Annual Quality Report

Child Health Plan Plus (CHP+) HMO

Fiscal Year 2016

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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 (COA) 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.

The first half of Fiscal Year 2016 (FY16) continued to be plagued with enrollment issues for the Colorado Access CHP+HMO plan. Membership reached its nadir with approximately 26,000 members in November 2015. However, as a result of the MMIS continuous eligibility fix implemented, membership rebounded to nearly 33, 000 members by the end of the fiscal year. With more of our members remaining continuously enrolled with the plan, Colorado Access has been able to better employ care management interventions that help families access the care that their children need. Overall, Colorado Access has been able to take pride in our efforts to best serve our CHP+ population throughout the year.

FY16 Key Accomplishments

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 quality measures have improved over the past fiscal year, including the CAHPS survey, which demonstrates 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 well child and immunization visits, with adolescent member demonstrating the greatest increases.

COA has also employed some quality initiatives in partnership with federally qualified health centers (FQHCs) that have demonstrated success in helping children attend the recommended annual well child visits.

FY17 Key Initiatives

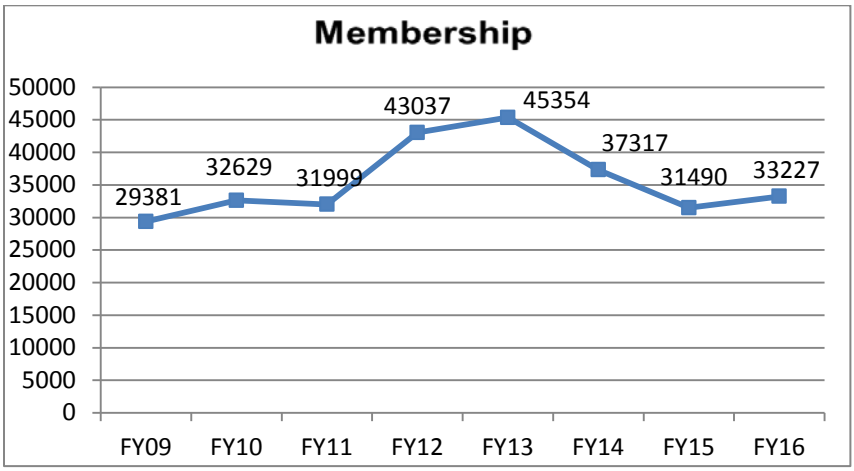
Colorado Access has partnered with the Colorado Community Health Network to improve well-child visit rates. We achieved this goal in FY15, and we moved forward in FY16 to further increase well-child rates as well as the rates of specific preventive services that should take place at the well-visit such as: vision screens, BMI screens, Depression screens, nutrition and physical activity counseling and fluoride varnish. COA and partnering providers continue to set higher goals for improving these measures in FY17.

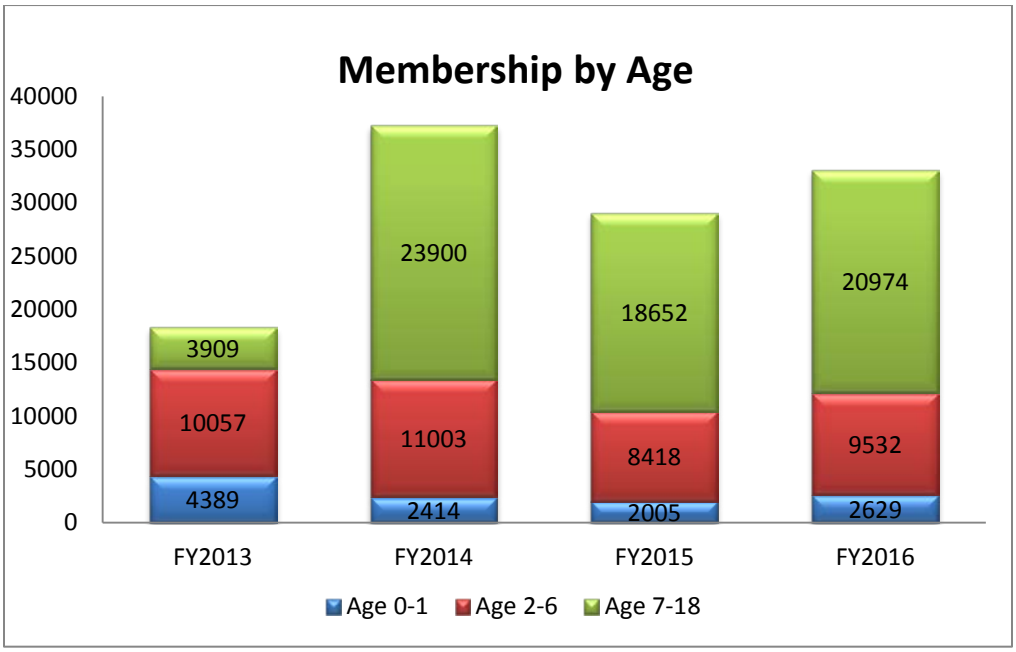
Colorado Access will also continue to outreach to older members through our Age Out program to assist in transitioning to the next level of health care coverage, and to help them therefore avoiding gaps in care and potentially poor health outcomes and considerable financial consequences.

