



**COLORADO**  
Department of Health Care  
Policy & Financing

1570 Grant Street  
Denver, CO 80203

July 31, 2020

Mr. Alex Azar, Secretary  
U.S. Department of Health & Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Mr. Azar:

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

Thank you very much for this opportunity. Should you have any questions or concerns, please contact Tracy Johnson, Medicaid Director at the Department of Health Care Policy & Financing, at (303) 866-3065 or [Tracy.Johnson@state.co.us](mailto:Tracy.Johnson@state.co.us).

Sincerely,



Jared Polis  
Governor of Colorado



Attachments:

- Demonstration Extension Application: Colorado Adult Prenatal Coverage in CHP+ (No. 21-W-00014/8)
- Historical and Projected Expenditures
- Interim Evaluation Report
- 2019 HEDIS® Aggregate Report for Child Health Plan *Plus*
- 2018-2019 Child Health Plan *Plus* Technical Report
- Compliance with Special Terms and Conditions Document

cc: Calder Lynch, Deputy Administrator, and Director  
Center for Medicaid and CHIP Services

Tracy Johnson, Medicaid Director  
Colorado Department of Health Care Policy & Financing

Laurel Karabatsos, Deputy Medicaid Director  
Colorado Department of Health Care Policy & Financing



# Section 1115(a) Demonstration Extension Application Colorado Adult Prenatal Coverage in Child Health Plan *Plus* (CHP+)

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*Demonstration No. 21-W-00014/8: Section 1115(a)  
Extension Application*

August 11, 2020



**COLORADO**  
Department of Health Care  
Policy & Financing

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## I. Historical Narrative Summary of the Demonstration Project

In September 2002, the State of Colorado received approval from the Centers for Medicare and Medicaid Services (CMS) for a five-year demonstration period through September 2006 for its “Adult Prenatal Coverage in CHP+” program. This program permitted the state to use Title XXI funds to expand coverage to uninsured pregnant women with family incomes between 133% and 185% of the federal poverty level (FPL). Subsequently, in January 2006, CMS approved an amendment to the demonstration, allowing Colorado to expand eligibility for uninsured pregnant women under the demonstration, from 185% to 200% of the FPL. On September 29, 2006, CMS approved Colorado’s request to renew the demonstration for a three-year period through September 30, 2009. CMS then approved Colorado’s extension request, which extended the program through June 2012. On July 30, 2012, Colorado received approval to expand coverage for uninsured pregnant women from 200% to 250% of the FPL. In July 2015, the Colorado’s application for extension of Colorado’s title XXI section 1115 demonstration project No. 21-W-00014/8 was approved by CMS. This extension effectively continued the project at the 2012 FLP levels that raised the upper limit to 250% FPL and applied a five-year demonstration period.

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

To comply with the spirit of CHIPRA, Colorado submitted a Medicaid State Plan Amendment and received approval for transitioning pregnant women from 133% to 185% of the FPL, to the Medicaid State Plan and to provide full Medicaid benefits to these women. The State has continued to receive Title XXI funds for uninsured pregnant women from 133% to 185% of the FPL. In addition, the State submitted and received approval for a corresponding CHIP State Plan Amendment to transition pregnant women between 185% and 250% of the FPL



to the CHIP State plan. As required under Special Terms and Conditions (STCs) #17, the State transitioned coverage of pregnant women from this demonstration to the Medicaid State Plan and the CHIP State Plan, effective January 1, 2013<sup>1</sup>.

The demonstration population includes pregnant Medicaid expansion clients who would have been covered under CHP+ if not for the expansion (142%-195% FPL). The state targeted this population to achieve three key objectives:

1. Decrease the uninsured rate for pregnant women<sup>2</sup>;
2. Increase prenatal and postpartum care for pregnant women enrolled in the Demonstration;
3. Increase the number of healthy babies born to pregnant women enrolled in the Demonstration

During the present demonstration period, August 1, 2015 through July 31, 2020, the following objectives, hypotheses and methodology were used to determine if Colorado is achieving the demonstration's goals:

Table 1. Evaluation Objectives, Hypotheses and Methodology:

Hypothesis	Methodology
OBJECTIVE 1: Increase the percentage of pregnant women in the demonstration who received prenatal and postpartum care	
Pregnant women enrolled in the CHP+ demonstration will have a statistically significant increase in prenatal care visits.	Use of claims data, birth certificate data, and HEDIS data to measure prenatal and postpartum care for the women in the demonstration program, as well as, for the pregnant women in CHP+ and Medicaid.
Pregnant women enrolled in the CHP+ demonstration will have a statistically significant increase in postpartum care visits.	
OBJECTIVE 2: Increase the number of healthy babies born to pregnant women enrolled in the Demonstration	

<sup>1</sup> The federal poverty levels listed in the Historical Summary of the Demonstration Project section prior to January 2014 are pre-MAGI-converted levels.

<sup>2</sup> This objective was not part of the approved demonstration evaluation design, dated April 26, 2017 and is addressed further in the Interim Evaluation Report.

<p>The proportion of babies born to women enrolled in CHP+ and admitted to the NICU will decrease over the five years of the demonstration.<sup>3</sup></p> <p>The proportion of babies born to women enrolled in the demonstration that weigh under 2,500 grams will decrease by 10 percent over the five-year demonstration.</p>	<p>Use of claims data, birth certificate data, HEDIS data, and PRAMS data to track the birth weights of newborns and length of stay and time spent in the ICU for babies born to mothers in the demonstration program, as well as, for the newborns born to mothers in Medicaid as a whole.<sup>4</sup></p>
<b>OBJECTIVE 3: Decrease the uninsured rate for pregnant women</b>	
<p>This objective is included here for completion but was not part of the approved demonstration evaluation design, dated April 26, 2017.</p>	<p>As described in the interim evaluation report, the absence of an appropriate dataset prevented the state from further analysis during the demonstration period.</p>

## II. Demonstration Results and Evaluation Activities

The demonstration's success in achieving the stated objectives are more extensively described in the Interim Evaluation Report presented in Appendix B of this application. In summary, the interim evaluation suggests that the demonstration was partially successful in meeting its objectives, showing favorable results for two of the three measures—higher rate of postpartum care visits and fewer low birthweight babies.

However, the hypothesis that more pregnant women would receive prenatal care during demonstration years as compared to the baseline was not supported by study findings. The demonstration population did not improve on the rate of prenatal care visits, as a higher percentage of clients received prenatal care during the baseline year compared to all demonstration years (Table 2).

<sup>3</sup> The original evaluation proposal included this hypothesis, but a corresponding measure was not included in approved demonstration evaluation design, dated April 26, 2017. Details on this change are included in the Interim Evaluation Report.

<sup>4</sup> If the mother loses Medicaid eligibility after the baby has been delivered, the mother and the baby are not assigned the same case number and not linked together. As a result, the outcomes will be approximate as some of the babies may not be included in the evaluation since there is no link to the mother who was in this category.

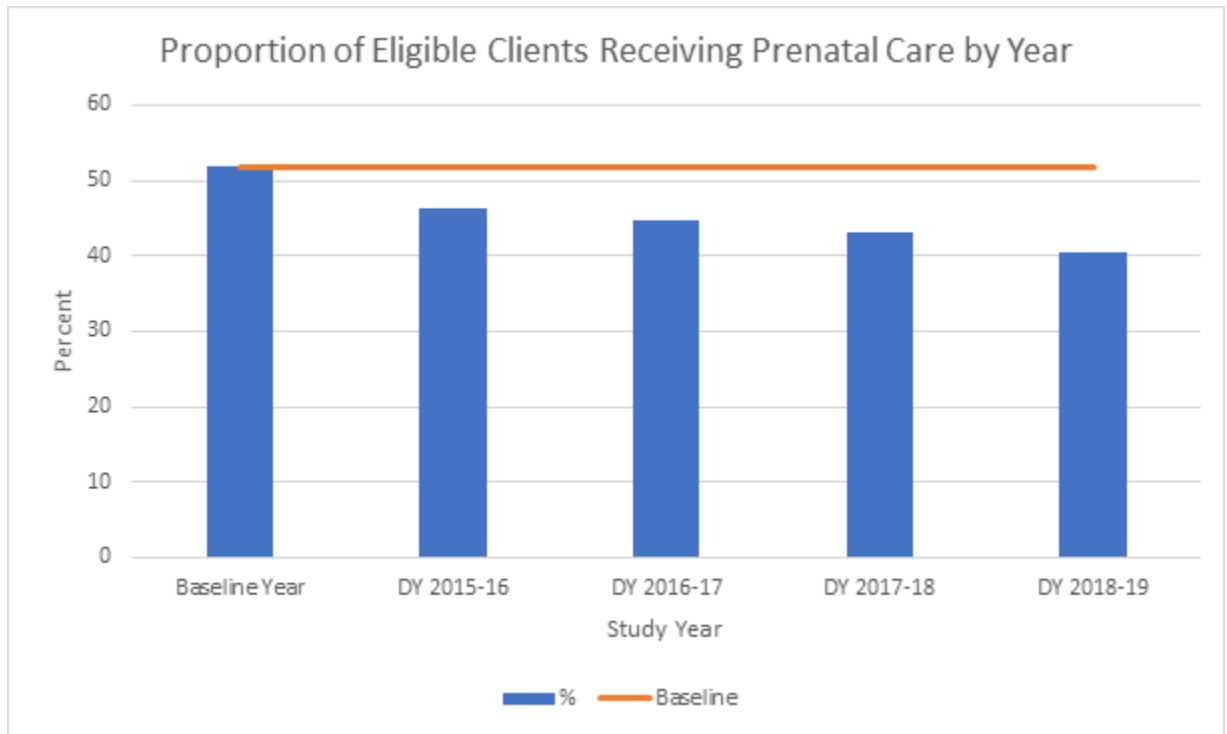


Table 2. Comparison of Pregnant Women with Prenatal Care Across All Study Years

Year	Number Received Prenatal Care	Percent Received Prenatal Care (%)	Percentage Point Difference from Baseline	Rate of change year over year	Rate of change from baseline
Baseline Year	1637	51.8	--	--	--
Demonstration Year 1	1287	46.4	-5.4	-10.4%	-10.4%
Demonstration Year 2	1284	44.7	-7.1	-3.7%	-13.7%
Demonstration Year 3	1279	43.1	-8.7	-3.6%	-16.8%
Demonstration Year 4	1199	40	-11.8	-7.2%	-22.8%

As a descriptive study comparing unadjusted percentage differences and year-to-year percent changes, it was not possible to assess whether the percent decrease represents a statistically significant finding; however, as it relates to practical relevance, the evaluation identified a potential decreasing trend in the number of eligible clients receiving prenatal care across the demonstration years (Figure 1), as defined by the study parameters.

Figure 1. Proportion of Eligible Clients Receiving Prenatal Care by Year



These results should be interpreted with caution due to methodological limitations. Specifically, changes in the way data was collected across demonstration years introduced variability and potential bias. To better evaluate this measure, the state reviewed historical Medicaid prenatal outcomes from HEDIS datasets. Comparing against Colorado’s Medicaid population revealed multiple substantive changes to the definitions of prenatal metrics between 2014 to 2017. The process of refining these metrics is necessary to more validly capture outcomes; however, it prevents comparisons during this time. Additionally, due to the frequent refinement of variable definitions, it is not possible to assess the presence of a possible secular trend.

To address this deficiency in the renewal period the Department intends to ensure valid study design, including limiting variability in the way prenatal metrics are defined across the demonstration period. This approach will clarify the prenatal findings from the present demonstration while keeping the current program parameters. Further, the Department intends to use a regional

benchmark as an additional, external comparison group to compare future demonstration objectives against.<sup>5</sup>

Application of a regional benchmark and improved study design for assessing the percent of low birth weights in the renewal demonstration period is another intention of the Department's. Given the results outlined in the detailed evaluation report, future evaluation design shall also include improved inclusion and exclusion criteria for mothers who gave birth to multiple babies, alternatives to improve birth certificate match rates, and a targeted proportion of healthy babies born to pregnant women enrolled in the demonstration.

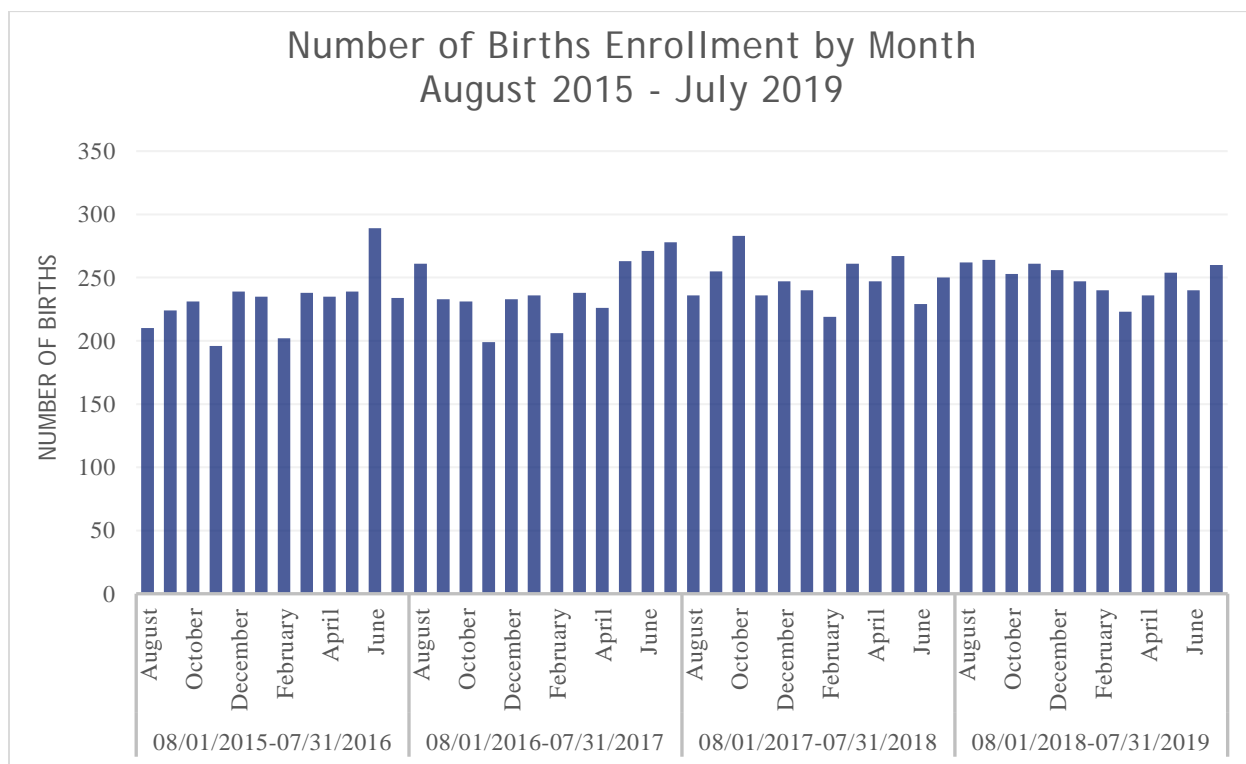
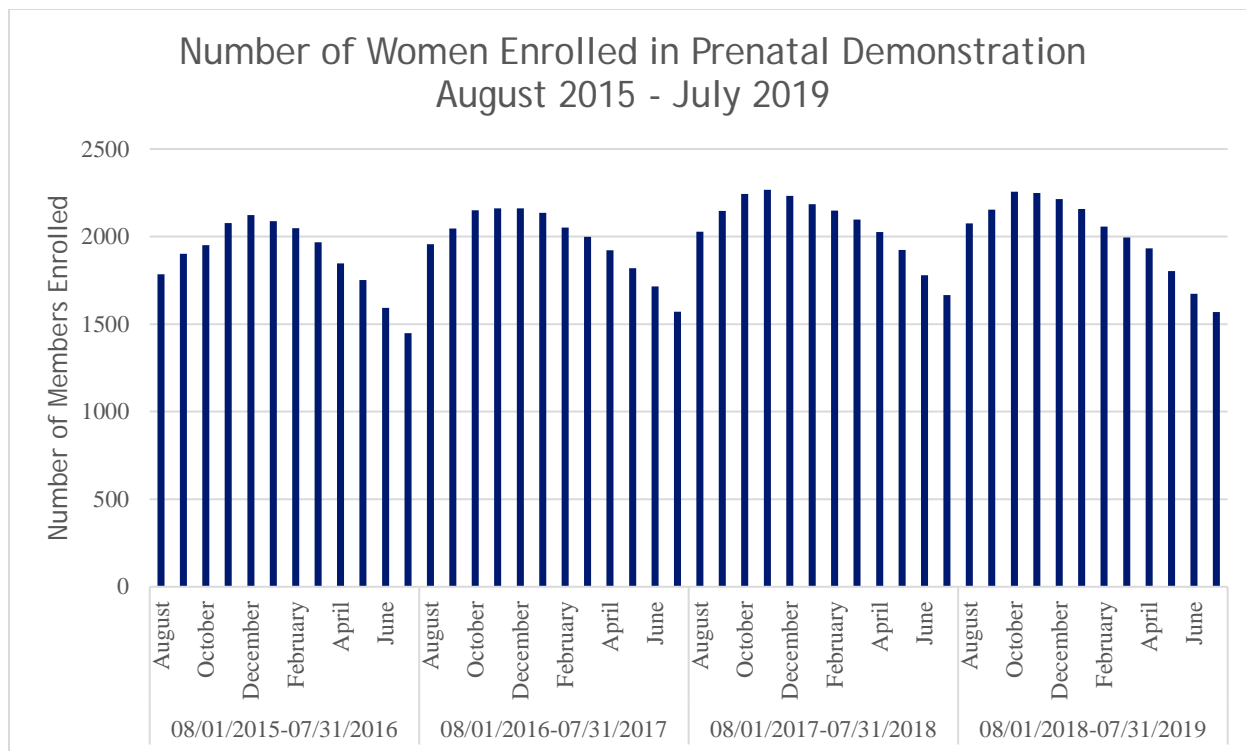
#### **A. Prenatal Demonstration Population**

The average monthly enrollment of clients enrolled in the prenatal program during demonstration years one through four (August 1, 2015 through July 31, 2019) was 2,903. The following chart illustrates the monthly average number of pregnant women enrolled in the demonstration and number of births since 08/01/2015.

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<sup>5</sup> Benchmark for determination during evaluation design—Colorado Medicaid specific data or March of Dimes presently in consideration.





One of the goals of the program is to improve health outcomes for low-income mothers and their babies. To achieve this goal, clients identified as pregnant receive a call to complete a prenatal risk assessment and a Patient Health Questionnaire (PHQ-9), which aims to identify community and educational resources that may benefit the clients, such as Women, Infants and Children (WIC), Prenatal Plus (PN+), Nurse Family Partnership (NFP), and Healthy Start. Members who are identified as high risk are enrolled in the Intensive Case Management program.

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

### III. Extension Request

Colorado requests an extension to the demonstration from August 1, 2020, through July 31, 2025. Specifically, the State requests an extension of the federal authority for Colorado to continue to receive title XXI funds for uninsured pregnant women with income from 142% of the FPL to 195% of the FPL. The State is not requesting any program changes during the requested renewal period. Title XXI funds will continue to be used for pregnant women in this income range who are insured. During this timeframe, Colorado will continue to reach out in order to enroll and provide prenatal and postpartum care to eligible pregnant women from 142% of the FPL to 260% of the FPL to achieve the goals and objectives of this program.<sup>6</sup>

Under this demonstration, fee-for-service and managed care delivery systems will cover pregnant women. Cost sharing is not applied to this population for any type of service. Colorado will continue to contract with Health Services Advisory Group (HSAG) as the external quality review organization (EQRO) to measure and evaluate the timeliness and adequacy of prenatal and postpartum care.

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<sup>6</sup> The federal poverty levels listed in the Extension Request section are post-MAGI-converted levels.





## IV. Waiver and Expenditure Authority

Colorado is requesting the same waiver and expenditure authority as approved in the current demonstration to authorize title XXI expenditures for health benefits coverage to uninsured pregnant women age 19 and over, with family income above 141% through 195% of the Federal Poverty Level (FPL).

Specifically, Colorado requests, under the authority of section 1115(a)(2) of the Social Security Act (the Act), that expenditures made by Colorado identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XXI plan:

### 1. Section 2112(b)(2) Minimum Income Standard for Pregnant Women in CHIP

To permit Colorado to have income levels for eligibility for the specified demonstration population that are lower than applicable Medicaid levels, to the extent necessary to provide title XXI coverage for the Medicaid benefit package for pregnant women.

### 2. Section 2105(c)(6)(B) CHIP Secondary Payer to Medicaid

To permit Colorado to make payment under title XXI primary to payment under Medicaid for this demonstration population, to the extent necessary to provide title XXI coverage for the Medicaid benefit package to pregnant women with incomes above 141% of the FPL through 195% of the FPL.

Annual expenditures that apply to the Demonstration are provided in the Historical and Projected Expenditures document.

## V. Projected Demonstration Enrollment Impact

Historical and projected enrollment trends for Colorado's Combination CHIP program are referenced in Appendix A, which represent the Separate CHIP population (SCHIP), Medicaid expansion CHIP population (MCHIP), and the Prenatal Demonstration CHIP population. These figures are presented in Tables 3 through 6, which also serves to provide an assessment of how the proposed

demonstration is expected to impact CHIP program enrollment for the extension period Colorado is requesting. These figures are total annual, unduplicated, person counts.

