Annual Quality Report

Child Health Plan Plus (CHP+) HMO

Fiscal Year 2015

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Section 1: Executive Summary

Colorado Access Mission Statement

Partner with communities and empower people through access to quality, affordable care

Colorado Access CHP+ HMO is the largest CHP+ plan in Colorado and has been providing services for over 10 years. The quality improvement program seeks to provide children and their families with access to improved health services in a safe, coordinated, and cost-effective manner resulting in enhanced satisfaction and improved health outcomes. The program extends to all levels and departments within Colorado Access and partners with participating providers, in acknowledgment that teamwork and collaboration are essential for improvement. In support of the mission to assist underserved Coloradans, Colorado Access continues to monitor and create specialized services for children through its various CHP+ programs.

Fiscal year 14-15 continued to be plagued with enrollment issues for the Colorado Access CHP+ HMO plan. With an additional loss of approximately 10,000 members during this fiscal year, our membership currently stands at approximately 26,000 enrolled members. System issues with MMIS, including but not limited to a lack of functionality of continuous enrollment has led to this problem. However, despite these eligibility losses, Colorado Access has enjoyed many successes with the CHP+ population through FY2015.

FY15 Key Accomplishments

The Colorado Access CHP+ HMO plan expanded into 5 additional counties in FY2015 including: Eagle, Summit, Cheyenne, Delta and Baca.

In an effort to expand affordable health care coverage to eligible but unenrolled community members, CoA also opened an eligibility and enrollment site that helps connect Coloradans with health insurance. Since January, 2015, we have connected more than 1500 previously uninsured Coloradans with health insurance.

Many of our quality measures have improved over the past fiscal year such as CAHPS results which demonstrate increases in access to care, patient experience, how well doctors communicate and rating of personal doctor.

Colorado Access has also had significant success in increasing our well child and immunization visits for kids in our HMO plan. Adolescent members demonstrated the greatest increases for these measures.

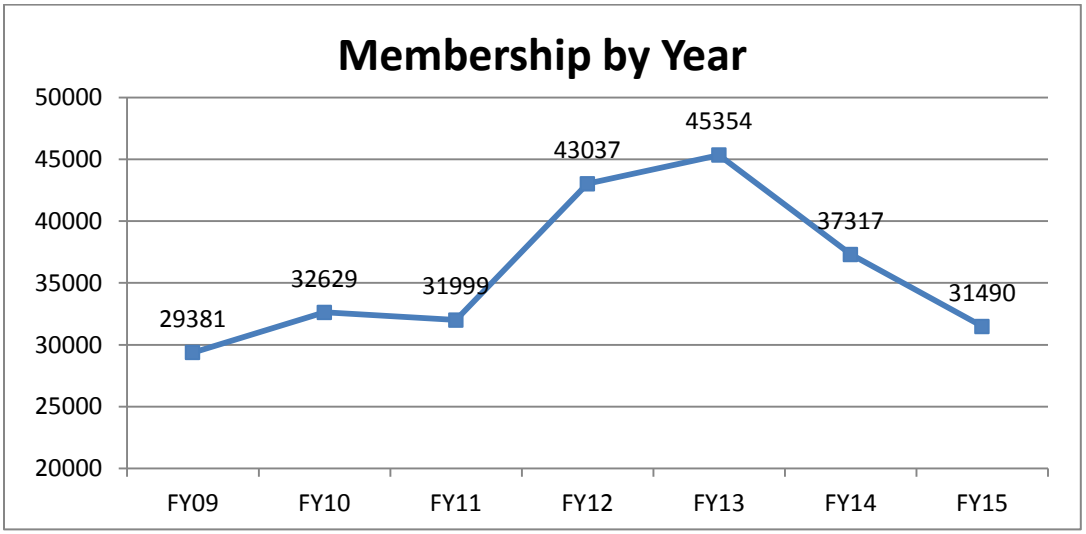
FY16 Key Initiatives

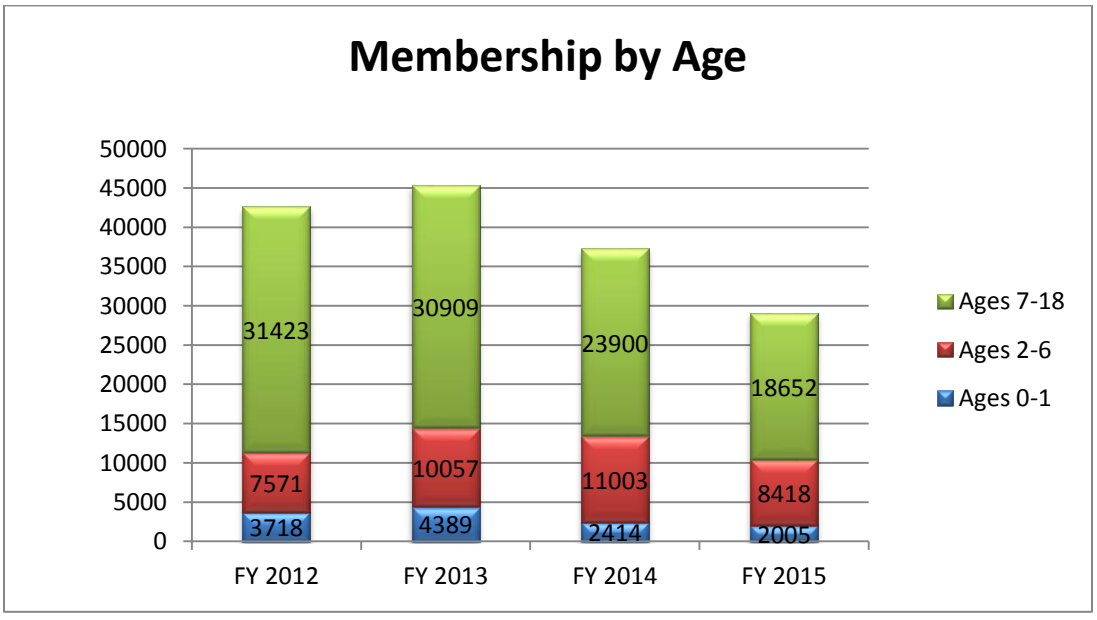
Colorado Access has partnered with the Colorado Community Health Network to improve well-child visit rates. We achieved this goal in FY2015, and we move forward in FY2016 to further increase well-child rates as well as the rates of specific preventive services that should take place at the well-visit such as: vision screens, BMI screens, Depression screens, nutrition and physical activity counseling and fluoride varnish.

Colorado Access will also continue to outreach to older members reaching the age of nineteen through our Age Out program to assist them in transitioning to the next level of health care coverage and to help them avoid gaps in care that could lead to poor health outcomes and considerable financial consequences.

Section 2: Membership

Membership for CHP+ HMO decreased from 37,317 in FY14 to 31,490 in FY15. Data is from Colorado Access Decision Support monthly statistics and is a snapshot as of June at the end of each Fiscal Year (FY). 6.8% (2,005) of members are infants aged 0-1 and 28.7% (8,418) are young children ages 2-6, with the majority ages 7-18 at 63.6% (18,652). There was a general decline in membership for FY15 in all age categories, proportionate to the overall membership decrease from last year. Information on characteristics and trends in the population can provide a basis for evaluating the adequacy of the CHP+ network resources and capacity. Started in March, 2014, 12-month continuous enrollment went into effect for CHP+ members. However, the continuous enrollment function has not been operational for some time, and has contributed to a downturn in membership.





Section 3: Network Adequacy & Credentialing

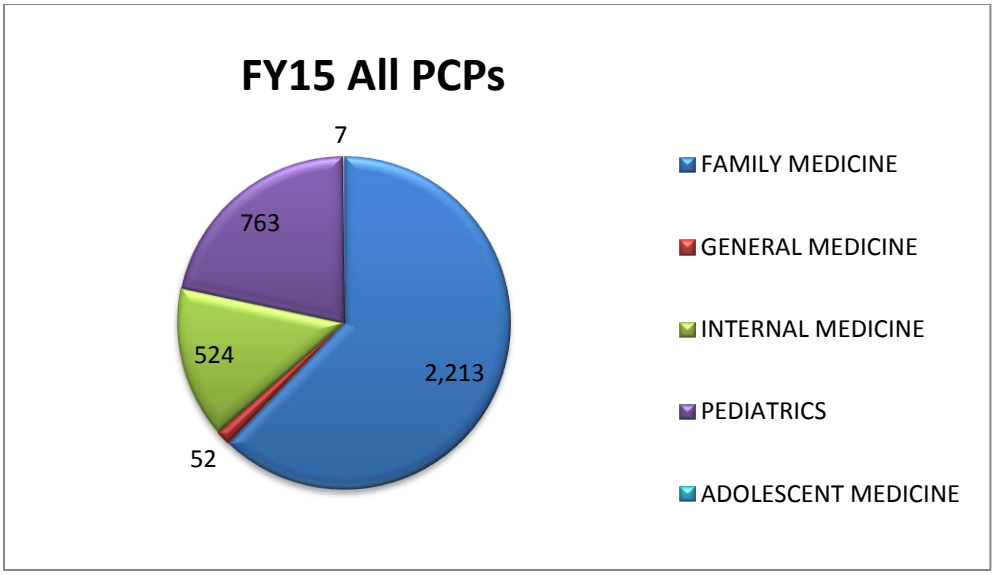
Member access to PCP and specialty care is an important component of timely medical care and member satisfaction. Practitioner availability monitoring that includes geographic access, member complaints, member to provider ratios, and disenrollment is conducted to determine if trends exist and to develop strategies for potential network enhancements.