Access to Care

Membership

Membership for CHP+ HMO increased overall from 31,490 in FY15 to 33,227 for FY16. Data is from Colorado Access Decision Support monthly statistics and is a snapshot as of June at the end of each fiscal year. Total membership increased by 5.5% and we saw an increase in all age categories (see charts below).





Service Accessibility

Access to care and service is one of the key drivers of member satisfaction. Appropriate access to the primary care practitioner (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.

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. After-hours testing focuses efforts on testing access to care and availability 24 hours a day, 7 days a week.

Goals from FY16

- 90% of appointments fall within the standards for each appointment category
    - Routine and non-urgent appointment available within 30 days
    - Urgent appointment available within 48 hours
- Accessibility rate of 90% for After Hours availability 24 hours/day, 7 days a week

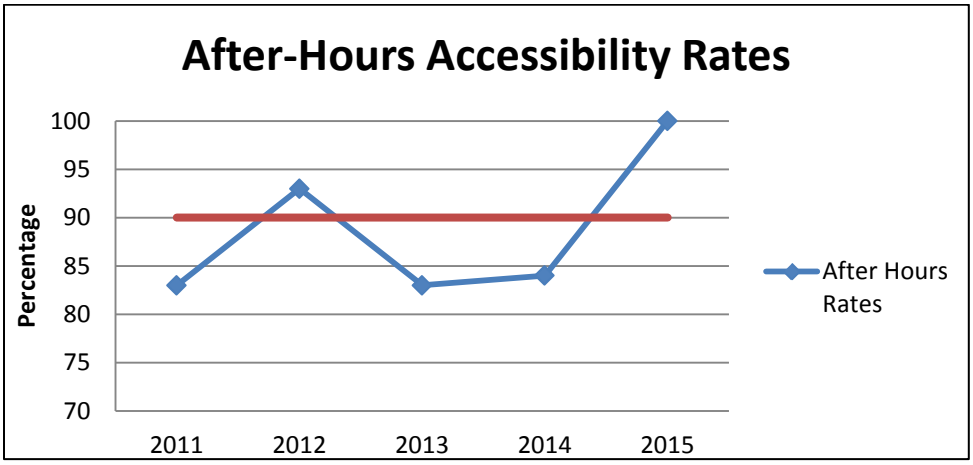
Interventions implemented during FY16

During FY16, Colorado Access implemented the new after-hours testing method, testing each provider for both the access to care standards and the after-hours standards. Previously, different sets of providers were identified separately for access to care and after-hours monitoring.

Results and Analysis

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 evaluated during the year. The goal for all appointment scenarios was 90%. The goal was exceeded on all standards, with providers offering timely appointments according to standards.

For After-Hours monitoring, a total of 12 provider's sites were evaluated and all sites were compliant.



Strategies and Planned Interventions for FY17

- 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
- Develop more robust provider feedback system for Secret Shopper/After Hours results

Goals FY17

- Perform at the standards level or higher for access to care
- Continue to monitor all standards in a streamlined process

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 from FY16

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

Interventions implemented during FY16

The Customer Service Quality Monitoring program was revised in May 2016. Customer Service representatives will now be monitored and scored to identify areas for improvement based on the revised quality guidelines.

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 FY16. The number one reason for Customer Service calls continues to be eligibility verification, followed by claim status inquiry.

Calls Answered 30 Seconds				
	FY16			
	Q1	**Q2**	**Q3**	**Q4**
Customer Service	91.5%	82.5%	80.5%	70.7%
Coord. Clinical Service	96%	95%	97%	99%
Goal	*80%*	*80%*	*80%*	*80%*
	FY16			
	Q1	**Q2**	**Q3**	**Q4**
Customer Service	1.9%	2.5%	2.5%	2.9%
Coord. Clinical Service	1.0%	2.0%	3.0%	3.0%
Goal	*5%*	*5%*	*5%*	*5%*
	FY16			
	Q1	**Q2**	**Q3**	**Q4**
Customer Service	1.0%	1.0%	1.0%	1.0%
Coord. Clinical Service	1.0%	1.0%	1.0%	1.0%
Goal	*5%*	*5%*	*5%*	*5%*

Strategies and Planned Interventions for FY17

- Customer Services staffing experienced higher-than-normal attrition in the last 2 quarters of FY16, which impacted call metrics. A new hire training class was implemented in July 2016 and another new hire class will start in September 2016.

Goals FY17

- Maintain staffing levels to ensure that call timeliness guidelines are consistently met.
- Meet or exceed all standard contractual metrics.