Table 3. Historical and Projected Enrollment Figures by Category

	Total Combination CHIP Enrollment by Year	SCHIP Plan Enrollment by Year	MCHIP Plan Enrollment by Year	Total 1115 Demonstration Enrollment by Year (142%-195% FPL)
FFY 2015	107,800	52,346	53,747	1,707
FFY 2016	117,471	54,549	61,103	1,819
FFY 2017	137,145	69,603	65,503	2,039
FFY 2018	147,012	81,893	62,854	2,265
FFY 2019	141,221	80,967	57,995	2,259
FFY 2020	135,265	76,032	57,088	2,145
FFY 2021	137,874	77,519	58,121	2,234
FFY 2022	140,290	79,121	58,856	2,313
FFY 2023	140,290	79,121	58,856	2,313
FFY 2024	140,290	79,121	58,856	2,313
FFY 2025	140,290	79,121	58,856	2,313

Due to the State's 2013 transition of pregnant women from this demonstration to the Medicaid State Plan and the subsequent MAGI conversion, the demonstration extension not implemented, individuals receiving benefits through the demonstration and with income between 142% and 195% FPL would be expected to enroll in benefits through Medicaid.

Table 4. Annual counts of individuals expected to be enrolled in the demonstration, assuming that the proposed demonstration is implemented.

	Annual counts of individuals expected to be enrolled in the demonstration by year
FFY 2021	2,234
FFY 2022	2,313
FFY 2023	2,313
FFY 2024	2,313

FFY 2025	2,313
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Table 5. Annual counts of individuals that would be expected to enroll in CHIP, if the proposed demonstration is not implemented, based on historical program trends and assumptions as described in the state's analysis. <sup>7</sup>

	Annual counts of individuals that would be expected to enroll in CHIP, if the proposed demonstration is not implemented.
FFY 2021	135,640
FFY 2022	137,977
FFY 2023	137,977
FFY 2024	137,977
FFY 2025	137,977

Table 6. Annual counts of individuals expected to be enrolled in CHIP, assuming that the proposed components of the demonstration are implemented, for each year of the proposed demonstration period, and by each category of beneficiary whose Medicaid or CHIP enrollment is likely to be impacted by the demonstration.

	Total Combination CHIP Enrollment by Year	SCHIP Plan Enrollment by Year	MCHIP Plan Enrollment by Year	Total 1115 Demonstration Enrollment by Year (142%-195% FPL)
FFY 2021	137,874	77,519	58,121	2,234
FFY 2022	140,290	79,121	58,856	2,313
FFY 2023	140,290	79,121	58,856	2,313
FFY 2024	140,290	79,121	58,856	2,313
FFY 2025	140,290	79,121	58,856	2,313

## VI. Compliance with Special Terms and Conditions

Colorado implemented the current demonstration according to the approved Standard Terms and Conditions (STC), dated April 26, 2017. The discussion

<sup>7</sup> The annual counts in Table 5 are calculated by removing the projected annual demonstration population figure from the corresponding annual total combination CHIP enrollment figure(s). These individuals would be expected to enroll in benefits under the Medicaid state plan.

presented throughout the application and supporting materials demonstrate the actions taken by the state to implement the program in compliance with the STCs, as of July 2020.

Colorado has complied with the STCs provisions regarding the demonstration's eligibility, the program benefits, cost sharing and delivery system. Further, all general financial requirements were implemented according to the STCs. The state submits quarterly eligibility, enrollment and financial reports through varied mechanism, including, but not limited to, CHIP Statistical Enrollment Data Reports (SEDS) using forms 64EC, 64.21E, and 21E. Colorado gathers monthly enrollment data, which are exhibited in this extension application, and has not needed to limit enrollment in the demonstration. The State has complied with all general financial requirements under title XXI and as discussed in STC Attachment A: General Financial Requirements Under Title XXI.

Actions to comply with section VIII—General Reporting and Monitoring—and section X—Evaluation of the Demonstration—of the STCs are included as attachments to this demonstration extension application. Specifically, Appendix B is the state's interim evaluation report, which is attached and referenced throughout the application body. The state's post award forum, which is described in more detail in Appendix D, was held on May 27, 2020 and the recording of that presentation remained active for public comment through July 10, 2020. Finally, the state will continue to work with CMS to submit all required and requested annual monitoring reports for the current demonstration period.

## **VII. Compliance with Public Notice, Tribal Consultation and Consultation with Interested Parties**

During the process of developing this section 1115(a) demonstration extension application and complying with general reporting and monitoring actions listed in the STCs, the state consulted with interested parties and providing the public meaningful opportunity to comment on the demonstration extension application.



On July 10, 2020 Colorado published an abbreviated public notice and a comprehensive public notice to the Colorado Register and the Department's waiver application webpage, respectively. These notices, which addressed the requested section 1115(a) demonstration extension and the duration of the public comment period from July 10, 2020 through August 10, 2020, were posted as required by federal regulations at 42 CFR § 431.408 and 431.420.

All comments submitted to the state are included in summary with corresponding responses in Appendix D of this application. Further, the state's efforts to address comments in the extension application are also outlined in that section. Finally, the state's comprehensive public notice document and an abbreviated public notice are included as attachments to this application.

Table 8. Summary of Public Notice, Tribal Consultation and Consultation with Interested Parties

Date	Notice or Document	URL or Distribution
02/01/2020	Department conducts consultation with tribal populations on the proposed demonstration waiver	In accordance with 42 CFR 431.408(b)
05/27/2020	Department holds Post Award Forum at the State Medical Assistance & Services Advisory Council quarterly meeting, recording the presentation for further public comment	In accordance with 42 CFR 431.420(c)
06/10/2020	Post Award Forum recording posted on the Department's website for viewing and public comment, including instructions for submitting comments	<a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus</a>
07/09/2020	Information and details about the requested 1115(a) demonstration extension application and forthcoming public hearing meetings posted on the Department's website	<a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus-prenatal-waiver">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus-prenatal-waiver</a>
07/09/2020	Notification regarding public comment period and public hearings sent to stakeholder(s) electronic distribution list—5,243 recipients	In accordance with 42 CFR 431.408(b)
07/09/2020	Department updates 02/01/2020 tribal consultation to include website	In accordance with 42 CFR 431.408(b)

	link for the comprehensive public notice	
07/10/2020	Notice of Public Comment Process published in the State of Colorado Register (2020 - Volume 43, No. 13) on the Colorado Secretary of State website	<a href="https://www.sos.state.co.us/CCR/RegisterContents.do?publicationDay=07/10/2020&amp;Volume=43&amp;yearPublishNumber=13&amp;Month=7&amp;Year=2020">https://www.sos.state.co.us/CCR/RegisterContents.do?publicationDay=07/10/2020&amp;Volume=43&amp;yearPublishNumber=13&amp;Month=7&amp;Year=2020</a>
07/10/2020	Section 1115(a) demonstration extension application posted on the Department's website for viewing and public comment	<a href="https://www.colorado.gov/pacific/sites/default/files/CHPPlusPrenatal1115DemonstrationApplication.pdf">https://www.colorado.gov/pacific/sites/default/files/CHPPlusPrenatal1115DemonstrationApplication.pdf</a>
07/10/2020	Section 1115(a) demonstration interim evaluation report posted on the Department's website for viewing and public comment	<a href="https://www.colorado.gov/pacific/sites/default/files/CHPPlusPrenatal1115InterimEvaluation.pdf">https://www.colorado.gov/pacific/sites/default/files/CHPPlusPrenatal1115InterimEvaluation.pdf</a>
07/10/2020	Notice of Public Comment Process posted on the Department's website	<a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus-prenatal-waiver">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus-prenatal-waiver</a>  <a href="https://www.colorado.gov/pacific/hcpf/communication">https://www.colorado.gov/pacific/hcpf/communication</a>
07/15/2020	Section 1115(a) demonstration extension application presented a public hearing, held virtually to accommodate public health emergency proximity limitations	In accordance with 42 CFR 431.408(3)(ii) & (iv)  Conference Line 1-877-820-7831 Participant Code 499-449 #  <a href="https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/">https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/</a>
07/16/2020	Section 1115(a) demonstration extension application presented a public hearing, held virtually to accommodate public health emergency proximity limitations.  A recording of this hearing was published to the state website for further access and review	In accordance with 42 CFR 431.408(3)(ii) & (iv)  Conference Line 1-877-820-7831 Participant Code 499-449 #  <a href="https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/">https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/</a>  <a href="https://www.youtube.com/watch?v=6cLvR2aVzz4&amp;feature=youtu.be">https://www.youtube.com/watch?v=6cLvR2aVzz4&amp;feature=youtu.be</a>
07/29/2020	Notification regarding the impending closing of the public comment period sent to stakeholder(s) electronic distribution list—5,243 recipients	In accordance with 42 CFR 431.408(2)

08/10/2020	Public Comment period closed at 5:00 p.m. MDT and all comments submitted are responded to in the application	In accordance with 42 CFR 431.408
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The state certifies that in completing the post award forum it invited input from interested parties and ensured members of the public were afforded an opportunity to provide meaningful comment on the demonstration's progress in compliance with 42 CFR § 431.420(3)(c). Colorado presented the results of the demonstration to the State Medical Assistance & Services Advisory Council on May 27, 2020. This meeting was recorded and posted to the state's website on June 10, 2020 to provide the public further opportunity to submit comments to the state.

In addition to publishing the presentation recording and slide deck, the state included links to the approved demonstration evaluation design, application, historical information on the program, and how to learn more about section 1115 demonstrations. Finally, the state provided instructions on how individuals could submit comments to the state in writing, by mail or email.

The state invited input on the waiver application during the public comment period starting at 8:00 a.m. on July 10, 2020 and ending August 10, 2020 (Mountain Daylight Time) and accepted comments submitted during this window. During the public comment period the state followed proper social distancing and safety precautions for the COVID-19 public health emergency, which prevented the ability for individuals to access hard copies of the demonstration application at the Department's office.

To ensure interested parties were able to access and review a hard copy of the demonstration extension application and supporting documents, the public notices and state website provided instructions on how an individual could request a printed copy of these documents be mailed to them. These instructions included mechanisms for an individual to submit a request by telephone or email.

The state held two public hearings, during which participants received an overview of the requested demonstration extension, as well as, opportunities to provide comments or ask questions. Due to the limitations placed on social gatherings during the COVID-19 public health emergency, both public hearings were held virtually with teleconferencing and webinar capabilities to allow participants to provide comments or questions remotely. The public hearings were held as follows:

	Public Hearing #1	Public Hearing #2
Date	Wednesday July 15, 2020	Thursday July 16, 2020
Time	11:00 am – 1:00 pm	11:00 am – 1:00 pm
Venue	Virtual Remote Meeting	Virtual Remote Meeting
Teleconference	Conference Line: 1-877-820-7831 Participant Code: 499-449 #	Conference Line: 1-877-820-7831 Participant Code: 499-449 #
Webinar	<a href="https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/">https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/</a>	<a href="https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/">https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/</a>

A recording of the July 16, 2020 public hearing was published to the state website, which included a running transcript of the hearing and the one public comment submitted during the July 15, 2020 hearing. The meeting recording will remain available on the website throughout the application period.

Finally, Colorado certifies that it conducted tribal consultation in accordance with transparency regulations under 42 C.F.R. 431.408(b) regarding the proposed demonstration waiver. During the tribal consultation period from February 1, 2020 through March 2, 2020, the state did not receive any comments or questions. Notice of the publication of additional application material and the comprehensive public notice was sent on July 9, 2020 for additional tribal consultation. During this consultation period, which ended on August 10, 2020, the state did not receive any comments or questions.



## VIII. Appendices

### IX. Appendix A: Financial Data and Budget Neutrality

Table 7. Summary Historical and Projected Demonstration Expenditures

Demonstration Population Annual Expenditures and Projected Annual Costs for Requested Extension Period	
Federal Fiscal Year (Demonstration Period)	Expenditure
FFY 2016 (Current Demonstration Period - Year 1)	\$ 18,135,045
FFY 2017 (Current Demonstration Period - Year 2)	\$ 14,820,787
FFY 2018 (Current Demonstration Period - Year 3)	\$ 18,689,341
FFY 2019 (Current Demonstration Period - Year 4)	\$ 23,151,976
FFY 2020 (Current Demonstration Period - Year 5)	\$ 22,279,510
FFY 2021 (Requested Demonstration Extension Period - Year 1)	\$ 23,153,954
FFY 2022 (Requested Demonstration Extension Period - Year 2)	\$ 24,075,335
FFY 2023 (Requested Demonstration Extension Period - Year 3)	\$ 25,055,201
FFY 2024 (Requested Demonstration Extension Period - Year 4)	\$ 26,074,948
FFY 2024 (Requested Demonstration Extension Period - Year 5)	\$ 27,136,198

A more detail financial analysis of historical and projected expenditures is provided in the attached Historical and Projected Expenditures spreadsheet. This document also shows the projected number of eligible members per month, which is anticipated to grow each year.

### X. Appendix B: Interim Evaluation Report

The overall impact of the demonstration is presented throughout the attached Interim Evaluation Report, which includes findings to date and recommendations for evaluation activities over the requested extension period.

## **XI. Appendix C: Summary of External Quality Review Organization Reports**

The Department contracted with Health Services Advisory Group, Inc. (HSAG) as the external quality review organization (EQRO) to evaluate the adequacy and efficacy of prenatal and postpartum care for eligible pregnant women from above 195% of the FPL to 260% of the FPL. Colorado Access, a contractor for the state managed care network, provided data to the State to determine the impact of prenatal care on birth outcomes for women in the CHP+ State plan. The major findings that occurred in SFY 2017-2019 for these prenatal women include:

- The timeliness of prenatal care increased by 1.21 percentage points to 58.29 percent points from SFY 2017 to SFY 2018; it then decreased by 3.16 percentage points to 55.13 percent points from SFY 2018 to SFY 2019.
- Postpartum care increased by 0.92 percentage points to 43.42 percent points from SFY 2017 to SFY 2019; it then increased by 1.59 percentage points to 45.01 percent points from SFY 2018 to SFY 2019

The quality assurance reports produced by HSAG, including the 2019 HEDIS® Aggregate Report for Child Health Plan Plus and the 2018-2019 External Quality Review Technical Report for Child Health Plan Plus, show the results regarding the adequacy and efficacy of prenatal and postpartum care. The reports are provided as separate documents, and outcomes can be found on the following pages of the reports.

### **2019 HEDIS Aggregate Report for Child Health Plan Plus**

- Table 1-1 - Colorado CHP+ Statewide Weighted Averages, pg. 1-3
- Access to Care bullet, pg. 1-4
- Access to Care section, pg. 4-1 - 4-10
- Table 4-1 - Individual Access to Care Performance Summary by Measure, pg. 4-10
- Table 4-2 - Prenatal and Postpartum Care, pg. 4-3
- Trend Tables by Plan, pg. B-1--B-21

## 2018-2019 External Quality Review Technical Report for Child Health Plan Plus

- Performance Measure Results, pg. 1-3
- Statewide Conclusions and Recommendations, pg. 1-13
- Strengths section, pg. 4-6
- Table 2-7 - Assignment of Activities to Performance Domains, pg. 2-List Bullet
- Table 1-23-27 - Colorado CHP+ Weighted Averages - HEDIS 2019 High Performers, pg. 1-4
- Table 1-3 - Colorado CHP+ Weighted Averages - HEDIS 2019 Low Performers, pg. 1-5List Bullet
- Validation of Performance Measures, pg. 4-3 List Bullet
- Table 4-3 - MCO and Statewide Results, pg. 4-3 -- 4-6 eligible members per month, which is anticipated to grow each year.

## XII. Appendix D: Summary of Comments and State Response

The public comment period for Colorado's section 1115 prenatal demonstration extension application opened at 8:00 a.m. on July 10, 2020 and ended at 5:00 p.m. August 10, 2020 (Mountain Daylight Time). Nine comments were submitted during the public comment period and are summarized below, one of which was submitted during a public hearing. Two additional comments were submitted during the Post Award Forum and are also included in this section with the Department's responses.

### Public Comments, Response, and Incorporation Within Application:

The nine comments received through the public comment period consistently expressed support for the proposed demonstration extension application. No comments of opposition were received.

The comments submitted during the post award forum comment period, however, were focused on recommendations for how the state may improve the evaluation design. The state addressed each comment in this section. Additionally, included in this extension application are the state's proposed



changes to future demonstration evaluation design, which incorporate the recommendations submitted.

#### **Public Hearing Comment:**

The July 15, 2020 public hearing held by the state was attended by one individual and the July 16, 2020 public hearing was attended by two individuals. One comment was submitted to the state during the first public hearing, which is presented in summary below, and no comments were submitted during the second public hearing.

**Summary Public Hearing Comment:** This has been a very important program for us, as we see a fair number of patients accessing prenatal and postpartum care. This program has been greatly appreciated and we are in support of continuing with an additional waiver time period.

**Response:** The state appreciates your engagement, comment and support for this demonstration.

#### **Public Comment Period:**

Comments and questions were accepted by the state through a variety of submission mechanisms outside of the scheduled public hearings. During the public comment period from July 10, 2020 through August 10, 2020, the state received eight comments, which expressed support for the proposed extension.

Several of these comments included supporting information on how this demonstration has affected services provided by an organization and the breadth of Coloradans depending on the program. One of these comments also encouraged the exploration of specialized NICU case management.

**Response:** The state appreciates the engagement, comment and support expressed for this demonstration. In response to potential exploration of NICU case management, the discussion of future evaluation improvement in this application describes the state's intention to work with CMS to refine evaluation parameters during the requested extension. NICU case management will be brought forward as a parameter of consideration.

## Post Award Forum Comments:

The post award forum public comment period was open during the presentation on May 27, 2020 and again from June 10, 2020 through July 10, 2020. The state received two comments during the post award forum, which are summarized below:

**Summary Post Award Forum Comment #1:** Do you have any benchmark or comparable populations to use in assessing if it is possible that prenatal care in general, coincidentally went down in this population? We are struggling in various parts of the country with reductions in families choosing to access traditional medical care around pregnancy.

**Response:** In completing the interim evaluation we identified the need to have a comparison population to further analyze the demonstrations results. The identification and inclusion of a comparison population, either local, regional or national, is one of the key changes the state plans for future evaluations of this program.

**Summary Post Award Forum Comment #2:** Continue to look at a metric of low birth weight. But, when you're talking about prenatal and postnatal care, you're also talking about infant mortality rates, which are often related to lack of or inadequate care during that prenatal and postnatal care timeframe.

Rather than just looking at a broad finding of if the number of prenatal visits increased, using a benchmarking to look at the complications that are typically found during prenatal visits will allow for more specific metric development. With a very specific metric when you are comparing to a benchmark you are then able to compare to known disparities of care by demographic population. This will allow you to really see how we are impacting quality of care and determine if it is having a positive impact.

**Response:** The state is committed to expanding future evaluation designs to include appropriate benchmark populations, which may also allow for the inclusion of co-morbidity analysis as it relates to the demonstration objects. Additionally, further specifying evaluation metrics in future evaluation designs

is aligned with the State's proposed evaluation design changes listed in this application.