Goals

- GeoAccess Monitoring of 1 provider within 30 miles
- Primary care provider to member ratio of 1:2000
- Physician specialist to member ratio of 1:2000
- PCP accepting new patients at 90%
- Specialists accepting new patients at 85%

Results and Analysis

PCPs and PCPs accepting new patients have remained stable with a slight increase since last year. Specialists (all types) remained relatively stable with decreases in some specialties such as Cardiovascular Disease and OB/GYN, but increases in other areas like Dermatology and Surgery. 83.8% of PCPs are accepting new patients, up from 77.6% last year.



The goals for access to PCP and specialists by geographic location along with the PCP and specialists-to-member ratios were exceeded this fiscal year. The CHP+ HMO population is most dense in El Paso County with 4, 247 members followed by Adams County with 4,085 members. The least dense county is Kit Carson with one member but no matter the number of members, the access to practitioners falls no lower than 99.70% for the 30 minute/mile standard and well below the 1:2000 standard ratio. While the results indicate that the network is more than adequate to meet the needs of members, Colorado Access continues to pursue contracts with

PCPs and specialists.

Of the 31,490 CHP+ members enrolled in June 2015, almost all members had access to a PCP, PCPs Accepting Patients, and Specialists within 30 miles.

Provider Type	Standard	Goal	FY13	FY14	FY15
PCPs	1 provider within 30 min or miles	90%	99.90%	99.90%	99.90%
PCPs Accepting Patients		90%	99.90%	99.90%	99.90%
Specialists		85%	99.5%*	99.50%	99.80%
Behavioral Health		85%	-	99.80%	99.70%

Includes Behavioral Health providers

Provider Type	Goal	FY13	FY14	FY15
PCPs	1:2000	1:16 (6511/51,293)	1:48 (762/37, 307)	1:8 (3559/31,490)
PCPs accepting patients		1:21 (2436/51,293)	1:15 (2383/37,307)	1:10 (2982/31,490)
Specialists		1:8 (6511/51,293)*	1:5 (6452/37,307)	1:4 (7831/31,490)
Behavioral Health		-	1:21 (1734/36,898)	1:15 (1993/31,490)

Interventions and Strategies

- Continue adding specialty, ancillary, hospital, and primary care providers throughout the state
- Continue to assess network adequacy and monitor provider to member ratios to maintain adequate access

Goals FY16

- Maintain network adequacy performance at standard or above

Section 4: Access to Care

Service Accessibility

Access to care and service is one of the key drivers of member satisfaction. Appropriate access to the PCP facilitates continuity of care and receipts of medical services are all pivotal to member satisfaction. Appointment availability is measured and monitored using a variety of data sources including the Secret Shopper Program and the After-Hours Survey.

Secret Shopper Program

The Secret Shopper Program is designed to evaluate, educate and increase awareness and understanding among the provider community of the appointment and access to care standards. Performance goals were established based on prior year measurement results, benchmark data when available, and the ability to positively impact the result.

Goals

- 90% of appointments fall within the standards for each appointment category
- Routine appointment available within 30 days
- Non-urgent appointment available within 2 weeks
- Urgent appointment available within 48 hours
- BH routine appointment within 7 days

Up to 25 CHP+HMO provider sites were surveyed for the Secret Shopper program. Both high volume (>500 members) and low volume (<100 members) sites were included in the survey. And three (3) types of appointments (routine, non-urgent and urgent) were requested during the year.

Mental Health/Substance Use Disorder Appointment Availability was also included in the survey. 3 random MH/SUD providers were included on the calls for routine appointments and tested compliant.

Results and Analysis

The goal for all appointment scenarios was 90%. The goal was exceeded for routine care at 96%. For non-urgent care appointments, 96% of the surveyed providers offered an appointment within the standard. For urgent care appointments, 98% of surveyed providers offered and appointment within the standard.

Strategies and Planned Interventions

- Provider Network Services will continue to follow-up with providers who were unable to offer an appointment within the recommended access to care standards
- Ongoing educational articles in the Provider Newsletter regarding the Secret Shopper Program and the After Hours Program, including a report card to tested providers with office results.
- Re-surveying non-compliant provider sites in the next fiscal year
- Continue to monitor access to care standards through Secret Shopper program

Goals FY16

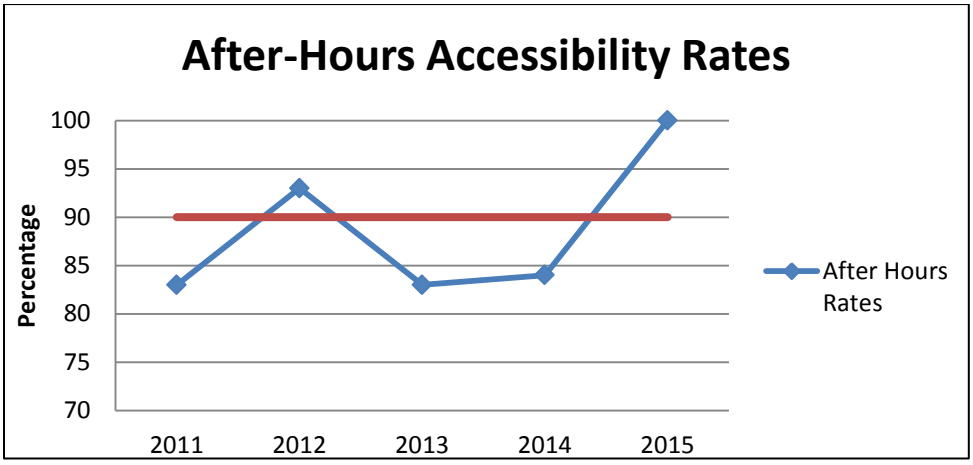
- Perform at the standards level or higher for access to care

After Hours

The FY2015 After Hours Study focused efforts on testing access to care and availability 24 hours a day, 7 days a week. A total of 50 provider's sites were called during the study, 47 of which were CHP+ HMO sites, and 40 sites were compliant. The overall accessibility rate was 85%; the overall goal is 90%. Provider Network Services followed up with the offices (7) that did not offer members access to care outside of office hours. Provider Network Services will be updating the provider database with any discrepancies in phone numbers. Sites that were non-compliant in FY2015 will be resurveyed again next year. Opportunities exist for follow-up and education of individual practice sites where the member is asked to leave a message or those providers who provided no live options to access care.

Goals

- Accessibility rate of 90% for After Hours availability 24 hours/day, 7 days a week



Strategies and Planned Interventions

- Continue to remind provider offices to refer members back to Colorado Access customer service if the office is unable to meet the availability access standard
- More timely updates on provider website
- More timely feedback provided to sites regarding results of calls
- Ongoing educational articles in the Provider Newsletter regarding the Secret Shopper Program and the After Hours Program, including a report card to tested providers with office results.

Goals FY16

- Perform at the standards level or higher for access to care

Telephone Accessibility

Customer Service Representatives are available to assist members with their access to healthcare needs. Telephone monitoring is conducted daily, weekly, and monthly to evaluate access to services that include benefit clarification, eligibility verification, practitioner selection, and general information. The reports generated from the telephone tracking system provide information on the total number of calls entering the system, the average number of seconds to answer, the percent answered within 30 seconds, the number of calls abandoned, the number of calls entering overflow or voice mail, and call reasons.

Goals

- 80% of calls answered within 30 seconds or less
- Abandonment rate is ≤5%
- Overflow rate is≤5%

Results and Analysis

Per the state contract abandoned calls should be 5% or less; call answer time should be 80% within 30 seconds. All overflow calls should account for 5% or less of all incoming calls. All goals were exceeded for FY2015. The number one reason for Customer Service calls continues to be eligibility verification followed by claim status inquiry.