Network Adequacy

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 from FY16

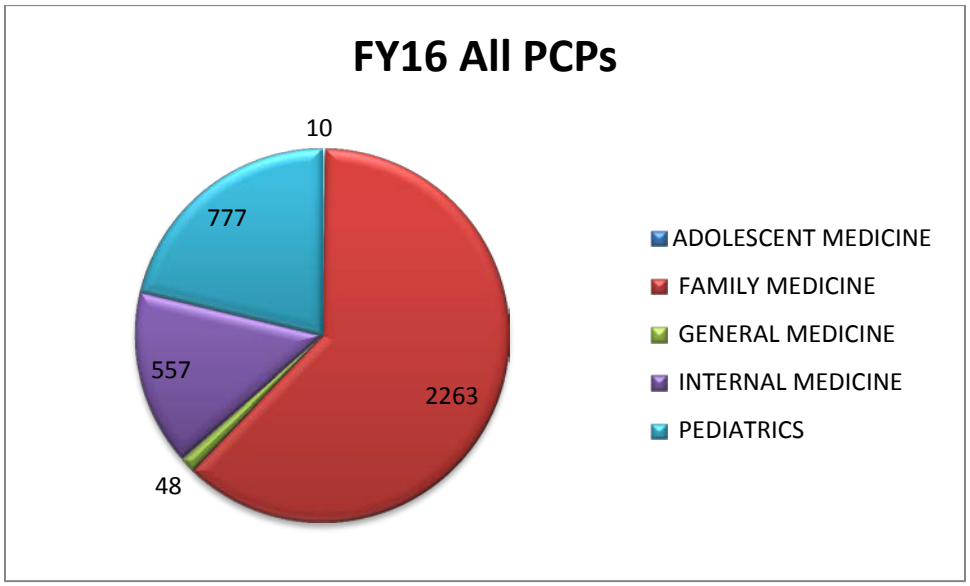
- GeoAccess monitoring of 1 provider within 30 miles
- Primary care provider to member ratio of 1:2000
- Physician specialist to member ratio of 1:2000
- PCP accepting new patients at 90%
- Specialists accepting new patients at 85%

Interventions implemented during FY16

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.

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 exceed the standards this fiscal year. The CHP+ HMO population is most dense in El Paso County with 5,049 members, followed by Adams County with 4,167 members. Even in the least dense county (Moffat County with only one member), the access to practitioner rate falls no lower than 99.70% for the 30 minute/mile standard, well below the 1:2000 standard ratio.

Of the 33,073 CHP+ members enrolled in FY 2016, almost all members had access to a PCP, PCPs Accepting Patients, and Specialists within 30 miles.

Provider Type	Standard	Goal	FY14	FY15	FY16
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%	99.50%	99.80%	99.70%
Behavioral Health		85%	99.80%	99.70%	99.80%

Provider Type	Goal	FY14	FY15	FY16
PCPs	1:2000	1:48 (762/37, 307)	1:8 (3559/31,490)	1:10 (3655/33010)
PCPs accepting patients		1:15 (2383/37,307)	1:10 (2982/31,490)	1:12 (3103/33010)
Specialists		1:5 (6452/37,307)	1:4 (7831/31,490)	1:10 (8865/32911)
Behavioral Health		1:21 (1734/36,898)	1:15 (1993/31,490)	1:20 (2447/32900)

Strategies and Planned Interventions for FY17

- 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 FY17

- Maintain network adequacy performance at standard or above

Member 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.

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.

Interventions implemented during FY16

The Customer Service Quality Monitoring program was revised in May 2016. Customer Service representatives will now be monitored and scored to identify areas for improvement based on the revised quality guidelines. Customer Service has a 4-week training program that includes a comprehensive review of member benefits and department workflows, training on all applicable systems and trainees take mock and live calls in the training environment before they are release to the floor. Customer Service Representatives (CSR) are scored and monitored to meet minimum quality standards:

- Greeting and verification,
- Eligibility, Claim and benefit information
- Call Reason and resolution information
- Documentation information
- Closing
- Soft skills

Results and Analysis

The COA CHP+ HMO response rate went up this year by 1.44% from 31.06% to 32.50%.
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 were compared to NCQA Benchmarks and Thresholds for Accreditation in the table below. Satisfaction in the area of Rating of All Health Care went up two stars and Rating of Personal Stars up to five stars. COA continues to trend upward in Getting Care Quickly and How Well Doctors Communicate. 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.

Overall Member Satisfaction Ratings					
	Colorado Access	**Colorado Choice**	**DHMP**	**Kaiser**	**RMHP**
Global Rating					
Rating of Health Plan	* 2.494	* 2.3250	* 2.507	* 2.449	* 2.484
Rating of All Health Care	***** 2.652	* 2.401	** 2.515	**** 2.599	**** 2.581
Rating of Personal Doctor	***** 2.727	** 2.504	***** 2.711	***** 2.664	**** 2.653
Rating of Specialist Seen Most Often	****+ 2.620	**+ 2.545	*+ 2.472	*+ 2.512	***** 2.750
Composite Measure					
Getting Needed Care	* 2.472	*** 2.487	* 2.077	*** 2.489	** 2.458
Getting Care Quickly	*** 2.561	*** 2.630	* 2.306	*** 2.678	*** 2.629
How Well Doctors Communicate	***** 2.817	*** 2.685	*** 2.694	**** 2.768	***** 2.754
Customer Service	* 2.355	*+ 2.379	* 2.375	* 2.467	* 2.310
***** 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.					

Strategies and Planned Interventions for FY17

- Continue with the Customer Service Quality Monitoring program intervention that was implemented in FY16. Because of the late implementation, it is expected that scores will not be impacted until the FY17 survey.

