weighted Average	_	_	_	_				



Table A-10—Asthma Medication Ratio										
Health Plan Name	Ages 5 to 11 Years		Ages 12 to 18 Years		Ages 19 to 50 Years		Ages 51 to 64 Years		Total	
	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate
Colorado Access	108	80.56%	92	73.91%	1	NA	0	NA	201	77.61%
Colorado Choice	5	NA	7	NA	0	NA	0	NA	12	NA
Denver Health Medical Plan	9	NA	6	NA	0	NA	0	NA	15	NA
Kaiser Permanente	13	NA	15	NA	1	NA	0	NA	29	NA
Rocky Mountain Health Plans	29	NA	16	NA	0	NA	0	NA	45	75.56%
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average		76.22%	_	70.47%	_	NA		NA	_	73.78%
2013 Colorado CHP+ Weighted Average	_	_	_	_	_	_			_	
2012 Colorado CHP+ Weighted Average	_	_	_	_	_	_	_	_	_	

Table A-11—Prenatal and Postpartum Care										
Health Plan Name	Timeline Prenatal		Postpartum Care							
nealth Flatt Name	Eligible Population	Rate	Eligible Population	Rate						
2014 SMCN Rate		70.80%	_	63.26%						
2013 SMCN Rate	_	78.59%	_	67.88%						
2012 SMCN Rate		72.26%		67.88%						



Table A-12—Childro	Table A-12—Children's and Adolescents' Access to Primary Care Practitioners									
Health Dlan Name	Ages 12 to 24 Months		Ages 25 Mo 6 Yea		Ages 7 to 1	1 Years	Ages 12 Year			
Health Plan Name	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate	Eligible Population	Rate		
Colorado Access	789	92.78%	4,163	84.27%	2,141	89.96%	2,690	88.18%		
Colorado Choice	21	NA	147	76.87%	90	88.89%	126	91.27%		
Denver Health Medical Plan	127	86.61%	608	74.84%	345	84.35%	406	87.68%		
Kaiser Permanente	99	95.96%	629	90.78%	287	95.47%	422	95.97%		
Rocky Mountain Health Plans	307	88.60%	1,617	77.74%	819	86.94%	944	86.55%		
SMCN	NR	NR	NR	NR	NR	NR	NR	NR		
2014 Colorado CHP+ Weighted Average	_	91.36%	_	82.41%	_	89.16%	_	88.60%		
2013 Colorado CHP+ Weighted Average	_	_	_	_	_	_	_	_		
2012 Colorado CHP+ Weighted Average										



Table A-13—Ambulatory Care: Total Outpatient Visits Per 1,000 MM									
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10–19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65–74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	620.73	239.65	212.36	71.43					239.95
Colorado Choice	538.31	184.39	174.91						189.86
Denver Health Medical Plan	270.50	107.89	106.66	28.57					111.45
Kaiser Permanente	200.32	150.81	172.99						163.04
Rocky Mountain Health Plans	567.31	210.95	177.87	0.00					208.28
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	544.57	212.58	192.59	44.78					214.08
2013 Colorado CHP+ Weighted Average	_		_	_	_		_	_	_
2012 Colorado CHP+ Weighted Average	679.98	211.73	189.84	358.87	527.78				224.09



Table A-14—Ambulatory Care: Total Emergency Department Visits Per 1,000 MM									
Health Plan Name	Age <1 Year	Ages 1-9 Years	Ages 10-19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65–74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	64.28	32.01	27.36	0.00					30.97
Colorado Choice	15.72	18.01	20.39						19.09
Denver Health Medical Plan	70.02	33.58	22.98	0.00					29.68
Kaiser Permanente	9.63	9.92	11.47						10.69
Rocky Mountain Health Plans	33.47	19.41	19.31	0.00					19.82
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	53.15	27.28	23.68	< 0.01					26.47
2013 Colorado CHP+ Weighted Average	56.84	29.02	27.19	66.17	47.62				30.07
2012 Colorado CHP+ Weighted Average	47.43	26.21	26.18	53.76	27.78				27.79



Table A-15—Inpatient Utilization—General Hospital/Acute Care: Total—Discharges per 1,000 MM (Inpatient)									
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10-19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65–74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	6.09	1.29	1.22	0.00					1.42
Colorado Choice	5.89	0.68	1.16						1.06
Denver Health Medical Plan	4.79	1.18	0.61	0.00					1.01
Kaiser Permanente	1.20	0.70	0.84						0.78
Rocky Mountain Health Plans	4.68	0.95	0.74	0.00					0.98
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	5.27	1.15	1.05	0.00					1.23
2013 Colorado CHP+ Weighted Average	_	_	_	_	_	_	_	_	
2012 Colorado CHP+ Weighted Average	6.13	1.15	1.65	90.70	55.56				4.05



Table A-16—Inpatient Utiliz	ation—Ge	neral Hos	pital/Acu	te Care: T	otal—Day	s per 1,00	00 MM (Inp	oatient)	
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10–19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65–74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	29.31	4.46	4.31	0.00					5.22
Colorado Choice	23.58	1.47	3.13						2.89
Denver Health Medical Plan	12.57	3.00	1.85	0.00					2.72
Kaiser Permanente	2.41	1.79	3.05						2.41
Rocky Mountain Health Plans	11.57	2.04	1.77	0.00					2.23
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	22.47	3.57	3.53	0.00					4.16
2013 Colorado CHP+ Weighted Average	_	_	_	_	_	_	_	_	_
2012 Colorado CHP+ Weighted Average	40.24	3.25	5.62	246.40	166.67				12.53



Table A-17—Inpatient Utilizati	ion—Gene	ral Hospi	tal/Acute	Care: Tota	al—Avera	ge Length	of Stay (Inpatient)	
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10–19 Years	Ages 20–44 Years	Ages 45–64 Years	Ages 65–74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	4.82	3.45	3.54	NA					3.68
Colorado Choice	4.00	2.17	2.70						2.74
Denver Health Medical Plan	2.63	2.55	3.06	NA					2.70
Kaiser Permanente	2.00	2.55	3.64						3.09
Rocky Mountain Health Plans	2.47	2.16	2.38	NA					2.28
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	4.26	3.12	3.38	NA					3.37
2013 Colorado CHP+ Weighted Average		_	_	_	_	_	_	_	_
2012 Colorado CHP+ Weighted Average	6.56	2.84	3.42	2.72	3.00				3.09



Table A-18—Inpatient Utilization—General Hospital/Acute Care: Total—Discharges per 1,000 MM (Medicine))		
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10-19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65-74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	5.03	1.03	0.61	0.00					0.97
Colorado Choice	0.00	0.11	0.70						0.39
Denver Health Medical Plan	4.19	1.09	0.30	0.00					0.81
Kaiser Permanente	1.20	0.59	0.54						0.58
Rocky Mountain Health Plans	4.18	0.62	0.39	0.00					0.64
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	4.35	0.90	0.54	0.00					0.85
2013 Colorado CHP+ Weighted Average	_	_	_	_	_		_	_	
2012 Colorado CHP+ Weighted Average	5.25	0.95	0.74	0.25	0.00				1.00



Table A-19—Inpatient Utilization—General Hospital/Acute Care: Total—Days per 1,000 MM (Medicine)									
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10-19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65-74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	19.69	2.85	1.61	0.00					2.85
Colorado Choice	0.00	0.34	2.32						1.28
Denver Health Medical Plan	11.37	2.80	0.94	0.00					2.17
Kaiser Permanente	2.41	1.54	1.89						1.73
Rocky Mountain Health Plans	10.34	1.16	0.84	0.00					1.32
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	15.46	2.36	1.49	0.00					2.38
2013 Colorado CHP+ Weighted Average	_	_	_	_	_	_	_	_	
2012 Colorado CHP+ Weighted Average	28.01	2.20	1.90	1.09	0.00				3.05



Table A-20—Inpatient Utilizat	Table A-20—Inpatient Utilization—General Hospital/Acute Care: Total—Average Length of Stay (Medicine)								
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10–19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65–74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	3.91	2.76	2.65	NA					2.93
Colorado Choice	NA	3.00	3.33						3.29
Denver Health Medical Plan	2.71	2.57	3.11	NA					2.68
Kaiser Permanente	2.00	2.62	3.52						2.98
Rocky Mountain Health Plans	2.47	1.88	2.14	NA					2.08
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	3.56	2.63	2.74	NA					2.81
2013 Colorado CHP+ Weighted Average	_	_	_	_			_	_	
2012 Colorado CHP+ Weighted Average	5.34	2.32	2.57	4.33	NA				3.05



Table A-21—Inpatient Utilization—General Hospital/Acute Care: Total—Discharges per 1,000 MM (Surgery)									
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10-19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65-74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	1.06	0.26	0.36	0.00					0.33
Colorado Choice	0.00	0.11	0.70						0.39
Denver Health Medical Plan	0.60	0.09	0.24	0.00					0.17
Kaiser Permanente	0.00	0.11	0.16						0.13
Rocky Mountain Health Plans	0.49	0.33	0.33	0.00					0.34
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	0.81	0.24	0.33	0.00					0.30
2013 Colorado CHP+ Weighted Average	_	_	_	_	_	_	_	_	
2012 Colorado CHP+ Weighted Average	0.88	0.20	0.45	0.25	0.00				0.34



Table A-22—Inpatient Utili	Table A-22—Inpatient Utilization—General Hospital/Acute Care: Total—Days per 1,000 MM (Surgery)								
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10-19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65–74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	9.63	1.61	2.09	0.00					2.10
Colorado Choice	0.00	0.34	2.32						1.28
Denver Health Medical Plan	1.20	0.21	0.71	0.00					0.46
Kaiser Permanente	0.00	0.25	0.81						0.51
Rocky Mountain Health Plans	1.23	0.89	0.87	0.00					0.89
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	6.52	1.19	1.64	0.00					1.56
2013 Colorado CHP+ Weighted Average	_	_	_	_	_	_	_	_	
2012 Colorado CHP+ Weighted Average	12.23	1.05	2.55	0.46	0.00				2.17



Table A-23—Inpatient Ut	Table A-23—Inpatient Utilization—General Hospital/Acute Care: Total—Length of Stay (Surgery)								
Health Plan Name	Age <1 Year	Ages 1–9 Years	Ages 10-19 Years	Ages 20-44 Years	Ages 45–64 Years	Ages 65-74 Years	Ages 75–84 Years	Ages 85+ Years	Total
Colorado Access	9.12	6.27	5.80	NA					6.34
Colorado Choice	NA	3.00	3.33						3.29
Denver Health Medical Plan	2.00	2.33	3.00	NA					2.73
Kaiser Permanente	NA	2.20	5.00						3.83
Rocky Mountain Health Plans	2.50	2.68	2.61	NA					2.64
SMCN	NR	NR	NR	NR	NR	NR	NR	NR	NR
2014 Colorado CHP+ Weighted Average	8.10	5.05	4.97	NA					5.27
2013 Colorado CHP+ Weighted Average	_	_	_	_	_	_	_	_	_
2012 Colorado CHP+ Weighted Average	13.90	5.26	5.73	1.83	NA				6.35



Table A-24—Inpatient Utilization—General Hospital/Acute Care: Total—Discharges per 1,000 MM (Maternity)						
Health Plan Name	Ages 10–19 Years	Ages 20-44 Years	Ages 45–64 Years	Total		
Colorado Access	0.25	0.00		0.25		
Colorado Choice	0.23			0.23		
Denver Health Medical Plan	0.07	0.00		0.07		
Kaiser Permanente	0.14			0.14		
Rocky Mountain Health Plans	0.02	0.00		0.02		
SMCN	NR	NR	NR	NR		
2014 Colorado CHP+ Weighted Average	0.19	0.00		0.19		
2013 Colorado CHP+ Weighted Average	_	_	_	_		
2012 Colorado CHP+ Weighted Average	0.46	90.20	55.56	5.49		



Table A-25—Inpatient Utilization—General Hospital/Acute Care: Total—Days per 1,000 MM (Maternity)						
Health Plan Name	Ages 10–19 Years	Ages 20-44 Years	Ages 45–64 Years	Total		
Colorado Access	0.61	0.00		0.61		
Colorado Choice	0.35			0.35		
Denver Health Medical Plan	0.20	0.00		0.20		
Kaiser Permanente	0.35			0.35		
Rocky Mountain Health Plans	0.06	0.00		0.06		
SMCN	NR	NR	NR	NR		
2014 Colorado CHP+ Weighted Average	0.45	0.00		0.45		
2013 Colorado CHP+ Weighted Average	_	_	_	_		
2012 Colorado CHP+ Weighted Average	1.18	244.85	166.67	14.84		



Table A-26—Inpatient Utilization—General Hospital/Acute Care: Total—Average Length of Stay (Maternity)						
Health Plan Name	Ages 10–19 Years	Ages 20-44 Years	Ages 45–64 Years	Total		
Colorado Access	2.44	NA		2.44		
Colorado Choice	1.50			1.50		
Denver Health Medical Plan	3.00	NA		3.00		
Kaiser Permanente	2.50			2.50		
Rocky Mountain Health Plans	3.00	NA		3.00		
SMCN	NR	NR	NR	NR		
2014 Colorado CHP+ Weighted Average	2.44	NA		2.44		
2013 Colorado CHP+ Weighted Average	_	_	_			
2012 Colorado CHP+ Weighted Average	2.54	2.71	3.00	2.70		



Appendix B. Trend Tables

Appendix B includes trend tables for each of the Colorado CHP+ health plans. Where applicable, measure rates for HEDIS 2012, HEDIS 2013, and HEDIS 2014 are presented. Also, the HEDIS 2014 rates were compared to the HEDIS 2013 rates using a Pearson's Chi-square test to determine statistically significant changes in rates from one year to the next. These results are presented as percentage point changes and can be interpreted based on the legend below. Please note that statistical tests were not performed for measures under the Use of Service domain.

Change From HEDIS 2012–2013	Interpretation
+2.5	The HEDIS 2014 rate is 2.5 percentage points <i>higher</i> than the HEDIS 2013 rate.
- 2.5	The HEDIS 2014 rate is 2.5 percentage points <i>lower</i> than the HEDIS 2013 rate.
+2.5	The HEDIS 2014 rate is 2.5 percentage points <i>statistically significantly higher</i> than the HEDIS 2013 rate.
- 2.5	The HEDIS 2014 rate is 2.5 percentage points <i>statistically significantly lower</i> than the HEDIS 2013 rate.