Calls Answered 30 Seconds								
	FY14				**FY15**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Customer Service	82.8%	89.3%	85.8%	82.7%	92.0%	86.0%	89.6%	91.8%
Coord. Clinical Service	94.3%	94.0%	91.7%	91.7%	90.0%	92.0%	95.0%	98.0%
Goal	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Abandonment Rates								
	FY14				**FY15**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Customer Service	2.3%	1.6%	2.9%	2.0%	1.0%	2.0%	2.0%	1.7%
Coord. Clinical Service	0.7%	0.0%	1.5%	1.4%	0.7%	0.0%	1.5%	1.4%
Goal	*5%*	*5%*	*5%*	*5%*	*5%*	*5%*	*5%*	*5%*
Call Overflow								
	FY14				**FY15**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Customer Service	1.7%	1.6%	2.9%	2.9%	1.0%	1.0%	1.0%	1.0%
Coord. Clinical Service	2.4%	3.0%	2.6%	2.0%	2.0%	1.0%	0.0%	0.0%
Goal	*5%*	*5%*	*5%*	*5%*	*5%*	*5%*	*5%*	*5%*

Strategies and Planned Interventions

- Continued regular monitoring of Customer Service representatives to identify areas for improvement

Goals FY2016

- Continue to perform at the standard rates or better

Section 5: Patient Experience

Consumer Assessment of Health Plans Survey (CAHPS)

The Colorado Department of Health Care Policy and Financing (HCPF) collects information about Child Health Plan Plus (CHP+) members and their caretakers' experiences with and ratings of CHP+ plans via the annual Consumer Assessment of Health Plans Study (CAHPS) survey. The goal of this effort is to provide performance feedback that is actionable and will aid in improving overall member satisfaction. HCPF has been performing this survey for CHP+ plans since 2009; 2011 was the first year each plan was surveyed individually allowing plan specific results. The survey was not administered in 2012 due to financial constraints.

CAHPS is a standardized survey that assesses member and caregiver satisfaction with the experience of care that includes services provided by CoA, other CHP+ plans, and care delivered by network physicians. The survey data are used for continuous quality improvement. By establishing benchmarks and/or goals for performance, overall levels of satisfaction are evaluated, and a determination is made as to whether CHP+ plans and their providers are meeting customer expectations. Opportunities for improvement in care and service delivery are identified and prioritized, and intervention strategies developed as appropriate.

Results and Analysis

The CoA CHP+ HMO response rate fell by 6% this year from 37.18% to 31.05%. Overall member satisfaction ratings for the four global ratings and four composite measures calculated (using the 3 point mean scale methodology outlined by NCQA) were compared to NCQA 2014 HEDIS Benchmarks and Thresholds for Accreditation in the table below. Satisfaction in the area of Personal Doctor went up significantly from two stars to four stars since last year. We have also seen a trend upwards in the area of provider communication with members as well as specialists visits.

Rating of Health Plan and Customer Service continue to perform poorly for all the CHP+ health plans statewide. The Customer Service measure may be impacted by the enrollment and eligibility issues as members call Colorado Access Customer Service, but must be redirected to the state's enrollment vendor in order for resolution. It should be noted that Colorado Access CHP+ is significantly trending upward in Rating of Health Plan and Customer Service however; this plan still falls into a 1 Star category.

NCQA Comparisons Overall Member Satisfaction Ratings					
	Colorado Access	**Colorado Choice**	**DHMP**	**Kaiser**	**RMHP**
Global Rating					
Rating of Health Plan	★ 2.466	★ 2.367	★ 2.408	★★ 2.539	★ 2.495
Rating of All Health Care	★★ 2.510	★ 2.407	★★ 2.504	★★★★ 2.589	★★★ 2.528
Rating of Personal Doctor	★★★★ 2.665	★ 2.513	★★★★ 2.681	★★★★★ 2.709	★★★ 2.644
Rating of Specialist Seen Most Often	★★★ 2.590	★★+ 2.545	★★+ 2.545	★★★★+ 2.656	★★+ 2.586
Composite Measure					
Getting Needed Care	★ 2.415	★★ 2.463	★ 2.145	★★★ 2.518	★★ 2.441
Getting Care Quickly	★★ 2.561	★★★★ 2.662	★ 2.337	★★★ 2.624	★★★★ 2.688
How Well Doctors Communicate	★★★★ 2.721	★★★ 2.714	★★ 2.669	★★★★★ 2.768	★★★★★ 2.750
Customer Service	★ 2.426	★+ 2.364	★ 2.453	★ 2.467	★ 2.320
★★★★★ 90th Percentile or Above ★★★★ 75th-89th Percentiles ★★★ 50th-74th Percentile ★★ 25th-49th Percentiles ★ Below 25th Percentile					
Please note: 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.					

Source: HSAG FY 2014-2015 Child Health Plan Plus Member Satisfaction Report, September 2015, Table 2-4.

Strategies and Planned Interventions

- Customer Service monitoring scripting and training; implementation of a position to audit the quality of customer service calls
- The Secret Shopper process will undergo significant process improvement in order to more accurately assess member Access to Care and deliver more meaningful feedback to providers

Goals FY16

- Obtain member feedback in order to identify areas of success as well as areas in need of improvement for member experience
- Identify improvement opportunities, develop intervention strategies and conduct re-measurement

Grievances

Members are informed of their right to file a grievance or appeal through various means including the Colorado Access Evidence of Coverage booklets or Member Handbooks, and through verbal communication with Colorado Access staff at the time the member contacts the health plan. Treating providers are also required to provide some information on a member's right to file a grievance.

Timely resolution of member issues contributes to increased satisfaction with plan operations. Data are aggregated from the grievance database to evaluate whether time frames for resolution have been met and to track and trend reasons. Measures include quarterly and annual calculation of member grievances per 1000 to determine the volume of grievances as it relates to membership.

Goals

- 100% resolution within 15 business days, or, if extension is required, an additional 14 calendar days
- Less than 2.0 grievances per 1000 members

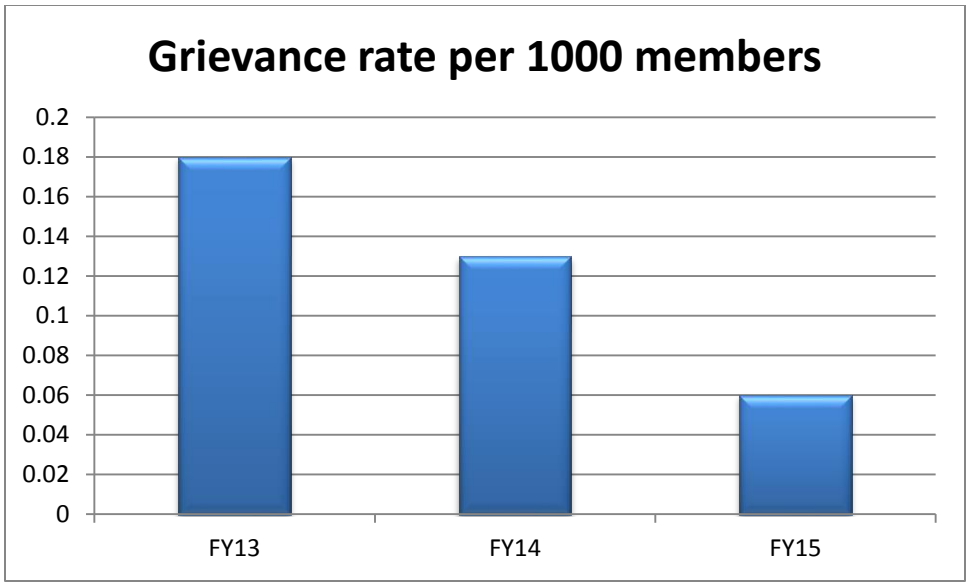
Results and Analysis

In FY15, Colorado Access was informed during our external quality review site visit that member reimbursement and billing issues did not need to be logged as grievances. Therefore, performance from the past 3 years has been readjusted to reflect a more accurate portrayal of member complaints.

In FY15, Colorado Access received a total of 2 grievances for the CHP+ line of business. Both grievances were related to Access & Availability of Services, and both grievances were resolved according to contractual requirements.

Performance for the past three fiscal years remains well below the identified goal of less than 2 grievances per 1000 members.

Fiscal year	Corrected # of Grievances	Corrected Rate	Goal
FY13	8	.18	< 2.0
FY14	5	.13	< 2.0
FY15	2	.06	< 2.0



Strategies and planned interventions

- Continue to monitor grievance rates and timeframe compliance on a quarterly basis in order to identify any possible patterns or opportunities for improvement.

Goals for FY16

- Maintain grievance rate of less than 2.0 grievances per 1000 members
- Maintain 100% compliance for contractually required grievance timeframes

Quality of Care (QOC) Concerns

Quality of Care (QOC) concerns are defined as "any grievance made in regard to the professional competence and/or conduct of a physician or other healthcare provider which could adversely affect the health or welfare of a member."

There were no CHP+ QOC grievances in FY 2015. QM and Credentials Committee monitors QOC scores and trending based on provider and facility involved.