Goals FY17

- Improve Customer Satisfaction rating to the 25th-49th percentile

Grievances

Members are informed of their right to file a grievance or appeal through various means, including the Colorado Access Evidence of Coverage booklets, Member Handbooks, and through verbal communication with Colorado Access Customer Services staff when members call. 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 from FY16

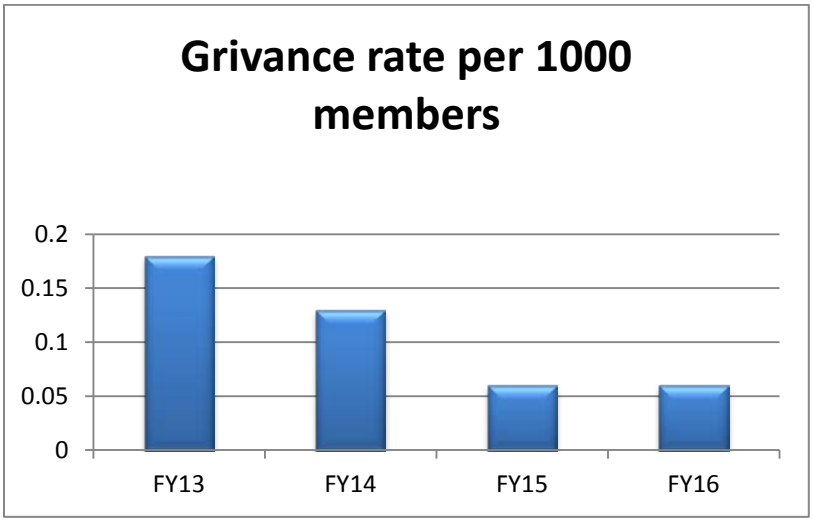
- 100% resolution within 15 business days, or, if extension is required, an additional 14 calendar days
- Less than 2.0 grievances per 1000 members

Results and Analysis

In FY16, Colorado Access received a total of 3 grievances for the CHP+ line of business. All grievances were related to Customer Service, and all 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	# of Grievances	Rate	Goal
FY13	8	.18	< 2.0
FY14	5	.13	< 2.0
FY15	2	.06	< 2.0
FY16	3	.06	<2.0



Strategies and planned interventions for FY17

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

Goals FY17

- 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."

Colorado Access's Quality of Care (QOC) process identifies, investigates, and addresses potential quality of care concerns, including those involving physician providers. QOCs can be raised by members, providers, or COA staff and include all potential problems, concerns, or complaints concerning access to urgent or emergent care, delay or denial of care or services, after-hours services, professional conduct or competence, coordination of care, medication issues, diagnosis issues, service plan or delivery issues, or concerns with legal or member rights. QOCs are also triggered by care resulting in unexpected death, suicide attempts requiring medical attention, medication errors, or adverse medication effects requiring medical attention, preventable complication requiring medical attention, assault or accident related injuries requiring medical attention, or an at-risk client missing from a 24-hour facility.

Potential QOCs are forwarded to the Quality Improvement Department for initial investigation and are then submitted to a Colorado Access Medical Director for review and a determination. Findings are confidential under peer review statutes.

Goals from FY16

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

Results and Analysis

There were no CHP+ QOC grievances in FY 2016.

Score	FY12	FY13	FY14	FY15	FY16
0	1	2	1	0	0
1	0	1	1	0	0
2	0	0	0	0	0
3	0	1	0	0	0
Total	**1**	**4**	**2**	**0**	**0**

Strategies and Planned Intervention for FY17

- Monitor and track QOC concerns and take action as needed

Goals FY17

- Ensure investigation and timely completion of Quality of Care concerns

Health Outcomes

Colorado Access designs and implements population health initiatives that focus on 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.

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 2015 (CY15). For details about the initiatives for particular measures, please reference the according subsequent section.

Goals from FY16

- Performance at or above statewide average on CHP+ HEDIS measures

Results and Analysis

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.

The Colorado Access HMO has increased from HEDIS 2015 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.

COA's performance on the CHP+ HEDIS measures can be seen in the table below.

Performance Measures	Fiscal Year			2016 Hybrid Rates	2015 State Average
	2014	2015	2016		
Immunizations					
CIS: Combination 2	72.51%	63.37%	68.86%	69.10%	61.27%
CIS: Combination 3	68.61%	61.76%	65.21%	67.40%	59.59%
CIS: Combination 4	61.31%	55.21%	58.64%	59.37%	55.61%
CIS: Combination 5	59.37%	52.81%	57.18%	58.15%	50.42%
CIS: Combination 6	49.64%	42.91%	41.61%	48.66%	42.40%
CIS: Combination 7	54.50%	47.59%	52.07%	51.58%	47.06%
CIS: Combination 8	45.50%	39.30%	39.17%	44.77%	40.03%
CIS: Combination 9	44.04%	37.43%	37.71%	42.58%	37.13%
CIS: Combination 10	41.12%	34.36%	36.01%	39.17%	35.06%
IMA: Combination 1	64.96%	64.35%	71.43%	66.58%	64.11%
IMA: Tdap/Td	81.44%	84.39%	85.71	89.21%	79.64%
Well-Child Visits					
W15: Zero Visits	2.19%	1.33%	3.21%	1.33%	18.20%**
W15: Six or More Visits	70.80%	62.83%	66.79%	72.12%	45.18%**
W34: Well-Child Visits age 3-6	70.35%	65.85%	66.11%	68.68%	61.59%
AWC: Adol. Well-Care Visits	43.80%	42.49%	50.85%	50.61%	40.38%
Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents					
BMI Assessment: Total	61.56%	50.12%	57.91%	N/A	60.81%
Counsel. for Nutrition	61.31%	52.80%	57.66%	N/A	61.19%
Counsel. for Physical Activity	53.28%	48.66%	48.18%	N/A	57.49%
Children's & Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	92.78%	96.66%	93.65%	N/A	93.22%
Ages 25 Months to 6 Years	84.27%	85.23%	87.50%	N/A	80.57%
Ages 7 to 11 Years	89.96%	92.71%	92.85%	N/A	89.64%
Ages 12 to 19 Years	88.18%	92.29%	92.81	N/A	90.09%
Follow-up Care for Children Prescribed ADHD Medication					
Initiation	0.55%	43.59%	.74%	N/A	46.01%
Continuation	0.00%	43.33%	0.00%	N/A	41.82%
Other Measures					
Testing for Pharyngitis	76.78%	77.64%	79.59%	N/A	79.64%
Asthma Medication Ratio	77.61%	76.79%	75.00%	N/A	