The health plan and statewide trend tables are presented as follows:

- Table B-1—Colorado Access
- Table B-2—Colorado Choice
- Table B-3—Denver Health Medical Plan, Inc. (DHMP)
- Table B-4—Kaiser Permanente (Kaiser)
- Table B-5—Rocky Mountain Health Plans (RMHP)
- Table B-6—State Managed Care Network (SMCN)
- Table B-7—Colorado CHP+ Statewide Trend Table



Table B-1—Colorado Access Trend Table					
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014	
Pediatric Care					
Childhood Immunization Status ¹					
DTaP	83.38%	62.04%	77.86%	+15.82	
IPV	92.52%	73.22%	88.56%	+15.34	
MMR	91.97%	81.12%	86.37%	+5.25	
HiB	94.18%	75.92%	89.78%	+13.86	
Hepatitis B	87.26%	67.44%	87.10%	+19.66	
VZV	91.14%	78.42%	84.43%	+6.01	
Pneumococcal Conjugate	83.93%	63.01%	77.86%	+14.85	
Hepatitis A	37.12%	67.82%	73.97%	+6.15	
Rotavirus	63.43%	52.02%	71.05%	+19.03	
Influenza	52.08%	49.13%	60.10%	+10.97	
Combination 2	77.01%	54.53%	72.51%	+17.98	
Combination 3	74.79%	52.41%	68.61%	+16.20	
Combination 4	32.69%	46.82%	61.31%	+14.49	
Combination 5	52.35%	41.43%	59.37%	+17.94	
Combination 6	45.15%	34.30%	49.64%	+15.34	
Combination 7	21.88%	37.57%	54.50%	+16.93	
Combination 8	21.61%	31.41%	45.50%	+14.09	
Combination 9	35.18%	28.13%	44.04%	+15.91	
Combination 10	16.07%	25.82%	41.12%	+15.30	
Immunizations for Adolescents	-1		ı		
Meningococcal		_	65.94%	_	
Tdap/Td	_		87.59%	_	
Combination 1	_		64.96%	_	
Well-Child Visits in the First 15 Months of Life ²	1	1	1	1	
Zero Visits*	4.59%	2.14%	2.19%	+0.05	
Six or More Visits	11.66%	13.64%	70.80%	+57.16	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ³	66.62%	63.20%	70.35%	+7.15	
Adolescent Well-Care Visits ⁴	44.50%	43.39%	43.80%	+0.41	



Table B-1—Colorado Access	Trend Table)		
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014
Weight Assessment and Counseling for Nutrition and Physical Activ	ity for Child	ren/Adolesc	ents	
BMI Assessment: Ages 3 to 11 Years	51.76%	64.23%	61.76%	-2.47
Nutrition Counseling: Ages 3 to 11 Years	57.25%	62.31%	63.24%	+0.93
Physical Activity Counseling: Ages 3 to 11 Years	41.18%	50.77%	50.00%	-0.77
BMI Assessment: Ages 12 to 17 Years	53.85%	63.58%	61.15%	-2.43
Nutrition Counseling: Ages 12 to 17 Years	51.92%	49.67%	57.55%	+7.88
Physical Activity Counseling: Ages 12 to 17 Years	54.49%	54.97%	59.71%	+4.74
BMI Assessment: Total	52.55%	63.99%	61.56%	-2.43
Nutrition Counseling: Total	55.23%	57.66%	61.31%	+3.65
Physical Activity Counseling: Total	46.23%	52.31%	53.28%	+0.97
Appropriate Testing for Children with Pharyngitis	_	_	76.78%	_
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	_	_	0.55%	_
Continuation	_		0.00%	_
Asthma Medication Ratio				1
Ages 5 to 11 Years	_	_	80.56%	_
Ages 12 to 18 Years	_		73.91%	_
Ages 19 to 50 Years	_		NA	_
Ages 51 to 64 Years	_		NA	_
Total	_	_	77.61%	_
Access to Care	1	I.	1	1
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	_	_	92.78%	_
Ages 25 Months to 6 Years	_	_	84.27%	_
Ages 7 to 11 Years	_	_	89.96%	_
Ages 12 to 19 Years	_	_	88.18%	_
Use of Services†	1		1	
Ambulatory Care: Total				
Outpatient Visits Per 1,000 MM: Total	234.54	_	239.95	_
Emergency Department Visits Per 1,000 MM: Total	28.97	32.93	30.97	-1.96
Inpatient Utilization—General Hospital/Acute Care: Total	l	I	l	<u> </u>
Discharges per 1,000 MM (Total Inpatient)	1.49	_	1.42	



Table B-1—Colorado Access Trend Table					
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014	
Days per 1,000 MM (Total Inpatient)	5.42		5.22	_	
Average Length of Stay (Total Inpatient)	3.64	_	3.68	_	
Discharges per 1,000 MM (Medicine)	0.97	_	0.97	_	
Days per 1,000 MM (Medicine)	2.50	_	2.85	_	
Average Length of Stay (Medicine)	2.58	_	2.93	_	
Discharges per 1,000 MM (Surgery)	0.35	_	0.33	_	
Days per 1,000 MM (Surgery)	2.53	_	2.10	_	
Average Length of Stay (Surgery)	7.17	_	6.34	_	
Discharges per 1,000 MM (Maternity)	0.35	_	0.25	_	
Days per 1,000 MM (Maternity)	0.82	_	0.61	_	
Average Length of Stay (Maternity)	2.33	_	2.44	_	

[—] is shown when no data were available or the measure was not reported in the HEDIS 2012 or HEDIS 2013 aggregate reports.

^{*} For the Well-Child Visits in the First 15 Months of Life—Zero Visits indicator, a lower rate indicates better performance.

[†] For measures in the *Use of Services* domain, statistical tests across years were not performed because variances were not provided in the plan-submitted file; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Individual plan demographics should be considered when reviewing performance.

The Department's reporting requirement for the *Childhood Immunization Status* measure was hybrid in HEDIS 2012 and 2014 but administrative in HEDIS 2013. Historical rate changes may not reflect actual performance changes. The HEDIS 2013 rates displayed reflect administrative data only and are not the final, reported hybrid rates in the plan's IDSS file. The plan's final, reported hybrid rates of 81.02 percent, 91.00 percent, 88.81 percent, 91.48 percent, 86.62 percent, 85.89 percent, 80.29 percent, 74.70 percent, 68.61 percent, 56.45 percent, 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—DTaP* through *Combination 10* indicators for HEDIS 2013, respectively.

² The Department's reporting requirement for all the indicators under the *Well-Child Visits in the First 15 Months of Life* measure were administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. Historical rate changes may not reflect actual performance changes. The HEDIS 2012 and 2013 rates for the *Zero Visits* and the *Six or More Visits* indicators displayed here reflect administrative data only and are not the final, reported hybrid rates in the plan's IDSS files. The final, reported hybrid HEDIS 2012 and 2013 rates for the *Zero Visits* indicator were 4.24 percent and 1.87 percent, and the rates for the *Six or More Visits* indicator were 51.59 percent and 57.22 percent, respectively.

³ The Department's reporting requirement for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. Historical rate changes may not reflect actual performance changes. The HEDIS 2012 and 2013 rates displayed here reflect administrative data only and are not the final, reported hybrid rate in the plan's IDSS files. The final, reported hybrid rates for HEDIS 2012 and 2013 were 71.97 percent and 66.37 percent, respectively.

⁴ The Department's reporting requirement for the *Adolescent Well-Care Visits* measure was administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. Colorado Access followed the Department's requirement in HEDIS 2012 and 2013. The HEDIS 2012 and 2013 rates displayed here were the plan's final rates in its IDSS files.



Table B-2—Colorado Choice	Trend Table	;		
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014
Pediatric Care				
Childhood Immunization Status ¹				
DTaP	_	NA	NA	_
IPV	_	NA	NA	_
MMR	_	NA	NA	_
HiB	_	NA	NA	_
Hepatitis B	_	NA	NA	_
VZV	_	NA	NA	_
Pneumococcal Conjugate	_	NA	NA	_
Hepatitis A	_	NA	NA	_
Rotavirus	_	NA	NA	_
Influenza	_	NA	NA	_
Combination 2	_	NA	NA	_
Combination 3	_	NA	NA	_
Combination 4	_	NA	NA	_
Combination 5	_	NA	NA	_
Combination 6	_	NA	NA	_
Combination 7	_	NA	NA	_
Combination 8	_	NA	NA	_
Combination 9	_	NA	NA	_
Combination 10	_	NA	NA	_
Immunizations for Adolescents		-		
Meningococcal	_	_	25.81%	_
Tdap/Td	_	_	61.29%	_
Combination 1	_	_	25.81%	_
Well-Child Visits in the First 15 Months of Life ²				
Zero Visits*		NA	NA	
Six or More Visits	_	NA	NA	_
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ²	_	57.94%	57.98%	+0.04
Adolescent Well-Care Visits ²	_	36.33%	37.02%	+0.69



Table B-2—Colorado Choice	Trend Table	;		
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014
Weight Assessment and Counseling for Nutrition and Physical Activ	ity for Chila	lren/Adolesc	ents	
BMI Assessment: Ages 3 to 11 Years	_	12.72%	36.45%	+23.73
Nutrition Counseling: Ages 3 to 11 Years	_	13.16%	33.50%	+20.34
Physical Activity Counseling: Ages 3 to 11 Years	_	8.77%	29.06%	+20.29
BMI Assessment: Ages 12 to 17 Years	_	15.43%	44.27%	+28.84
Nutrition Counseling: Ages 12 to 17 Years	_	9.14%	24.43%	+15.29
Physical Activity Counseling: Ages 12 to 17 Years	_	24.57%	46.56%	+21.99
BMI Assessment: Total	_	13.90%	39.52%	+25.62
Nutrition Counseling: Total	_	11.41%	29.94%	+18.53
Physical Activity Counseling: Total	_	15.63%	35.93%	+20.30
Appropriate Testing for Children with Pharyngitis	_	_	57.14%	_
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	_	_	NA	_
Continuation	_	_	NA	_
Asthma Medication Ratio				
Ages 5 to 11 Years	_	_	NA	_
Ages 12 to 18 Years	_	_	NA	_
Ages 19 to 50 Years	_	_	NA	_
Ages 51 to 64 Years	_	_	NA	_
Total	_		NA	_
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	_	_	NA	_
Ages 25 Months to 6 Years	_	_	76.87%	_
Ages 7 to 11 Years	_	_	88.89%	_
Ages 12 to 19 Years	_	_	91.27%	_
Use of Services†				
Ambulatory Care: Total				
Outpatient Visits Per 1,000 MM: Total	_	_	189.86	_
Emergency Department Visits Per 1,000 MM: Total		20.84	19.09	-1.75



Table B-2—Colorado Choice Trend Table					
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014	
Inpatient Utilization—General Hospital/Acute Care: Total					
Discharges per 1,000 MM (Total Inpatient)	_	_	1.06	_	
Days per 1,000 MM (Total Inpatient)	_	_	2.89	_	
Average Length of Stay (Total Inpatient)	_	_	2.74	_	
Discharges per 1,000 MM (Medicine)	_		0.39		
Days per 1,000 MM (Medicine)	_	_	1.28	_	
Average Length of Stay (Medicine)	_	_	3.29	_	
Discharges per 1,000 MM (Surgery)	_	_	0.39	_	
Days per 1,000 MM (Surgery)	_	_	1.28	_	
Average Length of Stay (Surgery)	_		3.29		
Discharges per 1,000 MM (Maternity)	_	_	0.23	_	
Days per 1,000 MM (Maternity)	_	_	0.35	_	
Average Length of Stay (Maternity)	_	_	1.50	_	

[—] is shown when no data were available or the measure was not reported in the HEDIS 2012 or the HEDIS 2013 aggregate reports.

^{*} For the Well-Child Visits in the First 15 Months of Life—Zero Visits indicator, a lower rate indicates better performance.

[†] For measures in the *Use of Services* domain, statistical tests across years were not performed because variances were not provided in the plan-submitted file; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Individual plan demographics should be considered when reviewing performance.

¹ The Department's reporting requirement for the *Childhood Immunization Status* measure was hybrid in HEDIS 2012 and 2014 but administrative in HEDIS 2013. Historical rate changes may not reflect actual performance changes. Colorado Choice reported only administrative rates for this measure. Hybrid rates were not submitted, although the Department required a hybrid data collection methodology.

² The Department's reporting requirement for these measures was administrative in HEDIS 2012 and HEDIS 2013 but hybrid in HEDIS 2014: Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; and Adolescents Well-Care Visits. Historical rate changes may not reflect actual performance changes. Colorado Choice began providing services in July 2010; consequently, its population size did not meet the reporting requirements for FY 2011–2012 (HEDIS 2012). HEDIS 2013 was the first year for Colorado Choice to conduct an NCQA HEDIS Compliance Audit. The HEDIS 2013 rates for these measures displayed here were the plan's final, reported rates in its IDSS file.