Goals

- Ensure QOC's are investigated and completed in a timely manner following the timeline schedule

Score	FY12	FY13	FY14	FY15
0	1	2	1	0
1	0	1	1	0
2	0	0	0	0
3	0	1	0	0
Total	**1**	**4**	**2**	**0**

Scoring criteria are as follows:

- 0 = No quality of care incident identified. No action required.
- 1 = Minor or isolated professional incident causing no harm to the patient. Provider may receive an eduational letter or telephone call per discretion of Medical Director.
- 2 = Care or conduct deemed outside of professional standards with potential to cause harm or minimal acutal harm to the patient. Educational letter to the provider required and review at Credentials Committee. Corrective Action Plan (CAP) possible.
- 3 = Care or conduct deemed outside of professional standards and caused harm to the patient. Considered an adverse event. Requires notification of Sr. VP of Medical Services and Chair of Credentials Committee. CAP required, immediate termination possible.

Strategies and Planned Intervention

- Monitor and track QOC concerns and take action as needed

Goals FY16

- Ensure investigation and timely completion of Quality of Care concerns

Section 6: Health Outcomes & Disease Management

Colorado Access designs and implements population health initiatives that focus upon prevention and disease management. Continuous internal monitoring and performance evaluations such as annual HEDIS audits help to guide each year's priority population health initiatives. Through utilization of health risk assessments, programs that incentivize member use of prevention benefits, and targeted outreach to at-risk and in-need members, CoA works to encourage and motivate members to adopt behaviors that preserve or improve their health. Colorado Access also works on care coordination with providers in an effort to connect members with their necessary level of care.

High Risk OB

In an effort to reduce low birth weight and premature deliveries, as well as other adverse health outcomes for both baby and mother, Colorado Access provides a care management program that encourages the utilization of preventive services, advises expectant mothers about community resources for pregnant women, and promotes the importance of attending postpartum follow-up appointments.

All prenatal members receive care management at varying levels based on low or high-risk stratification. As the majority of all prenatal members in CHP+ HMO are under age 18 years of age, most of them are auto-enrolled in the high-risk program. All prenatal members receive a call from the prenatal Care Manager who conducts a health risk assessment (HRA) over the phone and encourages the member to access prenatal services as soon as possible. The Care Manager attempts to speak with the member and/or parent. If member needs help accessing care, the Care Manager coordinates care with a PCP/OB-Gyn.

All high-risk members are called again at 26-28 weeks into their pregnancy to assess physical, psychological, and social needs. Members are supplied with written materials and contacts for community organizations based on their questions or concerns. If necessary, the Care Manager will coordinate care with a provider.

Utilization Management notifies Care Management of all deliveries as soon after birth as possible so that Care Managers can make timely outreach to members. All high and low-risk members are called postpartum to assess needs of the mother and/or baby, to encourage post-partum care and if necessary, to coordinate establishment of a medical home for the baby. The Care Manager also attempts to deliver the Edinburgh Postpartum Depression Screen (EPDS) to all members within one month after delivery to assess signs of postpartum depression. High-risk members will receive the EPDS assessment again 30 days later. Based on member scores, the Care Manager will assess severity of each case and follow-up appropriately with the member and/or PCP to coordinate timely access to care.

All complicated deliveries and NICU babies are considered high-risk. Utilization Management alerts Care Managers of these members as soon after delivery as possible. Care Managers ensure that mom and/or baby is discharged home with: a care plan, scheduled follow-up visits, prescription medication and/or DME instructions and an established medical home for baby.

The HCPF Balanced Scorecard measure quantifies the percentage of low birth weight deliveries for members who are pregnant stratified by date of birth known and unknown. Low birth-weight totals for Q1 2015 are trending at the typical rate.

HCPF Balanced Scorecard Measure	FY12	FY13	FY14	FY15*
% Low Birth-Weight Deliveries (DOB unknown)	0%	4.2%	0%	0%
% Low Birth-Weight Deliveries (DOB known)	4.8%	10.7%	12.5%	0%

* ***Only one quarter of data available.***

Strategies and Planned Interventions

- Continued outreach to prenatal members for HRA completion and to encourage prenatal services
- Continued timely outreach to members after birth to assess needs and encourage post-partum care

Goals for FY16

- Improve health outcomes through the OB high risk programs

Asthma

The purpose of the asthma care management program is to improve asthma treatment and maintenance by influencing members to increase the ratio of controller medication refills to total asthma medication (controller + rescue/Asthma Medication Ratio). An AMR < 0.5 indicates an over-dependence on rescue medications, therefore reflecting potential poor control and lack of adherence to clinical guidelines. Our goal is to remain above the Medicaid 90th Percentile for the HEDIS AMR-Total performance measure. We achieved this goal in HEDIS measurement for calendar years 2012, 2013 and 2014.

Each month Decision Support Services (DSS) sends Care Management a claims-based list of CHP+ members with asthma that have an AMR<0.5 or have presented as inpatient or ED utilizers in the previous 2 months. This list is created with assistance from the Pharmacy Department and a contracted company called Navitus that works with CoA to manage pharmacy data. The list identifies members who do not demonstrate good maintenance of their asthma. The list excludes members under 5 years of age and those using medications indicative of a diagnosis of COPD or cystic fibrosis.

The care management process involves a licensed RN Care Manager (CM) attempting to contact all members with inpatient or ED utilization histories to educate member/guardian about asthma maintenance behaviors and to coordinate care with the PCP or specialist. The Care Manager intensifies the level of outreach with member/guardian and PCP for those members that are frequent ED or inpatient utilizers through transitions of care planning and ongoing education. Any members that are unreachable by phone are mailed a letter detailing the reason for outreach.

Navitus sends a monthly letter to prescribing providers that lists all patients that have filled more than 6 rescue inhalers in the previous 12 months AND have an AMR <0.5. The letter encourages providers to educate parent/guardian about asthma self-management skills. Navitus also sends a letter to the members' parent/guardian that educates them about the reasons that the asthma may not be well-controlled and advises them consult with the child's PCP.

This year's HEDIS scores reflect a 0.82% (77.61% in 2013 to 76.79%) decrease in members with an AMR greater than 0.5, reflecting good management of their condition. An additional Navitus report shows that an average of 23.88% of members that received interventions were able to increase AMRs above 0.5 within 12 months of the intervention.

HCPF monitors several measures that are aligned with the State's priorities in health. These metrics are included in a Balanced Scorecard for all CHP+ plans statewide and calculated quarterly by Optimus. Because there is a lag in receiving Optimus-generated quarterly outcome reports, data is only available through Q1 FY15. Emergency department visits among the asthmatic population are trending at the typical rate.

HCPF Balanced Scorecard Measure	FY12	FY13	FY14	FY15*
Members w/ Asthma and ER Visits	-	278 (6.1%)	289 (7.0%)	79 (6.5%)

******Only one quarter of data available.***

Strategies and Planned Interventions

- Continued monitoring of member asthma medication adherence and PCP/member outreach regarding asthma self-management best practices
- Continued monitoring, outreach, and education to members with inpatient and/or ED utilization history

Goal for FY16

- Decrease in members with AMR greater than 0.5
- Decrease in inpatient and ED visits
- Improve health outcomes through the asthma care management program

Diabetes

Although a diabetes diagnosis affects a small segment of the overall member population (0.42%, or 121/28873), Colorado Access would be remiss to dismiss this population. Currently, Care Managers refer members to the specialized services offered at the Barbara Davis Center for Childhood Diabetes. This center is located within 50 miles of approximately two-thirds of the affected population, and thus serves as a relatively accessible place of service to most of the diabetic population.

Strategies and Planned Interventions

- Colorado Access has developed a strategic plan and begun to engage stakeholders in the development of robust diabetes prevention and management programs.

Goal for FY16

- Improve health outcomes through the diabetes prevention and care management program

Depression

The Depression Care Management Program currently includes outreach to members who have visited the Emergency Department or been admitted to a hospital or other type of treatment facility. Upon discharge notification from Utilization Management, Care Managers outreach each family to assist with coordination of services, to ensure that a solid discharge plan has been established and to verify that the member is able to adhere to it. Coordination of services often involves referrals for in-home therapy services, connecting member to outpatient providers, and linking families to community-based organizations that focus on their specific needs.

Care Managers also receive referrals for outreach from PCPs and other providers, Customer Service, and members that call in with questions about mental health benefits. The Care Management staff advocates on behalf of the member with providers, pharmacies, and internal departments to facilitate authorizations and ensure access to medications and services.

Strategies and Planned Interventions

- For FY 2016, Care Management will work with CHP+ Executive Director, the Quality Improvement Team, and the Population Health Department to determine a plan that targets at-risk members and further promotes increased access to mental health services.
- Additionally, CoA is working with Colorado Community Health Network (CCHN) FQHCs on a program that aims to increase rates of depression screens at well-visits by the end of CY16.