### **XIII. Appendix E: Public Notice Documents**



1115 Demonstration Extension Application - Budget Template With Historical & Projected Expenditures

COLORADO	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025
	Federal Fiscal Year -5	Federal Fiscal Year -4	Federal Fiscal Year -3	Federal Fiscal Year -2	Federal Fiscal Year -1	Federal Fiscal Year	Federal Fiscal Year +1	Federal Fiscal Year +2	Federal Fiscal Year +3	Federal Fiscal Year +4	Federal Fiscal Year +5
State's Allotment	\$157,511,557	\$228,329,398	\$210,135,383	\$270,402,569	\$298,413,539	\$315,357,876	\$333,264,336	\$352,187,550	\$352,187,550	\$352,187,550	\$352,187,550
Funds Carried Over From Prior Year(s)	\$97,768,837	\$86,450,144	\$86,279,015	\$98,298,761	\$83,200,533	\$46,495,074	\$101,485,396	\$204,147,961	\$318,344,565	\$294,639,591	\$295,276,504
SUBTOTAL (Allotment + Funds Carried Over)	\$255,280,394	\$314,779,542	\$296,414,398	\$368,701,330	\$381,614,072	\$361,852,950	\$434,749,732	\$556,335,511	\$525,893,686	\$525,893,686	\$525,893,686
Reallocated Funds (Redistributed or Retained that are Currently Available)											
TOTAL (Subtotal + Reallocated funds)	\$255,280,394	\$314,779,542	\$296,414,398	\$368,701,330	\$381,614,072	\$361,852,950	\$434,749,732	\$556,335,511	\$525,893,686	\$525,893,686	\$525,893,686
State's Enhanced FMAP Rate	66.71%	88.50%	88.01%	88.00%	88.00%	76.51%	65.00%	65.00%	65.00%	65.00%	65.00%

COST PROJECTIONS OF APPROVED SCHIP PLAN											
Benefit Costs											
Insurance payments											
Managed care	\$117,903,938	\$123,353,654	\$141,907,980.17	\$188,991,081.53	\$210,827,181.19	\$185,558,963.00	\$194,980,225.00	\$202,135,034.00	\$206,379,869.71	\$210,713,846.98	\$215,138,837.76
per member/per month rate @ # of eligibles	187.70 @ 52,346 avg elig/mo	187.18 @ 54,549 avg elig/mo	\$169.31 @ 69,603 avg elig/mo	\$192.32 @ 81,893 avg elig/mo	\$274.65 @ 80,967	\$203.38 @ 76,032	\$209.61 @ 77,519	\$212.89 @ 79,121	\$217.36 @ 79,121	\$221.93 @ 79,121	\$226.59 @ 79,121
Total Benefit Costs	\$117,903,938	\$123,353,654	\$141,907,980	\$188,991,082	\$210,827,181	\$185,558,963	\$194,980,225	\$202,135,034	\$206,379,870	\$210,713,847	\$215,138,838
(Offsetting beneficiary cost sharing payments)	(\$1,135,268)	(\$826,734)	(\$495,694)	(\$580,095)	(\$1,023,877)	(\$1,131,280)	(\$1,135,947)	(\$1,161,651)	(\$1,161,651)	(\$1,161,651)	(\$1,161,651)
Net Benefit Costs	\$116,768,670	\$122,526,920	\$141,412,286	\$188,410,986	\$210,827,181	\$184,427,683	\$193,844,278	\$200,973,383	\$205,218,219	\$209,552,196	\$213,977,187

COST PROJECTIONS OF APPROVED MCHIP PLAN											
Benefit Costs											
Insurance payments											
Managed care	\$14,747,350	\$14,382,637	\$13,728,229	\$9,968,618	\$14,612,491	\$17,372,270	\$18,638,744	\$19,504,965	\$19,787,787	\$20,074,710	\$20,365,793
per member/per month rate @ # of eligibles	\$176.95 @ 53,747 avg elig/mo	\$154.16 @ 61,103 avg elig/mo	\$81.55 @ 65,503 avg elig/mo	\$145.63 @ 62,854 avg elig/mo	\$194.83 @ 57,995	\$178.46 @ 57,088	\$181.27 @ 58,121	\$183.71 @ 58,856	\$186.37 @ 58,856	\$189.07 @ 58,856	\$191.81 @ 58,856
Fee for Service	\$99,378,269	\$98,652,959	\$50,395,546	\$99,868,755	\$120,881,144	\$104,881,546	\$107,790,728	\$110,241,983	\$111,840,492	\$113,462,179	\$115,107,380
Total Benefit Costs	\$114,125,619	\$113,035,595	\$64,123,775	\$109,837,373	\$135,493,635	\$122,253,816	\$126,429,472	\$129,746,948	\$131,628,279	\$133,536,889	\$135,473,174

Administration Costs											
Personnel	\$157,219	\$252,957	\$371,521	\$284,843	\$580,799	\$580,799	\$580,799	\$580,799	\$580,799	\$580,799	\$580,799
General administration	\$959,829	\$1,009,042	\$543,828	\$544,193	\$1,726,235	\$1,726,235	\$1,726,235	\$1,726,235	\$1,726,235	\$1,726,235	\$1,726,235
Contractors/Brokers (e.g., enrollment contractors)	\$1,874,853	\$1,091,567	\$1,499,241	\$993,769	\$3,051,816	\$3,051,816	\$3,051,816	\$3,051,816	\$3,051,816	\$3,051,816	\$3,051,816
Claims Processing	\$181,818	\$924,776	\$1,179,120	\$3,714,307	\$2,798,965	\$2,798,965	\$2,798,965	\$2,798,965	\$2,798,965	\$2,798,965	\$2,798,965
Outreach/marketing costs	\$1,427,908	\$1,112,097	\$1,111,190	\$2,786,611	\$2,786,497	\$2,786,497	\$2,786,497	\$2,786,497	\$2,786,497	\$2,786,497	\$2,786,497
Other	\$268,713	\$104,687	\$44,077	\$399,301	\$399,939	\$399,939	\$399,939	\$399,939	\$399,939	\$399,939	\$399,939
Total Administration Costs	\$4,870,340	\$4,495,126	\$4,748,977	\$7,495,024	\$11,344,251	\$11,344,251	\$11,344,251	\$11,344,251	\$11,344,251	\$11,344,251	\$11,344,251
10% Administrative Cap											

Federal Title XXI Share	\$157,278,584	\$212,451,013	\$185,071,862	\$269,054,177	\$314,745,259	\$243,321,501	\$215,551,701	\$222,341,978	\$214,968,215	\$214,968,215	\$214,968,215
State Share	\$78,486,045	\$27,606,629	\$25,213,176	\$36,689,206	\$42,919,808	\$74,704,249	\$116,066,300	\$119,722,604	\$115,752,116	\$115,752,116	\$115,752,116
TOTAL COSTS OF APPROVED CHIP PLANS	\$235,764,629	\$240,057,642	\$210,285,038	\$305,743,383	\$357,665,067	\$318,025,750	\$331,618,001	\$342,064,582	\$330,720,331	\$330,720,331	\$330,720,331

COST PROJECTIONS OF 1115 DEMONSTRATION PROPOSAL											
Demonstration Population (pregnant women 142% - 195% FPL)											
Insurance payments											
Managed care	\$524,592	\$2,128,650	\$983,044	\$1,762,913	\$4,365,192	\$823,709	\$897,345	\$960,418	\$999,507	\$1,040,187	\$1,082,523
per member/per month rate @ # of eligibles	\$845.35 @ 1,707 avg elig/mo	\$830.82 @ 1,819 avg elig/mo	\$605.72 @ 2,039 avg elig/mo	\$605.72 @ 2,265 avg elig/mo	\$854.06 @ 2,259	\$865.56 @ 2,145	\$863.7 @ 2,234	\$867.39 @ 2,313	\$902.69 @ 2,313	\$939.43 @ 2,313	\$977.67 @ 2,313
Fee for Service	\$16,791,651	\$16,006,395	\$13,837,743	\$16,926,428	\$18,786,784	\$21,455,801	\$22,256,609	\$23,114,917	\$24,055,694	\$25,034,761	\$26,053,676
Total Benefit Costs for Waiver Population	\$17,316,244	\$18,135,045	\$14,820,787	\$18,689,341	\$23,151,976	\$22,279,510	\$23,153,954	\$24,075,335	\$25,055,201	\$26,074,948	\$27,136,198

Total Benefit Costs	\$17,316,244	\$18,135,045	\$14,820,787	\$18,689,341	\$23,151,976	\$22,279,510	\$23,153,954	\$24,075,335	\$25,055,201	\$26,074,948	\$27,136,198
(Offsetting beneficiary cost sharing payments) * Premium Payments will be net of cost sharing											
Net Benefit Costs	\$17,316,244	\$18,135,045	\$14,820,787	\$18,689,341	\$23,151,976	\$22,279,510	\$23,153,954	\$24,075,335	\$25,055,201	\$26,074,948	\$27,136,198

Federal Title XXI Share	\$11,551,666.09	\$16,049,514.52	\$13,043,774.57	\$16,446,619.65	\$20,373,738.92	\$17,046,053.10	\$15,050,070.10	\$15,648,967.75	\$16,285,880.74	\$16,948,716.08	\$17,638,528.83
State Share	\$5,764,577.48	\$2,085,530.14	\$1,777,012.35	\$2,242,720.86	\$2,778,237.12	\$5,233,456.90	\$8,103,883.90	\$8,426,367.25	\$8,769,320.40	\$9,126,231.74	\$9,497,669.37
TOTAL COSTS FOR DEMONSTRATION	\$17,316,244	\$18,135,045	\$14,820,787	\$18,689,341	\$23,151,976	\$22,279,510	\$23,153,954	\$24,075,335	\$25,055,201	\$26,074,948	\$27,136,198

TOTAL PROGRAM COSTS (State Plan + Demonstration)	\$253,080,872	\$258,192,686	\$225,105,825	\$324,432,724	\$380,817,043						
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Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$255,280,394	\$314,779,542	\$296,414,398	\$368,701,330	\$381,614,072	\$361,852,950	\$434,749,732	\$556,335,511	\$525,893,686	\$525,893,686	\$525,893,686
Total Federal Title XXI Program Costs (State Plan + Demonstration)	\$168,830,249.92	\$228,500,527.29	\$198,115,636.49	\$285,500,797.00	\$335,118,998.10	\$260,367,554.55	\$230,601,770.85	\$237,990,946.15	\$231,254,095.89	\$231,916,931.23	\$232,606,743.98
Unused Title XXI Funds Expiring (Allotment or Reallocated)											
Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	\$86,450,144.08	\$86,279,014.79	\$98,298,761.31	\$83,200,533.31	\$46,495,074.22	\$101,485,395.67	\$204,147,960.90	\$318,344,564.71	\$294,639,590.58	\$293,976,755.23	\$293,286,942.49

# Colorado Adult Prenatal Coverage in Child Health Plan *Plus* (CHP+)

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*1115 Interim Evaluation Report for Demonstration  
Years 1–4: 08/01/2015–07/31/2019*

May 19, 2020



**COLORADO**  
Department of Health Care  
Policy & Financing



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## I. Executive Summary

Colorado's Title XXI Section 1115 waiver - Adult Prenatal Coverage in Child Health Plan Plus (CHP+) - was most recently renewed to be effective from August 1, 2015 through July 31, 2020. This report serves as the interim evaluation of the demonstration, which expanded the income eligibility for uninsured pregnant Medicaid expansion clients who would have been covered under CHP+ if not for the federal poverty level (FPL) expansion of 142% to 195%. The three objectives for this demonstration are to increase the proportion of women in the target population receiving prenatal and postpartum care and for the infants born to these women to be of a healthy weight. In order to evaluate the demonstration's success in achieving these objectives, we used the 2015 population as the baseline population and calculated the percent change for the three measures in the subsequent demonstration years. Results found that the population demonstration showed favorable results for two of the three measures: higher rates of postpartum care and fewer low birthweight babies. The demonstration population did not improve on the rate of prenatal visits. These results should be interpreted with caution due to several methodological limitations including an overlap between the baseline and demonstration population, difficulties in matching a mother's information with a child's birth certificate, and apparent issues in the birthweight data that will need to be explored further. The Department plans to address these limitations in the final evaluation due later in 2020. With these limitations in mind, the interim evaluation suggests that the demonstration was partially successful in meeting the objectives.

## II. General Background Information about the Demonstration

Colorado's title XXI section 1115 demonstration project number 21-W-0014/8, entitled Adult Prenatal Coverage in Child Health Plan Plus (CHP+), was most recently approved by the Center for Medicare and Medicaid Services (CMS) on July 24, 2015. The demonstration renewal period that was approved is effective from August 1, 2015 through July 31, 2020, encompassing five (5) demonstration years. On April 26, 2017 CMS approved Colorado's Special Terms and Conditions (STCs) and evaluation design. See attachment 1.



Under this demonstration's five-year renewal period, Colorado expanded the income eligibility level for uninsured pregnant Medicaid expansion clients who would have been covered under CHP+ if not for the FPL expansion of 142% to 195%. Aiming to further the objectives of title XIX and XXI by providing necessary prenatal, delivery, and postpartum care to low-income pregnant women within the program cohort, CMS has granted Colorado expenditure authorities under section 2104 of the Social Security Act (Act) to provide eligible prenatal women coverage under the Medicaid State Plan and receive federal matching of demonstration costs not otherwise matchable Title XXI funds.

The demonstration population includes pregnant Medicaid expansion clients who would have been covered under CHP+ if not for the expansion (142%-195% FPL). The state has targeted this population to achieve three key objectives:

1. Decrease the uninsured rate for pregnant women;
2. Increase prenatal and postpartum care for pregnant women enrolled in the demonstration; and;
3. Increase the number of healthy babies born to pregnant women enrolled in the demonstration.

To achieve these objectives, Medicaid clients who identified as pregnant received a call to complete a prenatal risk assessment and a PHQ9, which together aim to identify community and educational resources that may benefit the clients, such as Women, Infants and Children (WIC), Prenatal Plus (PN+), Nurse Family Partnership (NFP), and Healthy Start. Members who have been identified as high risk are enrolled in the Intensive Case Management Program.

## History

The interim evaluation analysis contained throughout this report serves to provide a public assessment of Colorado's Adult Prenatal Coverage in CHP+ demonstration from August 1, 2015, through July 31, 2019. Additionally, the state will present this evaluation as a component of its extension application to continue the demonstration for one additional demonstration term.



In September 2002, the State of Colorado received approval from the Centers for Medicare and Medicaid Services (CMS) for a four-year demonstration period through September 2006 for its “Adult Prenatal Coverage in CHP+” program. This program permitted the state to use Title XXI funds to expand coverage to uninsured pregnant women with family incomes between 133% and 185% of the FPL. Subsequently, in January 2006, CMS approved an amendment to the demonstration. This allowed Colorado to expand eligibility for uninsured pregnant women under the demonstration from above 185% to 200% of the FPL. On September 29, 2006, CMS approved Colorado’s request to renew the demonstration for a three-year period through September 30, 2009. CMS then approved Colorado’s extension request, which extended the program through June 2012. On July 30, 2012, Colorado received approval to expand coverage for uninsured pregnant women from 200% to 250% of the FPL. In April 2015, the Colorado Department of Health Care Policy and Financing submitted an application for an extension of Colorado’s title XXI section 1115 demonstration project No. 21-W-00014/8. This extension effectively continued the project at the 2012 FLP levels that raised the upper limit to 250% FPL.

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

To comply with the spirit of CHIPRA, Colorado submitted a Medicaid State Plan Amendment and received approval for transitioning pregnant women from 133% to 185% of the FPL to the Medicaid State Plan and provide full Medicaid benefits to these women. The State has continued to receive Title XXI funds for uninsured pregnant women from 133% to 185% of the FPL. In addition, the State submitted and received approval for a corresponding CHIP State Plan Amendment to transition pregnant women above 185% of the FPL to 250% of the FPL to the CHIP State plan. As required under Special Terms and Conditions (STCs) #17, the State transitioned coverage of pregnant women from this



demonstration to the Medicaid State Plan and the CHIP State Plan, effective January 1, 2013.<sup>1</sup>

### III. Evaluation Questions and Hypotheses

#### Evaluation, Methods and Hypotheses

Intending to achieve its three primary goals for the demonstration population—pregnant Medicaid expansion clients with income from 142% to 195% of the federal poverty level (FPL) who would have been covered under CHP+ prior to the expansion. The state, in consultation with CMS, developed three quantifiable targets to evaluate the efficacy of the program. During the extension period, the following objectives of the demonstration include:

- Objective 1: Increase the percentage of pregnant women who receive prenatal and postpartum care for those enrolled in the demonstration.
- Objective 2: Increase the number of healthy babies born to pregnant women enrolled in the demonstration.
- Objective 3: Decrease the uninsured rate for pregnant women.

In achieving these objectives, the State developed the following hypotheses. By providing health insurance for this population with Title XXI funds under the demonstration, it is anticipated that Colorado will see the following:

1. The prenatal waiver will result in an increase in prenatal care provided to women enrolled in the program;
2. The prenatal waiver will result in an increase in postpartum care provided to women enrolled in the program;
3. The prenatal waiver will result in an increase in the number of healthy babies born in Colorado.

Of note, we were unable to identify an appropriate dataset described in the approved evaluation design that addresses Objective 3 above. Increases in insurance rates are well researched and shown to have positive influence on

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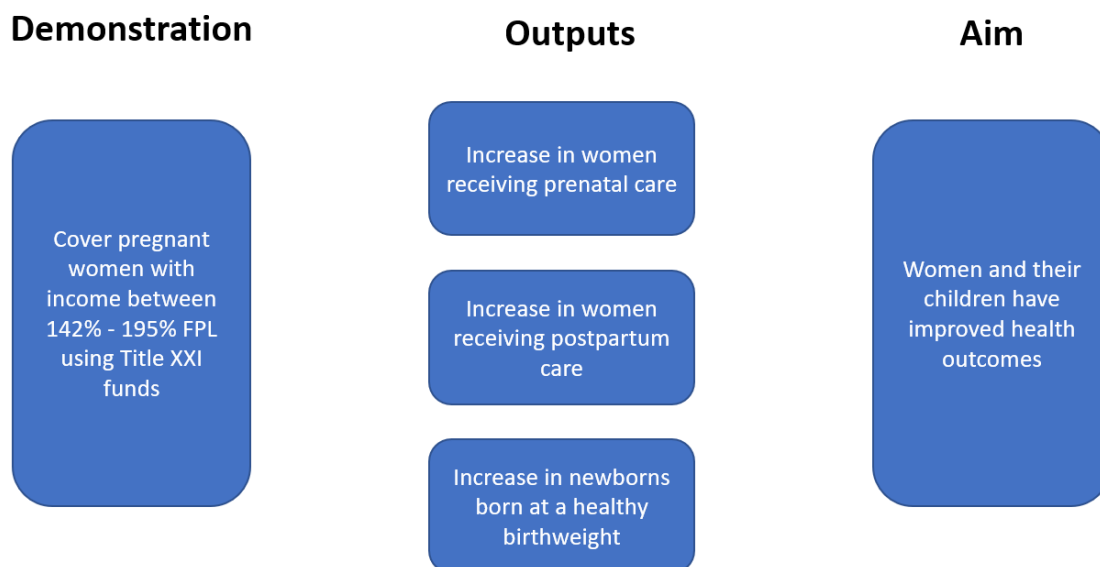
<sup>1</sup> The FPLs listed in the Historical Summary of the Demonstration Project section are pre-MAGI-converted levels

health outcomes.<sup>2</sup> As a result, this objective was not pursued further in this evaluation.

These predictions were translated into two formal hypotheses for testing, which are incorporated in Attachment C of the STCs dated April 26, 2017. As presented in Attachment C, to determine if Colorado is achieving the objectives of the demonstration, the State will test the following:

- Hypothesis 1: The proportion of pregnant women enrolled in the CHP+ demonstration will have a statistically significant increase in prenatal care visits and a statistically significant increase in postpartum care visits from SFY 2015 to SFY 2020.
- Hypothesis 2: The proportion of babies born to women enrolled in the CHP+ demonstration and admitted to the NICU will decrease over the five years of the demonstration term. The proportion of babies born to women enrolled in the CHP+ demonstration that weigh under 2,500 grams will decrease by 10% from SFY 2015 to SFY2020.

### Theory of Change Diagram



2 American College of Obstetricians and Gynecologists. "Benefits to Women of Medicaid Expansion Through the Affordable Care Act" (Washington: American College of Obstetricians and Gynecologists, January 2013), available at <https://www.acog.org/ClinicalGuidance-and-Publications/Committee-Opinions/Committeeon-Health-Care-for-Underserved-Women/Benefits-to-Women-of-Medicaid-Expansion-Affordable-Care-Act>.

The evaluation's first hypothesis is linked to the demonstration's objective, explicitly measuring the projected increase in prenatal and postpartum care for pregnant women enrolled in the demonstration. The second hypothesis is directly tied to measuring the impact the demonstration has on improving health outcomes for low-income mothers and their babies, the weight of the babies being a representation of the targeted health outcome. Taken together, the measures, hypotheses and predictions of the evaluation are implicitly aligned with the demonstration's ultimate goal of improving health outcomes for the program cohort.

Through the life of this demonstration, Colorado has continually expanded the objectives with each iteration to further improve the health outcomes of low-income mothers and their babies. The evaluation presented in the demonstration extension application dated April 15, 2015, focused on the timeliness of prenatal and postpartum care in addition to the percentage of healthy births.

Given the findings of the previous demonstration period, the State modified the measures in the present evaluation to focus on an increase in prenatal and postpartum care. An increase in prenatal care—healthcare and consultation received while pregnant—is a primary driver of improving health outcomes for mothers and their infant<sup>3</sup>. Therefore, tracking the extent to which the population receives this care allows this evaluation to build upon the results of the last analysis, which is necessary to increase the continued efficacy of the demonstration.

The additional measure of increasing postpartum care for the demonstration population is not only an additional change from the prior evaluation but is also an important component of furthering the objectives of title XIX and XXI by providing necessary prenatal, delivery, and postpartum care to low-income pregnant women. Improving the health of these members is a shared objective,

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3 March of Dimes. Prenatal Care Checkups. Available at:  
<https://www.marchofdimes.org/pregnancy/prenatal-care-checkups.aspx#>





which requires that high quality care continue through pregnancy, post-delivery, and early life.

## IV. Methodology

The methodology prescribed for the evaluation of this demonstration is presented in Attachment 1 of this report, which is part of the Demonstration Evaluation Plan in the CMS approved STCs, dated April 26, 2017. In completing this evaluation, data was obtained from Colorado's Medicaid claims data MMIS System, as well as, Colorado's birth certificate data supplied by the Colorado Department of Public Health and Environment (CDPHE).

### Measure Stewards and Data Validation

The data in this report was pulled and evaluated by the Colorado Department of Health Care Policy and Financing's Data Analytics Section. Data is checked for completeness, accuracy, and reasonableness via peer review of SQL codes. Additionally, staff who have the expertise and knowledge of the birth and pregnancy data sources review the codes and data utilized in this study. Finally, a comparison is made between budget and other reports to assess reasonableness of the data. For example, prior budget demonstration forecasts were evaluated to assess reasonableness of actual data pulled. Further, the Colorado Medicaid Program within the Colorado Department of Health Care Policy and Financing is responsible for maintaining and cleaning data within the MMIS System on a regular basis.

Finally, one data validation technique employed was to require that claims within the dataset have a value of "paid". This helped ensure non-eligible clients were excluded from analysis and decreased potential duplicate claims. This served as a proxy to ensure individuals who were not eligible or who had submitted multiple claims were not captured in the population groups. Denied and processing claims were used as a proxy for individuals who were not enrolled or not eligible, or who had submitted multiple claims.