Goals for FY17

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

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 least once per trimester throughout their pregnancy to assess physical, psychological, and social needs. Members are supplied with written materials and contacts for community organizations based on their questions and/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.

Strategies and Planned Interventions for FY17

- 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 FY17

- 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.

Each month Decision Support Services 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, who 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 nurse Care Manager attempting to contact all members with asthma-related inpatient, urgent-care, 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 1.79% (76.79% in 2014 to 75%) 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 33.33%, an increase of 9.45% of members that received interventions were able to increase AMRs above 0.5 within 12 months of the intervention.

Strategies and Planned Interventions for FY17

- 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

Goals for FY17

- Decrease in members with AMR greater than 0.5
- Decrease rates of 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 (0.33%) or 10/33224), Colorado Access would be remiss to dismiss this population. Currently, Colorado Access Care Managers outreach all members that have been hospitalized with a primary or secondary diagnosis of diabetes within 3 days of discharge. In cases where the families need the support of diabetes specialist, Care Managers refer members to the specialized services offered at the Barbara Davis Center for Childhood Diabetes.

Strategies and Planned Interventions for FY17

Colorado Access partnered with the University of Colorado, Children's Hospital, several FQHCs and CDPHE in a grant that will implement an evidence-based program designed to prevent the development of diabetes in high risk children and their families. Work on this 2 year grant commences October 1, 2016.

Goals for FY17

- Improve health outcomes through the diabetes prevention and care management programs.

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 FY17

- For FY 2017, 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.
- COA is working with Colorado Community Health Network (CCHN) FQHCs on a program that aims to increase rates of depression screens at well-visits.

Goals for FY17

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

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 FY15, CHP+ members began receiving 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 for FY17

- Continue IVR HRA calls to all new members for health assessment
- Continue to identify and outreach those members that are in need of help in accessing health care or social services.

Goals for FY17

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

Oral Health Improvement Plan

In 2015, Colorado Access began a project in collaboration with the Colorado Community Health Network (CCHN) to improve well-child visit rates at a number of Federally Qualified Health Centers (FQHCs). The number of fluoride varnishes is one service on which clinics have been asked to focus. However, as many of these clinics also have dental offices on site, it is likely that these services occur in the dental setting and are billed to Delta Dental.

Strategies and Planned Interventions for FY17

In FY17, Delta Dental and Colorado access will begin working together to share data, in the hopes of increasing utilization rates of preventive dental services and decreasing the rate of children that require general anesthesia and ambulatory surgical intervention.

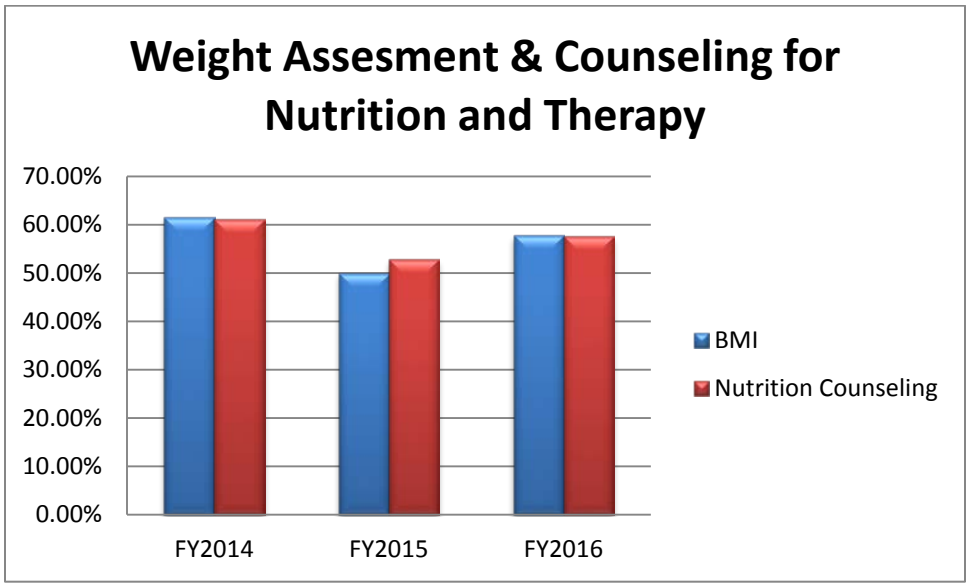
In addition to these efforts, Colorado Access will continue promoting the dental benefit to all new and existing members through flyers in their welcome packets, and through our CHP+ television commercial.