Goals for FY16

- Improve health outcomes through the depression prevention and care management program

Health Risk Assessments

Starting in January 2013, all CHP+ members received a paper, mail-in HRA within the first month of enrolling in the CHP+ plan. In FY 2015, CHP+ members received the HRA via Interactive Voice Recognition (IVR) technology. This HRA is used to assess the member's health risk and quality of health. Once received, the HRA is loaded into the care management tool. Any members whose answers indicate a need for follow-up are outreached by our Care Management team. Often these call backs lead to coordination of care in the form of identifying a primary care, behavioral health or dental provider and making a first appointment.

Strategies and Planned Interventions

- Continue IVR HRA calls to all members for health assessment
- Continue to identify and have care management team contact those members that are in need of outreach

Goal for FY16

- Utilize HRA assessment in stratifying for interventions and improving health outcomes

Oral Health Improvement Plan

In FY2015, an interactive voice recognition (IVR) call was made to all member households. The call reminded members of the importance of oral health and the existence of their recently expanded dental benefit.

Colorado Access also continued the well-child reminder call campaign where COA representatives call members who have not been in for a well-visit in the past year and remind them to utilize their preventive health benefits. This call also includes a reminder that members have dental benefits and offers to help them find a family dentist that accepts Delta Dental insurance.

In CY2015, Colorado Access began a project wherein the Colorado Community Health Network (CCHN) oversees improvements in well-child rates at a number of Federally Qualified Health Centers (FQHCs). The first year of this project has served as a ramp-up year in which sites merely have to show some improvement in their rates. In CY2016, Colorado Access will assign goals to the FQHCs that include an increase in the provision of fluoride varnish to eligible members.

In addition to these efforts, Colorado Access will continue promoting the dental benefit to all new and existing members through flyers in their welcome packets, and through our CHP+ television commercial. Colorado Access will continue to make attempts to collect data from Delta Dental on the utilization rates on shared members.

Strategies and Planned Interventions

- Continue IVR reminder calls to all members regarding dental benefit
- Continue promotion of dental benefit to members through marketing materials
- Work with FQHC's to increase rate of fluoride varnish to members
- Monitor and track utilization rates

Goal for FY16

- Increased utilization of the dental benefit as preventive care by members
- Increase in provision of fluoride varnish

HEDIS Performance

In addition to ongoing internal monitoring of public health initiatives throughout the year, several quality measures are collected annually through the Healthcare Effectiveness Data and Information Set (HEDIS) administrative data and hybrid medical record review and are used to identify opportunities for improvement as well as benchmark to other health plans state-wide and nationally. The HEDIS Results Table provides measures from the most recent available HEDIS data, Calendar Year 2014 (CY14).

Goals

- Performance at or above statewide average

HCPF again allowed CHP+ plans to report well-visit measures using the hybrid methodology which allows for chart review. Colorado Access believes this methodology more accurately demonstrates measure results.

Performance Measures	Administrative Rates		Hybrid Rates CY14	Statewide Average
	CY2013	CY2014		
Childhood Immunizations - Combination 2	72.51%	63.37%	69.10%	61.27%
Childhood Immunizations - Combination 3	68.61%	61.76%	67.40%	59.59%
Childhood Immunizations - Combination 4	61.31%	55.21%	59.37%	55.61%
Childhood Immunizations - Combination 5	59.37%	52.81%	58.15%	50.42%
Childhood Immunizations - Combination 6	49.64%	42.91%	48.66%	42.40%
Childhood Immunizations - Combination 7	54.50%	47.59%	51.58%	47.06%
Childhood Immunizations - Combination 8	45.50%	39.30%	44.77%	40.03%
Childhood Immunizations - Combination 9	44.04%	37.43%	42.58%	37.13%
Childhood Immunizations - Combination 10	41.12%	34.36%	39.17%	35.06%
Well Child (0-15 mo) Zero Visits	2.19%	1.33%	1.33%	18.20%*
Well Child (0-15 mo) Six or More Visits	70.80%	62.83%	72.12%	45.18%*
Well-Child Visits (age 3-6)	70.35%	65.85%	68.68%	61.59%
Adolescent Well-Care Visits	43.80%	42.49%	50.61%	40.38%
BMI Assessment: Total	61.56%	50.12%*	N/A	60.81%
Counseling for Nutrition: Total	61.31%	52.80%*	N/A	61.19%
Counseling for Physical Activity: Total	53.28%	48.66%*	N/A	57.49%
Immunizations for Adol – Combination 1	64.96%	64.35%	66.58%	64.11%
Testing for Children w/Pharyngitis	76.78%	77.64%*	N/A	79.64%
Access to Primary Care (Ages 12 to 24 mo)	92.78%	96.66%*	N/A	93.22%
Access to Primary Care (Ages 25 mo to 6yr)	84.27%	85.23%*	N/A	80.57%
Access to Primary Care (Ages 7 to 11 yrs)	89.96%	92.71%*	N/A	89.64%
Access to Primary Care (Ages 12 to 19 yrs)	88.18%	92.29%*	N/A	90.09%
Asthma Medication Ratio: Total	77.61%	76.79%*	N/A	N/A
Children and ADHD medication - Initiation	0.55%	43.59%*	N/A	46.01%
Children and ADHD medication - Continuation	0.00%	43.33%*	N/A	41.82%

*Hybrid Rates

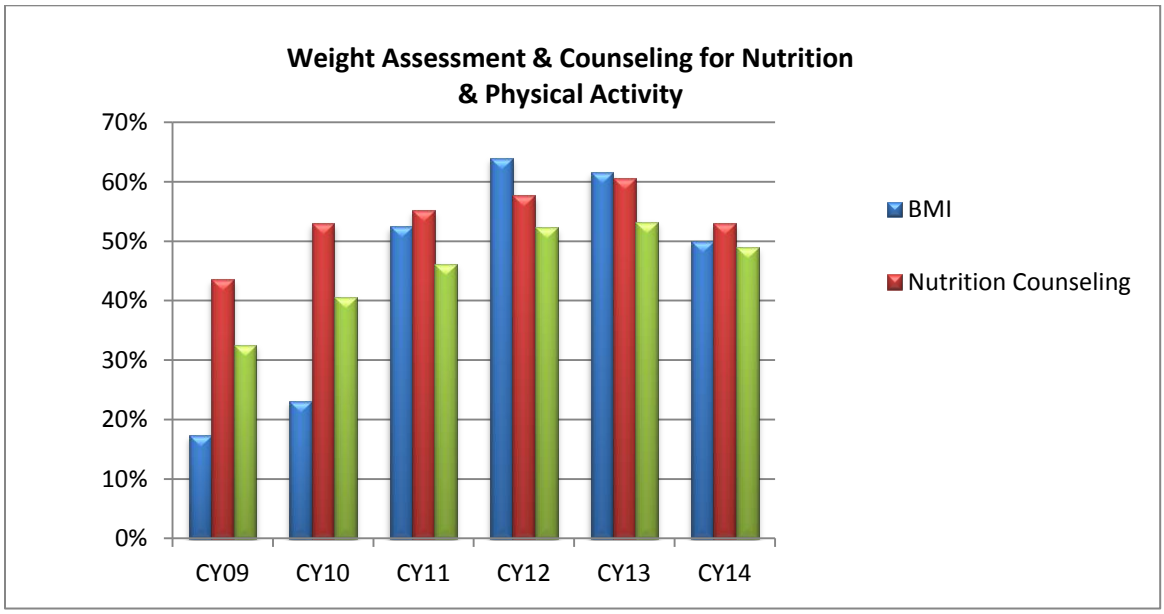
The Colorado Access HMO has remained relatively stable with some decline from HEDIS 2014 in the majority of the measures. Members in diverse open networks such as Colorado Access CHP+ HMO have access to services through a variety of providers such as the public health department or free immunization clinics. Capturing complete and accurate data can be a challenge due to open network access, inconsistencies in provider coding, providers not participating in CIIS, and/or location of charts for medical record review.

Goal for FY16

- Perform at or above state average on all HEDIS measures (including hybrid results)

Obesity Prevention

Since overweight and obesity affect about a third of our CHP+ HMO population, obesity prevention remains a priority at Colorado Access. CoA will continue to track BMI assessments through HEDIS, and will focus further on improving nutrition and physical activity follow-up counseling for kids with abnormal BMIs. This will be a crucial feature of our diabetes prevention program.