### Evaluation Period

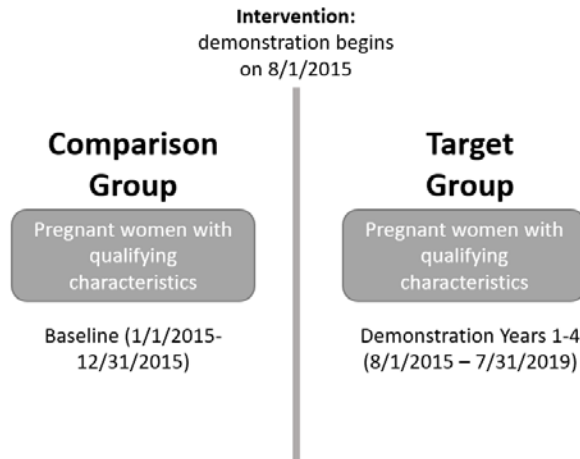
The evaluation period for the comparison population, also referred to as the baseline, was set as the 2015 calendar year, with dates between 01/01/2015 and 12/31/2015. The target population period was divided into four separate

demonstration years between 08/01/2015 and 07/31/2019. The specific demonstration years encompassed the entire target population are presented below. It is important to note that the baseline population period used to generate the baseline data set included four months in 2015, which are also included in demonstration year 1, 08/01/2015 through 12/31/2015.

Demonstration Year	Beginning Date	End Date
1	08/01/2015	07/31/2016
2	08/01/2016	07/31/2017
3	08/01/2017	07/31/2018
4	08/01/2018	07/31/2019

### Evaluation Design Overview

This evaluation compared a group of women whose characteristics would have made them eligible prior to the demonstration period (baseline) with women who had qualifying characteristics during the demonstration period (target). A percent change between the baseline time period and the demonstration years is subsequently calculated for three different measures. The design then assumes that the differences in outcomes observed between these two groups is attributable to the demonstration. Full limitations of this design are described in further detail in the Limitations Section V.



### Comparison Population Inclusion Criteria

Clients (women) ages 15-44 years between 142% - 195% FPL with a service date between 01/01/2015 and 12/31/2015 and a global bill, or a hospital delivery DRG, captured with the following APR-DRGs were eligible for inclusion in the comparison population:

- DRG APR codes for cesarean delivery (540), vaginal delivery (541, 542, and 560), and claim type B or M
- Procedure codes for prenatal care (59400, 59510), postpartum care (59610, 59618, 59410, 59409, 59515, 59614, 59622, 59612, 59620) and claim type E, K, or N

### Target Population Inclusion Criteria

Clients (women) ages 15-44 years between 142%-195% FPL with a service date between 08/01/2015 and 07/31/2019 and a global bill, or a hospital delivery DRG, captured with the following APR-DRGs were eligible for inclusion in the target population:

- DPG APR codes for cesarean delivery (540), vaginal delivery (541, 542, and 560) and claim type I or A
- Procedure code for prenatal care (59400, 59510), postnatal care (59610, 59618, 59410, 59409, 59515, 59614, 59622, 59612, 59620) and claim type M
- Procedure code 59425, 59426, or 59430 and claim type M
- Procedure code 99201 - 99215 and a procedure code modifier equal to 'TH'

## Comparison and Target Population Exclusion Criteria

The exclusion criteria applied in this evaluation were selected to keep the denominator consistent between the prenatal and postpartum measures. With this aim, clients were excluded if they were dually eligible for the ACC Medicare Medicaid Program (MMP), were eligible for both a Medicare and a Medicaid benefit, were in the Working Adults with Disabilities Buy-in Eligibility Type or were clients in the Children with Disabilities Buy-in Eligibility Type (032). Clients were also excluded from analysis if their claim status was not equal to paid.

## Hypothesis Development

The demonstration's approved evaluation plan contains two hypotheses, referenced as Hypothesis 1 and Hypothesis 2 below.

**Hypothesis 1:** *The proportion of pregnant women enrolled in the CHP+ demonstration will have a statistically significant increase in prenatal care visits and a statistically significant increase in postpartum care visits from SFY 2015 to SFY 2020.*

The evaluation plan contains two hypotheses. The first hypothesis contains two measure driven hypotheses. Those two hypotheses are:

H1<sub>A0</sub>: Pregnant women prenatal care visits SFY 2015 to 2020 < or = prenatal care visits in baseline

H1<sub>A1</sub>: Pregnant women prenatal care visits SFY 2015 to 2020 > prenatal care visits in baseline

and;

H1<sub>B0</sub>: Pregnant women postpartum care visits SFY 2015 to 2020 < or = postpartum care visits in baseline

H1<sub>B1</sub>: Pregnant women postpartum care visits SFY 2015 to 2020 > postpartum care visits in baseline

**Hypothesis 2:** *The proportion of babies born to women enrolled in the CHP+ demonstration and admitted to the NICU will decrease over the five years of the demonstration period. The proportion of babies born to women enrolled in the CHP+ demonstration that weigh under 2,500 grams will decrease by 10% from SFY 2015 to SFY 2020.*

H2<sub>A0</sub>: Percent of babies born weighing less than 2,500 grams within population cohort = no change from SFY 2015 to SFY 2020.

H2A1: Percent of babies born weighing less than 2,500 grams within population cohort  $\geq 10\%$  decrease from SFY 2015 to SFY 2020.

Through the STCs and evaluation plan development process, Hypothesis 1 was broken into two evaluation measures, which are referred to throughout as Measure 1 and Measure 2. These measures target the rate of pregnant women with prenatal care and the rate of pregnant women with postpartum care, respectively. Hypothesis 2 was developed into a single metric, which is referred to as Measure 3 and tracks the percentage of births weighing less than 2,500 grams. Though the NICU measure is useful, it was ultimately not included in this evaluation. More details on this exclusion are included in the Limitations Section V. Each measure is defined below with a description of the criteria deployed to develop the corresponding data set.

***Measure 1 Criteria- Number of Pregnant Women with Prenatal Care***

Clients were counted in the numerator of this measure if they met the above comparison or target inclusion criteria, respectively, and were also identified as having one of the following procedure codes related to prenatal care: 59400, 59510, 59426, 59610, 59618, 59622, or codes 99201-99215 with the 'TH' modifier.

***Measure 2 Criteria -Number of Pregnant Women with Postpartum Care***

Clients were counted in the numerator of this measure if they met the above comparison or target inclusion criteria, respectively, and were also identified as having one of the following procedure codes related to postpartum care: 59400, 59510, 59410, 59515, 59430, 59610, 59614, 59618, 59622

***Measure 3 Criteria - Percent of Births Weighing < 2,500 Grams***

Clients were counted in the numerator of this measure if they met the above comparison or target inclusion criteria, respectively. Additionally, birth data must have included the weight data of the infant. Target population data excluded mothers who gave birth to multiples. Clients who gave birth to multiples were included in Measure 3 of the comparison group. This is discussed further in the limitations section.

For all three measures and each population, it was necessary to update the defined ICD-9 codes from the 2017 STCs to ICD-10, as ICD-9 is no longer accepted as the primary diagnosis coding subset in Colorado's MMIS System. The crosswalk from ICD-9 to ICD-10 is included as Attachment 2 in this report.

Analytical methodology used to assess each measure is prescribed in the Demonstration Evaluation Plan.

### ***Hypothesis 1 (Measures 1 & 2) Methodology***

The data needed to test the first hypothesis came from Medicaid claims data in the state MMIS system. Total number of births is pulled from the claims for the previous calendar year. Three types of birth data were used: inpatient deliveries, global bills and antepartum/standalone care (other criteria are also assessed, per the specifications). The data was used to identify the prenatal and postpartum care based on the numerator criteria for the measure—Attachment 1.

The analytical strategy used to evaluate the data is a year-to-year percentage change. The annual difference is calculated by subtracting the previous year's value from the current year's value. Then the annual difference is divided by the previous year's value to get a comparison. This figure is then multiplied by 100 to obtain the year-over-year percentage change.

### ***Hypothesis 2 (Measure 3) Methodology***

The data for Hypothesis 2 was taken from claims data from the Department's MMIS system and birth certificate data provided by our sister agency, CDPHE. Claims data and CDPHE's birth certificate registry is matched by birth mother. The infant's birth weight is then pulled from the matched birth certificate. Only infants with a birth weight of less than 2,500 grams are included in the report.

The methodology is a pre- and post-measurement to compare the number of babies born to pregnant women in the demonstration population weighing less than 2,500 grams during the waiver period. The analytical strategy used to evaluate this data is a year-to-year percentage change. The annual difference is calculated by subtracting the previous year's value from the current year's value. Then the annual difference is divided by the previous year's value to get a comparison. This figure is then multiplied by 100 to obtain the year-to-year percentage change.

### **Evaluation Changes Made to Address Discrepancies Identified During Analysis**

The demonstration evaluation plan divided hypothesis 1 into two measures—measure 1 and measure 2—for tracking and analysis. The prescribed plan defines the denominators differently between these measures, which are designed to evaluate one hypothesis. The additional diagnosis codes specified in the postpartum care denominator were tested and found to add an additional six (6) clients compared to the Department's standard criteria and SQL language for identifying deliveries. In order for the denominators to match

between measure 1 and measure 2, the Department decided to use the standard delivery criteria originally proposed for measure 1 so that it matched measure 2. With this change, the baseline dataset was developed with a consistent denominator for all measures. Following a similar approach, the application of the Department's standard definition for deliveries was applied to all three measures for the comparison group.

The baseline data set and the prescribed evaluation design were structured with prenatal care codes that are single instances of prenatal care and not global bills. By limiting prenatal and postpartum care visits to those billed in the specified demonstration year, the design unintentionally introduced potential bias and risk of not fully capturing all related care. As an example of this challenge, it is possible that some prenatal care visits were billed before the demonstration year for a given birth, such as prenatal care delivered in April 2016 (Demonstration Year 1) for a birth in September 2016 (Demonstration Year 2). A similar situation is also plausible for postpartum care visits. Without controlling for these situations, it is reasonable to expect a meaningful portion of women would be incorrectly excluded from the evaluation results.

To address this limitation and control for risk of population undercount, the state deviated from the evaluation design and utilized a look-back period of eight (8) months and a look-forward period of 60 days. The eight month look-back period was used to identify prenatal care occurring before the estimated date of delivery. Similarly, the 60-day look-forward period was used to identify any post-partum care occurring after the estimated date of delivery.

The data for this evaluation was gathered using the same client exclusion parameters as the baseline dataset with two exceptions—FPL bracket(s) and age range.

- The baseline data was gathered using an FPL bracket of 142%-195% during calendar year 2015, while the evaluation data set used a client's FPL bracket during the month of the delivery claim.

Remaining consistent with the use of the Department's standard delivery data criteria, the eligible client population was limited to ages ranging from 15-44, opposed to the 15-55 listed in the demonstration evaluation plan. This age range is consistent with the baseline dataset.

Finally, the demonstration measures, as defined in the baseline data set and evaluation plan, did not address how to control the pregnant women that gave birth to multiple infants, which is a confounding variable to assess gross birth



weight. To resolve this issue, women who gave birth to multiple infants at delivery were excluded for the comparison population for measure 3.

### Enrollment Definition

In this evaluation, a member is considered "enrolled" in the program if the member gave birth during the demonstration year and had an FPL of 142% - 195% during the month of birth. A member is counted in an enrollment month if the member was enrolled in Medicaid during the month (regardless of if the member was pregnant or within the 60-day postpartum period). Members who were pregnant but did not give birth during the demonstration year are not counted in this enrollment population.

Enrollment patterns measured include:

- All births in the demonstration year by month
- Total Births
- Members in the demonstration population who maintained Medicaid eligibility during the demonstration period (any FPL bracket)
- Members in the demonstration population who maintained the same FPL bracket during the demonstration period
- Total member months
- Unique clients
- Average member months per client

## V. Methodological Limitations

### Lack of Concurrent Control Group

One concern regarding the design of the evaluation is the lack of a concurrent control group. There are two separate pieces contributing to this concern. First, the baseline year covers calendar year 2015 in its entirety (January 1 - December 31, 2015). Due to the demonstration period beginning in August of 2015, there are four months of data that overlap between the baseline and demonstration years. The second and perhaps larger factor contributing to the lack of a concurrent control group is the nature of the demonstration itself. Because this demonstration was an extension of previously established FPL guidelines that apply to all pregnant women who meet the criteria, we do not have a counterfactual to measure the outcomes of pregnant women in this income range who do not fall under the demonstration. It is not possible to know what would have happened in the absence of this demonstration because the demonstration by definition covers all eligible women. It is possible that outcomes for women and their children would have been worse in the absence of the demonstration, but we cannot properly evaluate that potential outcome.



## Inclusion Criteria

For our inclusion criteria, we require that both the comparison and target population be between the ages of 15-44 years. By narrowing eligibility criteria to this age range, we aligned methodology with Colorado's Mother and Infant Health grant. This additional criterion potentially controls multiple confounding factors specific to pregnant women outside this age range. These age-related factors include birthweight outcomes and a mother's likelihood of receiving prenatal and postpartum care.

Inclusion criteria for both the comparison and target groups included that the claim status must have been paid. This additional criterion was set to verify that the claims input data was both accurate and non-duplicative, as described in the data validation section. It is important to highlight that implementation of this data quality control does pose a small risk of inadvertently excluding some eligible clients from the comparison and target populations.

## Birthweight (Measure 3)

There are two specific study limitations that apply directly to Measure 3 (evaluation of birth weight) in this study. First, the target population added a further criterion to exclude data from mothers who gave birth to multiples. Infants who are part of multiples are more likely to be of a low birthweight due to biological constraints.<sup>4</sup> As Measure 3 specifically uses low birth weight as a proxy for poor birth outcomes, mothers who gave birth to multiples were excluded from analysis in the target population. At the time when the comparison population was defined, mothers who gave birth to multiples were not excluded. Therefore, there is potential for introduction of Type I statistical error into this study - risk of incorrectly identifying a significant decrease in number of infants less than 2,500 grams between the comparison and target population increases. This limitation will be addressed in the final evaluation to be completed later in 2020.

However, the number of mothers who give birth to multiples is fairly low in the United States. Final data from the 2018 National Vital Statistics Report published by the CDC indicates the 2018 twin birth rate was 32.6 per 1,000 births and the triplet and higher multiple birth rate for 2018 was 93.0 per 100,000 live births.<sup>5</sup> Therefore, we assess that the error introduced into the study does not account for the entirety of the large difference we observe in the baseline year compared to the demonstration years.

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4 Jin, J. "Babies with Low Birth Weight." JAMA. (2015).

5 US Department of Health and Human Services. "Births: Final Data for 2018." National Vital Statistics Reports.



Secondly, in order to obtain birth weight data, eligible mothers with appropriate claims indicating a live birth were matched with birth certificate data. The infant's birth weight was then abstracted from the certificate. It is estimated that between 15-20% of the target population group was unable to match mother's delivery claim with a birth certificate, which lowered the evaluation numerator. The evaluation denominator was generated from claims data, which resulted in a static denominator being used with a lower numerator--artificially driving the low birth weight measure lower. Any time there is significant missing data, bias is introduced into the analysis. We do not have any data to suggest that mothers with specific characteristics were differentially excluded from the birth weight analysis; however, future studies could assess ways in order to assist with the matching process.

The matching of delivery claim(s) and birth certificate(s) is completed by CDPHE and the matched files are then sent to the Department. Therefore, the Department is limited in its ability to control a direct improvement of the match rate. In an attempt to address this limitation, the Department will complete a deep dive into the matching process within the final evaluation to identify alternate mechanisms or data properties that may increase the match rate. Any identified improvement or work-around identified in this process will be included in the proposed evaluation design of future demonstration extension periods.

Of note, while an increase in matched files would certainly improve the analysis by increasing the sample size, the results of the analysis may or may not be impacted by the missing data. If the women and newborns with missing matched files do not have characteristics that are different than the population with matched files, then we would not expect the trends we see to differ. However, if there is something unique about the characteristics of women who do not have matched files, then we would expect the results to be impacted. The uncertainty around the characteristics of these women, however, prohibits any attempt at modeling the missing data.

### **Prenatal Care Codes**

The baseline dataset and the prescribed evaluation design were structured with some prenatal care codes that are single instances of prenatal care, not global bills. As the baseline data was generated with this approach, which only identified codes billed within the demonstration year, the same approach was used for the evaluation. Limiting prenatal and postpartum care visits to those billed in the specified demonstration year generates some probability that some prenatal care visits are being billed before the demonstration year for births that happened within the demonstration year.

## **Enrollment**

The number of clients who maintained some type of Medicaid eligibility after the two-month period postpartum would be a more accurate analysis of program disenrollment than looking at member months over time. In the past, we have done reporting on the number of clients who dropped off of Medicaid eligibility two months after giving birth vs the number of clients who maintained some kind of Medicaid eligibility after this period, which would be a more accurate analysis of program disenrollment than looking at member months over time.

## **Lack of Distinct Demonstration Years**

The design of this study did not account for women who span demonstration years, with prenatal care occurring in one demonstration year time period and delivery and/or postpartum care occurring in a different demonstration year time period.

## **Analytic Strategy**

The analysis set for this study was a percentage over year change. Further studies could instead explore a comparison of the demonstration population versus state or national benchmarks. This would be a more realistic measure of success given that these measures are difficult to make great change on from a year to year basis. The analysis employed in this study includes non-normalized comparison of unadjusted counts. The percentage change by year did not control for population change or overall enrollment changes. Further studies can look to include analyses that explore these potential effects.

## **Omission of NICU Data**

The original proposal for this study included a hypothesis potentially comparing changes in the number of infants born to women enrolled in the program that were subsequently admitted to the NICU. Though an important measure by all accords, upon initiating the study, it was determined this measure was not well defined and would not be easily controlled. Deeper analysis employing control of confounding variables would be needed to address this item. It was therefore not included in our current, final study based on the scope and purpose of the current study objectives.

# **VI. Results**

As outlined in methodology, we calculated percent change to compare differences in the proportion of clients meeting the defined three measures.

### Measure 1 Results- Number of Pregnant Women with Prenatal Care

A higher percentage of eligible clients received prenatal care during the baseline year compared to all demonstration years (Table 1). A clear decrease in percentage of clients receiving care occurred between baseline and demonstration year 1 (10.4% rate of change), at which point a smaller year-to-year percent decrease continued across all additional years. The specific year-to-year percent change comparison between baseline and demonstration year 4 was -22.8%.

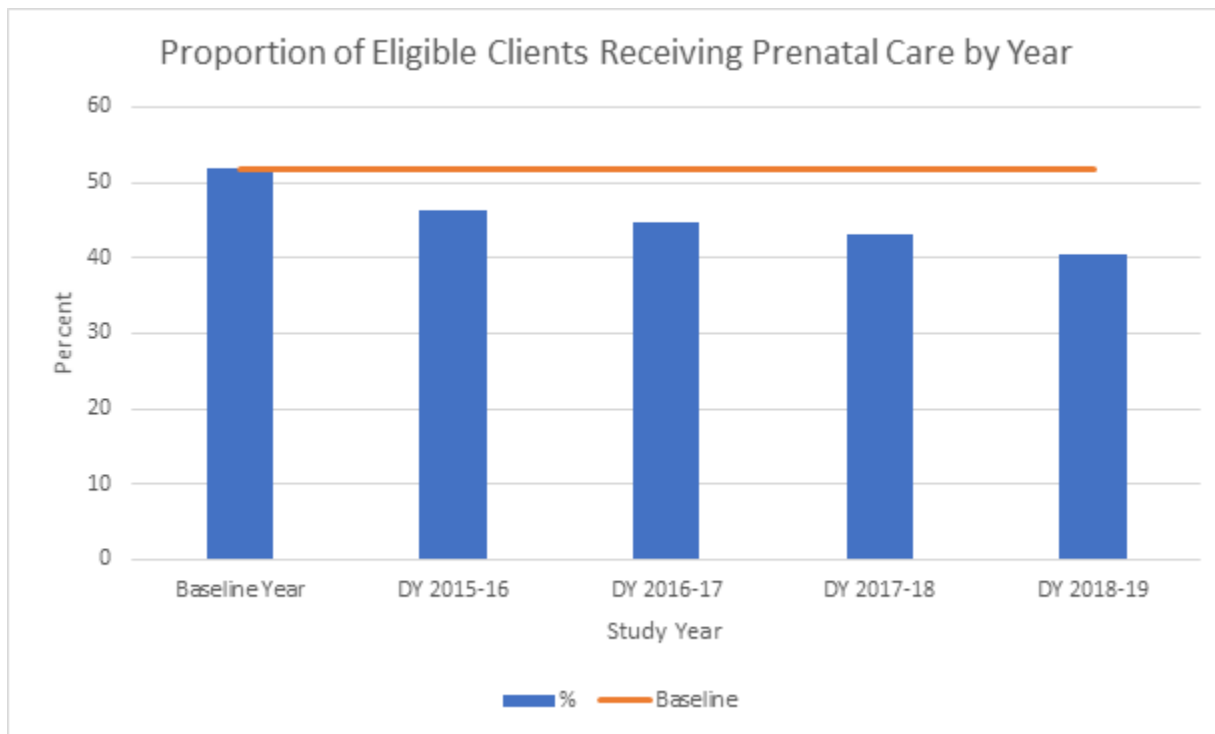
The hypothesis that more pregnant women would receive prenatal care during demonstration years as compared to the baseline was not supported by study findings. As a descriptive study comparing unadjusted percentage differences and year-to-year percent changes, we are unable to make a determination as to whether the percent decrease represents a statistically significant finding. However, as it relates to practical relevance, we have identified a potential decreasing trend in the number of eligible clients receiving prenatal care across the demonstration years (Figure 1), as defined by the study parameters.