Table B-3—Denver Health Medical	Plan Trend	Table		
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014
Pediatric Care	·			
Childhood Immunization Status ¹				
DTaP	91.23%	84.31%	89.33%	+5.02
IPV	100.00%	93.14%	98.67%	+5.53
MMR	100.00%	88.24%	93.33%	+5.09
HiB	100.00%	93.14%	98.67%	+5.53
Hepatitis B	100.00%	94.12%	97.33%	+3.21
VZV	100.00%	87.25%	93.33%	+6.08
Pneumococcal Conjugate	96.49%	86.27%	93.33%	+7.06
Hepatitis A	61.40%	89.22%	94.67%	+5.45
Rotavirus	75.44%	70.59%	88.00%	+17.41
Influenza	82.46%	74.51%	78.67%	+4.16
Combination 2	91.23%	83.33%	89.33%	+6.00
Combination 3	91.23%	82.35%	89.33%	+6.98
Combination 4	61.40%	82.35%	89.33%	+6.98
Combination 5	73.68%	64.71%	81.33%	+16.62
Combination 6	80.70%	69.61%	76.00%	+6.39
Combination 7	49.12%	64.71%	81.33%	+16.62
Combination 8	56.14%	69.61%	76.00%	+6.39
Combination 9	68.42%	56.86%	68.00%	+11.14
Combination 10	43.86%	56.86%	68.00%	+11.14
Immunizations for Adolescents				-
Meningococcal		_	90.98%	_
Tdap/Td	_	_	91.80%	_
Combination 1	_	_	90.16%	_
Well-Child Visits in the First 15 Months of Life ²			-	
Zero Visits*	3.23%	0.00%	2.22%	+2.22
Six or More Visits	9.68%	2.13%	62.22%	+60.09
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ³	69.38%	58.53%	67.15%	+8.62
Adolescent Well-Care Visits ⁴	49.55%	42.00%	48.91%	+6.91



Table B-3—Denver Health Medical	Plan Trend	Table		
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014
Weight Assessment and Counseling for Nutrition and Physical Activ	ity for Child	ren/Adolesc	ents	
BMI Assessment: Ages 3 to 11 Years	86.97%	90.55%	93.96%	+3.41
Nutrition Counseling: Ages 3 to 11 Years	82.38%	78.74%	81.13%	+2.39
Physical Activity Counseling: Ages 3 to 11 Years	64.75%	59.45%	61.13%	+1.68
BMI Assessment: Ages 12 to 17 Years	92.67%	89.81%	93.15%	+3.34
Nutrition Counseling: Ages 12 to 17 Years	84.67%	71.97%	76.03%	+4.06
Physical Activity Counseling: Ages 12 to 17 Years	85.33%	69.43%	76.71%	+7.28
BMI Assessment: Total	89.05%	90.27%	93.67%	+3.40
Nutrition Counseling: Total	83.21%	76.16%	79.32%	+3.16
Physical Activity Counseling: Total	72.26%	63.26%	66.67%	+3.41
Appropriate Testing for Children with Pharyngitis	_	_	84.21%	_
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	_		NA	_
Continuation	_	_	NA	_
Asthma Medication Ratio				
Ages 5 to 11 Years	_		NA	_
Ages 12 to 18 Years	_	_	NA	_
Ages 19 to 50 Years	_	_	NA	_
Ages 51 to 64 Years	_	_	NA	_
Total	_	_	NA	_
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	_		86.61%	
Ages 25 Months to 6 Years	_	_	74.84%	_
Ages 7 to 11 Years	_	_	84.35%	<u> </u>
Ages 12 to 19 Years	_	_	87.68%	_
Use of Services†		1		
Ambulatory Care: Total				
Outpatient Visits Per 1,000 MM: Total	157.26	_	111.45	_
Emergency Department Visits Per 1,000 MM: Total	30.64	31.48	29.68	-1.80



Table B-3—Denver Health Medical Plan Trend Table					
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014	
Inpatient Utilization—General Hospital/Acute Care: Total					
Discharges per 1,000 MM (Total Inpatient)	1.66	_	1.01	_	
Days per 1,000 MM (Total Inpatient)	2.81	_	2.72	_	
Average Length of Stay (Total Inpatient)	1.69	_	2.70	_	
Discharges per 1,000 MM (Medicine)	1.13	_	0.81	_	
Days per 1,000 MM (Medicine)	1.76	_	2.17	_	
Average Length of Stay (Medicine)	1.56	_	2.68	_	
Discharges per 1,000 MM (Surgery)	0.35		0.17	_	
Days per 1,000 MM (Surgery)	0.73	_	0.46		
Average Length of Stay (Surgery)	2.07	_	2.73		
Discharges per 1,000 MM (Maternity)	0.37	_	0.07		
Days per 1,000 MM (Maternity)	0.65	_	0.20	_	
Average Length of Stay (Maternity)	1.75	_	3.00	_	

[—] is shown when no data were available or the measure was not reported in the HEDIS 2012 or the HEDIS 2013 aggregate reports.

^{*} For the Well-Child Visits in the First 15 Months of Life—Zero Visits indicator, a lower rate indicates better performance.

[†] For measures in the *Use of Services* domain, statistical tests across years were not performed because variances were not provided in the plan-submitted file; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Individual plan demographics should be considered when reviewing performance.

¹ The Department's reporting requirement for the *Childhood Immunization Status* measure was hybrid in HEDIS 2012 and 2014 but administrative in HEDIS 2013. Historical rate changes may not reflect actual performance changes. DHMP followed the Department's requirement in HEDIS 2013; the HEDIS 2013 rates displayed here were the plan's final rates in its IDSS file.

² The Department's reporting requirement for all the indicators under the *Well-Child Visits in the First 15 Months of Life* measure were administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. Historical rate changes may not reflect actual performance changes. The HEDIS 2012 rates for the *Zero Visits* and the *Six or More Visits* indicators displayed here reflect administrative data only and are not the final, reported hybrid rates in the plan's IDSS file. The final, reported hybrid HEDIS 2012 rate for the *Zero Visits* indicator were 3.23 percent and the rate for the *Six or More Visits* indicator was 67.74 percent, respectively.

³ The Department's reporting requirement for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. Historical rate changes may not reflect actual performance changes. The HEDIS 2012 rate displayed here reflects administrative data only and is not the final, reported hybrid rate in the plan's IDSS file. The final, reported hybrid rate for HEDIS 2012 was 73.94 percent. DHMP followed the Department's requirement in HEDIS 2013; the HEDIS 2013 rates displayed here were the plan's final rate in its IDSS file.

⁴ The Department's reporting requirement for the *Adolescent Well-Care Visits* measure was administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. The HEDIS 2012 rate displayed here reflects administrative data only and is not the final, reported hybrid rate in the plan's IDSS file. The final, reported hybrid rate for HEDIS 2012 was 56.69 percent. DHMP followed the Department's requirement in HEDIS 2013; the HEDIS 2013 rates displayed here were the plan's final rate in its IDSS file.



DTaP	Table B-4—Kaiser Permanento	Trend Tabl	е		
DTaP	Measures				From
DTaP	Pediatric Care				
IPV	Childhood Immunization Status ¹				
MMR 92.11% 92.22% 96.08% +3.86 HiB 92.11% 93.33% 94.12% +0.79 Hepatitis B 93.42% 93.33% 94.12% +0.79 VZV 89.47% 92.22% 97.06% +4.84 Pneumococcal Conjugate 90.79% 90.00% 92.16% +2.16 Hepatitis A 77.63% 93.33% 96.08% +2.75 Rotavirus 84.21% 75.56% 71.57% -3.99 Influenza 51.32% 56.67% 64.71% +8.04 Combination 2 81.58% 90.00% 85.29% -4.71 Combination 3 81.58% 88.89% 84.31% -4.58 Combination 4 75.00% 88.89% 84.31% -4.58 Combination 5 75.00% 74.44% 68.63% -5.81 Combination 6 47.37% 55.56% 59.80% +4.24 Combination 8 46.05% 55.56% 59.80% +4.24 Combination 10	DTaP	86.84%	91.11%	87.25%	-3.86
HiB 92.11% 93.33% 94.12% +0.79 Hepatitis B 93.42% 93.33% 94.12% +0.79 VZV 89.47% 92.22% 97.06% +4.84 Pneumococcal Conjugate 90.79% 90.00% 92.16% +2.16 Hepatitis A 77.63% 93.33% 96.08% +2.75 Rotavirus 84.21% 75.56% 71.57% -3.99 Influenza 51.32% 56.67% 64.71% +8.04 Combination 2 81.58% 90.00% 85.29% -4.71 Combination 3 81.58% 88.89% 84.31% -4.58 Combination 4 75.00% 88.89% 84.31% -4.58 Combination 5 75.00% 74.44% 68.63% -5.81 Combination 6 47.37% 55.56% 59.80% +4.24 Combination 8 46.05% 55.56% 59.80% +4.24 Combination 10 43.42% 50.00% 51.96% +1.96 Immunizations for Adolescents — — 99.38% — Tdap/Td <td>IPV</td> <td>90.79%</td> <td>92.22%</td> <td>95.10%</td> <td>+2.88</td>	IPV	90.79%	92.22%	95.10%	+2.88
Hepatitis B	MMR	92.11%	92.22%	96.08%	+3.86
VZV 89.47% 92.22% 97.06% +4.84 Pneumococcal Conjugate 90.79% 90.00% 92.16% +2.16 Hepatitis A 77.63% 93.33% 96.08% +2.75 Rotavirus 84.21% 75.56% 71.57% -3.99 Influenza 51.32% 56.67% 64.71% +8.04 Combination 2 81.58% 90.00% 85.29% -4.71 Combination 3 81.58% 88.89% 84.31% -4.58 Combination 4 75.00% 78.444 68.63% -5.81 Combination 5 75.00% 74.44% 68.63% -5.81 Combination 6 47.37% 55.56% 59.80% +4.24 Combination 8 46.05% 55.56% 59.80% +4.24 Combination 9 44.74% 50.00% 51.96% +1.96 Immunizations for Adolescents - - 90.38% - Meningococcal - - 90.38% - Tdap/Td	HiB	92.11%	93.33%	94.12%	+0.79
Pneumococcal Conjugate	Hepatitis B	93.42%	93.33%	94.12%	+0.79
Hepatitis A 77.63% 93.33% 96.08% +2.75	VZV	89.47%	92.22%	97.06%	+4.84
Rotavirus	Pneumococcal Conjugate	90.79%	90.00%	92.16%	+2.16
Influenza	Hepatitis A	77.63%	93.33%	96.08%	+2.75
Section Combination 2 81.58% 90.00% 85.29% -4.71	Rotavirus	84.21%	75.56%	71.57%	-3.99
Combination 3 81.58% 88.89% 84.31% -4.58 Combination 4 75.00% 88.89% 84.31% -4.58 Combination 5 75.00% 74.44% 68.63% -5.81 Combination 6 47.37% 55.56% 59.80% +4.24 Combination 7 72.37% 74.44% 68.63% -5.81 Combination 8 46.05% 55.56% 59.80% +4.24 Combination 9 44.74% 50.00% 51.96% +1.96 Immunizations for Adolescents 43.42% 50.00% 51.96% +1.96 Immunizations for Adolescents — 90.38% — Tdap/Td — 90.38% — Tdap/Td — 90.38% — Well-Child Visits in the First 15 Months of Life² Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Influenza	51.32%	56.67%	64.71%	+8.04
Combination 4 75.00% 88.89% 84.31% -4.58 Combination 5 75.00% 74.44% 68.63% -5.81 Combination 6 47.37% 55.56% 59.80% +4.24 Combination 7 72.37% 74.44% 68.63% -5.81 Combination 8 46.05% 55.56% 59.80% +4.24 Combination 9 44.74% 50.00% 51.96% +1.96 Combination 10 43.42% 50.00% 51.96% +1.96 Immunizations for Adolescents — — 90.38% — Meningococcal — — 90.38% — Tdap/Td — — 90.38% — Well-Child Visits in the First 15 Months of Life² — — 89.42% — Well-Child Visits in the First 15 Months of Life² 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 2	81.58%	90.00%	85.29%	-4.71
Combination 5 75.00% 74.44% 68.63% -5.81 Combination 6 47.37% 55.56% 59.80% +4.24 Combination 7 72.37% 74.44% 68.63% -5.81 Combination 8 46.05% 55.56% 59.80% +4.24 Combination 9 44.74% 50.00% 51.96% +1.96 Combination 10 43.42% 50.00% 51.96% +1.96 Immunizations for Adolescents — — 90.38% — Meningococcal — — 90.38% — Tdap/Td — — 92.31% — Combination 1 — — 92.31% — Well-Child Visits in the First 15 Months of Life² — 89.42% — Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 3	81.58%	88.89%	84.31%	-4.58
Combination 6 47.37% 55.56% 59.80% +4.24 Combination 7 72.37% 74.44% 68.63% -5.81 Combination 8 46.05% 55.56% 59.80% +4.24 Combination 9 44.74% 50.00% 51.96% +1.96 Immunizations for Adolescents — — 90.38% — Meningococcal — — 90.38% — Tdap/Td — — 92.31% — Combination 1 — — 89.42% — Well-Child Visits in the First 15 Months of Life² — 89.42% — Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 4	75.00%	88.89%	84.31%	-4.58
Combination 7 72.37% 74.44% 68.63% -5.81 Combination 8 46.05% 55.56% 59.80% +4.24 Combination 9 44.74% 50.00% 51.96% +1.96 Combination 10 43.42% 50.00% 51.96% +1.96 Immunizations for Adolescents — 90.38% — Meningococcal — 90.38% — Tdap/Td — 92.31% — Combination 1 — 92.31% — Well-Child Visits in the First 15 Months of Life² Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 5	75.00%	74.44%	68.63%	-5.81
Combination 8 46.05% 55.56% 59.80% +4.24 Combination 9 44.74% 50.00% 51.96% +1.96 Combination 10 43.42% 50.00% 51.96% +1.96 Immunizations for Adolescents	Combination 6	47.37%	55.56%	59.80%	+4.24
Combination 9 44.74% 50.00% 51.96% +1.96 Combination 10 43.42% 50.00% 51.96% +1.96 Immunizations for Adolescents Meningococcal — — 90.38% — Tdap/Td — — 92.31% — Combination 1 — — 89.42% — Well-Child Visits in the First 15 Months of Life² Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 7	72.37%	74.44%	68.63%	-5.81
Combination 10 43.42% 50.00% 51.96% +1.96 Immunizations for Adolescents — — 90.38% — Meningococcal — — 90.38% — Tdap/Td — — 92.31% — Combination 1 — — 89.42% — Well-Child Visits in the First 15 Months of Life² — 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 8	46.05%	55.56%	59.80%	+4.24
Immunizations for Adolescents — — 90.38% — Tdap/Td — — 92.31% — Combination 1 — — 89.42% — Well-Child Visits in the First 15 Months of Life² Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 9	44.74%	50.00%	51.96%	+1.96
Meningococcal — — 90.38% — Tdap/Td — — 92.31% — Combination 1 — — 89.42% — Well-Child Visits in the First 15 Months of Life² Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 10	43.42%	50.00%	51.96%	+1.96
Tdap/Td — — 92.31% — Combination 1 — 89.42% — Well-Child Visits in the First 15 Months of Life² Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Immunizations for Adolescents				
Combination 1 — 89.42% — Well-Child Visits in the First 15 Months of Life² Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Meningococcal	_	_	90.38%	_
Well-Child Visits in the First 15 Months of Life² Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Tdap/Td	_	_	92.31%	_
Zero Visits* 0.00% 0.00% 0.00% 0.00 Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life² 75.79% 66.35% 68.02% +1.67	Combination 1	_	_	89.42%	_
Six or More Visits 50.85% 54.35% 51.92% -2.43 Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ² 75.79% 66.35% 68.02% +1.67	Well-Child Visits in the First 15 Months of Life ²				•
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ² 75.79% 66.35% 68.02% +1.67	Zero Visits*	0.00%	0.00%	0.00%	0.00
Life ² /5.79% 66.33% 68.02% +1.67	Six or More Visits	50.85%	54.35%	51.92%	-2.43
Adolescent Well-Care Visits ² 58.16% 52.03% 49.78% -2.25	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ²	75.79%	66.35%	68.02%	+1.67
	Adolescent Well-Care Visits ²	58.16%	52.03%	49.78%	-2.25