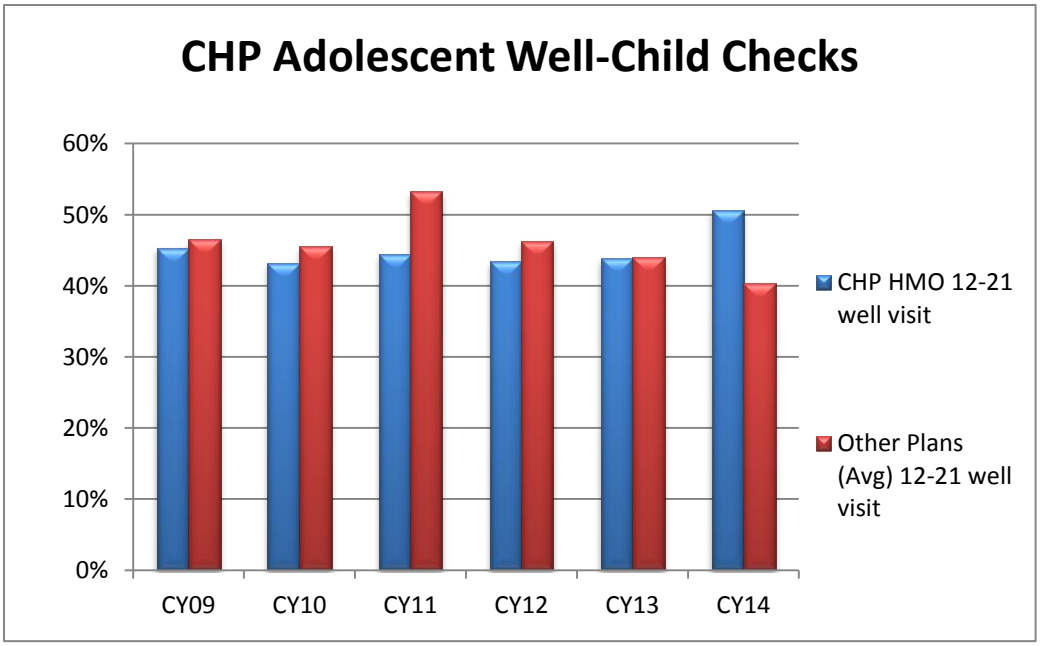
CoA has included the following question in our new-member health risk assessment (HRA): "Would you like any information on healthy eating habits and nutritional counseling covered by your health plan?" All members that respond "yes" to this question are outreached by a Care Manager to discuss nutrition benefits, dietary guidelines, methods of incorporating more physical activity into a child's daily life, and community programs that focus on these initiatives.

Colorado Access recognizes that partnering with community providers is an important step in the process of reducing and preventing childhood obesity. Therefore we have implemented goals and metrics that promote BMI screening and nutrition/physical activity counseling at well visits into our wellness program partnership with the CCHN Federally Qualified Health Centers.

Well Visits

In order to increase the number of members who receive these preventive services, we have focused on encouraging members to attend annual well-visits. The following initiatives were implemented throughout the year:

- **Visit to Win It** – CoA implemented the Visit to Win It raffle to incentivize kids and families to attend a well-child visit. All members that attend a well-visit are automatically entered in a raffle to win prizes that might be especially attractive to adolescent members such as gift cards and movie tickets.
- **Birthday Cards** –There are 3 separate cards with age groups segmented at 0-7; 8-13; 14-18 to allow for age-appropriate messaging. All cards promote the value of a well-child visit as well as the new Visit to Win It raffle.
- **Targeted Outreach** – Over the last year, CoA outreached members that have not been in for a well-visit in the past 15 months. The population was stratified by age and/or chronic illness. Approximately 1250 of these calls were made throughout FY 2015.
- **FQHC Agreement** – CoA has partnered with CCHN to incentivize 12 FQHCs to outreach all assigned members that have not received a well-child visit in the past 15 months (1 year plus time for claims lag). Providers are paid a per member per month capitation for these care management services. As previously mentioned, clinics are also evaluated for improvements in BMI screen, physical activity and nutrition counseling rates.
- **IVR Outreach** – Members without a recent well-visit that are assigned to PCPs at Inner City Health Center and Children's Health Clinic are being outreached by an automated voice message that reminds them that they are due for a well-visit. The message was recorded to sound as though it is coming from their physician's office and has an option to warm transfer to a receptionist at the respective clinic.



Strategies and Planned Interventions

- HEDIS results distributed in the provider newsletter
- Continue partnership with CCHN and FQHCs to increase well-visits and the preventive services provided at those visits
- Continue IVR reminders on behalf of providers, and possibly expand the number of clinics to which we provide this service

Goals FY16

- Ensure measures selected are relevant to Colorado Access population and meet HCPF requirements for HEDIS reporting.
- Perform at or above statewide average

Practice Guidelines

Colorado Access adopts current, evidence-based, nationally recognized standards of care based on the needs of the membership. Each guideline is reviewed annually and approved by the Colorado Access Quality and Performance Advisory Committee, comprised of physicians and providers from the Colorado Access provider network. Approved practice guidelines are available to members and providers on the Colorado Access website or by request.

Goals

- Reduce variation in practice patterns and improve outcomes in care
- Adopt and disseminate evidence-based nationally recognized guidelines that promote prevention and/or early detection
- Promote access to and increase percent of recommended preventative screening activities through member and provider education and outreach

Results and Analysis

Colorado Access completed significant process improvement regarding the tracking and review of clinical practice guidelines in FY15. CoA has adopted a new tracking mechanism, a specific timeline for review, and format for review by CoA medical directors, and review and approval by QPAC. This has resulted in increased efficiency and improved communication between quality staff, medical directors, and committee members.

Colorado Access has adopted the following behavioral health, physical health, and preventative care guidelines:

Behavioral Health	
Adolescent alcohol and substance use screening, brief intervention and referral to treatment (the CRAFFT tool)	Adult alcohol and substance use screening, brief intervention and referral to treatment (SBIRT)
Attention Deficit Hyperactivity Disorder	Bipolar Disorder (Adult)
Metabolic Monitoring of Adults Prescribed Antipsychotics	Bipolar Disorder (Child)
Substance Use Disorders	Major Depressive Disorder

Physical Health	
Abnormal Cervical Cancer Screen	Appropriate Antibiotic Use – Adults
Asthma	Appropriate Antibiotic Use - Children
Diabetes Care	Gastroesophageal Reflux Disease
Obesity – Adult	Smoking Cessation
Obesity – Child	

Preventative Care	
Adult Health Maintenance	Adult Immunizations
Child Health Maintenance	Child Immunizations
Influenza Vaccination	Prevention of Cardiovascular Disease/Stroke
Perinatal Care	

Strategies and Planned Interventions

Colorado Access experienced significant success in the process improvement efforts that were implemented in FY15. CoA hopes to continue expanding these efforts into the guideline dissemination aspects of the clinical guideline process to create a streamline process of updating the guidelines on the website and distributing guidelines to providers through the provider newsletter.

Goals for FY16

- Continue to review and adopt clinical guidelines annually
- Streamline the clinical guideline dissemination process

Medical Trends

Colorado Access trends the following measures quarterly. The following table shows results for the last four years. There was a slight increase in admits for FY2015 with a decrease across the board in readmissions as well as ER T&R compared to last year.

CHP+ HMO Medical Trends	Goal	FY 2012	FY 2013	FY 2014	FY 2015
Admits/1000	< 20.0	20.94	22.51	19.05	19.71
Readmissions/1000 - 7 Days	< 2.0	0.84	0.81	0.65	0.45
Readmissions/1000 - 30 Days	< 3.0	1.94	2.04	1.69	1.68
Readmissions/1000 - 90 Days	< 4.0	3.06	2.90	2.55	2.55
PCP Visits/1000	> 1500.00	1579.08	1512.19	1683.8	1925.9
ER Treat &Release Visits/1000	< 500.0	449.17	502.95	416.0	395.74
Non-Emergency ER Visits/1000	< 1.0	1.10	1.48	0.94	0.48

Strategies and Planned Interventions

- Follow up by CM & Pharmacy for potential lower readmissions rates
- Incentives for higher PCP visits
- Educate member on ER, Urgent Care & PCP visits (ER vs. NEMER)

Goals for FY16

- Monitor potential over and underutilization patterns
- Perform at or above set goals

Section 7: Utilization Management

UM Decision Making

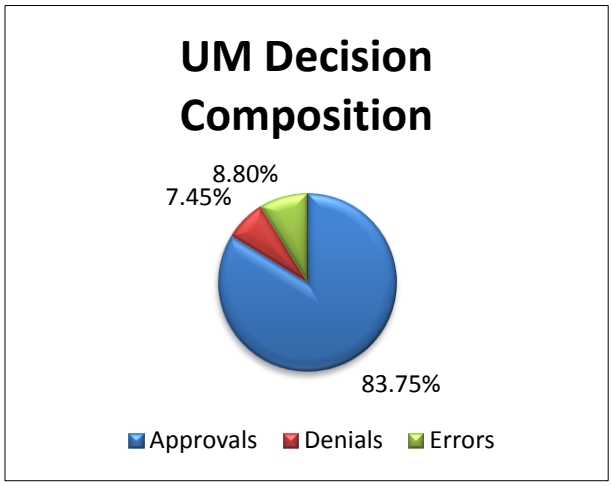
Timeliness of utilization management (UM) decision making is monitored regularly in order to assure that decisions are made according to contractual requirements and to support members' accessibility to services according to need. Patterns in decision making are analyzed in order to identify opportunities for improved efficiency and consistency among decision makers.