Table 1. Comparison of Pregnant Women with Prenatal Care Across All Study Years

Year	Number Received Prenatal Care	Percent Received Prenatal Care (%)	Percentage Point Difference from Baseline	Rate of change year over year	Rate of change from baseline
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Baseline Year	1637	51.8	--	--	--
Demonstration Year 1	1287	46.4	-5.4	-10.4%	-10.4%
Demonstration Year 2	1284	44.7	-7.1	-3.7%	-13.7%
Demonstration Year 3	1279	43.1	-8.7	-3.6%	-16.8%
Demonstration Year 4	1199	40	-11.8	-7.2%	-22.8%

Figure 1. Proportion of Eligible Clients Receiving Prenatal Care by Year



Participant race and ethnicity data was not obtained at the initiation of this study for the baseline year. Therefore, a more thorough comparison between baseline and demonstration years, stratified by race and ethnicity, cannot be completed. However, race/ethnicity data is available for demonstration years 1-4 and was therefore assessed to better understand the decreasing trend in prenatal care observed across demonstration years.

### Measure 2 Results - Number of Pregnant Women with Postpartum Care

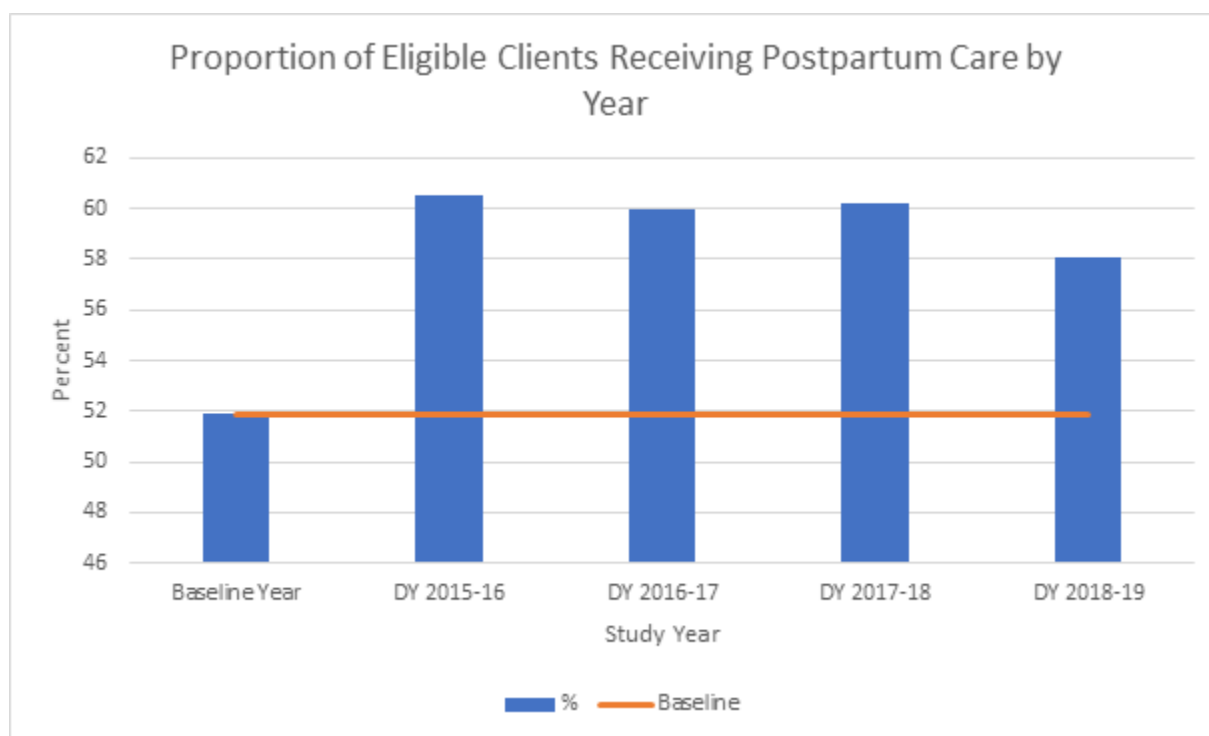
An increase in the percentage of eligible clients who received postpartum care was identified across all demonstration years, as compared to the baseline. Specifically, there was an 8.6%, 8.1%, 8.3%, and 6.2% difference from baseline for demonstration years 1-4, respectively (Table 2). A marked change was seen between baseline year and demonstration year 1 (16.6% year-to-year rate increase) (Figure 2). However, the proportion of eligible clients who received postpartum care remained relatively stable across demonstration years 1 - 4, with only slight year-to-year percent changes (-0.8%, 0.3%, and -3.5% respectively).

Measure 2 findings support our hypothesis that we would observe a greater percentage of pregnant women who received postpartum care as compared to the baseline. Specifically, we observed an 11.9% year-to-year increase comparing the baseline year directly to demonstration year 4.

Table 2. Comparison of Pregnant Women with Postpartum Care Across All Study Years

Year	Number Received Postpartum Care	Percent Received Postpartum Care (%)	Percent Point Difference from Baseline	Rate of change year over year	Rate of change from baseline
Baseline Year	1642	51.9	--	--	--
Demonstration Year 1	1677	60.5	8.6	16.6%	16.6%
Demonstration Year 2	1724	60	8.1	-0.8%	15.6%
Demonstration Year 3	1788	60.2	8.3	0.3%	16.0%
Demonstration Year 4	1742	58.1	6.2	-3.5%	11.9%

Figure 2. Proportion of Eligible Clients Receiving Postpartum Care by Year



### Measure 3 Results - Percentage of Births Weighing < 2,500 Grams

The study outlined a goal of achieving a 10% or greater year-to-year decrease in the proportion of clients who gave birth to LBW infants between baseline and demonstration year 4. According to this data, the goal was greatly exceeded.

Compared to the baseline year, demonstration years 1-4 saw an -11.3%, -11.8%, -11.7%, and -11.5% percentage point difference in LBW infants. Similar to measure 2 findings, an initial large year-to-year decrease of 63.8% was observed between baseline and demonstration year 1 (Table 3). Subsequent year-to-year percent change was minimal after this initial large decrease, displaying a plateau across all demonstration years (Figure 3).

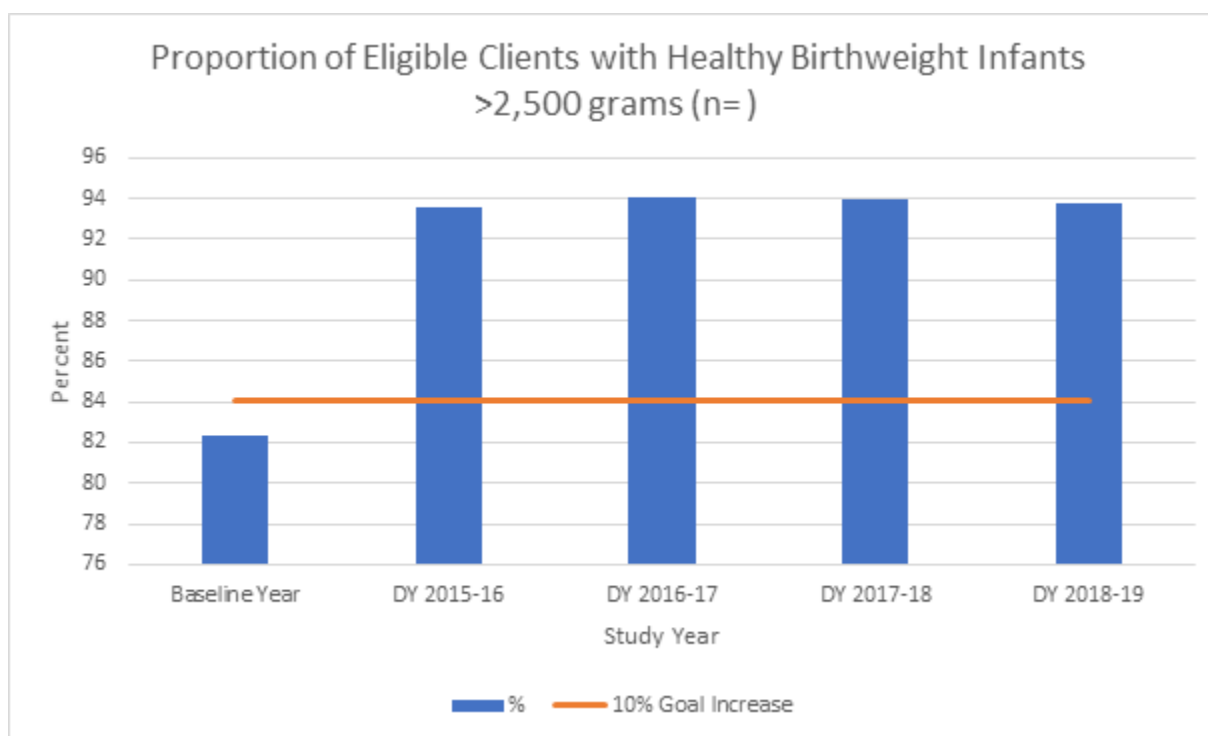
While this data is suggestive of positive improvement in LBW infants in Colorado Medicaid, these results should be interpreted with caution. Clearly, 2015 is an outlier in the data. In addition, the rates for LBW are lower than the state and national averages. Future analyses will take a deep dive into the data used for this analysis. This is discussed further in the limitations section.



Table 3. Comparison of LBW Infants Across All Study Years

Year	Number LBW Births	Percent LBW Births (%)	Percent Point Difference from Baseline	Rate of change year over year	Rate of change from baseline
Baseline Year (n=3,162)	559	17.7	--	--	--
Demonstration Year 1 (n=2,772)	175	6.4	-11.3	-63.8%	-63.8%
Demonstration Year 2 (n=2,875)	167	5.9	-11.8	-7.8%	-66.7%
Demonstration Year 3 (n=2,970))	175	6	-11.7	1.7%	-66.1%
Demonstration Year 4 (n=2,996)	184	6.2	-11.5	3.3%	-65.0%

Figure 3. Proportion of Eligible Clients with Healthy Birth Weight Infants



### Demonstration Enrollment

Enrollment data presented through this evaluation includes monthly snapshot member months, unique clients, and total births. Further, to help assess member churn while within the demonstration, snapshot enrollment was measured for the demonstration population who maintained the same FPL bracket during the demonstration and those that changed FPL cohorts, but maintained overall demonstration eligibility.

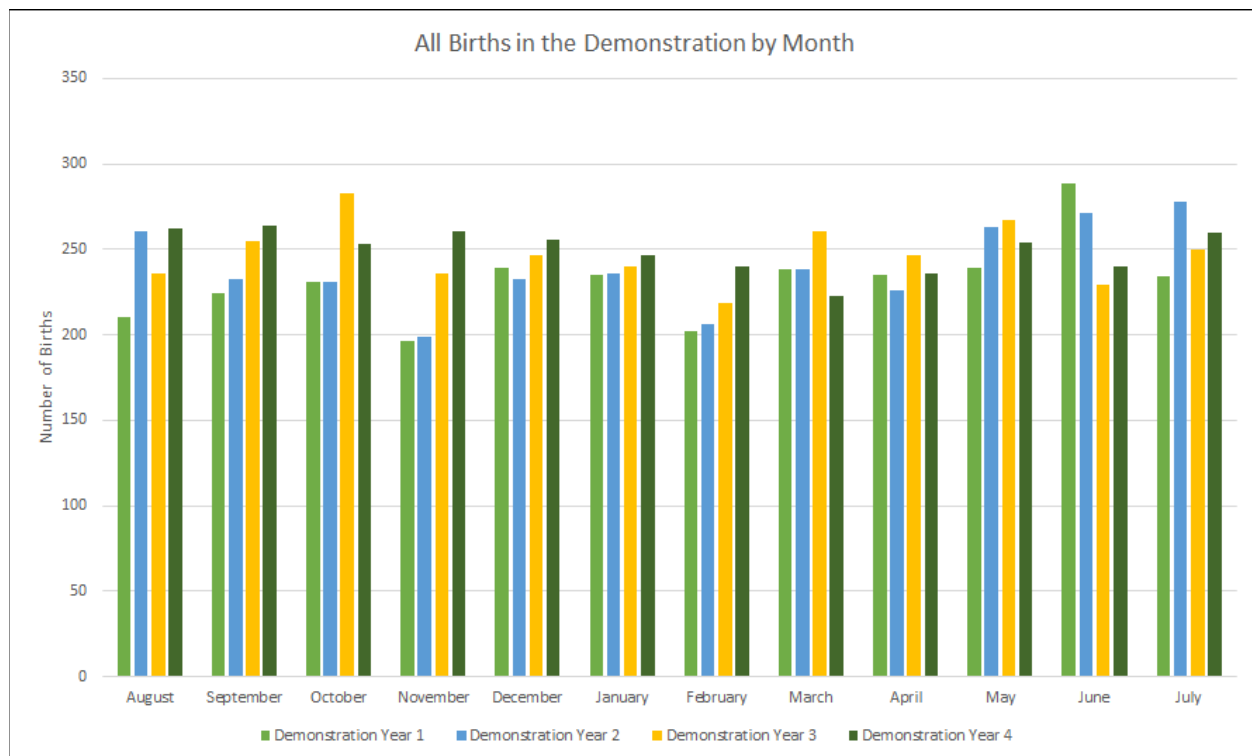
Of note, member enrollment spans may fall outside of when the client was pregnant or in their postpartum period and these numbers only represent clients that gave birth during the demonstration year—it does not include any members that were pregnant during the demonstration year but hadn't given birth yet. This fact is why the enrollment numbers fall off towards the end of the year.

In the following section are demonstration enrollment trends in both table and graphic format.

Table 4. All Births in the Demonstration Year by Month

Enrollment Table A: All births in the demonstration year by month													
	Total Births	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
Demonstration Year 1	2772	210	224	231	196	239	235	202	238	235	239	289	234
Demonstration Year 2	2875	261	233	231	199	233	236	206	238	226	263	271	278
Demonstration Year 3	2970	236	255	283	236	247	240	219	261	247	267	229	250
Demonstration Year 4	2996	262	264	253	261	256	247	240	223	236	254	240	260

Figure 4. All Births in the Demonstration Grouped by Month



*\*Number of births per month is included, as it is likely a better representation of enrollment trends over time.*

Table 5. Members in the Demonstration Population Who Maintained Medicaid Eligibility During the Demonstration Period (Any FPL Bracket)

Enrollment Table 2: Members in the demonstration population who maintained Medicaid eligibility during the demonstration period (any FPL bracket)															
	<i>Total Member Months</i>	<i>Uniqu e Clients</i>	<i>Average member months/ client</i>	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
<b>Demonstration Year 1</b>	22578	2772	8.1	1784	1901	1951	2077	2122	2088	2047	1968	1847	1752	1593	1448
<b>Demonstration Year 2</b>	23691	2875	8.2	1957	2046	2151	2161	2161	2136	2052	1999	1921	1820	1716	1571
<b>Demonstration Year 3</b>	24745	2970	8.3	2027	2147	2244	2267	2233	2185	2149	2098	2025	1924	1780	1666
<b>Demonstration Year 4</b>	24134	2996	8.1	2075	2154	2256	2248	2214	2158	2057	1994	1932	1803	1674	1569

Figure 6. Members in Demonstration Population in any FPL Bracket Grouped by Month

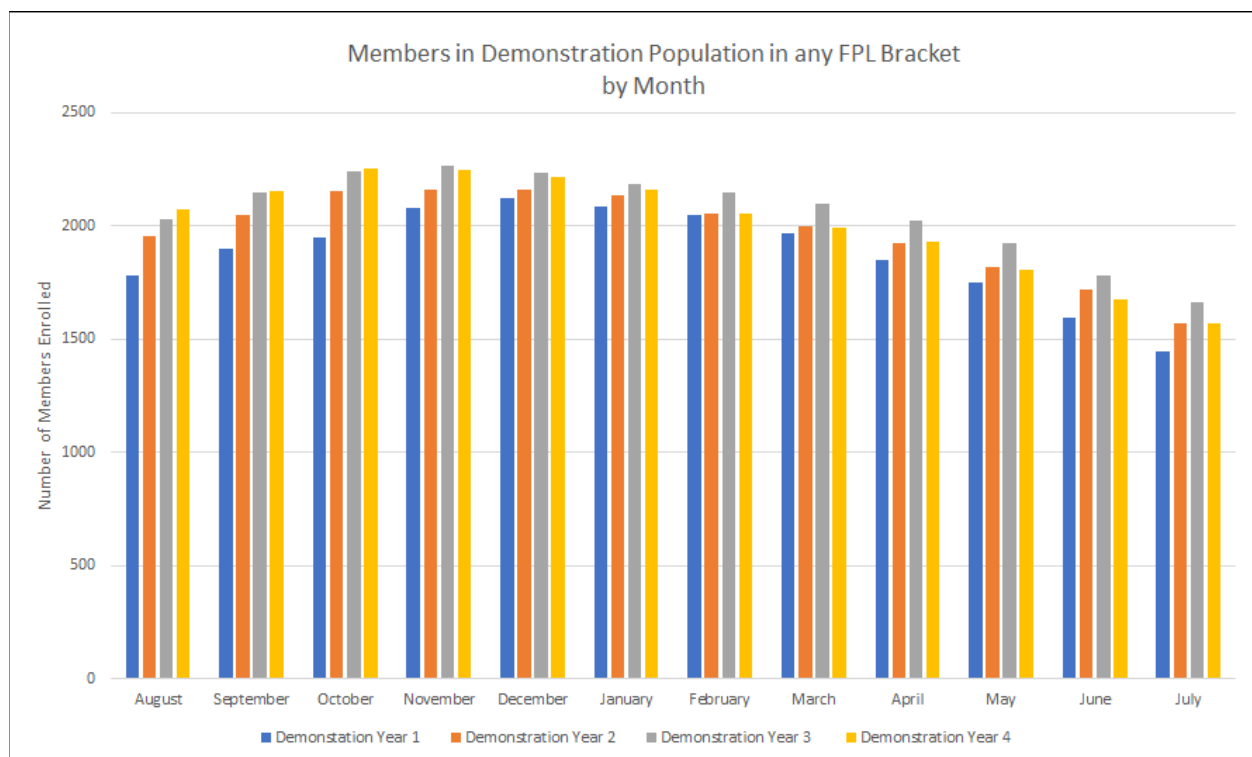
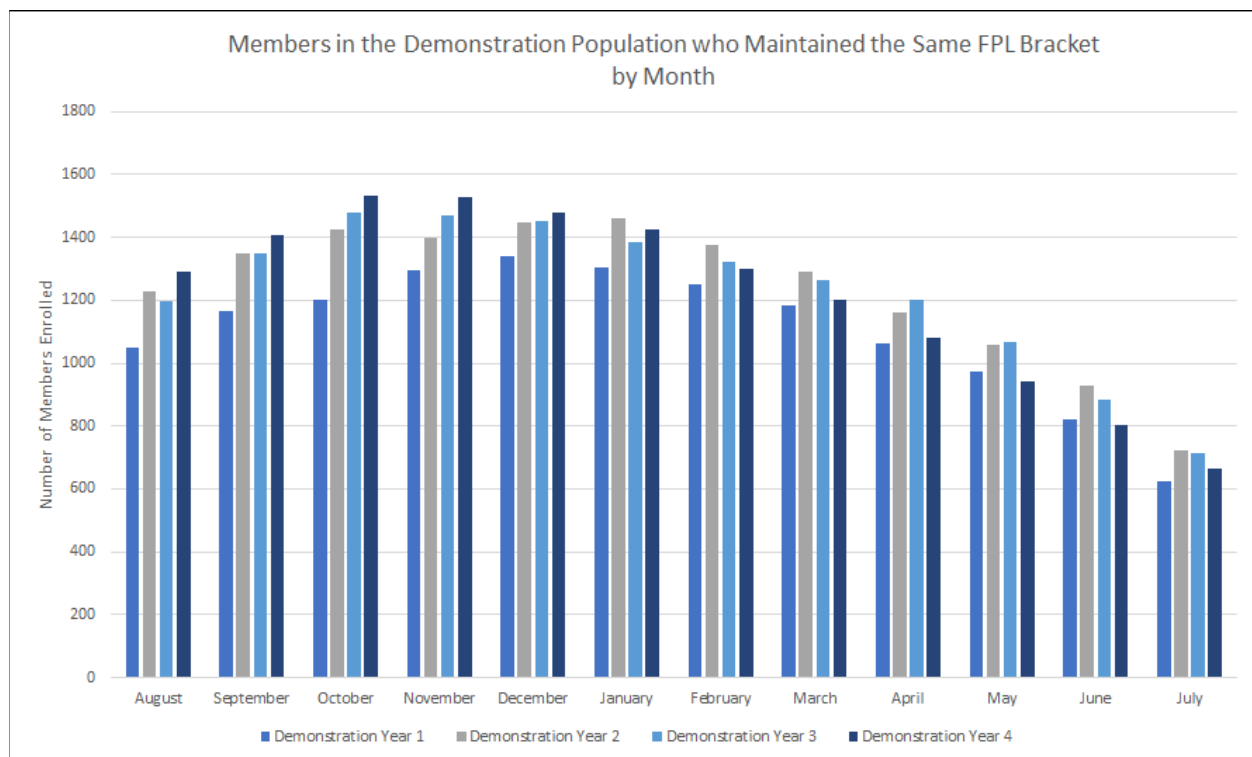


Table 6. Members in the Demonstration Population Who Maintained the Same FPL Bracket During the Demonstration Period

Enrollment Table 3: Members in the demonstration population who maintained the same FPL bracket during the demonstration period															
	<i>Total Member Months</i>	<i>Unique Clients</i>	<i>Average member months/client</i>	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
<b>Demonstration Year 1</b>	13275	2772	4.8	1048	1165	1202	1295	1340	1306	1251	1185	1063	975	820	625
<b>Demonstration Year 2</b>	14845	2875	5.2	1230	1347	1425	1398	1447	1462	1376	1289	1163	1057	928	723
<b>Demonstration Year 3</b>	14796	2970	5	1199	1350	1480	1470	1453	1386	1323	1266	1203	1069	885	712
<b>Demonstration Year 4</b>	14659	2996	4.9	1293	1408	1534	1528	1478	1426	1300	1203	1080	941	802	666

Figure 7. Members in the Demonstration Population Who Maintained the Same FPL Bracket During the Demonstration Period Grouped by Month



## Demonstration Expenditures and Budget Neutrality

A summary table of demonstration expenditures by demonstration year is presented below and a detailed budget neutrality analysis is included as Attachment 3.