Table B-4—Kaiser Permanente	Trend Tab	e		
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014
Weight Assessment and Counseling for Nutrition and Physical Activ	ity for Child	ren/Adolesc	ents	
BMI Assessment: Ages 3 to 11 Years	97.37%	97.23%	90.09%	-7.14
Nutrition Counseling: Ages 3 to 11 Years	73.25%	100.00%	90.09%	-9.91
Physical Activity Counseling: Ages 3 to 11 Years	73.25%	100.00%	90.09%	-9.91
BMI Assessment: Ages 12 to 17 Years	95.45%	97.87%	92.16%	-5.71
Nutrition Counseling: Ages 12 to 17 Years	71.21%	100.00%	92.16%	-7.84
Physical Activity Counseling: Ages 12 to 17 Years	71.21%	100.00%	92.16%	-7.84
BMI Assessment: Total	96.67%	97.51%	90.74%	-6.77
Nutrition Counseling: Total	72.50%	100.00%	90.74%	-9.26
Physical Activity Counseling: Total	72.50%	100.00%	90.74%	-9.26
Appropriate Testing for Children with Pharyngitis	_	_	91.15%	_
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	_	_	38.71%	_
Continuation	_	_	NA	_
Asthma Medication Ratio				
Ages 5 to 11 Years	_	_	NA	_
Ages 12 to 18 Years	_	_	NA	_
Ages 19 to 50 Years	_	_	NA	_
Ages 51 to 64 Years	_	_	NA	_
Total	_	_	NA	_
Access to Care				
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	_	_	95.96%	_
Ages 25 Months to 6 Years	_	_	90.78%	_
Ages 7 to 11 Years	_	_	95.47%	_
Ages 12 to 19 Years	_	_	95.97%	_
Use of Services†	•			
Ambulatory Care: Total				
Outpatient Visits Per 1,000 MM: Total	232.89		163.04	_
Emergency Department Visits Per 1,000 MM: Total	24.34	24.73	10.69	-14.04



Table B-4—Kaiser Permanente Trend Table					
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014	
Inpatient Utilization—General Hospital/Acute Care: Total					
Discharges per 1,000 MM (Total Inpatient)	0.91	_	0.78	_	
Days per 1,000 MM (Total Inpatient)	2.92	_	2.41	_	
Average Length of Stay (Total Inpatient)	3.20	_	3.09	_	
Discharges per 1,000 MM (Medicine)	0.63	_	0.58	_	
Days per 1,000 MM (Medicine)	1.67	_	1.73	_	
Average Length of Stay (Medicine)	2.66	_	2.98	_	
Discharges per 1,000 MM (Surgery)	0.12		0.13	_	
Days per 1,000 MM (Surgery)	0.45	_	0.51		
Average Length of Stay (Surgery)	3.86	_	3.83		
Discharges per 1,000 MM (Maternity)	0.31	_	0.14	_	
Days per 1,000 MM (Maternity)	1.50	_	0.35	_	
Average Length of Stay (Maternity)	4.80	_	2.50	_	

[—] is shown when no data were available or the measure was not reported in the HEDIS 2012 or the HEDIS 2013 aggregate reports.

^{*} For the Well-Child Visits in the First 15 Months of Life—Zero Visits indicator, a lower rate indicates better performance.

[†] For measures in the *Use of Services* domain, statistical tests across years were not performed because variances were not provided in the plan-submitted file; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Individual plan demographics should be considered when reviewing performance.

¹ The Department's reporting requirement for the *Childhood Immunization Status* measure was hybrid in HEDIS 2012 and 2014 but administrative in HEDIS 2013. Nonetheless, being a staff HMO, Kaiser's administrative data and medical record data are fully integrated in its system for HEDIS reporting. Despite choosing hybrid methodology for measure reporting, almost all the rates were derived from administrative data. The HEDIS 2012, 2013, and 2014 rates displayed here are Kaiser's final rates in its submitted file.

² The Department's reporting requirement for these measures was administrative in HEDIS 2012 and HEDIS 2013 but hybrid in HEDIS 2014: Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; and Adolescents Well-Care Visits. Nonetheless, being a staff HMO, Kaiser's administrative data and medical record data are integrated in its system for HEDIS reporting. Despite choosing hybrid methodology for measure reporting, almost all the rates were derived from administrative data. The HEDIS 2012, 2013, and 2014 rates displayed here are Kaiser's final rates in its submitted file.



Table B-5—Rocky Mountain Health Plans Trend Table						
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014		
Pediatric Care						
Childhood Immunization Status ¹						
DTaP	86.39%	62.94%	74.83%	+11.89		
IPV	89.35%	78.17%	85.76%	+7.59		
MMR	86.39%	82.23%	83.77%	+1.54		
HiB	89.35%	80.20%	83.44%	+3.24		
Hepatitis B	84.62%	53.81%	85.10%	+31.29		
VZV	83.43%	79.70%	83.77%	+4.07		
Pneumococcal Conjugate	82.84%	62.94%	75.83%	+12.89		
Hepatitis A	21.30%	65.48%	68.21%	+2.73		
Rotavirus	63.91%	57.36%	64.57%	+7.21		
Influenza	54.44%	53.81%	56.95%	+3.14		
Combination 2	77.51%	43.15%	69.87%	+26.72		
Combination 3	74.56%	42.64%	67.88%	+25.24		
Combination 4	21.30%	36.55%	57.95%	+21.40		
Combination 5	60.36%	32.99%	51.66%	+18.67		
Combination 6	48.52%	27.41%	49.67%	+22.26		
Combination 7	18.34%	29.95%	49.01%	+19.06		
Combination 8	18.34%	25.38%	44.70%	+19.32		
Combination 9	42.01%	23.35%	40.40%	+17.05		
Combination 10	16.57%	22.34%	38.74%	+16.40		
Immunizations for Adolescents						
Meningococcal	_	_	55.13%	_		
Tdap/Td	_	_	88.97%	_		
Combination 1	_	_	55.13%	_		
Well-Child Visits in the First 15 Months of Life ²						
Zero Visits*	2.70%	4.79%	2.67%	-2.12		
Six or More Visits	23.42%	20.55%	69.08%	+48.53		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ³	60.98%	62.14%	55.41%	-6.73		
Adolescent Well-Care Visits ⁴	41.20%	41.10%	40.40%	-0.70		



Table B-5—Rocky Mountain Health Plans Trend Table						
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Assessment: Ages 3 to 11 Years	66.41%	74.74%	78.00%	+3.26		
Nutrition Counseling: Ages 3 to 11 Years	63.36%	66.44%	61.67%	-4.77		
Physical Activity Counseling: Ages 3 to 11 Years	58.02%	59.17%	58.33%	-0.84		
BMI Assessment: Ages 12 to 17 Years	67.06%	73.01%	77.78%	+4.77		
Nutrition Counseling: Ages 12 to 17 Years	53.53%	49.69%	52.94%	+3.25		
Physical Activity Counseling: Ages 12 to 17 Years	60.00%	57.67%	51.63%	-6.04		
BMI Assessment: Total	66.67%	74.12%	77.92%	+3.80		
Nutrition Counseling: Total	59.49%	60.40%	58.72%	-1.68		
Physical Activity Counseling: Total	58.80%	58.63%	56.07%	-2.56		
Appropriate Testing for Children with Pharyngitis	_	_	82.52%	_		
Follow-up Care for Children Prescribed ADHD Medication						
Initiation	_	_	44.64%	_		
Continuation		_	NA	_		
Asthma Medication Ratio						
Ages 5 to 11 Years			NA	_		
Ages 12 to 18 Years		_	NA	_		
Ages 19 to 50 Years	_	_	NA	_		
Ages 51 to 64 Years	<u> </u>	_	NA	_		
Total	<u> </u>	_	75.56%	_		
Access to Care	<u>'</u>	<u> </u>	'	'		
Children's and Adolescents' Access to Primary Care Practitioners						
Ages 12 to 24 Months	_	_	88.60%	_		
Ages 25 Months to 6 Years	<u> </u>	_	77.74%	_		
Ages 7 to 11 Years	_	_	86.94%	_		
Ages 12 to 19 Years	_	_	86.55%	_		
Use of Services†			1			
Ambulatory Care: Total						
Outpatient Visits Per 1,000 MM: Total	252.41	_	208.28	_		
Emergency Department Visits Per 1,000 MM: Total	24.02	22.76	19.82	-2.94		



Table B-5—Rocky Mountain Health Plans Trend Table					
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013–2014	
Inpatient Utilization—General Hospital/Acute Care: Total					
Discharges per 1,000 MM (Total Inpatient)	1.64	_	0.98	_	
Days per 1,000 MM (Total Inpatient)	4.18	_	2.23	_	
Average Length of Stay (Total Inpatient)	2.54	_	2.28	_	
Discharges per 1,000 MM (Medicine)		_	0.64	_	
Days per 1,000 MM (Medicine)		_	1.32	_	
Average Length of Stay (Medicine)		_	2.08	_	
Discharges per 1,000 MM (Surgery)			0.34	_	
Days per 1,000 MM (Surgery)		_	0.89	_	
Average Length of Stay (Surgery)		_	2.64	_	
Discharges per 1,000 MM (Maternity)		_	0.02	_	
Days per 1,000 MM (Maternity)	0.10	_	0.06	_	
Average Length of Stay (Maternity)	2.00	_	3.00	_	

[—] is shown when no data were available or the measure was not reported in the HEDIS 2012 or the HEDIS 2013 aggregate reports.

^{*} For the Well-Child Visits in the First 15 Months of Life—Zero Visits indicator, a lower rate indicates better performance.

[†] For measures in the *Use of Services* domain, statistical tests across years were not performed because variances were not provided in the plan-submitted file; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Individual plan demographics should be considered when reviewing performance.

The Department's reporting requirement for the *Childhood Immunization Status* measure was hybrid in HEDIS 2012 and 2014 but administrative in HEDIS 2013. Historical rate changes may not reflect actual performance changes. The HEDIS 2013 rates displayed reflect administrative data only and are not the final, reported hybrid rate in the plan-submitted file. RMHP reported the final, hybrid rates of 75.63 percent, 87.82 percent, 83.76 percent, 86.29 percent, 83.25 percent, 81.73 percent, 75.63 percent, 67.51 percent, 65.99 percent, 55.33 percent, 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*— *DTaP* through *Combination 10* indicators for HEDIS 2013, respectively.

² The Department's reporting requirement for all the indicators under the *Well-Child Visits in the First 15 Months of Life* measure were administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. Historical rate changes may not reflect actual performance changes. The HEDIS 2012 and 2013 rates for the *Zero Visits* and the *Six or More Visits* indicators displayed here reflect administrative data only and are not the final, reported hybrid rates in the plan's IDSS files. The final, reported hybrid HEDIS 2012 and 2013 rates for the *Zero Visits* indicator were 1.80 percent and 3.42 percent, and the rates for the *Six or More Visits* indicator was 63.96 percent and 65.75 percent, respectively.

³ The Department's reporting requirement for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure was administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. Historical rate changes may not reflect actual performance changes. The HEDIS 2012 rate displayed here is the final, reported rate in RMHP's submitted file. The HEDIS 2013 rate displayed here reflects administrative data only and is not the final, reported hybrid rate in the plan's file. The final, reported hybrid HEDIS 2013 rate was 66.89 percent.

⁴ The Department's reporting requirement for the *Adolescent Well-Care Visits* measure was administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. The HEDIS 2012 and 2013 rates displayed here reflect administrative data only and are not the final, reported hybrid rates in the plan's submitted files. The final, reported hybrid HEDIS 2012 and 2013 rates were 44.91 percent and 40.18 percent, respectively.