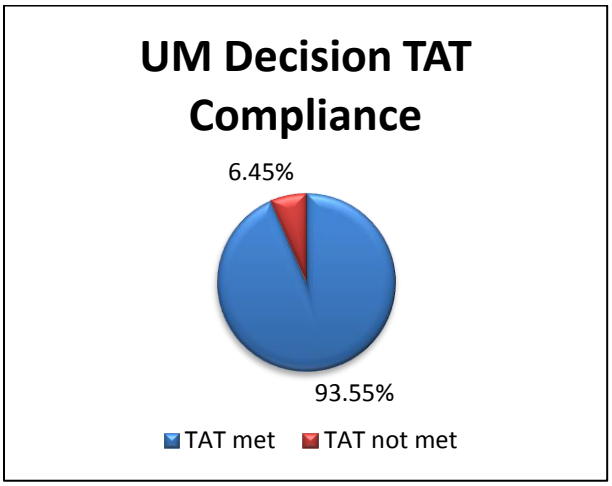
Goals

- 100% of UM decisions made according to timeliness standards

Results and Analysis

In FY15, Colorado Access began monitoring the timeliness of all UM decisions, both approvals and denials (historically, only timeliness of denials was monitored). Both the proportion of approvals to denials and the percentage of compliance with turn-around times (TAT) for all decisions are shown in the figures below.





During the fourth quarter of FY15, Colorado Access identified significant issues with data entry in the utilization management system used – Altruista. These data entry errors (such as missing request dates, errors in data entry, etc.) resulted in missing data for nearly 9% of all UM decisions. In addition, several miscommunications and workflow issues were identified that were causing non-compliance with decision timeframes, including decisions involving a single-case agreements. The quality team has worked in collaboration with the UM team in order to resolve these issues.

Strategies and planned interventions

- Significant training with UM staff regarding data entry mistakes, with emphasis on required fields. The monthly monitoring reports now also include detail on the errors made by staff member. In addition, Colorado Access has requested several updates to the Altruista system, including making various fields required entry before saving.
- The monthly monitoring report was also revised to include detail of missed TAT by staff member in order to provide more focused staff training around missed timeframes.

Goals for FY16

- Reduce UM decision error rate to at least 1%
- Improve TAT compliance to 97% or higher

Appeals

Members have the right to appeal any action that denies services or pharmaceuticals. Colorado Access tracks the number and types of appeals received in order to monitor for any decision patterns or possible issues related to the accessibility of services.

Goals

- 100% of appeals resolved within contractually required timeliness standards
- Monitor appeal rates for any patterns

Results and Analysis

In FY15, Colorado Access received a total of 39 appeals for the CHP+ line of business. This is approximately 9.77% of the 399 denials issued in FY15. As noted in the grievance section above, appeal rates were unintentionally deflated in previous fiscal years due to a miscalculation in average membership. Both previously reported rates and corrected rates are reflected in the table and figure below.

Fiscal year	Reported rate	Corrected rate
FY13	.21	.77
FY14	.40	1.63
FY15	NA	1.23

Inter-Rater Reliability (IRR)

The utilization management inter-rater reliability study was conducted to objectively assess the degree to which different raters answer the same questions in the same way (reliability) and to measure the level of consistency and adherence to Colorado Access approved medical management criteria/guidelines.
The goal of the periodic inter-rater reliability study is to minimize variation in the application of approved criteria in order to:

- evaluate staff's ability to identify potentially avoidable utilization
- target any previously identified specific areas most in need of improvement
- identify those staff needing additional training
- avoid potential litigation due to inconsistently applied approved criteria/guidelines
- meet specific contractual, regulatory agency or accrediting agency requirements.

The Coordinated Clinical Services (CCS) Department is divided into physical health and behavioral health and pharmacy specialty areas. The CCS Clinical/UM Staff who review physical health requests are licensed registered nurses and licensed practical nurses who apply clinical criteria and utilize clinical judgment within their scope of practice. The behavioral health concurrent review staff are licensed mental health professionals who apply clinical criteria and utilize clinical judgment within their scope of practice. The Intake Specialists are a team in this department who has received specialized training in following scripted protocols to enter pre-authorizations for routine levels of care or specialty referrals that do not require the review of a licensed professional. The Pharmacy staff are licensed Pharmacy Technicians who review all pharmacy requests using the Colorado Access formulary as well as scripted drug protocols.

For the Coordinated Clinical Services UM Staff the McKesson InterQual®(IQ) Interrater Reliability Tool is utilized. Two different measurement instruments were used based on the work expectations and the scope of clinical knowledge necessary to make clinical determinations: The Level of Care Acute Criteria (Adult) and the Behavioral Health Criteria (Adolescent & Child Psychiatry) Interrater Reliability Tools. The Intake Specialists were given a set of case studies and questions that involve approved scripted criteria/guideline application to determine if the request could be approved or required referral to the CCS Clinical Staff for further review. Prior Authorization cases were selected from the pharmacy drug criteria on which the Pharmacy Technicians have been trained. Each clinical area is then scored and reported separately.

Results and Analysis
IRR specific to pediatric physical health is conducted on a biennial cycle of which FY2015 was the off year. Also due to changes in staffing in the Pharmacy department, the IRR was also not conducted for Pharmacy Technicians for FY2015. The plan is to resume with IRR for pediatric physical health, behavioral health and pharmacy specialty areas for FY2016.

Strategies and Planned Intervention

- Annual IRR review for Adults and Pediatrics
- CCS Management Staff will continue individual focused coaching of staff regarding scripted guidelines and InterQual® criteria interpretation and use.
- All staff who did not pass with 90% or greater will be required to attend an annual Policy & Procedure training, refresher course on how to apply InterQual® criteria, review of tools/resources loaded on the 'Resource Page' in the clinical documentation system, and contractual/Federal and State mandated turn-a-round timelines.
- Any individual staff who did not meet 90% benchmark will be re-tested after focused training completed.

Goals FY16

- Complete child and adult IRR analysis annually
- Achieve minimum of 90% agreement amongst raters

Section 8: Compliance Monitoring

Performance Improvement Project (PIP)

Improving the Transition Process for Children Aging Out of CHP+ HMO Plan

Colorado Access began the Transition Process for Children Aging Out of CHP+HMO plan for the FY2014-2015. CHP+ targeted high risk members with chronic medical or mental illness, have had 3 or more Emergency Department visits in the year prior, or are prescribed a medication that costs $300.00 or more per fill who were losing their CHP+ plan coverage after turning age 19 in the measurement year to prepare them for the transition to new health insurance coverage and adult care. This population is especially vulnerable during the transition from CHP+ HMO to a different health insurance because they have medical or mental conditions that require continuity in services and medication. If a member isn't prepared to transition, they may experience a gap in insurance which could disrupt their medical/behavioral health services and medications and lead to complications or a worsening in their medical or mental condition. Since the plan may lose contact with a member after they age out of their CHP+ HMO coverage, it is important to focus on the time the plan still has with a member before they age out and prepare them in the best way possible to transition to a different health insurance so they don't experience a gap in insurance. CoA will use several modes of contact (i.e., telephone, mail, internet) to assist members with preparing for this transition.

The intervention includes sending out a post card to the members 6 months before their 19th birthday; reminding them they will need to think about what insurance they will transition to once they turn 19. They have the option to complete a short survey through mail or online about their plans for the transition and receive a $10 gift card. Through the survey they can request assistance if they have questions or concerns.

For the high risk members, they will receive a care manager transition preparation call 90 days before they turn 19. Our care manager either talks to the teen or the parent, depending on the parent's preference. Discussion with member or parent surrounds coverage ending with CHP+ and plans for transitioning to other health insurance. Other items are also brought up and discussed such as Assistance with Medicaid application, choosing a PCP for adults, making medical appointments and refilling medications are other topics that are brought up during the phone conversation. And there is emphasis on the importance of having health insurance.

The care manager will help the member or parent get in contact with AMES program to start process for checking eligibility for government programs (Medicaid).

This program started January, 2015. 188 members are in the high risk cohort. So far, 104 members have been called and 32 of those members have completed the preparation call with the care manager.

The overall response has been that parents think that CHP+ will automatically roll over into Medicaid, or they don't know where their child will get health insurance next, in which case they are referred to the AMES program for assistance in researching options.

The biggest barriers are:

- Having accurate contact information for these members
- The care manager usually speaks with the parent, not the teen. The parents are hesitant to give out contact information or even to have them talk to our care manager.
- Base on initial call responses, preparation needs to start before the teen even turns 18.

Some of the biggest successes have been the few teens that are engaged and interested in how to get insurance after CHP+. For example, a couple of teens have called the care manager back to talk about their options more.