Goals for FY17

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

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 continues to include 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, and methods of incorporating more physical activity into a child's daily life, and community programs that focus on these initiatives.

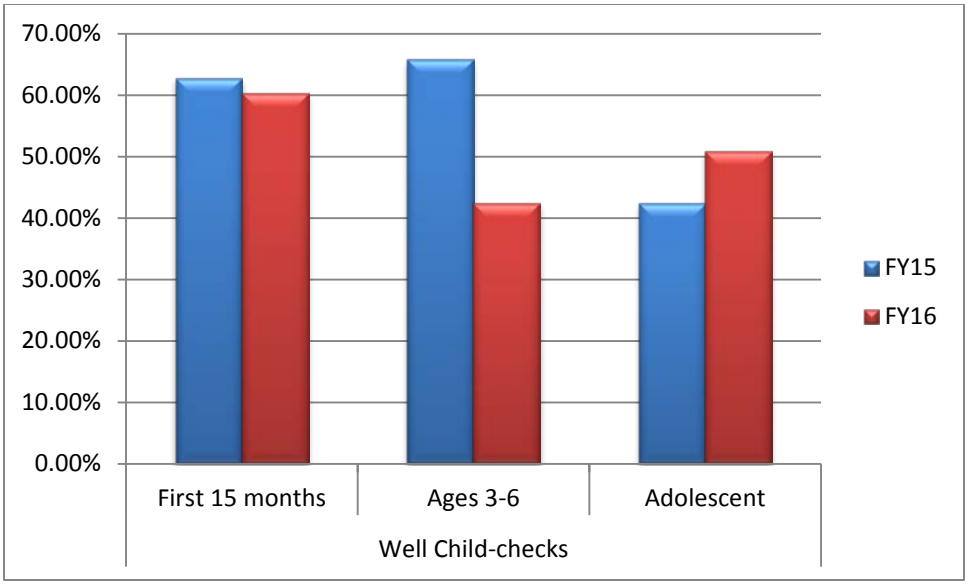
Colorado Access recognizes that partnering with community providers is an important step in the process of reducing and preventing childhood obesity. Therefore we have implemented goals and metrics that promote BMI screening and nutrition/physical activity counseling at well visits into our wellness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

Interventions Implemented during FY16

COA has partnered with CCHN to incentivize 7 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. Clinics are also evaluated for improvements in BMI screen, physical activity, and nutrition counseling rates.



Strategies and Planned Interventions for FY17

- 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 for FY17

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

Controlling Costs

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 from FY16

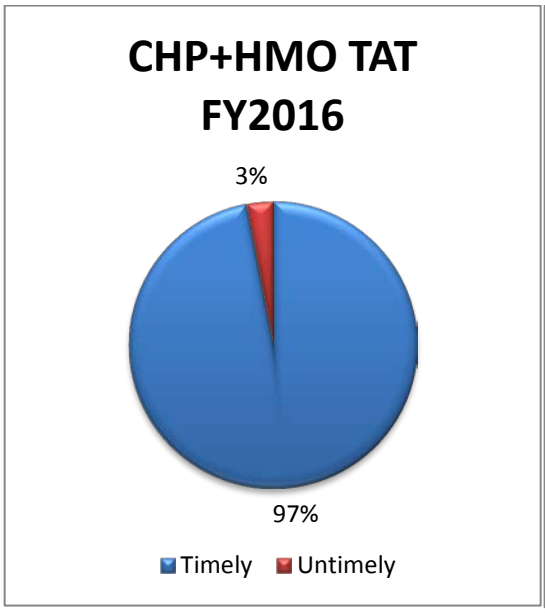
- 100% of UM decisions made according to timeliness standards

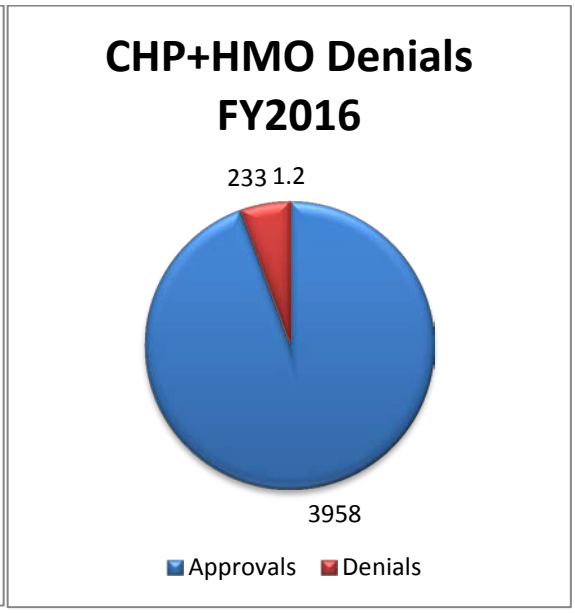
Interventions implemented during FY16

- Previously identified issues with errors in data entry have been addressed by modifying the data entry system to make certain fields mandatory and by implementing reminder pop-up windows.
- Additional training was implemented for UM staff to reduce common errors such as errors in authorizations involving single case agreements.