Table B-6—State Managed Care Network Trend Table						
Measures						
Access to Care						
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	72.26%	78.59%	70.80%	-7.79		
Postpartum Care	67.88%	67.88%	63.26%	-4.62		



Table B-7—Colorado CHP+	Table B-7—Colorado CHP+ Statewide Trend Table					
Measures	HEDIS 2012	HEDIS 2013	HEDIS 2014	Change From 2013– 2014	Plan Rate Range [¥]	
Pediatric Care						
Childhood Immunization Status ¹						
DTaP	83.08%	65.98%	77.85%	+11.87	74.83%–89.33%	
IPV	90.96%	77.41%	88.08%	+10.67	85.76%–98.67%	
MMR	90.02%	81.88%	86.65%	+4.77	83.77%–96.08%	
HiB	91.90%	78.84%	88.35%	+9.51	83.44%-98.67%	
Hepatitis B	87.90%	70.00%	86.90%	+16.90	85.10%-97.33%	
VZV	89.08%	79.64%	85.62%	+5.98	83.77%-97.06%	
Pneumococcal Conjugate	83.32%	66.16%	78.61%	+12.45	75.83%–93.33%	
Hepatitis A	37.84%	70.71%	75.27%	+4.56	68.21%-96.08%	
Rotavirus	64.75%	55.80%	69.60%	+13.80	64.57%-88.00%	
Influenza	51.35%	50.36%	60.00%	+9.64	56.95%-78.67%	
Combination 2	76.73%	58.04%	73.25%	+15.21	69.87%-89.33%	
Combination 3	74.50%	55.89%	70.33%	+14.44	67.88%-89.33%	
Combination 4	35.36%	51.43%	63.50%	+12.07	57.95%-89.33%	
Combination 5	56.16%	44.11%	58.90%	+14.79	51.66%-81.33%	
Combination 6	44.54%	36.70%	51.53%	+14.83	49.64%-76.00%	
Combination 7	27.37%	41.16%	55.43%	+14.27	49.01%-81.33%	
Combination 8	23.73%	34.73%	47.79%	+13.06	44.70%-76.00%	
Combination 9	37.01%	30.45%	44.66%	+14.21	40.40%-68.00%	
Combination 10	19.62%	28.93%	42.56%	+13.63	38.74%-68.00%	
Immunizations for Adolescents	'	'				
Meningococcal	_	_	67.02%	_	25.81%-90.98%	
Tdap/Td	_	_	87.99%	_	61.29%-92.31%	
Combination 1	<u> </u>	_	66.27%	_	25.81%-90.16%	
Well-Child Visits in the First 15 Months of Life ²						
Zero Visits*	4.21%	2.67%	2.16%	-0.51	0.00%-2.67%	
Six or More Visits	25.28%	25.48%	67.41%	+41.93	51.92%-70.80%	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ²	64.17%	61.26%	66.29%	+5.03	55.41%-70.35%	
Adolescent Well-Care Visits ²	44.79%	42.09%	44.00%	+1.91	37.02%-49.78%	



Table B-7—Colorado CHP+ Statewide Trend Table					
Measures		HEDIS 2013	HEDIS 2014	Change From 2013– 2014	Plan Rate Range [¥]
Weight Assessment and Counseling for Nutrition and Physical A	ctivity for	Children/	Adolescen	ets	
BMI Assessment: Ages 3 to 11 Years	60.05%	69.32%	69.60%	+0.28	36.45%-93.96%
Nutrition Counseling: Ages 3 to 11 Years	63.34%	66.53%	66.24%	-0.29	33.50%-0.09%
Physical Activity Counseling: Ages 3 to 11 Years	46.44%	55.43%	55.93%	+0.50	29.06%-90.09%
BMI Assessment: Ages 12 to 17 Years	55.69%	67.98%	69.60%	+1.62	44.27%-93.15%
Nutrition Counseling: Ages 12 to 17 Years	53.36%	55.23%	61.14%	+5.91	24.43%-92.16%
Physical Activity Counseling: Ages 12 to 17 Years	54.04%	58.75%	62.79%	+4.04	46.56%-92.16%
BMI Assessment: Total	57.50%	68.80%	69.59%	+0.79	39.52%-93.67%
Nutrition Counseling: Total	58.51%	62.24%	64.47%	+2.23	29.94%-90.74%
Physical Activity Counseling: Total	49.16%	56.68%	58.26%	+1.58	35.93%-90.74%
Appropriate Testing for Children with Pharyngitis		_	79.09%	_	57.14%-91.15%
Follow-up Care for Children Prescribed ADHD Medication					
Initiation		_	16.78%	_	0.55%-44.64%
Continuation		_	30.77%	_	0.00%-0.00%
Asthma Medication Ratio					
Ages 5 to 11 Years		_	76.22%	_	80.56%-80.56%
Ages 12 to 18 Years		_	70.47%		73.91%-73.91%
Ages 19 to 50 Years		_	NA	_	_
Ages 51 to 64 Years		_	NA		_
Total		_	73.78%		75.56%-77.61%
Access to Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	72.26%	78.59%	70.80%	-7.79	70.80%-70.80%
Postpartum Care	67.88%	67.88%	63.26%	-4.62	63.26%-63.26%
Children's and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months		_	91.36%		86.61%-95.96%
Ages 25 Months to 6 Years		_	82.41%	_	74.84%-90.78%
Ages 7 to 11 Years	_	_	89.16%	_	84.35%-95.47%
Ages 12 to 19 Years	_		88.60%	_	86.55%-95.97%



Table B-7—Colorado CHP+ Statewide Trend Table					
Measures		HEDIS 2013	HEDIS 2014	Change From 2013– 2014	Plan Rate Range [¥]
Use of Services†					
Ambulatory Care: Total					
Outpatient Visits Per 1,000 MM: Total	224.09		214.08	_	111.45–239.95
Emergency Department Visits Per 1,000 MM: Total	27.79	30.07	26.47	-3.60	10.69–30.97
Inpatient Utilization—General Hospital/Acute Care: Total					
Discharges per 1,000 MM (Total Inpatient)	4.05		1.23	_	0.78-1.42
Days per 1,000 MM (Total Inpatient)	12.53		4.16	_	2.23-5.22
Average Length of Stay (Total Inpatient)	3.09		3.37	_	2.28-3.68
Discharges per 1,000 MM (Medicine)	1.00		0.85	_	0.39-0.97
Days per 1,000 MM (Medicine)	3.05		2.38	_	1.28-2.85
Average Length of Stay (Medicine)	3.05		2.81	_	2.08-3.29
Discharges per 1,000 MM (Surgery)	0.34		0.30	_	0.13-0.39
Days per 1,000 MM (Surgery)	2.17		1.56	_	0.46-2.10
Average Length of Stay (Surgery)	6.35	_	5.27	_	2.64-6.34
Discharges per 1,000 MM (Maternity)	5.49	_	0.19	_	0.02-0.25
Days per 1,000 MM (Maternity)	14.84	_	0.45	_	0.06-0.61
Average Length of Stay (Maternity)	2.70		2.44		1.50-3.00

[—] is shown when no data were available or the measure was not reported in the HEDIS 2012 or the HEDIS 2013 aggregate reports.

^{*} For the Well-Child Visits in the First 15 Months of Life—Zero Visits indicator, a lower rate indicates better performance.

[†] For measures in the *Use of Services* domain, statistical tests across years were not performed because variances were not provided in the plan-submitted file; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Individual plan demographics should be considered when reviewing performance.

[¥] Non-reportable rates such as NA, NB, or NR were excluded when calculating plan rate range.

¹ The Department's reporting requirement for this measure was hybrid in HEDIS 2012 and 2014 but administrative in HEDIS 2013. Historical rate changes may not reflect actual performance changes.

² The Department's reporting requirement for this measure was administrative in HEDIS 2012 and 2013 but hybrid in HEDIS 2014. Historical rate changes may not reflect actual performance changes.





This appendix contains detailed methodology for the following analysis components:

- Percentile ranking
- Star rating
- Trend analysis
- Data collection methods: Administrative versus Hybrid
- Measure audit results
- Understand sampling error

Percentile Rankings

Plan-specific and statewide performance levels are described in this report using several methods. In general, the plan rates or the statewide rates are compared to the corresponding national HEDIS 2013 Medicaid benchmarks. Since national HEDIS 2013 Medicaid percentiles are not available for the CHIP population, the CHP+ plans and the SMCN's rates as well as the Colorado CHP+ weighted averages were compared to the national HEDIS 2013 Medicaid percentiles, which comprised all Medicaid plans. The HEDIS 2013 benchmarks, expressed in percentiles of national performance for different measures, were the most recent data available from NCQA at the time of the publication of this report. Since the NCQA Audit Means and Percentiles data that is comprised of HEDIS Means and Percentiles for Reporting is the proprietary intellectual property of NCQA, this report will not display any actual percentile values. Nonetheless, percentile level rankings are presented. Since the HEDIS 2013 percentiles are displayed to the second decimal place, planspecific rates and statewide rates are rounded to the second decimal place before the plan's performance level is determined. When a health plan with a reported rate exceeds the 90th percentile, this means that the plan's performance ranks in the top 10 percent of all health plans nationally. Similarly, health plans reporting rates below the 25th percentile rank in the bottom 25 percent of all health plans nationally.

This report uses two consistent methods to describe plan and statewide performance. First, planspecific or statewide rates are compared to a high performance level (HPL) and a low performance level (LPL) predetermined by the Department. HSAG uses this approach to report plan-specific or statewide performance based on a plan's rank relative to the HPL and the LPL. The results are mostly reported in the horizontal bar graph displayed for each measure within each dimension of care section. For this report, the 90th percentile is determined as the HPL and the 25th percentile as the threshold associated with the LPL. For the inverted measures such as *Well-Child Visits in the First 15 Months of Life—Zero Visits*, since a lower rate (i.e., fewer "no-visits" or fewer "poor control" cases) indicates better care, the 10th percentile (rather than the 90th percentile) represents high performance and the 75th percentile (rather than the 25th percentile) represents low performance.



Star Ratings

HSAG also reported plan-specific and statewide performance for each measure using a 5-star rating system, shown in Table C-1 below. The 5-star rating system provides a more detailed evaluation of the health plan's and statewide performance. Star rating results are displayed in a summary table under the Summary of Findings heading within each dimension of care section.

Table C-1—Star Rating Summary				
Performance Star Description				
Excellent Performance (★★★★)	indicates a rate at or above the 90th percentile			
Good Performance (★★★)	indicates a rate at or above the 75th percentile and below the 90th percentile			
Average Performance (★★★)	indicates a rate at or above the 25th percentile and below the 75th percentile			
Fair Performance (★★)	indicates a rate at or above the 10th percentile and below the 25th percentile			
Poor Performance (★)	indicates a rate below the 10th percentile			
NA (No stars assigned)	indicates NA audit designation (i.e., too small denominator size)			
NR (No stars assigned)	indicates NR audit designation (i.e., not reported)			
NB (No stars assigned)	indicates NB audit designation (i.e., benefit not offered)			
NC (No stars assigned)	indicates Not Comparable (i.e., measure not comparable to national percentiles or national percentiles not available)			

Performance level analysis is performed for all measures except those under the Use of Services dimension. Since changes in utilization rates as reported in the IDSS may be due to factors other than quality improvement initiatives that aim at reducing costly services use (e.g., changes in a member's demographic and clinical profiles), *Ambulatory Care* and *Inpatient Utilization—General Hospital/Acute Care* are considered a utilization-based measures and not strictly performance measures. As such, performance summaries are not included for this measure.

For the Well-Child Visits in the First 15 Months of Life—Zero Visits indicator, where lower rates represent better performance, the percentiles were inverted to align with performance (e.g., if the Well-Child Visits in the First 15 Months of Life—Zero Visits rate was above the 10th percentile and at or below the 25th percentile, it would be inverted to be at or above the 75th percentile and below the 90th percentile to represent the level of performance, i.e., four stars $\bigstar \bigstar \bigstar \bigstar$.



Trend Analysis

In addition to the performance level and star rating results, HSAG also evaluates the extent of changes observed in the statewide rates and in the plan rates in this report. For each measure, a graph depicting three-year-changes in statewide rates is shown under each dimension of care section. Plan-level rate changes are reported in Appendix B. Plan-specific HEDIS 2014 rates are compared to their HEDIS 2013 results for each measure, using Pearson's Chi-square tests.

In general, results from the trend analysis and statistical significance tests provide information on whether a change in the rate may suggest improvement or decline in performance. Nonetheless, changes (regardless of whether they are statistically significant) could be related to the following factors independent of any effective interventions designed to improve the quality of care:

- The observed changes could be due to substantial changes in measure specifications. Appendix D lists measures with specification changes made by NCQA for HEDIS 2014.
- The observed changes could be due to health plans using different data collection methods between HEDIS reporting years or due to a change in the data reporting requirements made by the Department. Appendix C also describes the two data collection methods a health plan could use for reporting HEDIS measures. Since hybrid methodology uses medical records to supplement the results using administrative data, health plans using hybrid methods generally report higher rates when compared to using the administrative method only.
- The observed changes could be due to substantial changes in membership composition within a health plan.

At the statewide level, if the number of health plans reporting *NR* differs vastly from year to year, the statewide performance may not represent all of the contracted health plans; and any changes observed across years may need to take this factor into consideration.

Although three years of HEDIS rates are presented for utilization measures under the Use of Services dimension, statistical significance testing was not performed. Since these measures report rates per 1,000 member months or averages instead of percentages, variances were not available in the IDSS for HSAG to use for statistical testing. As such, differences in the reported rates for these measures were presented without statistical test results.



Collection Methods: Administrative Versus Hybrid

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data, derived from claims and encounters (i.e., statistical claims). In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely from administrative data. Medical records cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed. There are measures in one of the three dimensions of care in which HEDIS methodology requires that the rates be derived using only the administrative method, and medical record review is not permitted.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data and then extract a systematic sample of members from the eligible population, which becomes the denominator. Administrative data are used to identify services provided to those members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher rates because the completeness of documentation in the medical record exceeds what is typically captured in administrative data; however, the medical record review component of the hybrid method is considered more labor intensive. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The health plan chooses to use the hybrid method. After randomly selecting 411 eligible members, the health plan finds that 161 members had evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record. Therefore, the final rate for this measure, using the hybrid method, would be (161 + 54)/411, or 52.3 percent, a 13.1 percentage point increase from the administrative only rate of 39.2 percent.

Rotated Measures

It should be noted that NCQA allows health plans to "rotate" select HEDIS measures in certain circumstances. A "rotation" schedule enables health plans to use the audited and reportable rate from the prior year. This strategy allows health plans with higher rates for some measures to focus resources on other measures' rates. Rotated measures must have been audited in the prior year and must have received a *Report* audit designation. Only hybrid measures are eligible to be rotated. The health plans that meet the HEDIS criteria for hybrid measure rotation may exercise that option if they choose to do so.



Understanding Sampling Error

Correct interpretation of results for measures collected using the HEDIS hybrid methodology requires an understanding of sampling error. It is rarely possible, logistically or financially, to complete medical record review for the entire eligible population for a given measure. Measures collected using the HEDIS hybrid method include only a sample from the eligible population, and statistical techniques are used to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire eligible population, the process of sample selection must be such that everyone in the eligible population has an equal chance of being selected. The HEDIS hybrid method prescribes a systematic sampling process selecting at least 411 members of the eligible population. Health plans may use a 5 percent, 10 percent, 15 percent, or 20 percent oversample to replace invalid cases (e.g., a male selected for *Postpartum Care*).