Strategies and Planned Interventions

- Continue outreach to targeted members with chronic illness
- Identify improvement opportunities in communicating with all applicable members
- Begin contacting members before the age of 18
- Encourage parents to get involved in preparing transitioning member for transition

Goals FY16

- Provide the communication, education and resources for all applicable members to prepare for transitioning to another health plan

External Quality Review Organization (EQRO) Site Review

Colorado Access participates in an annual external independent review of quality outcomes, timeliness of, and access to services covered under its CHP+ HMO contract. This review was conducted by Health Services Advisory Group (HSAG)

Based on the results from the compliance monitoring tool and conclusions drawn from the review activities, HSAG assigned each requirement within the standards in the compliance monitoring tool a score of *Met*, *Partially Met, Not Met,* or *Not Applicable.* HSAG assigned required actions to any individual requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Summary of Scores for the Standards							
Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
V. Member Information	23	23	21	2	0	0	91%
VI. Grievance System	26	26	20	6	0	0	77%
VII. Provider Participation and Program Integrity	17	17	17	0	0	0	100%
IX. Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**71**	**71**	**63**	**8**	**0**	**0**	**89%**

Summary of Scores for the Record Reviews						
Description of the Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Grievances	45	30	23	7	15	77%
Appeals	60	57	43	14	3	75%
Totals	**105**	**87**	**66**	**21**	**18**	**76%**

Strengths

Standard V – Member Information

The EOCs and other vital member materials were written in easy-to-understand language and were translated into Spanish and available in other languages upon request. Member materials were provided upon enrollment and at other times as required. The member welcome packet included a well-organized booklet that summarized major plan benefits and referred the member to the Colorado Access website or customer services for additional information. The website, which allowed members to select translation of online information into more than 50 languages, also provided access to the EOCs, member rights, provider directories, and many other member information resources. Staff provided evidence of extensive internal resources used to support the provision of interpreter services in any language requested by members or

providers. Enrollment information notified members that the searchable CHP+ provider directory was available online and that a hard copy could be requested through customer services. The online directory was updated through a real-time interface with the provider database.

Policies and procedures and supporting documentation confirmed that members were notified within the required time frames of any significant changes in information or any provider termination. Colorado Access notified parents of CHP+ members annually of their right to request a member handbook, which included member rights and protections. The EOCs and other member materials included information about covered benefits and applicable copayment amounts, utilization management, grievance and appeal procedures, advance directives, emergency and post-stabilization services, referrals and out-of-network services, enrollment and disenrollment, scheduling guidelines, and other requirements of the contract with the Department.

Standard VI – Grievance System

Appeals and grievance processes were thoroughly defined in policies and procedures, described in the member handbooks and other member communications, and included in an appeals information attachment sent with notices of action and appeal resolution letters. State fair hearing processes were also thoroughly addressed in policies and member communications. Appeal and grievance decisions were made by persons uninvolved in any previous decision-making and by persons with appropriate clinical expertise, as applicable. Staff members stated that Colorado Access contracts with an external medical review vendor to make appeal decisions when an appropriate specialist is unavailable internally. Time frames for filing grievances and appeals were accurately defined and record reviews documented that all grievances and appeals were acknowledged within two days. Member and provider communications included the time frames for filing and processing grievances and appeals. On-site record reviews confirmed that Colorado Access resolved all expedited and standard appeals within the required time frames. The grievance and appeal resolution letter templates included a section for results of the resolution process and date resolved. Expedited appeal procedures and the option for members to request continuation of benefits were also adequately described in policies and member communications. Member communications also clearly defined the circumstances in which the member may or may not be responsible to pay for continuation of benefits. CHP+ provider manual includes an accurate and thorough description of the grievance system. All appeals and grievances were documented and tracked through the central Altruista information system. Colorado Access submitted quarterly reports of all grievances and appeals to the Department, as required.

Standard VII – Provider Participation and Program Integrity

Policies and procedures documented that Colorado Access has a thorough process for credentialing and recredentialing of providers in compliance with National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Committee (URAC) standards. Policies also specified methods for precredentialing and monthly monitoring for provider sanctions against applicable federal and state databases, monitoring for grievances and other

quality of care actions against providers, annual on-site audit of medical record standards for a rotating sample of high volume providers, quarterly surveys to monitor access to care standards, and profiling of utilization patterns and CHP+ Healthcare Effectiveness Data and Information Set (HEDIS®)1-2 measures. All findings were reported to senior management committees and the Quality Improvement Committee (QIC), as evidenced in on-site review of QIC meeting minutes. Results were considered in the recredentialing process, as appropriate, and provider corrective action plans were developed to address identified deficiencies. Policies and procedures stated that Colorado Access does not discriminate against providers and does not restrict providers from acting on behalf of their patients. Colorado Access notified providers of reasons for declining participation in the network, which staff stated is generally due to analysis of network sufficiency for the number or types of providers needed to serve the members.

Numerous corporate policies and procedures, the Corporate Compliance Plan, and the Medicaid Compliance Plan (applicable to CHP+) documented robust and well-established procedures to guard against fraud, waste, and abuse (FWA) and to maintain all corporate compliance standards. All adverse outcomes related to sanction screenings, suspected FWA, quality of care concerns, and HIPAA violations were reported to the Department. Staff described internal processes (including suspension of provider payments and contract termination) that could be implemented as a result of any identified suspicion of provider fraud.

Standard IX – Subcontracts and Delegation

All policies, procedures, and processes related to the requirements for Subcontracts and Delegation applied to all Colorado Access lines of business and were corporately driven. All elements in this Standard have been implemented for CHP+ and SMCN. CHP+ delegated credentialing, claims processing, and other select administrative responsibilities to subcontractors. Policies and written agreements with delegates documented that Colorado Access retains ultimate responsibility for delegated functions. Pre-delegation assessment of a prospective delegate's capabilities included extensive desk review and on-site audit of policies, procedures, and adequacy of staff to perform the delegated activities. Colorado Access performed a comprehensive annual audit of its delegates and performed ongoing monitoring through periodic reports submitted by those delegates. Any deficiencies identified in pre-delegation or ongoing audits required a corrective action plan, with re- audit every three months until action plans were completed. Delegation agreements described the delegated responsibilities in detail, periodic reporting responsibilities of the delegate, annual audit by Colorado Access with corrective action plans to remedy any deficiencies, and Colorado Access' ability to revoke delegated functions or the entire delegation agreement based on inadequate performance. **Colorado Access** maintained documentation of both audit findings and any required follow-up in a comprehensive database, the Compliance 360 system. All delegation assessment results and ongoing monitoring activities were reported to the Delegation Oversight Committee (DOC), as evidenced in the DOC meeting minutes.

Required Actions

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

Standard V – Member Information

- Colorado Access must include information in the EOC and related policies to ensure that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so and inform members about how to access the Department concerning disenrollment.
- Colorado Access must remove statements from the CHP+ HMO EOC regarding the potential for members to be charged for missed appointments and ensure that providers do not charge CHP+ members for not following the PCP's appointment cancellation policies.

Standard VI - Grievance System

- Colorado Access policies, CHP+ provider manuals and EOCs accurately defined a grievance according to the requirement. However, the grievance record review included six records that were member requests for reimbursement of out-of-pocket expenses. (These records were omitted from the record review sample.) A member request for reimbursement is not an "expression of dissatisfaction" and, therefore, not a grievance. Colorado Access should revise internal procedures to ensure that the grievance tracking system accurately designates "grievance" as a member complaint or "expression of dissatisfaction" about any matter other than an action.
- Colorado Access must:
  - Implement mechanisms to complete the resolution of grievances, whether or not the time frame has expired.
  - Revise member resolution letters to include an appropriate explanation of the disposition of the grievance. (Letters informing members that a case is being closed because the time frame has expired are not resolutions.) Resolution letters must include a description of the *results* of the resolution process and the date the grievance was *resolved.*
  - Ensure that it resolves grievances within the required time frame, unless it is clearly in the member's best interest to extend the time frame for resolution.
- Colorado Access must correct policies and procedures and related CHP+ member and provider communications to accurately describe:
  - That a member may file an appeal or request a State fair hearing for any action (including suspension, termination, or reduction of services) within 30 calendar days from the date of the notice of action, unless the member is requesting continuation of previously authorized services during the appeal or State fair hearing process.
  - That the 10-day requirement for filing an appeal or requesting a State fair hearing applies only when the member is requesting continuation of benefits pending the outcome of an appeal or State fair hearing.

- Colorado Access must revise inaccuracies in member communications, including the Appeal Upheld letter and CHP+ EOC, to clarify that the member has a right to request a State fair hearing if not satisfied with the outcome of the appeal.
- Colorado Access must develop a mechanism to ensure that appeal resolution letters are written in language that is easy for members to understand.

Colorado Access has submitted the corrective action plan to HSAG and fulfilled all of its agreed upon commitments to the satisfaction of the EQRO.

Standard VII – Provider Participation and Program Integrity
There were no required actions for this Standard.

Standard IX – Subcontracts and Delegation
There were no required actions for this standard.

Goal for FY16

- Perform at or above previous year's performance