Results and Analysis

In FY16, Colorado Access continued to monitor 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 FY16, the interventions implemented to address the error rate were so successful that the error rate becomes negligible in early FY17. Therefore, Colorado Access has discontinued the calculation of this measure.

Strategies and planned interventions for FY17

- Continue to monitor compliance with timeframes on a monthly basis

Goals for FY17

- Improve TAT compliance to 99% 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 from FY16

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

Results and Analysis

In FY16, Colorado Access received a total of 31appeals for the CHP+ line of business (volume stable as compared with FY15 – 39 appeals). This is approximately 13.3% of the 233 denials issued in FY16.

Fiscal year	Reported Rate
FY13	.77
FY14	1.63
FY15	1.23
FY16	1.06

Goals for FY17

- Maintain 100% resolution of appeals within contractual and regulatory standards

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.

Goals from FY16

- Obtain IRR of 90% or higher for both intake and clinical staff

Results and Analysis

The overall score for the CCS Intake Staff was 92% which meets the 90% benchmark. The CCS Clinical/UM staff scored 97.66% overall on IQ Acute Criteria Pediatric Med/Surg, which meets the 90% goal.

All UM staff met the 90% or greater benchmark for Inter-rater Reliability. IQ criteria were specifically reviewed in UM meetings during 2015. UM staff reviewed any questions that were missed in order to better understand the process. No corrective action plan needed at this time.

Goals for FY17

- Maintain IRR rate of 90% or higher for both intake and clinical staff.

Other Quality Monitoring

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).

Goal from FY16

- Perform at or above previous year's performance.

Results and Analysis

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)
III Coordination and Continuity of Care	12	12	11	1	0	0	92%
IV. Member Rights and Protections	5	5	4	0	1	0	80%
VIII. Credentialing and Re-credentialing	48	47	44	3	0	1	94%
X. Quality Assessment and Performance Improvement	15	15	15	0	0	0	100%
Totals	**80**	**79**	**74**	**4**	**1**	**1**	**94%**

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)
Credentialing	90	83	83	0	7	100%
Re-credentialing	90	90	88	2	0	98%
Totals	**180**	**173**	**171**	**2**	**7**	**99%**

Strengths

Standard III-Coordination and Continuity of Care

Colorado Access policies and procedures outlined its processes for care coordination for members with intensive care coordination or special healthcare need as including completion of a health risk assessment, (HRA), member outreach, care planning and interventions, and coordinating with outside agencies and health plans. Colorado access informed its primary care providers of their responsibility to coordinate care with specialist and COA care managers are available to assist with members with complex needs. Colorado Access ensured all members were assigned to PCPS within three days of enrollment and contact within 30 days of enrollment to complete HRA. Care Managers followed up with members identified on the HRA who have specials needs or need potential transition of care needs to perform a more in-depth needs assessment, and develop a care plan.

Colorado Access continues reorganizing its care coordination program and better defines specialized care management teams it will revise its policies and procedures to be more specific. Colorado Access has been recommended to expedite the internal care coordination transformation process to prevent from inadequate, confusing, inefficient, or incomplete implementation of the reorganization plan.

Standard IV- Member Rights and Protections

The Member Rights policies and procedures affirmed Colorado Access' commitment to ensuring the rights of its members. The Nondiscrimination, Problem Reporting and Non-Retaliation, and Member Disability Rights Request and Complaint Resolution policies provided guidance to staff members on how to report suspected and alleged rights violations described the process for investigating such reports. All Colorado Access customer service staff members participated in member rights training within the review period and were provided with a list of member rights to be posted at their desks. All new providers were offered and introductory webinar training that included a review of member rights and how to report suspected and alleged rights violations, also included in the provider manual. Colorado Access also displayed member rights policies in newsletter, annual mailings and on the website, as well as handbooks.

Standard VIII- Credentialing and Re-credentialing

The policies and procedures related to credentialing and re-credentialing are compliant with National Committee for Quality Assurance (NCQA) standards. During the on-site interview, the credentialing department demonstrated a manner and knowledge consistent with well-written procedures. Files included an application printed from the Council of Afford able Quality Healthcare, and documentation that demonstrated verification of licensure, DEA or CDS certification as applicable, board certification status, education and training g, work history and current malpractice insurance. Colorado Access delegates credentialing and re-credentialing to several of its contracted organizations. The delegation agreements describe activities, responsibilities, and reporting requirements and describe the remedies available to Colorado Access should the delegate fall short of its obligations. Colorado access retained the right to approve, suspend, or terminate providers approved by any of its delegated entities. Colorado access required corrective actions when necessary and followed up as appropriate. Colorado Access indicated that they were in process of consolidating the carious policies and procedures in to one document.