Figure C-1 shows that if 411 health plan members are included in a measure, the margin of error is approximately \pm 4.9 percentage points. Note that the data in this figure are based on the assumption that the size of the eligible population is greater than 2,000. The smaller the sample included in the measure, the larger the sampling error.

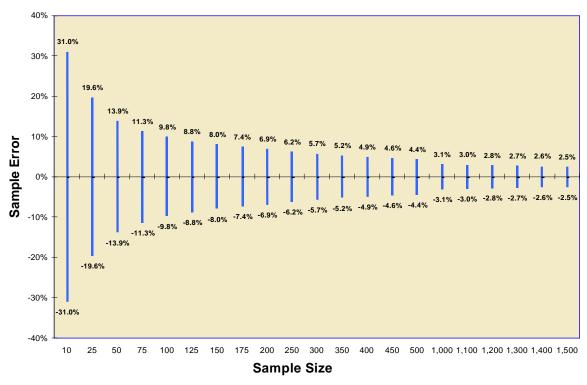


Figure C-1—Relationship of Sample Size to Sample Error

As Figure C-1 shows, sample error decreases as the sample size gets larger. Consequently, when sample sizes are very large and sampling errors are very small, almost any difference is statistically significant. This does not mean that all such differences are important. On the other hand, the difference between two measured rates may not be statistically significant but may, nevertheless, be important. The judgment of the reviewer is always a requisite for meaningful data interpretation.



Appendix D. NCQA Specification Changes to Measures

The following is a list of measures required by the Department for HEDIS 2013 and 2014 reporting that contain changes NCQA made to specifications from 2013 to 2014. These changes may have an effect on the rates reported by health plans.

NCQA Changes to HEDIS 2014 Measures

Well-Child Visits in the First 15 Months of Life

Revised example in continuous enrollment to account for leap year.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

- Clarified that ranges and thresholds do not meet numerator criteria for BMI percentile.
- Clarified that members must receive educational materials during a face-to-face visit in order to meet Hybrid specification criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators.
- Added a note stating that a physical exam finding or observation alone is not compliant for Counseling for physical activity.
- Clarified in the note section that services specific to an acute or chronic condition do not count toward the Counseling for nutrition and Counseling for physical activity indicators.

Prenatal and Postpartum Care

- Moved steps to identify the eligible population (which previously were steps 1 and 2 under the Denominator section of the Administrative specification) to the Eligible Population section.
- Removed references to "family practitioner" and "midwife" because these practitioners are included in the definitions of PCP and OB/GYN and other prenatal care practitioners, respectively.
- Consolidated the steps for identifying numerator events.
- Consolidated four decision rules (formerly in Table PPC-C) into three decision rules.



Appendix E. Information System Findings

Information Systems Findings

NCQA's IS standards are the guidelines used by certified HEDIS compliance auditors to assess a health plan's HEDIS reporting capabilities. HSAG evaluated each health plan on seven IS standards. To assess a health plan's adherence to standards, HSAG reviewed several documents for the CHP+ plans and the SMCN which included the final audit reports (generated by an NCQA-licensed audit organization [LO]), IDSS files, and audit review tables. The findings indicated that, overall, the health plans were compliant with most of NCQA's IS standards. However, none of the issues identified resulted in a bias to any HEDIS results. All health plans were able to accurately report all of the Department-required HEDIS performance measures.

All health plans except Kaiser contracted with a vendor to produce the reported HEDIS measures. The vendors submitted programming codes developed for each HEDIS measure to NCQA to undergo the measure certification process. NCQA certification helps to ensure the validity of the results that are produced. Through certification, NCQA tests that software produces valid results and the calculations meet NCQA standards. Kaiser's auditor reviewed and approved source code for each reported measure.

Each Colorado CHP+ health plan contracted with an LO to perform the NCQA HEDIS Compliance Audit. HSAG audited the SMCN program, while the other health plans contracted with different LOs to perform their audits. The following table summarized the IS standards' audit findings for all CHP+ health plans and the SMCN program.



Table E-1—Summary of Complia	ance With IS Standards
NCQA's IS Standards	HSAG's Findings Based on HEDIS 2014 FAR Review
 IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture Industry standard codes are required and captured. Primary and secondary diagnosis codes are identified. Nonstandard codes (if used) are mapped to industry standard codes. Standard submission forms are used. Timely and accurate data entry processes and sufficient edit checks are used. Data completeness is continually assessed, and all contracted vendors involved in medical claims processing are monitored. 	The SMCN and all the MCOs were fully compliant with this standard. No issues or concerns were noted for this standard relevant to the selected Colorado CHP+ measures.
 IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry All HEDIS-relevant information for data entry or electronic transmissions of enrollment data are accurate and complete. Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place. The health plans continually assess data completeness and take steps to improve performance. The health plans effectively monitor the quality and accuracy of electronic submissions. The health plans have effective control processes for the transmission of enrollment data. 	The SMCN and all the MCOs were fully compliant with this standard. However, auditors from two MCOs and the SMCN noted their plans' challenges in ensuring the timely completeness of CHP+ enrollment data due to lack of immediate reconciliation with the State. Nonetheless, despite these challenges, the auditors identified no major impact on HEDIS reporting. Final audit reports for the SMCN and Colorado Access indicated the plan (also a third-party administrator for SMCN on behalf of the Department) had effective routines to capture correct enrollment data. For the other MCO (Denver Health Medical Plan), the auditor noted that despite challenges and changes in enrollment, the rates remained consistent over the years. None of the measures required for CHP+ reporting had an "NR" (Not Report due to material bias) audit designation in the IDSS.
 IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry Provider specialties are fully documented and mapped to HEDIS provider specialties. Effective procedures for submitting HEDIS-relevant information are in place. Electronic transmissions of practitioner data are checked to ensure accuracy. Processes and edit checks ensure accurate and timely entry of data into the transaction files. Data completeness is assessed and steps are taken to improve performance. Vendors are regularly monitored against expected performance standards. 	The SMCN and all MCOs were fully compliant with IS 3.0. No issues or concerns were noted for this standard relevant to the selected Colorado CHP+ measures.



HSAG's Findings Based on HEDIS 2014 FAR Review MCN and all MCOs were fully compliant with D. No issues or concerns were noted for this ard relevant to the selected Colorado CHP+ arres.
O. No issues or concerns were noted for this ard relevant to the selected Colorado CHP+
SMCN, the Department and its third-party histrator did not use any supplemental data for its 2014. All MCOs were fully compliant with D. Each MCO reported using both nonstandard tandard supplemental databases for reporting. Colorado Immunization Information System D and prior years' audited medical record data mentioned in several final audit reports as emental databases of choice. No issues or rms were noted for this standard relevant to the ed Colorado CHP+ measures.
standard was not applicable to the selected ado CHP+ measures under the scope of the
MCN and all MCOs were fully compliant with D. The SMCN and all but one MCO (Kaiser) a software vendor for HEDIS reporting. No or concerns were noted for this standard ant to the selected Colorado CHP+ measures.
S



Appendix F. Glossary

Appendix F includes terms, acronyms, and abbreviations that are commonly used in HEDIS and NCQA literature and text. This glossary can be used as a reference and guide to identify common language used throughout the report.



Terms, Acronyms, and Abbreviations

Administrative Data

Any automated data within a health plan (e.g., claims/encounter data, member data, provider data, hospital billing data, pharmacy data, and laboratory data).

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data. In addition, the numerator(s), or services provided to the members who are in the eligible population, are solely derived from administrative data. Medical records cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed.

The administrative method is cost efficient but can produce lower rates due to incomplete data submission by capitated providers. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The health plan chooses to perform the administrative method and finds that 4,000 members out of the 10,000 have evidence of a postpartum visit using administrative data. The final rate for this measure, using the administrative method, would therefore be 4,000/10,000, or 40 percent.

Audit Result

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its HEDIS measure rates. Each measure included in the HEDIS audit receives either a *Report*, *Not Applicable*, *No Benefit*, or *Not Report* audit result.

Software Vendor

A third party, with source code certified by NCQA, that contracts with a health plan to write source code for HEDIS measures. For the measures to be certified, the vendor must submit programming codes associated with the measure to NCQA for automated testing of program logic, and a minimum percentage of the measures must receive a "Pass" or "Pass With Qualifications" designation.

Continuous Enrollment Requirement

The minimum amount of time that a member must be enrolled in a health plan to be eligible for inclusion in a measure to ensure that the health plan has a sufficient amount of time to be held accountable for providing services to that member.

CHIP

Child Health Insurance Program.

CHP+

Child Health Plan Plus.



CPT®

Current Procedural Terminology (CPT®) is a listing of billing codes generated by the American Medical Association to report the provision of medical services and procedures.^{F-1}

Data Completeness

The degree to which occurring services/diagnoses appear in the health plan's administrative data systems.

Denominator

The number of members who meet all criteria specified in a measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.

DHMP

Denver Health Medical Plan, Inc.

DTaP

Diphtheria, tetanus toxoids, and acellular pertussis vaccine.

ED

Emergency department.

EDI

Electronic data interchange is the direct computer-to-computer transfer of data.

Electronic Data

Data that are maintained in a computer environment versus a paper environment.

Encounter Data

Billing data received from a capitated provider. Although the health plan does not reimburse the provider for each encounter, submission of encounter data allows a health plan to collect the data for future HEDIS reporting.

EQR

External quality review.

F.1 American Medical Association. *CPT-Current Procedural Terminology*. Available at: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml. Accessed on: August 30, 2011.



Exclusions

Conditions outlined in HEDIS measure specifications that describe when a member should not be included in the denominator.

Final Audit Report

Following a health plan's completion of any corrective actions, an auditor completes the final audit report, documenting all final findings and results of the HEDIS audit. The final report includes a summary report, IS capabilities assessment, medical record review validation findings, measure results, and audit opinion (the final audit statement).

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.

HEDIS Repository

The data warehouse where all data used for HEDIS reporting are stored.

HEDIS Warehouse

See HEDIS repository.

HiB Vaccine

Haemophilus influenza type B vaccine.

НМО

Health maintenance organization.

HPL

High performance level. For most key measures, the Department has defined the HPL as the most recent national HEDIS Medicaid 90th percentile, except for one measure (*Well-Child Visits in the First 15 Months of Life—Zero Visits*), for which a lower rate indicates better performance. For this measure, the 10th percentile (rather than the 90th) shows excellent performance.

HSAG

Health Services Advisory Group, Inc.

Hybrid Measures

Measures that can be reported using the hybrid method.

Hybrid Method

The hybrid method requires health plans to identify the eligible population using administrative data, then extract a systematic sample of 411 members from the eligible population, which becomes the denominator. Administrative data are then used to identify services provided to those 411



members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces better results but is considerably more labor intensive. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The health plan chooses to perform the hybrid method. After randomly selecting 411 eligible members, the health plan finds that 161 members have evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who do not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 are found to have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would therefore be (161 + 54)/411, or 52 percent.

ICD-9-CM

ICD-9-CM, the acronym for the International Classification of Diseases, Ninth Revision, Clinical Modification, is the classification of diseases and injuries into groups according to established criteria used for reporting morbidity, mortality, and utilization rates, as well as for billing purposes.

IDSS

The Interactive Data Submission System is a tool used to submit data to NCQA.

Inpatient Data

Data derived from an inpatient hospital stay.

IPV

Inactivated polio virus vaccine.

IS

Information System: An automated system for collecting, processing, and transmitting data.

IS Standards

Information system (IS) standards: An NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data F-2

IT

Information technology: The technology used to create, store, exchange, and use information in its various forms.

LPL

Low performance level. For most key measures, the Department has defined the LPL as the most recent national HEDIS Medicaid 25th percentile. For one measure (*Well-Child Visits in the First 15 Months of Life—Zero Visits*), a lower rate indicates better performance. The LPL for this measure is the 75th percentile rather than the 25th percentile.

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



Manual Data Collection

Collection of data through a paper versus an automated process.

Material Bias

For most measures reported as a rate, any error that causes a \pm 5 percent difference in the reported rate is considered materially biased. For non-rate measures, any error that causes a \pm 10 percent difference in the reported rate or calculation is considered materially biased.

Medical Record Validation

The process that auditors follow to verify that a health plan's medical record abstraction meets industry standards and abstracted data are accurate.

Medicaid Percentiles

The NCQA national percentiles for each HEDIS measure for the Medicaid product line used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.

Membership Data

Electronic health plan files containing information about members, such as name, date of birth, gender, current address, and enrollment (i.e., when the member joined the health plan).

MMR

Measles, mumps, and rubella vaccine.

NA

Not Applicable: If a health plan's denominator for a measure is too small (i.e., less than 30) to report a valid rate, the result/rate is NA.

NB

No Benefit: If a health plan did not offer the benefit required by the measure.

NCQA

The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed health care delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.

NR

The Not Report HEDIS audit finding.

A measure has an *NR* audit finding for one of three reasons:

- 1. The health plan chose not to report the measure.
- 2. The health plan calculated the measure but the result was materially biased.
- 3. The health plan was not required to report.



Numerator

The number of members in the denominator who received all the services as specified in the measure.

Over-read Process

The process of re-reviewing a sample of medical records by a different abstractor to assess the degree of agreement between two different abstractors and ensure the accuracy of abstracted data. The over-read process should be conducted by a health plan as part of its medical record review process. Auditors overread a sample of the health plan's medical records as part of the audit process.

PCP

Primary care practitioner.

PCV

Pneumococcal conjugate vaccine.

Provider Data

Electronic files containing information about physicians, such as type of physician, specialty, reimbursement arrangement, and office location.

Retroactive Enrollment

When the effective date of a member's enrollment in a health plan occurs prior to the date that the health plan is notified of that member's enrollment. Medicaid members who are retroactively enrolled in a health plan must be excluded from a HEDIS measure denominator if the time period from the date of enrollment to the date of notification exceeds the measure's allowable gap specifications.

Revenue Codes

Cost codes for facilities to bill based on the categories of services, procedures, supplies, and materials.

RMHP

Rocky Mountain Health Plans.