Table 7. Demonstration Population Expenditures (August 2015 - July 2019)

Demonstration Population (pregnant women 142% - 195% FPL) Expenditures	
Demonstration Period	Expenditure
8/1/2015 - 7/31/2016	\$17,941,864
8/1/2016 - 7/31/2017	\$14,722,934
8/1/2017 - 7/31/2018	\$18,905,554
8/1/2018 - 7/31/2019	\$22,511,714

## VII. G. Conclusions

### Final Conclusion - Hypothesis 1 (Measure 2) & Hypothesis 2 (Measure 3)

Findings from our study supported two of the three original hypotheses. First, a greater proportion of pregnant women received postpartum care during demonstration years as compared to the baseline. Secondly, we observed a decrease in the proportion of women who gave birth to LBW infants across all demonstration years. Based on the trended performance so far, we are currently on track to meet our goal of a 10% decrease in LBW births; however, as previously mentioned, the results on low birth weight should be interpreted with caution.

### Final Conclusion - Hypothesis 1 (Measure 1)

The study findings did not support our hypothesis that a higher proportion of pregnant women in the demonstration years would receive prenatal care compared to the baseline. Unfortunately, findings indicate a potential decreasing trend across all years for women receiving prenatal care, though further analysis is required to determine significance of this observation.

To better evaluate this finding, we reviewed historical Medicaid prenatal outcomes from HEDIS datasets. When comparing against Colorado's Medicaid population, we see that there have been multiple substantive changes to how prenatal metrics were defined between 2014 to 2017. The process of refining

these metrics is necessary to more validly capture outcomes. However, it prevents comparisons during this time. Additionally, due to the frequent refinement of variable definitions, we are unable to assess the presence of a possible secular trend. This deep dive neither supported nor refuted that our demonstration prenatal finding was an artifact of the data.

Colorado is invested in continually improving maternal health outcomes. This has been a focus in our Accountable Care Collaborative and is increasing in priority for the upcoming State fiscal year.

Alongside this priority, the Department is performing state and national review of population management. It remains imperative to continue the evaluation and monitoring of prenatal outcomes in the CHP+ and Medicaid population.

### **Population Demographics**

Racial disparities in obstetric and prenatal care utilization have been well characterized in current literature<sup>67</sup>. In order to take a deeper dive and explore potential factors related to Measure 1 results, we characterized client data by race/ethnicity to define the composition of the demonstration population. Baseline year race/ethnicity data was unavailable.

Upon comparing the distribution of self-identified race/ethnicity data among demonstration year clients, no apparent link was identified. However, the way in which race/ethnicity categories were collected differed across the demonstration. For instance, the use of a “multiple” category was unavailable for demonstration year 1. Additionally, the number of race/ethnicity categories for clients to self-select fluctuated across years, with 8, 16, 9, and 9 options available, respectively. Interestingly, there was a higher proportion of “multiple” race/ethnicity clients for demonstration years 3 and 4 compared to prior years, supporting the notion that race/ethnicity is a complex construct to analyze. Further evaluation including stratification by race and ethnicity is essential to identifying driving factors behind the potential trend in decreasing utilization of prenatal care.

### **Data Source**

Use of historical medical claims data remains a cost-effective strategy for undertaking large scale evaluations. However, interpretation of results must be done cautiously as the data was not collected with the sole intent of being used in analytical research. Inability to achieve the Measure 1 goal may be a by-product of a data validation and abstraction error. Specifically, the

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6 Gadson, A., Akpovi, E., & Mehta, P. “Exploring the Social Determinants of Racial/Ethnic Disparities in Prenatal Care Utilization, and Maternal Outcome.” Seminar in Perinatology. (2017)

7 Howell, E. & Zeitlin, J. “Quality of Care & Disparities in Obstetrics.” Obstet Gynecol Clin North Am. (2017)

decreasing trend in prenatal care may instead highlight a confounding trend related to billing and coding behaviors, database system changes, missing data, or other unidentified external factors.

### **Future Evaluation**

Another future opportunity to better understand and address the decrease in prenatal care among the demonstration population includes the analysis of geocoded data to visually map “hot spots” or clusters of clients not utilizing or under-utilizing obstetric care. The impact of other geographic factors (e.g. location of clinics, public transportation routes, etc.) would also need to be evaluated as part of this potential study.

The systematic analysis of confounding variables and how they relate to the decrease in prenatal care are limited in the current evaluation. Multiple factors must be considered as they relate to Measure 1 findings. Underutilization of healthcare can be impacted by numerous factors including mother’s marital status, age, and educational attainment. Before concluding the reasoning behind failure to achieve Measure 1, a thoughtful and analytical assessment of the root cause must first be completed.

## **VIII. Interpretations, Policy Implications and Interactions with Other State Initiatives**

### **Other State Initiatives**

The medical and social needs of the demonstration population are addressed by a patchwork of both federal and state funding streams. Providing a comprehensive maternal health package of benefits and support services to a high risk and costly population requires a coordinated statewide effort. The Department partners and collaborates with entities around the State to be able to support child and maternal health programming. These programs, described below, serve as a supplement to support women covered by entitlement programs to ensure mothers have the support they need to deliver a healthy infant. It is important to understand the landscape of these programs and supports available to the demonstration population in order to gain a clearer picture of their outcomes.

The Prenatal Plus Program is a program that provides support services to Health First Colorado recipients who are at high risk for negative maternal and infant health outcomes based upon physical and behavioral indicators, as well as, other social determinants of health. Care teams include a dietician, care coordinator, and mental health professional. Teams work together to ensure members are receiving needed support, education, and medical services throughout the pregnancy.



Another program available to Colorado mothers is the Nurse-Family Partnership, an evidenced based program where nurses make home visits to support first time mothers who are up to 200% of the FPL. The program is supported by the Maternal and Child Home visiting block grant (Title V) and administered by public health departments, community health centers, community nursing agencies, and hospital systems, in order to reach first time mothers across the state.

The Department continually collaborates with the Office of Behavioral Health to administer the Special Connections program and on other health initiatives aimed at improving health outcomes for pregnant women with SUD and other behavioral health issues. The Special Connections program is a program for pregnant women who qualify for Health First Colorado and are at risk of using alcohol or other substances during their pregnancy. The benefit supports women in pregnancy and during the postpartum period by providing outpatient and residential substance use disorder treatment, case management, and health education.

Regional Accountable Entities (RAEs) are the organizations in Colorado responsible for coordinating members' care, ensuring they are connecting with physical and behavioral health care, and developing regional strategies to service Health First Colorado members. Maternity is a large focus of the RAEs. Each RAE is responsible for developing a maternity based program that supports pregnant women in receiving needed prenatal care. Based upon direction from the Governor's Health Initiatives and evidenced-based practice, the Department and the RAEs are working together to further define the goals and necessary components of a maternity program that are in-line with national benchmarks for maternal health outcomes.

One important step to improving outcomes for women and their infants is understanding the drivers of poor outcomes, including maternal mortality. The Colorado Department of Public Health and Education oversees the Maternal Mortality Review Committee (MMRC). The existence of the MMRC ensures that the causes behind each and every death of a pregnant or postpartum woman is understood to the fullest extent possible. The multi-disciplinary committee has representation from the Department, members of the medical community, mental and behavioral health, public health, community members and other key stakeholders. The committee reviews medical records, police reports, coroner reports and death certificates to collect information regarding the circumstance that led to each woman's death, and to understand if and how that death could have been prevented. The committee then works to put into practice strategies that reduce and stop future deaths. Thanks to the passage of HB 129-122 in 2019, the MMRC has been formally recognized and will present



its findings and recommendations to the Colorado legislature in July 2020. Postpartum care is a particularly critical piece of preventing maternal mortality.

Substance use is a critical issue within the maternity space due to its detrimental impacts on both mother and infant. The Department applied for and was awarded one of the MOM (Maternal Opioid Misuse) Model grants through CMS, aimed at creating an innovative model to integrate SUD treatment into prenatal care clinics and improve birth outcomes and reduce costs for this high-risk population. Because of the current COVID pandemic, the MOM grant is currently on-hold but the Department is hopeful that the grant will proceed in the future.

### **Maternity and Birth Outcome Data**

The objectives of this demonstration focused on three key predictors of a child's future health: prenatal care, postpartum care, and birth weight. The assumption is that by covering these women under the Medicaid benefits package, the services and benefits available to them would result in improvements in these critical areas. Low birth weight is a particular area of concern, as babies born below 2,500 grams (5.5 pounds) are at risk of respiratory distress, bleeding in the brain, and jaundice.<sup>8</sup> Low birth weight babies are also a challenge for health care payers. The average hospital cost for LBW babies can be up to eight times as expensive as babies born at a healthy weight.<sup>9</sup> According to America's Health Rankings, Colorado's 2018 low birthweight rate of 8.3% earned a rank of 10th best in the country.<sup>10</sup> This is encouraging news at a state level, but we know that deep disparities exist for mothers based on their race/ethnicity, income level, education, health behaviors, and health status. In 2017, when Colorado's overall rate of low birthweight was 9.1%, 13.7% of non-Hispanic black mothers gave birth to babies below 2,500 grams.

Prenatal care is a vital component to preventing premature birth and the detrimental impacts it can have on an infant, including low birth weight. Women receive critical information during prenatal care visits that impact not

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8 March of Dimes. <https://www.marchofdimes.org/complications/low-birthweight.aspx>

9 Health Care Cost and Utilization Project. AHRQ. <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb163.pdf>

10 America's Health Rankings.

<https://www.americashealthrankings.org/explore/annual/measure/birthweight/state/CO>

only their own health during and after the pregnancy, but also the health of their child. Evidence on the importance of prenatal care is strong.

## IX. Lessons Learned and Recommendations

While this demonstration developed through many iterations, the evaluation presented in this interim report reveals many lessons on how to improve evaluation design. Given the limitations of our data and analytical approach deployed in the evaluation, it is prudent to modify the analysis in our final evaluation and any further demonstration iterations.

Rather than looking at a year-over-year percentage change, we plan to compare the demonstration metrics against a regional or national benchmark and aim to keep our performance within a set range. Other states would benefit in demonstration development by incorporating a similar approach. While a directional change may prove beneficial to a given design, a valid target must remain a consideration for states, which corresponding benchmarks provide.

Of importance for demonstrations with smaller populations, such as this program, evaluation design should plan for the frequency of future analysis. The prenatal population in our demonstration is small when analyzed annually, decreasing further for more frequent analysis. This makes quarterly evaluations challenging due to the statistical impact of small numbers. A more creative evaluation approach is needed in assessing measures on a quarterly basis. To increase the power of the study, instead of looking at each quarter individually, the use of trailing averages or a running 18-month population sample are options for consideration.

Finally, the approach to program enrollment in this study was problematic and limited the ability to measure disenrollment trends or normalize demonstration outcomes to larger population shifts or changes in health insurance coverage. Other states may consider these limitations in their demonstration design, including evaluation changes to more accurately measure program enrollment, disenrollment and confounding trends. One approach applicable to this demonstration utilized in other studies is to report on the number of clients who dropped from Medicaid eligibility two months after giving birth against the number of clients who maintained some kind of Medicaid eligibility after this period.

## **X. Attachments**

1. CMS Approved Evaluation Design Dated April 26, 2017
2. ICD-9 to ICD-10 Crosswalk
3. Budget Neutrality through 2019



## **ATTACHMENT C DEMONSTRATION EVALUATION PLAN**

### Objectives, Hypotheses and Evaluation Activities During the Extension Period

During the extension period, the following objectives of the demonstration include:

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

### The CHP+ Demonstration Population Includes:

Pregnant Medicaid expansion clients who would have been covered under CHP+ if not for the expansion (142%-195% FPL).

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

- Hypothesis 1: Pregnant women enrolled in the CHP+ demonstration will have a statistically significant increase in prenatal care visits and a statistically significant increase in postpartum care visits from SFY 2015 to SFY 2020.

Methodology: Data to test the hypothesis comes from Medicaid claims data in our MMIS system. Total number of births is pulled from the claims for the previous calendar year. Three types of birth data are used: inpatient deliveries, global bills and antepartum/standalone care (other criteria are also assessed, per the specifications). Those data are used to identify the prenatal and postpartum care based on the numerator criteria for the measure (see specifications).

Data are checked for completeness, accuracy and reasonableness via peer review of SQL code. Additionally, the code and data are reviewed by staff who work with birth and pregnancy data. Finally, a comparison is made between budget and other reports so as to assess reasonableness of the data.

The statistical test used to evaluate these data is a year-to-year percentage change. The annual difference is calculated by subtracting the previous year's value from the current year's value. Then the annual difference is divided by the previous year's value to get a comparison. This figure is then multiplied by 100 to obtain the year-over-year percentage change. See the CHP+ 1115 Waiver Prenatal Care and CHP+ 1115 Waiver Postpartum Follow-Up Care documents.

Accordingly, in performing analytics for these rates, Colorado will compare the numerators and denominators to those reported in previous years to see if the figures are similar or require further investigation. Colorado will strive for a statistically significant increase year-over-year to arrive at the projected increases. A deeper dive on the data will be taken if the projected significant increase is not realized. This deeper dive could include a geographic analysis, race and ethnicity analysis and input from current clients, case managers and providers. Colorado is also committed to further analyzing any significant improvement in order to identify and further share any best practices.

Baseline 2015 Data:

<b>Pregnant Medicaid Expansion Clients (142-195% of FPL)</b>		
<b><i>Measure 1</i></b>	<b><i>Rate of Pregnant Women With Prenatal Care</i></b>	<b>51.77 %</b>
Numerator	Number of Pregnant Women with Prenatal Care	1,637
Denominator	Number of Pregnant Women Eligible for Prenatal Care	3,162

<b><i>Measure 2</i></b>	<b><i>Rate of Pregnant Women With Postpartum Care</i></b>	<b>51.93%</b>
Numerator	Number of Pregnant Women with Postpartum Care	1,642
Denominator	Number of Pregnant Women Eligible for Postpartum Care	3,162

- Hypothesis 2: The proportion of babies born to women enrolled in the CHP+ demonstration and admitted to the NICU will decrease over the five years of the demonstration project. The proportion of babies born to women enrolled in the CHP+ demonstration that weigh under 2,500 grams will decrease by 10 percent from SFY 2015 to SFY 2020.

Methodology: The methodology is a pre- and post-measurement to compare the number of babies born to pregnant women in the demonstration population weighing less than 2,500 grams during the waiver period. The data for Hypothesis 2 are taken from claims data from the Department's MMIS system and birth certificate data provided by our sister agency, the Colorado Department of Public Health and Environment (CDPHE). The claims data birth mother is joined to CDPHE's birth mother, and the infant's birth weight is pulled from the birth certificate. Only infants with a birth weight of less than 2,500 grams is kept for the report.

Data are checked for completeness, accuracy and reasonableness via peer review of SQL code. Additionally, the code and data are reviewed by staff who work with birth and pregnancy data. Finally, a comparison is made between budget and other reports so as to assess reasonableness of the data.

The statistical test used to evaluate this data is a year-to-year percentage change. The annual difference is calculated by subtracting the previous year's value from the current year's value. Then the annual difference is divided by the previous year's value to get a comparison. This figure is then multiplied by 100 to obtain the year-to-year percentage change.

Accordingly, in performing analytics for these rates, Colorado will compare the numerators and denominators to those reported in previous years to see if the figures are similar or require further investigation. Colorado will strive for a statistically significant decrease year-to-year to arrive at the projected decreases. A deeper dive on the data will be taken if the projected significant decrease is not realized. This deeper dive could include a geographic analysis, race and ethnicity analysis and input from current clients,

case managers and providers. Colorado is also committed to further analyzing any significant improvement in order to identify and further share any best practices.

Baseline 2015:

<b>Pregnant Medicaid Expansion Clients (142-195% of FPL)</b>		
<b>Measure 3</b>	<b>% of births weighing &lt; 2,500 grams</b>	<b>17.68%</b>
Numerator	Babies weighing < 2,500 grams	559
Denominator	Pregnant moms between 14-54, in demonstration	3,162

### CHP+ 1115 Waiver Prenatal Care

<b>Measure Title</b>	CHP+ 1115 Waiver Prenatal Care
<b>Motivation</b>	Prenatal care is the healthcare you receive while you are pregnant. This healthcare and consultation can positively impact the health of the infant. Therefore, we track the extent to which our population receives this care.
<b>Denominator</b>	All women between 142% - 195% FPL with a global bill or hospital delivery DRG. These clients are captured with the following APR-DRGs: 540, 541, 542, and 560.
<b>Numerator</b>	Clients in denominator with one of the following CPT codes (59400, 59510, 99201-99215 w/modifier TH, 59425, 59426, 59610, 59618, 59622) at any time prior to delivery.
<b>Population Exclusions</b>	<ul style="list-style-type: none"> <li>• Clients who are dually eligible for the ACC Medicare Medicaid Program (MMP)</li> <li>• Clients with less than three months of eligibility</li> <li>• Clients eligible for both a Medicare and a Medicaid benefit</li> <li>• Clients who are defined as part of the Medicaid expansion population</li> <li>• Clients in the Working Adults with Disabilities Buy-in Eligibility Type (031)</li> <li>• Clients in the Children with Disabilities Buy-in Eligibility Type (032)</li> </ul>
<b>Time Period</b>	Rolling 12 months
<b>Claims Run Out</b>	90 days run out, 30 days processing
<b>References and Measure Origin</b>	<p>Proportion of pregnant women who receive early and adequate prenatal care (NQF 5684).</p> <p><b>HHS Agency:</b> Office of the Assistant Secretary for Health (OASH)</p> <p><b>Denominator:</b></p> <ul style="list-style-type: none"> <li>• Number of live births in states that use the 2003 standard certificate of birth</li> </ul> <p><b>Numerator:</b></p> <ul style="list-style-type: none"> <li>• Number of pregnant females receiving adequate prenatal care by the Adequacy of Prenatal Care Utilization Index (APNCU) in states that use the 2003 standard certificate of birth</li> </ul> <p>Please refer to KPI White paper State Fiscal Year 2015 on Dashboard for further details.</p>
<b>Version Date</b>	04/20/2016



### CHP+ 1115 Waiver Postpartum Follow-Up Care

<b>Measure Title</b>	CHP+ 1115 Waiver Postpartum Follow-Up Care
<b>Motivation</b>	Mothers on CHP+ and Medicaid now account for greater than 40% of all births in Colorado. It is important that we track the care that is being delivered to this population.
<b>Denominator</b>	<p>Clients will be counted in the denominator if they meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Between 142% -195% FPL</li> <li>• All women on CHP+ with a global bill or hospital delivery DRG or delivery CPT codes: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622</li> <li>• Or ICD-9 Procedure Codes: 72.0-73.99, 74.0-74.2, 74.4-74.99</li> <li>• Or DRG 370-375</li> <li>• Or APR-DRG 540-542 and 560</li> </ul> <p>Pregnancies not ending with a live birth are <u>excluded</u> from the denominator.</p>
<b>Numerator</b>	<p>Clients will be counted in the numerator if they meet the following criteria:</p> <ul style="list-style-type: none"> <li>• CPT codes: 59400, 59510, 59410, 59515, 59430, 59610, 59614, 59618, 59622</li> <li>• Postpartum care that is delivered before the client is enrolled with the CHP+ is also counted.</li> </ul>
<b>Population Exclusions</b>	<ul style="list-style-type: none"> <li>• Clients who are dually eligible for the ACC Medicare Medicaid Program</li> <li>• Clients with less than three months of eligibility</li> <li>• Clients eligible for both a Medicare and a Medicaid benefit</li> <li>• Clients who are defined as part of the Medicaid expansion population</li> <li>• Clients in the Working Adults with Disabilities Buy-in Eligibility Type (031)</li> <li>• Clients in the Children with Disabilities Buy-in Eligibility Type (032)</li> </ul>
<b>Time Period</b>	Rolling 12 months
<b>Claims Run Out</b>	90 days run out, 30 days processing
<b>References and Measure Origin</b>	<p><b>Prenatal and postpartum care: Postpartum Care Rate (NQF 1517):</b>  <b>HHS Agency -</b> Centers for Medicare &amp; Medicaid Services (CMS)  <b>Measure Steward -</b> National Committee for Quality Assurance (NCQA)  <b>Topic or Condition</b>  Health Services Administration - Access  Reproductive Health - Pregnancy  <b>Measure Domain -</b> Process  <b>Care Setting -</b> Ambulatory/Office-based Care  <b>Denominator</b>  Deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year  <i>Multiple Births:</i> Women who had two separate deliveries (different dates of service) between November 6 of the year prior.  <b>Numerator</b>  Timeliness of Prenatal Care: A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.  Postpartum Care: A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.  <b>Target Population Age -</b> Unspecified</p>

	<b>Data Source - Claims; Hybrid</b> <b>Measure Maintenance – Annually</b> Please refer to KPI White paper State Fiscal Year 2015 on Dashboard for further details.
<b>Version Date</b>	03/30/2015