Standard X- Quality Assessment and Performance Improvement

The Colorado Access Quality and Performance Improvement Program states that quality monitoring encompasses access and availability; utilization management (UM) membership satisfaction; clinical outcomes/performance measures; performance improvement projects (PIPs); and evaluation of internal operational performance, practice guidelines, and care management. Colorado Access used a variety of data from existing systems (e.g., claims/encounters, grievances and appeals, performance measures) for ongoing and periodic monitoring of services provided to members. Colorado Access staff provided reports demonstrating that its information systems can integrate data from multiple sources and produce reports for tracking, analysis, and profiling of quality performance within a variety of categories. Colorado Access developed practice guidelines for targeted populations, including those outlined in contract requirements. Practice guidelines were accessible to providers and members on the Colorado Access website. The Quality and Performance Advisory Committee reviews each practice guideline annually. Colorado Access reviews and analyzes CHP+ HEDIS measures and CAHPS results annually. The Quality Management Department conducts in-depth internal analysis of quality data, studies, and indicators, and works with providers and the Executive Management Team regarding improvements required

Required Actions

Based on findings from the site review, HSAG recommended Colorado Access implements the following per standard.

Standard III-Coordination and Continuity of Care

Colorado Access must remove statements from the CHP+ handbook that stipulate additional restrictions on when a member with special healthcare needs or a member in the second or third trimester of pregnancy may continue an ongoing course of treatment or services.

Standard IV- Member Rights and Protections

Colorado Access must revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights

Standard VIII- Credentialing and Re-credentialing

- Colorado Access must revise its policies regarding verification of board certification of CNMs or ensure that it verifies board certification of CNMs in compliance with its policies.
- Colorado Access must develop and employ a process to ensure that organizations with which it contracts are re-credentialed at least every three years.
- Colorado Access must develop and employ a process to ensure that organizations with which it contracts are re-credentialed at least every three years.
- Colorado Access must ensure that CMS and State quality reviews used are no more than three years old at the time of the credentialing decision; and if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access must document that the organization completed those corrective actions.

Goals for FY17

- Perform at or above previous year's performance.

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 in FY2014-2015. CHP+ has continued to implement the program throughout FY2015-2016. CHP+ targeted both low-risk and high-risk members. There was a bigger focus on high-risk members who are described as:

- had 3 or more Emergency Department visits in the year prior
- are prescribed medication that costs $300.00 or more
- specific high cost medical diagnosis
- specific mental illness diagnosis
- substance use disorder diagnosis

The high-risk 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 of their medical or mental health 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. COA uses several modes of contact (i.e., telephone, mail, internet, community outreach) to assist members with preparing for this transition.

The program includes sending out a post card to the members 1 year and then again 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 (for a $10 gift card) through mail or online about their plans for the transition and/or to request assistance if they have questions or concerns.

High risk members will also receive a care manager transition preparation call 90 days before they turn 19. The 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, refilling medications, and the importance of having health insurance. The care manager can also help the member or parent get in contact with the Colorado Access AMES program to start process for checking eligibility for government programs (Medicaid).

Inaccurate contact information continues to be one of the largest barriers to this (and many other) care management programs. However, some teens have been surprisingly engaged in the process of finding new health insurance, an outcome Colorado Access considers to be a significant success.

Strategies and Planned Interventions for FY17

- Continue outreach to targeted members both low-risk and high-risk
- 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
- Partner with school districts to incorporate insurance education during senior year

Goals for FY17

- Reach 350 members and provide successful outreach for transition
- Provide the communication, education and resources for all applicable members to prepare for transitioning to another health plan

Utilization and Medical Trends

Colorado Access trends the medical trends on a quarterly basis The measures include Admits, Readmissions 7, 30, and, 90 days, PCP visits ER Treat & Release and Non-Emergency ER visits. The following table shows the results for the past four years. The numbers from last year have been updated to reflect the correct calculation. The NEMER data warehouse presented an issue with calculations last year, and has since them been updated to reflect the correct amounts.

CHP+ HMO Medical Trends	Goal	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
Admits/1000	**<20.0**	2.12	2.25	1.96	2.49	1.72
Readmissions - 7 Days/1000	**<2.0**	0.07	0.07	0.06	0.04	0.03
Readmissions - 30 Days/1000	**<3.0**	0.16	0.17	0.15	0.13	0.10
Readmissions - 90 Days/1000	**<4.0**	0.26	0.24	0.22	0.19	0.17
PCP Visits/1000	**<1500.0**	132.25	126.88	138.25	159.65	147.16
ER Treat & Release (T&R) Visits/1000	**<500.0**	35.61	42.10	37.01	36.43	30.69
Non-Emergency ER (NEMER) Visits/1000	**<1.0**	1.96	2.44	1.79	2.10	3.67

Strategies and Planned Interventions for FY17

- Continue to increase follow up by Care Management for potential lower readmission rates
- Educate member on ER, Urgent Care & PCP visits (ER vs. NEMER)

Goals for FY17

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

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 from FY16

- 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 has adopted a new tracking mechanism, a specific timeline for review, and format for review by COA medical directors, and review and approval by Quality Performance Advisory Committee. 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 for FY17

Colorado Access will focus on collaboration between the Population Health and Quality department to best identify the practices in the best interest of the member and align with member centered initiatives. Colorado Access will continue to review and adopt guidelines that adopt best practices for better outcomes as well as continue to streamline processes around dissemination of the guidelines.

Goals for FY17

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