SMCN

State Managed Care Network.

The Department

The Colorado Department of Health Care Policy and Financing.

UB-04 Claims

A type of claim form used to bill hospital-based inpatient, outpatient, emergency room and clinic drugs, supplies, and/or services. UB-04 codes are primarily Type of Bill and Revenue codes. The UB-04 replaced the UB-92.



Vendor

Any third party that contracts with a health plan to perform services. The most common delegated services from venders are pharmacy services, vision care services, laboratory services, claims processing, HEDIS software services, and provider credentialing.

VZV

Varicella zoster virus (chicken pox) vaccine.

2013–2014 Child Health Plan *Plus* Technical Report

September 2014

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

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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.

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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 Project	cts					
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.



2. External Quality Review (EQR) Activities

Activities

This EQR report includes a description of four performance activities for the CHP+ health plans: compliance monitoring evaluations, validation of performance measures, 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 <i>Met</i> 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									
# of Sco # of Applicable # # Not # Not (% of Record Review Elements Elements Met Met Applicable 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

FINDINGS, STRENGTHS, AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS, AND ACCESS



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



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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 <i>Met</i> 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 <i>Met</i> 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.

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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 <i>Met</i> 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 <i>Met</i> 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

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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 <i>Met</i> 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 <i>Met</i> 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 <i>Met</i> 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	# Not Applicable	Score (% of <i>Met</i> Elements)					
Denials	101	51	36	15	50	71%			
Total	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

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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				
FY 2013–2014 Statew Standards 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			
 The health plan calculated the measure but the rate was materially biased; The health plan chose not to report the measure; or 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 methodole	ogy required by the Department from H	EDIS 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					
Dayfayman a Maaaaa	HEDIS	S Rate	Percentile	HEDIS 2014	
Performance Measures	2013	2014	Ranking ¹	Audit Result	
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					
Dorforman Marrows	HEDIS	S Rate	Percentile	HEDIS 2014	
Performance Measures	2013	2014	Ranking ¹	Audit Result	
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 Medic	cation				
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 H	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.

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

- 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

[—] 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.

^{**} 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)

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.



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					
Dayformanos Mossuros	HEDIS Rate		Percentile	HEDIS 2014	
Performance Measures	2013	2014	Ranking ¹	Audit Result	
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: To	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					
Daufaumanaa Maaassu	HEDIS 2014				
Performance Measures	2013	2014	Ranking ¹	Audit Result	
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.

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.

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

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



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	HEDIS Rate		HEDIS 2014		
renormance measures	2013	2014	Ranking ¹	Audit Result		
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		

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

Table 3-18—Review Audit Results for Performance Measures $\it for$ Colorado Choice					
Dayfaymana Maaaaaa	HEDIS	HEDIS Rate		HEDIS 2014	
Performance Measures	2013	2014	Ranking ¹	Audit Result	
Weight Assessment and Counseling for Nutrition and H	Physical Activi	ty for Childre	n/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 Medic	cation				
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.

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

[—] 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.

^{**} 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).

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.



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 $\it for$ Colorado Choice					
Desferment Messes	HEDI	HEDIS Rate		HEDIS 2014	
Performance Measures	2013	2014	Ranking ¹	Audit Result	
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.

¹Percentile 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 $\it for$ DHMP					
Darfarrana Massarra	HEDIS	Rate	Percentile	HEDIS 2014	
Performance Measures	2013	2014	Ranking ¹	Audit Result	
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	



FINDINGS, STRENGTHS, AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS, AND ACCESS

Table 3-20—Review and Audit Results for Performance Measures $\it for$ DHMP						
Dayfayman a Magazyaa	HEDIS Rate		Percentile	HEDIS 2014		
Performance Measures	2013	2014	Ranking ¹	Audit Result		
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 Prac	ctitioners					
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.

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

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.

[—] 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.

^{**} 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).

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.

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.



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					
Dayfayyaan Macayyaa	HEDIS	S Rate	Percentile	HEDIS 2014	
Performance Measures	2013	2014	Ranking ¹	Audit Result	
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)	<u> </u>	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.

¹Percentile 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 10th 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

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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 <i>for</i> Kaiser					
Performance Measures	HEDIS	S Rate	Percentile	HEDIS 2014	
Performance Measures	2013	2014	Ranking ¹	Audit Result	
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 Phys	ical Activity fo	or Children/A	dolescents		
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	on				
Initiation	_	38.71%	25th-49th	R	
Continuation	_	NA	NA	NA	
Asthma Medication Ratio—Total		NA	NA	NA	



FINDINGS, STRENGTHS, AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS, AND ACCESS

Table 3-22—Review and Audit Results for Performance Measures for Kaiser					
Performance Measures	HEDIS	HEDIS Rate		HEDIS 2014	
renormance weasures	2013 2014 Ra		Ranking ¹	Audit Result	
Children's and Adolescents' Access to Primary Care Prac	titioners				
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.

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

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

[—] 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.

^{**} 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).

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

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.



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					
Performance Measures	HEDI	S Rate	Percentile	HEDIS 2014	
refformance measures	2013	2014	Ranking ¹	Audit Result	
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.

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.

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

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



FINDINGS, STRENGTHS, AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS, AND ACCESS

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 <i>for</i> RMHP						
Performance Measures	HEDIS	Rate	Percentile	HEDIS 2014		
renormance measures	2013	2014	Ranking ¹	Audit Result		
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 Phy	sical 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.



FINDINGS, STRENGTHS, AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS, AND ACCESS

Table 3-24—Review Audit Results for Performance Measures <i>for</i> RMHP					
Performance Measures	HEDIS	HEDIS Rate		HEDIS 2014	
Performance measures	2013 2014		Ranking ¹	Audit Result	
Follow-up Care for Children Prescribed ADHD Medicati	on				
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 Practice	ctitioners				
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.

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).
- Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.
- 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*

[—] 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.



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	HEDI	S Rate	Percentile	HEDIS 2014		
Performance Measures	2013	2014	Ranking ¹	Audit Result		
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 $\it for$ RMHP					
Performance Measures	HEDIS Rate Percentile HED			HEDIS 2014	
renormance measures	2013 2014 Ranking ¹ Audit Resul				
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 programlevel 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						
HEDIS Rate Percentile HEDIS 20						
Performance Measures	2013	2014	Ranking ¹	Audit Result		
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.

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

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.

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			
i citorillance measures	2013	2014	Ranking ¹			
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 A	ctivity for Chil	dren/Adolesc	ents			
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						
Dayleyman of Macalina	HEDIS	HEDIS Rate				
Performance Measures	2013	2014	Ranking ¹			
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		1				
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 Practi	itioners					
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.

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.

[—] 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.



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						
Managemen	HEDIS	HEDIS Rate				
Measures	2013	2014	Ranking ¹			
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.

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*

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





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					
НМО	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						
	Percent of Applicable Elements					
Study Stage		Activity	Met	Partially Met	Not Met	
	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)	
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)	
Dagion	III.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)	
Design	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)	
	VII.	Data Analysis and Interpretation	100% (9/9)	0% (0/9)	0% (0/9)	
Implementation	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					
Percent of Applicable Elements					
Study Stage	Activity Met Partially Met Not I				
Implementation Total			100% (12/12)	0% (0/12)	0% (0/12)
Outsomes	mes IX. Real Improvement X. Sustained Improvement		100% (4/4)	0% (0/4)	0% (0/4)
Outcomes			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)				5)	

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						
Cturdu Ctarra			Percent of Applicable Elements			
Study Stage		Activity	Met	Partially Met	Not Met	
	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)	
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)	
Dagiga	III.	Study Indicator	100% (3/3)	0% (0/3)	0% (0/3)	
Design	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)	
	VII.	Data Analysis and Interpretation	75% (6/8)	25% (2/8)	0% (0/8)	
Implementation	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)	
Ontoomos	IX.	Real Improvement	25% (1/4)	0% (0/4)	75% (3/4)	
Outcomes	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	e of Ap	plicable Evaluation Elements Met	74	4% Percent (20/2)	7)	

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						
			sthma in Pediat			
PIP Study Indicator	Baseline	Remeasure- ment 1	Remeasure- ment 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 $\it for$ DHMP					
Churchy Charra		A mathematica	Percent	t of Applicable El	ements
Study Stage		Activity	Met	Partially Met	Not Met
	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
Dagion	III.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
Design	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)
	VII.	Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
Implementation	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)
Outcomo	IX.	Real Improvement	25% (1/4)	0% (0/4)	75% 3/4)
Outcomes	X. Sustained Improvement		0% (0/1)	0% (0/1)	100% (1/1)
	Outcomes Total			0% (0/5)	80% (4/5)
Percentage Scor	e of Ap	plicable Evaluation Elements Met	85	5% Percent (22/2	6)

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 <i>for</i> DHMP							
		PIP Topic: Impro	oving 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					
Chudu Chana		A matrician	Percent	of Applicable El	ements
Study Stage		Activity	Met	Partially Met	Not Met
	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
Dagion	III.	Study Indicator	100% (3/3)	0% (0/3)	0% (0/3)
Design	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)
	VII.	Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
Implementation	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)
Outcomos	IX.	Real Improvement	25% (1/4)	0% (0/4)	75% (3/4)
Outcomes	X. Sustained Improvement		100% (1/1)	0% (0/1)	0% (0/1)
	Outcomes Total			0% (0/5)	60% (3/5)
Percent Sco	re of A	pplicable Evaluation Elements Met	89	9% Percent (25/2	8)

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	Remeasure- ment 1	Remeasure- ment 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					
0. 1.0.		A matrician	Percent	of Applicable Ele	ments
Study Stage		Activity	Met	Partially Met	Not Met
	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
Dagian	III.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
Design	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)
	VII.	Data Analysis and Interpretation	89% (8/9)	0% (0/9)	11% (1/9)
Implementation	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)
Outcomes	X. Sustained Improvement		Not Assessed		
	Outcomes Total			75% (3/4)	0% (0/4)
Percent Sco	Percent Score of Applicable Evaluation Elements Met			3% 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	Table 3-40—Summary of Each HMO's PIP Validation Scores and Validation Status						
НМО	PIP Study	% of All Elements <i>Met</i>	% of Critical Elements <i>Met</i>	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)	



FINDINGS, STRENGTHS, AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS, AND ACCESS

Table 3-41—Statewide Summary of Improvement						
Colorado Colorado Access 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.

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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 $\it for$ 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'



FINDINGS, STRENGTHS, AND RECOMMENDATIONS WITH CONCLUSIONS RELATED TO HEALTH CARE QUALITY, TIMELINESS, AND ACCESS

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 10th 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:	
	• HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies.	
	HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, and on-site agendas, and to set review dates.	
	HSAG submitted all materials to the Department for review and approval.	
	• HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.	



	Table A-1—Compliance Monitoring Review Activities Performed		
For this step,	HSAG completed the following activities:		
Activity 2:	Perform Preliminary Review		
	 HSAG attended the Department's Medical Quality Improvement Committee meetings and provided group technical assistance and training, as needed. Sixty days prior to the scheduled date of the on-site portion of the review, HSAG e-mailed the health plans a request for desk review documents, including the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the two standards and on-site activities. Thirty days prior to the review, the health plans provided documentation for the desk review, as requested. Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ 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. The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review. 		
Activity 3:	Conduct Site Visit		
	 During the on-site portion of the review, HSAG met with the health plans' key staff members to obtain a complete picture of the health plans' compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plans' performance. HSAG reviewed a sample of administrative records and evaluated implementation of managed care regulations related to CHP+ service denials and notices of action. Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original-source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) At the close of the on-site portion of the site review, HSAG met with the plan's staff and Department personnel to provide an overview of preliminary findings. 		
Activity 4:	Compile and Analyze Findings		
	 HSAG used the FY 2013–2014 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. HSAG analyzed the findings. HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings. 		



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

Description of Data Sources

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

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

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

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

APPENDIX A. EQR ACTIVITIES—COMPLIANCE MONITORING SITE REVIEWS



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	<u> </u>
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 onsite 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; t	the HMO did not in	nclude this co	mponent in its HE	DIS 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.



APPENDIX D. EQR ACTIVITIES—CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS

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								
	CHP+ 2014							
Measure of Member Satisfaction	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	d in FY 201	2–2013.						

^{*} 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								
CO CO Description of Component CO CO Access Choice DHMP Kaiser RMHP Average								
Denials	95%	56%	87%	62%	71%	69%		
Credentialing	100%	97%	100%	100%	100%	99%		
Recredentialing	100%	91%	100%	100%	100%	98%		

Standards in black were reviewed in FY 2013–2014.



Results from the Validation of Performance Measures

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

	СО	СО					Statewide
Performance Measures	Access	Choice	DHMP	Kaiser	RMHP	SMCN	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 Mon	ths 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	r Nutrition	and Physic	cal Activity	for Child	ren/Adoles	cents	
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 Prescrit	bed ADHD	Medication	l				
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 Practi	tioners				
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							age	
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 Hospi	tal/Acute C	are: 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.

Tabl	Table E-4—Summary of Each HMO's PIP Validation Scores and Validation Status								
НМО	PIP Study	% of All Elements <i>Met</i>	% of Critical Elements <i>Met</i>	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.



COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS COLORADO ADULT PRENATAL COVERAGE IN CHP+ (NO. 21-W-00014/8)

COMPLIANCE WITH SPECIAL TERMS AND CONDITIONS

I. PREFACE

The following documents compliance as of April 2015 with the Special Terms and Conditions (STCs) for the Colorado Adult Prenatal Coverage in CHP+, a Children's Health Insurance Program section 1115 Demonstration, during the renewal period beginning August 1, 2012. The STCs are arranged in the following subject areas: Background and Objectives; General Program Requirements; Eligibility and Enrollment; Benefits; Cost Sharing; Maintenance of Coverage; General Reporting Requirements and Monitoring; Evaluation of the Demonstration; and Attachment A: General Financial Requirements Under Title XXI.