**Attachment 2. Coding Crosswalk From ICD-9 to ICD-10**

<b>ICD 9 surgical code</b>	<b>ICD 9 surgical code Description</b>	<b>ICD-10 PCS</b>	<b>ICD-10 PCS Description</b>
72	Low forceps operation	10D07Z3	Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening
72.1	Low forceps operation	0W8NXZZ	Division of Female Perineum, External Approach
72.1	Low forceps operation with episiotomy	10D07Z3	Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening
72.21	Mid forceps operation	0W8NXZZ	Division of Female Perineum, External Approach
72.21	Mid forceps operation with episiotomy	10D07Z4	Extraction of Products of Conception, Mid Forceps, Via Natural or Artificial Opening
72.29	Other mid forceps operation	10D07Z4	Extraction of Products of Conception, Mid Forceps, Via Natural or Artificial Opening
72.31	High forceps operation	0W8NXZZ	Division of Female Perineum, External Approach
72.31	High forceps operation with episiotomy	10D07Z5	Extraction of Products of Conception, High Forceps, Via Natural or Artificial Opening
72.39	Other high forceps operation	10D07Z5	Extraction of Products of Conception, High Forceps, Via Natural or Artificial Opening
72.4	Forceps rotation of fetal head	10S07ZZ	Reposition Products of Conception, Via Natural or Artificial Opening
72.51	Partial breech extraction with forceps to	10D07Z3	Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening
72.51	Partial breech extraction with forceps to	10D07Z4	Extraction of Products of Conception, Mid Forceps, Via Natural or Artificial Opening
72.51	Partial breech extraction with forceps to	10D07Z5	Extraction of Products of Conception, High Forceps, Via Natural or Artificial Opening
72.52	Other partial breech extraction	10D07Z6	Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening
72.53	Total breech extraction with forceps to	10D07Z3	Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening
72.53	Total breech extraction with forceps to	10D07Z4	Extraction of Products of Conception, Mid Forceps, Via Natural or Artificial Opening
72.53	Total breech extraction with forceps to	10D07Z5	Extraction of Products of Conception, High Forceps, Via Natural or Artificial Opening
72.54	Other total breech extraction	10D07Z6	Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening
72.6	Forceps application to aftercoming head	10D07Z3	Extraction of Products of Conception, Low Forceps, Via Natural or Artificial Opening
72.71	Vacuum extraction with	0W8NXZZ	Division of Female Perineum, External Approach
72.71	Vacuum extraction with episiotomy	10D07Z6	Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening
72.79	Other vacuum extraction	10A07Z6	Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
72.79	Other vacuum extraction	10D07Z6	Extraction of Products of Conception, Vacuum, Via Natural or Artificial Opening
72.8	Other specified instrumental delivery	10D07Z8	Extraction of Products of Conception, Other, Via Natural or Artificial Opening
72.9	Unspecified instrumental delivery	10D07Z8	Extraction of Products of Conception, Other, Via Natural or Artificial Opening
73.01	Induction of labor by artificial rupture of	10900ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Open Approach
73.01	Induction of labor by artificial rupture of	10903ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Percutaneous Approach

73.01	Induction of labor by artificial rupture of	10904ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Percutaneous Endoscopic
73.01	Induction of labor by artificial rupture of	10907ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Via Natural or Artificial
73.01	Induction of labor by artificial rupture of	10908ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Via Natural or Artificial
73.09	Other artificial rupture of membranes	10907ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Via Natural or Artificial
73.09	Other artificial rupture of membranes	10908ZC	Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Via Natural or Artificial
73.1	Other surgical induction	0U7C7ZZ	Dilation of Cervix, Via Natural or Artificial Opening
73.21	Internal and combined version without	10S07ZZ	Reposition Products of Conception, Via Natural or Artificial Opening
73.22	Internal and combined version with extraction	10D07Z7	Extraction of Products of Conception, Internal Version, Via Natural or Artificial Opening
73.3	Failed forceps	10J07ZZ	Inspection of Products of Conception, Via Natural or Artificial Opening
73.4	Medical induction of labor	3E030VJ	Introduction of Other Hormone into Peripheral Vein, Open Approach
73.4	Medical induction of labor	3E033VJ	Introduction of Other Hormone into Peripheral Vein, Percutaneous Approach
73.4	Medical induction of labor	3E040VJ	Introduction of Other Hormone into Central Vein, Open Approach
73.4	Medical induction of labor	3E043VJ	Introduction of Other Hormone into Central Vein, Percutaneous Approach
73.4	Medical induction of labor	3E050VJ	Introduction of Other Hormone into Peripheral Artery, Open Approach
73.4	Medical induction of labor	3E053VJ	Introduction of Other Hormone into Peripheral Artery, Percutaneous Approach
73.4	Medical induction of labor	3E060VJ	Introduction of Other Hormone into Central Artery, Open Approach
73.4	Medical induction of labor	3E063VJ	Introduction of Other Hormone into Central Artery, Percutaneous Approach
73.4	Medical induction of labor	3E0DXGC	Introduction of Other Therapeutic Substance into Mouth and Pharynx, External Approach
73.4	Medical induction of labor	3E0P3VZ	Introduction of Hormone into Female Reproductive, Percutaneous Approach
73.4	Medical induction of labor	3E0P7VZ	Introduction of Hormone into Female Reproductive, Via Natural or Artificial Opening
73.51	Manual rotation of fetal	10E0XZZ	Delivery of Products of Conception, External
73.59	Other manually assisted	10E0XZZ	Delivery of Products of Conception, External
73.6	Episiotomy	0W8NXZZ	Division of Female Perineum, External Approach
73.8	Operations on fetus to facilitate delivery	10907ZA	Drainage of Fetal Cerebrospinal Fluid from Products of Conception, Via Natural or Artificial Opening
73.8	Operations on fetus to facilitate delivery	10908ZA	Drainage of Fetal Cerebrospinal Fluid from Products of Conception, Via Natural or Artificial Opening
73.8	Operations on fetus to facilitate delivery	10A07ZZ	Abortion of Products of Conception, Via Natural or Artificial Opening
73.8	Operations on fetus to facilitate delivery	10A08ZZ	Abortion of Products of Conception, Via Natural or Artificial Opening Endoscopic
73.91	External version	10E0XZZ	Delivery of Products of Conception, External
73.91	External version	10S0XZZ	Reposition Products of Conception, External
73.92	Replacement of	10E0XZZ	Delivery of Products of Conception, External
73.92	Replacement of	10S0XZZ	Reposition Products of Conception, External
73.93	Incision of cervix to	0U7C7ZZ	Dilation of Cervix, Via Natural or Artificial Opening

73.93	Incision of cervix to	10E0XZZ	Delivery of Products of Conception, External
73.94	Pubiotomy to assist	0Q820ZZ	Division of Right Pelvic Bone, Open Approach
73.94	Pubiotomy to assist	0Q823ZZ	Division of Right Pelvic Bone, Percutaneous Approach
73.94	Pubiotomy to assist delivery	0Q824ZZ	Division of Right Pelvic Bone, Percutaneous Endoscopic Approach
73.94	Pubiotomy to assist	0Q830ZZ	Division of Left Pelvic Bone, Open Approach
73.94	Pubiotomy to assist	0Q833ZZ	Division of Left Pelvic Bone, Percutaneous Approach
73.94	Pubiotomy to assist delivery	0Q834ZZ	Division of Left Pelvic Bone, Percutaneous Endoscopic Approach
73.94	Pubiotomy to assist	10E0XZZ	Delivery of Products of Conception, External
73.99	Other	10D07Z8	Extraction of Products of Conception, Other, Via Natural or Artificial Opening
74	Classical cesarean section	10D00Z0	Extraction of Products of Conception, High, Open Approach
74.1	Low cervical cesarean section	10D00Z1	Extraction of Products of Conception, Low, Open Approach
74.2	Extraperitoneal cesarean section	10D00Z2	Extraction of Products of Conception, Extraperitoneal, Open Approach
74.4	Cesarean section of other specified type	10D00Z0	Extraction of Products of Conception, High, Open Approach
74.91	Hysterotomy to	10A00ZZ	Abortion of Products of Conception, Open Approach
74.91	Hysterotomy to terminate pregnancy	10A03ZZ	Abortion of Products of Conception, Percutaneous Approach
74.91	Hysterotomy to terminate pregnancy	10A04ZZ	Abortion of Products of Conception, Percutaneous Endoscopic Approach
74.99	Other cesarean section of unspecified type	10D00Z0	Extraction of Products of Conception, High, Open Approach
74.99	Other cesarean section of unspecified type	10D00Z1	Extraction of Products of Conception, Low, Open Approach
74.99	Other cesarean section of unspecified type	10D00Z2	Extraction of Products of Conception, Extraperitoneal, Open Approach

Adult Prenatal Coverage in Child Health Plan Plus (Project Number 21-W-00014/8 )

1115 Demonstration Interim Evaluation Report

Demonstration Years 1-4: 08/01/2015 -- 07/31/2019

COLORADO	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019
State's Allotment	\$157,511,557	\$228,329,398	\$210,135,383	\$270,402,569	\$298,413,539
Funds Carried Over From Prior Year(s)	\$97,768,837	\$86,450,144	\$86,279,015	\$98,298,761	\$83,200,533
SUBTOTAL (Allotment + Funds Carried Over)	\$255,280,394	\$314,779,542	\$296,414,398	\$368,701,330	\$381,614,072
Currently Available)					
TOTAL (Subtotal + Reallocated funds)	\$255,280,394	\$314,779,542	\$296,414,398	\$368,701,330	\$381,614,072
State's Enhanced FMAP Rate	66.71%	88.50%	88.01%	88.00%	88.00%

COST PROJECTIONS OF APPROVED SCHIP PLAN					
Benefit Costs					
Insurance payments					
Managed care	\$117,903,938	\$123,353,654	\$141,907,980.17	\$188,991,081.53	\$210,827,181.19
per member/per month rate @ # of eligibles	187.70 @ 52,346 avg elig/mo	187.18 @ 54,549 avg elig/mo	\$169.31 @ 69,603 avg elig/mo	\$192.32 @ 81,893 avg elig/mo	\$274.65 @ 80,967
Total Benefit Costs	\$117,903,938	\$123,353,654	\$141,907,980	\$188,991,082	\$210,827,181
(Offsetting beneficiary cost sharing payments)	(\$1,135,268)	(\$826,734)	(\$495,694)	(\$580,095)	(\$1,023,877)
Net Benefit Costs	\$116,768,670	\$122,526,920	\$141,412,286	\$188,410,986	\$210,827,181

COST PROJECTIONS OF APPROVED MCHIP PLAN					
Benefit Costs					
Insurance payments					
Managed care	\$14,747,350	\$14,382,637	\$13,728,229	\$9,968,618	\$14,612,491
per member/per month rate @ # of eligibles	\$176.95 @ 53,747 avg elig/mo	\$154.16 @ 61,103 avg elig/mo	\$81.55 @ 65,503 avg elig/mo	\$145.63 @ 62,854 avg elig/mo	\$194.83 @ 57,995
Fee for Service	\$99,378,269	\$98,652,959	\$50,395,546	\$99,868,755	\$120,881,144
Total Benefit Costs	\$114,125,619	\$113,035,595	\$64,123,775	\$109,837,373	\$135,493,635

Administration Costs					
Personnel	\$157,219	\$252,957	\$371,521	\$284,843	\$580,799
General administration	\$959,829	\$1,009,042	\$543,828	\$544,193	\$1,726,235
Contractors/Brokers (e.g., enrollment contractors)	\$1,874,853	\$1,091,567	\$1,499,241	\$993,769	\$3,051,816
Claims Processing	\$181,818	\$924,776	\$1,179,120	\$3,714,307	\$2,798,965
Outreach/marketing costs	\$1,427,908	\$1,112,097	\$1,111,190	\$1,558,611	\$2,786,497
Other	\$268,713	\$104,687	\$44,077	\$399,301	\$399,939
Total Administration Costs	\$4,870,340	\$4,495,126	\$4,748,977	\$7,495,024	\$11,344,251
10% Administrative Cap					

Federal Title XXI Share	\$157,278,584	\$212,451,013	\$185,071,862	\$269,054,177	\$314,745,259
State Share	\$78,486,045	\$27,606,629	\$25,213,176	\$36,689,206	\$42,919,808
TOTAL COSTS OF APPROVED CHIP PLANS	\$235,764,629	\$240,057,642	\$210,285,038	\$305,743,383	\$357,665,067

PROPOSAL					
Demonstration Population (pregnant women 142% -					
Insurance payments					
Managed care	\$524,592	\$2,128,650	\$983,044	\$1,762,913	\$4,365,192
per member/per month rate @ # of eligibles	\$845.35 @ 1,707 avg elig/mo	\$830.82 @ 1,819 avg elig/mo	\$605.72 @ 2,039 avg elig/mo	\$605.72 @ 2,265 avg elig/mo	\$854.06 @ 2,259
Fee for Service	\$16,791,651	\$16,006,395	\$13,837,743	\$16,926,428	\$18,786,784
Total Benefit Costs for Waiver Population	\$17,316,244	\$18,135,045	\$14,820,787	\$18,689,341	\$23,151,976

Total Benefit Costs	\$17,316,244	\$18,135,045	\$14,820,787	\$18,689,341	\$23,151,976
Premium Payments will be net of cost sharing					
Net Benefit Costs	\$17,316,244	\$18,135,045	\$14,820,787	\$18,689,341	\$23,151,976
Federal Title XXI Share	\$11,551,666.09	\$16,049,514.52	\$13,043,774.57	\$16,446,619.65	\$20,373,738.92
State Share	\$5,764,577.48	\$2,085,530.14	\$1,777,012.35	\$2,242,720.86	\$2,778,237.12
TOTAL COSTS FOR DEMONSTRATION	\$17,316,244	\$18,135,045	\$14,820,787	\$18,689,341	\$23,151,976

Demonstration)	\$253,080,872	\$258,192,686	\$225,105,825	\$324,432,724	\$380,817,043
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(Allotment + Reallocated Funds)	\$255,280,394	\$314,779,542	\$296,414,398	\$368,701,330	\$381,614,072
Demonstration)	\$168,830,249.92	\$228,500,527.29	\$198,115,636.49	\$285,500,797.00	\$335,118,998.10
Reallocated)					
Available Funding - Costs - Expiring Funds)	\$86,450,144.08	\$86,279,014.79	\$98,298,761.31	\$83,200,533.31	\$46,495,074.22



# CHP+

Child Health Plan *Plus*

## 2018–2019 External Quality Review Technical Report for Child Health Plan *Plus*

*November 2019*

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



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## Acknowledgments and Copyrights

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## 1. Executive Summary

### Summary of 2018–2019 Statewide Performance by External Quality Review Activity With Trends

#### *Assessment of Compliance With CHIP Managed Care Regulations*

##### Results

In fiscal year (FY) 2018–2019, Health Services Advisory Group, Inc. (HSAG) reviewed four standards as directed by the Colorado Department of Health Care Policy and Financing (the Department) (see Section 2—Reader’s Guide, Methodology).

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

**Table 1-1—Compliance With Regulations Statewide Trended Performance for CHP+ MCOs**

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review*
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	84%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	85%	93%
<b>Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)**</b>	<b>85%</b>	<b>80%</b>
<b>Standard IV—Member Rights and Protections (2015–2016, 2018–2019)**</b>	<b>80%</b>	<b>90%</b>
Standard V—Member Information (2014–2015, 2017–2018)	72%	95%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	65%	84%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	90%	90%
<b>Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)**</b>	<b>94%</b>	<b>97%</b>
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	92%	NA

<sup>1-1</sup> In FY 2018–2019 the Department contracted with one dental prepaid ambulatory health plan (PAHP). Therefore, no statewide performance or trend information related to dental care is available for this section. For complete external quality review (EQR) findings for the State’s dental PAHP, see Section 3.

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review*
<b>Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)**</b>	<b>88%</b>	<b>87%</b>

\*For all standards, the MCOs' contracts with the State may have changed since each of the previous review years and may have contributed to performance changes.

\*\*Bold text indicates standards that HSAG reviewed during FY 2018–2019.

Colorado's Child Health Plan *Plus* (CHP+) managed care organizations (MCOs) demonstrated improved performance in the most recent year of review for six of the 10 standards as compared to the previous year the standard was reviewed. For the standards with improved performance, four of the six standards, Standard I—Coverage and Authorization of Services, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard VI—Grievance and Appeal System, improved substantially (10 percentage points or more) compared to the previous year the standard was reviewed. One standard, Standard III—Coordination and Continuity of Care, experienced a 5 percentage point decline in performance. Two standards, Standard VII—Provider Participation and Program Integrity and Standard X—Quality Assessment and Performance Improvement, remained relatively stable. Due to new or revised federal requirements for Standard IX—Subcontracts and Delegation, HSAG scored requirements in this standard as not applicable to CHP+ MCOs in FY 2017–2018; therefore, no statewide comparative results are available for Standard IX.

Compliance results for Colorado's dental PAHP are not included in Table 1-1 due to the compliance review being in a readiness format which includes abbreviated standards. Therefore, results could not be averaged with the other CHP+ MCOs. For individual health plan scores and findings, including findings for the dental PAHP, see Section 3 of this report. For the MCO comparison of scores for 2018–2019 standards, see Section 4, Table 4-1.

## Statewide Opportunities for Improvement and Recommendations Related to Compliance With Regulations

In FY 2018–2019, CHP+ MCOs' statewide performance in six out of nine applicable standards was 90 percent overall compliance or better. In three standards, performance remained below 90 percent compliant. To assist the CHP+ MCOs with revisions to the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Regulations released in May 2016 and effective for CHIP health plans July 1, 2018, HSAG identified opportunities for improved performance and associated recommendations as well as areas requiring corrective actions.

Based on the described performance, HSAG recommends that CHP+ health plans continue to incorporate and implement processes to comply with federal managed care regulations released May 2016 (effective for CHP+ health plans as of July 1, 2018), paying particular attention to Standard III—Coordination and Continuity of Care, Standard VI—Grievance and Appeal System, and Standard X—Quality Assessment and Performance Improvement. Since Standard IX—Subcontracts and Delegation

was scored “NA” in its most recent year for review for the CHP+ MCOs, HSAG also recommends that the Department and the health plans ensure that policies, procedures, and processes are in place to implement these new regulations.

## Validation of Performance Measures

### Information Systems (IS) Standards Review Results

HSAG reviewed the final audit reports (FARs) produced by each MCO’s certified HEDIS compliance auditor. Each FAR included the auditor’s evaluation of the MCOs’ IS capabilities for accurate HEDIS reporting. For the current reporting period, Colorado Access (COA), Denver Health Medical Plan, Inc. (DHMP), Friday Health Plans of Colorado (FHP), Kaiser Permanente Colorado (Kaiser), and Rocky Mountain Health Plans (RMHP) were fully compliant with all IS standards relevant to the scope of the performance measure validation (PMV) performed by the MCOs’ licensed HEDIS auditors. During review of the IS standards, the HEDIS auditor did not identify any notable issues that had a negative impact on HEDIS reporting. Therefore, HSAG determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology, and the rates and audit results are valid, reliable, and accurate.

### Performance Measure Results

Table 1-2 and Table 1-3 display the Colorado CHP+ weighted averages for HEDIS 2017 through HEDIS 2019, along with the percentile ranking for each high- and low-performing HEDIS 2019 measure rate. Statewide performance measure results for HEDIS 2019 were compared to NCQA’s Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018 (referred to throughout this report as percentiles), when available. Rates for HEDIS 2019 shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates for HEDIS 2019 shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.<sup>1-2</sup>

Additional Colorado CHP+ weighted average measure rates can be found in Section 4. Of note, Delta Dental (i.e., the CHP+ dental PAHP) was only required to report one measure, *Annual Dental Visit*. These results can be found in Section 3.

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<sup>1-2</sup> Performance comparisons are based on the Chi-square test of significance. A change in performance is considered statistically significant in this report if the *p*-value from the Chi-square test was less than 0.05 and the rate difference was at least 3 percentage points.

Table 1-2—Colorado CHP+ Weighted Averages—HEDIS 2019 High Performers

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Pediatric Care</b>				
<b>Childhood Immunization Status<sup>1</sup></b>				
Combination 6	41.61%	40.51%	45.31%^	50th–74th
Combination 8	40.34%	39.53%	44.29%^	50th–74th
Combination 9	38.50%	36.49%	42.27%^	75th–89th
Combination 10	37.59%	35.77%	41.39%^	75th–89th
<b>Immunizations for Adolescents</b>				
Combination 2 (Meningococcal; Tetanus, Diphtheria Toxoids, and Acellular Pertussis [Tdap]; Human Papillomavirus [HPV])	—	33.79%	39.02%^	75th–89th
<b>Preventive Screening</b>				
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17%	0.07%	0.04%	≥90th
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
Appropriate Treatment for Children With Upper Respiratory Infection	91.24%	93.84%	94.09%	75th–89th
<b>Asthma Medication Ratio<sup>1</sup></b>				
Ages 5 to 11 Years	85.80%	82.90%	82.63%	≥90th
Ages 12 to 18 Years	73.72%	74.03%	71.32%	75th–89th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that NCQA recommended a break in trending for HEDIS 2018; therefore, HEDIS 2017 rates are not displayed for this measure. Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

The HEDIS 2019 statewide weighted average for measures within the Pediatric Care domain demonstrate strength with vaccinations for children and adolescents, with all five vaccination rates displayed in Table 1-2 demonstrating significant improvement from the prior year. Of note, COA exceeded the 75th percentile for all five rates and Kaiser exceeded the 90th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* rate. Conversely, performance for RMHP and FHP demonstrated opportunities for improvement with RMHP’s *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* rate below the 10th percentile and all five of FHP’s vaccination rates below the 10th percentile.