II. BACKGROUND AND OBJECTIVES

Background

On September 27, 2002, the Centers for Medicare and Medicaid (CMS) initially approved Colorado's "Adult Prenatal Coverage in CHP+" Demonstration for a four-year period through September 30, 2006. The Demonstration permitted the State to use title XXI funds to expand coverage to uninsured pregnant women with family incomes from 133 percent through 185 percent of the federal poverty level (FPL). Subsequently, on January 24, 2006, CMS approved an amendment to the Demonstration allowing Colorado to expand eligibility for uninsured pregnant women under the Demonstration from above 185 percent through 200 percent of the FPL. On September 29, 2006, CMS approved Colorado's request to renew the Demonstration for a three-year period through September 30, 2009. CMS then approved Colorado's extension request, which extended the program through June 2012. On July 30, 2012, Colorado received approval to expand coverage for uninsured pregnant women from 200 to 250 percent of the FPL.

Section 111 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) added Section 2112(b)(1)(A) of the Social Security Act, which specifies that a state must first cover pregnant women in Medicaid to at least 185 percent of the FPL before expanding coverage to pregnant women in the Children's Health Insurance Program (CHIP). Section 111 of CHIPRA also added a provision to provide states the option to provide necessary prenatal, delivery and postpartum care to targeted, low-income, pregnant women through the title XXI State plan.

To comport with the intent of CHIPRA, under this renewal, Colorado submitted a Medicaid State plan amendment and got approval for transitioning pregnant women through 185 percent of the FPL to the Medicaid State plan and to provide the full Medicaid benefit to these women. The State has continued to receive title XXI funds for uninsured pregnant women from 133 percent of the FPL through 185 percent of the FPL. In addition, the State submitted a corresponding CHIP State plan amendment to transition pregnant women from above 185 percent of the FPL through 250 percent of the FPL to the CHIP State plan. As



required under the Special Terms and Conditions (STC) #17, the State transitioned coverage of pregnant women from this Demonstration to the Medicaid and CHIP State Plans, effective January 1, 2013. In addition, the State opted to terminate its premium assistance program effective January 1, 2013. ¹

Objectives

Colorado's Adult Prenatal Coverage in CHP+ Demonstration has three main objectives:

- Decrease the uninsurance rate for pregnant women
- Increase prenatal and postpartum care for pregnant women enrolled in the Demonstration
- Increase the number of healthy babies born to pregnant women enrolled in the Demonstration

III. GENERAL PROGRAM REQUIREMENTS

- 1. **Definitions.** Colorado applied the definitions as outlined in the STCs document.
- 2. Compliance with Federal Non-Discrimination Statutes. Colorado complies with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of Section 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- **3.** Adequacy of Infrastructure. Colorado has made available adequate resources for the implementation and monitoring of the Demonstration, including education, outreach and enrollment; maintaining eligibility systems; compliance with cost-sharing limits; and reporting on financial and other issues.
- 4. Public Notice and Tribal Consultation, and Consultation with Interested Parties.

 Colorado complies with the State Notice Procedures set forth in 59 Fed. Reg. 49249. The State also complies with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan.
- **5. Extension of the Demonstration.** On December 11, 2014, the Governor of Colorado submitted to the Secretary of the U.S. Department of Health & Human Services a Demonstration extension request for Colorado's title XXI section 1115 Demonstration project No. 21-W-00014/8.

The Demonstration Extension Application provides documentation of compliance with the public and tribal notice requirements outlined in STC #4.

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¹ The federal poverty levels listed in the Background section are pre-MAGI-converted levels.

- a. <u>Demonstration Summary and Objectives:</u> The Demonstration Extension Application provides a narrative summary of the Demonstration project, reiterates the objectives set forth at the time the Demonstration was proposed, and provides evidence of how these objectives have been met as well as how future goals of the program can be met during the extension period.
- b. <u>Special Terms and Conditions (STCs):</u> This document provides documentation of compliance with each of the STCs.

<u>Waiver and Expenditure Authorities:</u> The specific waiver requested is "CHIP Secondary Payer to Medicaid rules" at Section 2105(c)(6)(B) of the Social Security Act. Colorado is requesting the same expenditure authority as approved under the current Demonstration.

Because Colorado received approval for increasing the income limit for pregnant women from 133 percent of the FPL to 185 percent of the FPL on the Medicaid State plan and expanding the income eligibility level for uninsured pregnant women through 250 of the FPL under the CHP+ State plan, Colorado no longer needs a waiver to provide prenatal and postpartum services to these women.²

- c. Quality: The 2014 HEDIS® Aggregate Report and the 2013-2014 CHP+ Technical Report conducted by Health Services Advisory Group (HSAG), the external quality review organization, are provided in the Demonstration Extension Application.
- d. <u>Compliance with the Allotment Neutrality Cap:</u> Financial data demonstrating the State's projected allotment neutrality for the period of the extension are provided in the Historical and Projected Expenditures spreadsheet as a separate document. The State will work with CMS to ensure federal expenditures under this extension do not exceed the federal expenditures that would otherwise have been made.
- e. <u>Draft Report with Evaluation Status Findings:</u> The State provided a summary of the evaluation design and plan for evaluation activities during the extension period.
- **6. Demonstration Phase-Out.** Colorado does not plan to suspend or terminate this Demonstration in whole, or in part, prior to the expiration date.

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² The federal poverty levels listed in the Waiver and Expenditure Authorities section are pre-MAGI-converted levels.



- **7. Enrollment Limitation During the Last Six Months.** Colorado anticipates that this Demonstration will be extended.
- **8. CMS Right to Terminate or Suspend.** CMS has not suspended or terminated the Demonstration (in whole or in part).
- **9. Compliance with CHIP Law, Regulation and Policy.** All requirements of CHIP expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part) were applied to the Demonstration.
- **10.** Changes in CHIP Law, Regulation, and Policy. No change in federal law, regulation, or policy affecting CHIP has occurred during this Demonstration approval period.
- **11.** Changes Subject to the Amendment Process. No changes were made related to eligibility, enrollment, benefits, cost sharing, sources of non-federal share of funding, budget neutrality, or other comparable program elements.
 - a. <u>Federal Financial Participation (FFP)</u>. No federal matching funds for expenditures for this Demonstration were requested for this Demonstration period prior to the effective date identified in the Demonstration approval letter.
- **12. Amendment Process.** Colorado has not submitted a request to amend this Demonstration.
- **13. General Financial Requirements.** The State has complied with all general financial requirements under title XXI and as discussed in Attachment A: General Financial Requirements Under Title XXI.
- **14. State Plan Amendments.** The Medicaid State plan amendment to increase the income limit for pregnant women from 133 percent of the FPL to 185 percent of the FPL was approved on March 27, 2013, and effective on January 1, 2013.

The CHP+ State plan amendment was approved on April 25, 2013, and effective on January 1, 2013. This amendment states that under or uninsured pregnant women with family income from 133 percent of the FPL and at or below 185 percent of the FPL are covered through a Medicaid Expansion, and uninsured pregnant women with family income at or below 250 percent of the FPL that are ineligible for Medicaid are moved from the Section 1115 Waiver to coverage through the CHIP State plan.³

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³ The federal poverty levels listed in the State Plan Amendment section are pre-MAGI-converted levels.



IV. ELIGIBILITY AND ENROLLMENT

- **15. Screening for Medicaid and Immigration Status.** Colorado continues to screen all applicants for the Demonstration for Medicaid eligibility and immigration status. Demonstration applicants eligible for Medicaid are enrolled in Medicaid and receive the full Medicaid benefit package. Only U.S. citizens and qualified aliens who have satisfied the five-year bar have been enrolled in the Demonstration.
- **16. Enrollment Limits.** Colorado has not needed to limit enrollment in the Demonstration.
- 17. Submission of Medicaid and CHIP State Plan Amendments to Transition Coverage of Pregnant Women from this Demonstration to the Medicaid and CHIP State Plans and Transition of Children in Premium Assistance to the CHIP State plan.
 - a. Transition Plan. Colorado submitted a draft transition plan to CMS on August 31, 2012, that outlined how the State would transition pregnant women with income through 185 percent of the FPL from the title XXI Demonstration to the Medicaid State plan and pregnant women above 185 percent of the FPL through 250 percent of the FPL from the Demonstration to the CHIP State plan. CMS did not provide comments on the plan. Colorado successfully transitioned the eligible pregnant women to the Medicaid State plan.⁴
- **18. Premium Assistance.** During the duration of the premium assistance program, the State followed and met the various eligibility, informed choice and opt out, informed choice materials, mandatory CHIP services, cost-effectiveness test, voluntary participation of employers and employer contribution, and waiting period requirements.

The State elected to terminate its premium assistance program on January 1, 2013. Consequently, the children who were enrolled in the program were enrolled successfully in direct coverage through the CHIP State plan or in an employer-sponsored plan.

V. BENEFITS

- **19. Demonstration Population 1a and 1b:** Demonstration enrollees receive all services pursuant to the approved CHIP State plan and Medicaid State plan.
- **20. Demonstration Population 2:** The benefit packages in the premium assistance program provided at a minimum well-baby and well-child care services, age-appropriate immunizations, and emergency services or a wrap-around for those services.

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⁴ The federal poverty levels listed in the Transition Plan section are pre-MAGI-converted levels.



VI. COST SHARING

- **21. Demonstration Population 1a and 1b:** The cost-sharing requirements described in the title XIX and XXI State plans are not applied to Population 1a and 1b.
- **22. Demonstration Population 2:** The cost-sharing requirements for children who chose to receive coverage through premium assistance were charged cost-sharing amounts set by their private or employer-based coverage and were not limited to the title XXI 5 percent cost-sharing limit of 5 percent of family income.

VII. MAINTENANCE OF COVERAGE

- **23. Concurrent Operation:** The State's title XXI state plan continues to operate concurrently with this section 1115 Demonstration.
- **24. Maintenance of Coverage and Enrollment Standards for Children:** The State complies with all of the maintenance of coverage and enrollment standards for children.

VIII. GENERAL REPORTING REQUIREMENTS AND MONITORING

25. Quarterly Progress Reports. The State gathers and analyzes quarterly balanced scorecard reports from Colorado Access, Colorado's contractor for the state managed care network. These reports include information on performance related to the prenatal program, including low birth-weight admissions. If needed, the State then works with Colorado Access to make modifications to the program to improve performance outcomes. State fiscal year (SFY) 2013 and SFY 2014 percentages of babies born with low birth weights (less than 2500 grams) to women in the prenatal program in the CHP+ State plan are included in the Demonstration Extension Application.

Colorado also submitted monthly and quarterly reports regarding the specific reporting requirements for the premium assistance program through December 31, 2012, the duration of the program.

- **26. Annual Progress Reports.** Each year, Colorado submits to CMS annual CHIP Annual Report Template System (CARTs) reports. These reports include information on the requested reporting requirements, including the timeliness of prenatal care, frequency of ongoing prenatal care, and the percentage of low birth-weight babies.
- **27. Quarterly and Monthly Enrollment Reports.** The State submits quarterly reports in the CHIP Statistical Enrollment Data Reports (SEDS) for forms 64EC, 64.21E, and 21E. In addition, Colorado gathers monthly enrollment data, which are exhibited in the Demonstration Extension Application.
- **28. Monitoring Calls.** CMS and Colorado held monitoring calls as needed to discuss issues associated with the continued operation of the Demonstration.



- **29. Final Report.** Colorado proposes to extend the Demonstration so the State does not plan to submit a final report at this time.
- **30. Evaluation Reporting.** Colorado informs CMS of the status of the State's evaluation in the required reports.

IX. EVALUATION OF THE DEMONSTRATION

- **31. Submission of Draft Evaluation Design.** The State submitted to CMS for approval a draft design for an overall evaluation of the Demonstration.
- **32. Interim Evaluation Reports.** Colorado will submit an interim evaluation report by the end of June 2015.
- **33. Final Evaluation Design and Implementation.** CMS did not provide comments on the design. Colorado continues to implement the evaluation design and report its progress.
- **34. Evaluation Topics.** Colorado monitored progress toward the goals for the program. See the 2014 HEDIS® Aggregate Report, the 2013-2014 CHP+ Technical Report conducted by HSAG that are provided in the Demonstration Extension Application.
- **35. Cooperation with Federal Evaluators.** The State fully cooperates with federal evaluators and their contractors' efforts to conduct independent federally funded evaluations. During the timeframe of this Demonstration, CMS did not undertake an evaluation of the Demonstration.
- **36. Monitoring Private Health Insurance Coverage.** The State monitored the program and provided monthly, quarterly and participation reports.



ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

- 1. The State provides quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan (CHP+) and those provided through the Adult Prenatal Coverage in CHP+ Demonstration under section 1115 authority.
- 2. The State reports Demonstration expenditures through the Medicaid and State Children's Health Insurance Budget and Expenditure System (MBES/CBES) during the quarterly CMS-21 reporting process. Title XXI Demonstration expenditures are reported on separate Forms CMS-21 Waiver/CMS-21P Waiver, identified by the Demonstration project number assigned by CMS.
 - a. Colorado makes all claims for expenditures related to the Demonstration (including any cost settlements) within two years after the calendar quarter in which the State made the expenditures and continued to identify separately net expenditures related to dates of service during the operation of the Demonstration. During the latter two-year period, the State will continue to identify separately net expenditures related to the dates of service during the operation of the Demonstration on the Form CMS-21.
 - b. Colorado continues to use the standard CHIP funding process during the Demonstration. The State continues to estimate the matchable CHIP expenditures on the quarterly CMS-21B. Colorado provides updated estimates of expenditures for the Demonstration populations on a separate CMS-21B. Within 30 days after the end of each quarter, Colorado submits the Form CMS-21 quarterly CHIP expenditure report.
 - c. The State certifies State/local monies used as matching funds for the Demonstration and certifies that such funds are not used as matching funds for any other Federal grant or contract, except as permitted by Federal law.
- 3. The State has not over expended its available title XXI Federal funds for any claiming period.
- 4. The State has not over expended its available title XXI Federal funds.
- 5. Total expenditures for outreach and other reasonable costs to administer the Demonstration have not exceeded 10 percent of total title XXI net expenditures.
- 6. The State does not charge enrollment fees for prenatal clients, so there are no fees or premiums to report for these clients.
- 7. The State has not exhausted available title XXI Federal funds during the Demonstration.
- 8. Colorado has not closed enrollment or instituted a waiting list with respect to the Demonstration Populations.