The statewide weighted average and rates for all five MCOs exceeded the 90th percentile for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure, indicating strength in the Preventive Screening domain by not screening young women for cervical cancer unnecessarily.



For the Respiratory Conditions domain, all five MCOs performed above the 50th percentile for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, with both DHMP and Kaiser exceeding the 90th percentile. The statewide weighted average rates for the *Asthma Medication Ratio* measure are mainly representative of COA's performance, as the other MCOs' rates were too small to report (i.e., denominator less than 30).

**Table 1-3—Colorado CHP+ Weighted Averages—HEDIS 2019 Low Performers**

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>				
<b><i>Childhood Immunization Status<sup>1</sup></i></b>				
<i>Combination 2</i>	65.30%	62.54%	66.78%^	10th–24th
<i>Combination 3</i>	63.61%	61.05%	65.16%^	10th–24th
<i>Combination 4</i>	61.14%	59.17%	63.13%^	10th–24th
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>				
<i>Zero Visits*</i>	3.04%	2.63%	5.06%	<10th
<i>Six or More Visits</i>	48.01%	51.41%	48.28%	<10th
<b><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></b>				
<i>Body Mass Index (BMI) Percentile Documentation—Total<sup>1</sup></i>	16.67%	19.89%	22.71%	<10th
<i>Counseling for Nutrition—Total</i>	18.14%	20.12%	21.46%	<10th
<i>Counseling for Physical Activity—Total</i>	14.31%	15.87%	17.58%	<10th
<b><i>Access to Care</i></b>				
<b><i>Children and Adolescents' Access to Primary Care Practitioners</i></b>				
<i>Ages 12 to 24 Months</i>	90.02%	90.65%	92.33%	10th–24th
<i>Ages 25 Months to 6 Years</i>	82.88%	80.91%	82.93%	10th–24th
<i>Ages 7 to 11 Years</i>	88.99%	87.49%	87.66%	10th–24th
<b><i>Preventive Screening</i></b>				
<b><i>Chlamydia Screening in Women</i></b>				
<i>Ages 16 to 20 Years</i>	35.31%	33.66%	36.52%	<10th
<b><i>Mental/Behavioral Health</i></b>				
<b><i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication<sup>2</sup></i></b>				
<i>Initiation Phase</i>	13.02%	21.84%	15.21%	<10th
<i>Continuation and Maintenance Phase</i>	20.00%	21.57%	20.00%	<10th
<b><i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents<sup>*1</sup></i></b>				
<i>Total</i>	3.37%	5.62%	4.04%	10th–24th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

<sup>2</sup> Due to changes in the technical specifications for this measure in 2018, NCQA recommends trending between 2018 and prior years be considered with caution.

Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.



Despite demonstrating significant improvement for three *Childhood Immunization Status* indicators for HEDIS 2019, opportunities exist for improvement as the statewide weighted average remained below the 25th percentile. Of note, the *Childhood Immunization Status* combination rates demonstrated significant improvement for COA, whereas performance for all other MCOs declined from the prior year. Further, the statewide weighted averages for the *Well-Child Visits in the First 15 Months of Life* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures fell below the 10th percentile, indicating improvement efforts should be focused on identifying the factors contributing to the rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source challenges) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.<sup>1-3</sup>

Within the Access to Care domain, the statewide weighted average fell below the 25th percentile for three of the *Children and Adolescents' Access to Primary Care Practitioners* measure indicators. Only one indicator rate for the MCOs (Kaiser's *Ages 12 to 24 Months*) performed above the 50th percentile, suggesting the MCOs and the Department should conduct root cause analyses for the low access to care rates to determine the nature and scope of the issue (e.g., are the issues related to barriers to accessing care or the need for community outreach and education). Once the causes are identified, the MCOs and the Department should work with providers to establish potential performance improvement strategies and solutions to increase the access to care rates.

None of the reportable *Chlamydia Screening in Women—Ages 16 to 20 Years* rates within the Preventive Screening domain were above the 50th percentile for HEDIS 2019, indicating opportunities exist to increase screenings for chlamydia for young women.

The measures determined to be low performers for HEDIS 2019 within the Mental/Behavioral Health domain are mainly representative of the performance of COA, Kaiser, and RMHP, as most rates for the remaining MCOs were not reportable (i.e., denominator less than 30). The MCOs and the Department should focus on ensuring appropriate prescribing and monitoring for child members on medications for behavioral health (BH) conditions.

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<sup>1-3</sup> American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Accessed on: July 2, 2019.

## Statewide Opportunities for Improvement and Recommendations Related to Performance Measure Rates and Validation

The MCOs' HEDIS compliance FARs indicated that all of the MCOs followed NCQA methodology, and that the rates submitted were valid, reliable, and accurate. Therefore, HSAG identified no opportunities for improvement or recommendations related to IS standards review.

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 2, 3, and 4*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits and Six or More Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, and Ages 7 to 11 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Statewide performance for HEDIS 2019 demonstrated opportunities to improve the access to preventive care and services for members, including chlamydia screening and follow-up care for members prescribed ADHD medications.

## Validation of Performance Improvement Projects

### Results

Table 1-4 summarizes performance improvement project (PIP) performance for each CHP+ health plan in FY 2018–2019. Each CHP+ health plan conducted a PIP focusing on a topic related to access to care.

**Table 1-4—Statewide PIP Results for CHP+ Health Plans**

Health Plan	PIP Topic	Module Status	Validation Status
COA	<i>Well-Child Visits for Members 10–14 Years of Age</i>	<i>Completed Module 1 and Module 2</i>	NA*
DHMP	<i>Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age</i>	<i>Completed Module 1 and Module 2</i>	NA*
FHP	<i>Well-Child Visits in the 6th Through 14th Years of Life</i>	<i>Completed Module 1 and Module 2</i>	NA*
Kaiser	<i>Improving CHP+ Adolescent Well-Visit Adherence</i>	<i>Completed Module 1 and Module 2</i>	NA*
RMHP	<i>Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18</i>	<i>Completed Module 1 and Module 2</i>	NA*
Delta Dental	<i>Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year</i>	<i>Completed Module 1 and Module 2</i>	NA*

\*NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2018–2019 validation cycle.

Table 1-4 summarizes PIP performance among the CHP+ health plans in FY 2018–2019. During this validation cycle, the CHP+ health plans initiated new rapid-cycle PIPs focusing on topics approved by the Department. The PIPs run on an 18-month schedule and will continue into the next FY. During FY 2018–2019, the primary PIP activities included the CHP+ health plans receiving training and technical assistance on the rapid-cycle PIP process and developing the foundation of the projects in the first two modules of the process. Table 1-4 summarizes how far through the five modules of the rapid-cycle PIP process each CHP+ health plan progressed. As noted in the “Validation Status” column in the table, no PIPs progressed to being evaluated on outcomes or receiving a final validation status.

During FY 2018–2019, the CHP+ health plans passed Module 1 and Module 2, achieving all validation criteria for the first two modules for all five PIPs. The FY 2018–2019 validation findings for the five PIPs suggested that all CHP+ health plans designed methodologically sound projects addressing Department-approved rapid-cycle PIP topics. In the next FY, four of the CHP+ health plans will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1. One health plan, Delta Dental, will not progress beyond Module 1 and Module 2 because Delta Dental’s contract with the State

of Colorado for provision of dental services for the Department’s CHP+ managed care program ended at the end of the FY.

## Statewide Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Going forward, HSAG recommends that the CHP+ health plans use appropriate tools, such as process maps and failure modes and effects analyses (FMEAs), to identify gaps and failures in the processes related to PIP outcomes. The CHP+ health plans should develop and test innovative interventions to address identified process failures through carefully designed Plan-Do-Study-Act (PDSA) cycles. Access to relevant data for tracking intervention effectiveness and overall progress toward achieving the goal for improvement will be critical to the success of the projects.

As the Department explores potential topics for the next round of rapid-cycle PIPs, HSAG recommends that data access and availability related to the potential topics be considered. For the CHP+ health plans to leverage the strengths of the rapid-cycle improvement process, ready access to both historical and prospective data is critical. Data are used to determine health plan-level baseline performance, to set a goal for improvement in relation to baseline performance, and to monitor progress toward achieving the goal for improvement. If relevant health plan-level data are not readily available, the CHP+ health plans will spend time, energy, and resources on developing data collection processes and tools that could otherwise be directed toward interventions that can directly lead to improvement.

## CAHPS Survey

### Results

Table 1-5 shows the statewide average results for each CAHPS measure for FY 2016–2017 through FY 2018–2019. The statewide averages presented in Table 1-5 are derived from the combined results of the five CHP+ MCOs.<sup>1-4</sup>

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

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
<i>Getting Needed Care</i>	85.7%	85.5%	87.1%
<i>Getting Care Quickly</i>	90.2%	91.2%	90.5%
<i>How Well Doctors Communicate</i>	95.9%	95.8%	95.4%
<i>Customer Service</i>	85.7%	84.1%	84.0%
<i>Shared Decision Making</i>	81.1%	78.5%	80.4%

<sup>1-4</sup> No CAHPS survey was conducted for Colorado’s dental PAHP, Delta Dental.

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
<i>Rating of Personal Doctor</i>	74.4%	75.7%	76.6%
<i>Rating of Specialist Seen Most Often</i>	70.9%	78.7%	77.9%
<i>Rating of All Health Care</i>	66.5%	68.1%	67.1%
<i>Rating of Health Plan</i>	61.0%	61.4%	67.1%

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

### Statewide Opportunities for Improvement and Recommendations Related to CAHPS Surveys

The CAHPS survey is designed primarily to measure perceived quality of care, with one measure also relating to timeliness of care (*Getting Care Quickly*) and another also relating to access to care (*Getting Needed Care*). Based on CAHPS results statewide, there were two measure rates for which four CHP+ MCOs experienced at least a slight decrease in performance from FY 2017–2018 to FY 2018–2019—*How Well Doctors Communicate* and *Rating of All Health Care*. The statewide average rate also demonstrated a slight decrease in performance for these rates. These rates may be a measure of the quality domain. Performance in the *How Well Doctors Communicate* and *Rating of All Health Care* measures may be related to a variety of factors including members’ perceived ability to access care, providers’ cultural competency or communication abilities regarding specific treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by office staff members and/or providers. HSAG offers the following recommendations for the Department to consider:

- Collaborate with the MCOs to assess provider staff members’ and providers’ communication skills and develop training programs designed to address issues found related to both staff members and providers.
- Consider encouraging coordination between MCOs to ensure diversity and frequency of trainings on communication and cultural competency using web-based or online trainings.
- Continue to reward creative mechanisms for member engagement, such as expanding member advisory committees, developing community-based member committees, offering member mentorship programs, coordinating with community organizations that support disease management programs, and offering health education and support related to chronic conditions.

## Validation of Network Adequacy

### Results

HSAG used a desk review approach to collect and review provider data from the CHP+ health plans (five MCOs, one dental PAHP, and one administrative service organization [ASO])—the State Managed Care Network [SMCN]); develop the provider crosswalks; and conduct a provider composition analysis (PCA) among all ordering, referring, and servicing providers contracted to provide care through the CHP+ health plans.

Prior to requesting the plans' provider network data, HSAG distributed a Data Structure Questionnaire to the plans, and the plans' responses reflected a variety of methods for collecting and maintaining provider data. Each plan reported conducting formal data validation to ensure that its data systems contain current contracting status, demographics, practice location(s), practice accommodation(s), and panel capacity for each contracted provider. Questionnaire findings also highlighted plans' inconsistent data collection for provider classification attributes (e.g., provider type, specialty, taxonomy code, and degree/credential), affecting the development of standard provider categories. Though plans reported that they verify providers' self-reported classification information, they did not supply documentation on the verification processes or specifications used to determine a provider's classification. Additionally, plans' questionnaire responses indicated that no standardized list of attribute options was offered to providers for use with the Colorado Health Care Professional (CHCP) application, resulting in a variety of similar provider type and specialty data values that may need to be incorporated into the plans' data cleaning efforts.

All plans submitted provider network data for the study, though the plans' data values did not consistently align with information on available provider attribute values reported in the Data Structure Questionnaires. Many plans' data did not contain sufficiently detailed provider attributes, and HSAG was unable to determine subspecialties for non-physician providers (e.g., nurse practitioners [NPs] or physician assistants [PAs]). While these plans collect detailed subspecialty information for physicians, similar information was not reported for the non-physician providers. For example, an NP may have been listed in the plan's data with a provider type of "Nurse Practitioner" and a provider specialty of "Nurse Practitioner." Without using taxonomy codes, HSAG was not able to assign these NPs to categories for primary care providers (PCPs) or women's health providers.

PCA results illustrated the need for standardized provider category definitions to ensure consistent network analysis results across plans. The PCA results also reinforced the need for the plans to evaluate the level of specificity available in their provider data systems. For example, plans may count any NP or clinical nurse specialist as a PCP, without regard to nursing subspecialties. Additionally, interChange provider data include hospitals, federally qualified health centers (FQHCs), rural health centers (RHCs), and community mental health centers (CMHCs); however, plans may not have had these providers counted in the PCA due to the way in which these providers were reflected in the plans' data.



## Statewide Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy

As the Department's first comprehensive investigation into the CHP+ health plans' provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing the plans' compliance with network adequacy standards. As such, HSAG offers the following recommendations to improve network adequacy data and oversight:

- To facilitate future network adequacy validation, the Department should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the plans. The Department should also develop standardized quarterly network adequacy reporting templates for each plan type (e.g., CHP+ MCOs versus the ASO or the CHP+ dental PAHP). To ensure consistent reporting within each plan type, templates should include the following minimum information:
  - A description of the expected file format and minimum content, as well as which content should be reported using data tables versus narrative text or maps
    - Content should allow the plan to demonstrate compliance with federal network adequacy requirements under 42 CFR §438.206<sup>1-5</sup> and reporting requirements under 42 CFR §438.207<sup>1-6</sup>
  - Definitions for all required provider categories and instructions for reporting any additional provider categories defined by the plan
  - Methodology information for any expected calculations (e.g., time/distance calculations should be based on driving distances between each member and the nearest applicable provider)
  - Templates for any expected data tables, including definitions for each cell that the plan is expected to populate
- While developing the provider crosswalks, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the plans and a lack of consistent use of taxonomy codes by the Department. The Department should collaborate with the plans to ensure consistent data collection for these crucial provider data fields for all provider data.
- HSAG's PCA identified numerous spelling variations and/or special characters for the plans' data values for provider type, specialty, and credentials. The plans should assess available data values in their provider data systems and standardize available data value options.

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<sup>1-5</sup> Availability of Services, 42 CFR §438.206. Available at [https://gov.ecfr.io/cgi-bin/text-idx?SID=94387567351b1f2780e32505a0d8a864&mc=true&node=se42.4.438\\_1206&rgn=div8](https://gov.ecfr.io/cgi-bin/text-idx?SID=94387567351b1f2780e32505a0d8a864&mc=true&node=se42.4.438_1206&rgn=div8). Accessed on May 20, 2019.

<sup>1-6</sup> Assurances of Adequate Capacity and Services, 42 CFR §438.207. Available at [https://gov.ecfr.io/cgi-bin/retrieveECFR?gp=&SID=94387567351b1f2780e32505a0d8a864&mc=true&r=SECTION&n=se42.4.438\\_1207](https://gov.ecfr.io/cgi-bin/retrieveECFR?gp=&SID=94387567351b1f2780e32505a0d8a864&mc=true&r=SECTION&n=se42.4.438_1207). Accessed on May 20, 2019.

## Statewide Conclusions and Recommendations

Based on the results of the five external quality review (EQR) activities performed during FY 2018–2019, HSAG made the following observations about how these activities provided assessment related to the quality, timeliness of, and access to care and services. Opportunities for improvement were primarily related to the quality and access domains of care. Related to the Compliance with Regulations EQR activity, the low-scoring standards were standards that may potentially impact the quality domain. Also related to the quality domain, recommendations resulting from the PIP activity and the validation of network adequacy were related to data quality for the CHP+ health plans as well as the Department. The two CAHPS measures in which four CHP+ MCOs experienced decreased performance were measures that were related to the quality of care domain. HEDIS measures demonstrated low performing scores in measures that were related to preventive care and immunizations, potentially related to the access and quality domains.

## Quality Strategy

The Health First Colorado 2019 Quality Strategy (Quality Strategy) addresses the key elements recommended in the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, as well as in the guidance published on the Medicaid.gov website and in the State Medicaid Director letter guidance on designing and implementing State Quality Strategies. As recommended by CMS, the Department's Quality Strategy provides a blueprint for advancing the State's commitment to improving quality healthcare delivered through the Regional Accountable Entities (RAEs) and their contracted MCOs. Colorado's primary system of healthcare delivery and payment is designed to reward value and quality of care received by Health First Colorado and CHP+ members. The Department, in alignment with the Governor's healthcare priorities, continues to focus on initiatives to improve quality of care based on the following Department Strategic Quality Improvement Goals:

- Decreasing healthcare costs and increasing affordability for individuals, families, employers, and the government
- Enhancing delivery system innovation to include:
  - Increasing and monitoring members' access to care and provider network adequacy
  - Increasing and strengthening partnerships to improve population health by supporting proven interventions to address behavioral determinants of health, in addition to delivering higher quality care
  - Protecting and improving the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles
  - Implementing pay-for-performance to providers for meeting pre-established health status efficiency and/or quality benchmarks for a panel of patients



- Improving patient safety to include:
  - Ensuring members are connected to the right care, at the right time, every time
  - Promoting effective prevention and treatment of chronic disease
- Improving health outcomes, member experience, and patient safety through clinical analytics, evidence-based practices, and adoption

The Department's Quality Strategy includes a variety of performance measures designed for driving performance-based outcomes. Overall quantifiable objectives are related to closing performance gaps by 10 percent while identifying specific processes and policies that can become more person-centered.

In addition, Colorado's Quality Strategy addresses transparency, care coordination, and social determinants of health where possible based on community feedback as recommended by CMS. Health plan and State quality reporting is available at <https://www.colorado.gov/hcpf>. The Quality Strategy describes the interagency and community-based committees and collaborative teams that provide input and feedback in the ongoing design and revision of the Medicaid and CHP+ healthcare delivery system.

The Department further leverages its relationship with its external quality review organization (EQRO), HSAG, to conduct all mandatory and several optional EQR-related activities. Over the 18-year relationship, HSAG and the Department have collaborated to design State-specific technical assistance and optional activities and projects developed to provide information needed to shape the iterative design of the Medicaid and CHP+ programs.

HSAG recommends that the Department further collaborate with CMS to identify when CMS will update the Quality Strategy Toolkit for States based on the revised Medicaid regulations released in May 2016 and the revised Code of Colorado Regulations at 10 CCR 2505-10, Section 8.209.<sup>1-7</sup> Although the Department is in compliance with identified regulations within the CMS Quality Strategy Toolkit for States, HSAG recommends that the Department revise the Quality Strategy for its next submission, via restatement of the current regulations or via a crosswalk to the CMS Quality Strategy Toolkit for States.

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<sup>1-7</sup> Department of Health Care Policy and Financing. Code of Colorado Regulations. Available at: <https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=8299&fileName=10 CCR 2505-10 8.200>. Accessed on: May 20, 2019.

### Report Purpose and Overview

States with CHIP healthcare delivery systems that include MCOs and PAHPs (collectively referred to as health plans) are required to annually provide an assessment of the State's health plans' performance related to the quality of, timeliness of, and access to care and services provided by each health plan (42 CFR §438.364). The Department administers and oversees the CHP+ program (Colorado's implementation of the Children's Health Insurance Program). To meet this requirement, the Department contracted with HSAG to perform the assessment and to produce this EQR annual technical report based on EQR-related activities that HSAG conducted with the CHP+ health plans throughout FY 2018–2019. The CHP+ health plans located in Colorado are listed in Table 2-1.

**Table 2-1—Colorado CHP+ Health Plans**

CHP+ Health Plans	Services Provided
Colorado Access (COA)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Denver Health Medical Plan, Inc. (DHMP)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Friday Health Plans of Colorado (FHP)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Kaiser Permanente Colorado (Kaiser)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Rocky Mountain Health Plans (RMHP)	Physical health primary care, physical and behavioral inpatient and outpatient services, and specialty care.
Delta Dental of Colorado (Delta Dental)	Dental services.

### How This Report Is Organized

*Section 1—Executive Summary* includes a high-level, statewide summary of results and statewide average information derived from conducting mandatory and optional EQRO activities in FY 2018–2019. This section also includes a summary description of relevant trends over a three-year period for each EQRO activity as applicable, with references to the section where the health plan specific results can be found where appropriate. In addition, Section 1 includes any conclusions drawn and recommendations made for statewide performance improvement, if applicable.

*Section 2—Reader's Guide* provides a brief overview of Colorado's CHP+ healthcare delivery system and its managed care organizations and describes the purpose and overview of this EQR annual technical report, the authority under which it must be provided, and the EQR activities conducted during

FY 2018–2019. Section 1 also provides an overview of the methodology for each EQR activity performed and how HSAG used results and data obtained to draw conclusions.

*Section 3—Evaluation of Colorado's CHP+ Health Plans* provides summary level results for each EQR activity performed for the CHP+ health plans. This information is presented by health plan and provides an activity-specific assessment of the quality of, timeliness of, and access to care and services for each health plan as applicable to the results obtained and activities performed.

*Section 4—Statewide Comparative Results, Assessment, Conclusions, and Recommendations* includes statewide comparative results organized by EQR activity. Three-year trend tables (when applicable) include summary results for each CHP+ health plan and statewide averages. This section also identifies, through presentation of results for each EQR activity, statewide trends and commonalities used to derive statewide conclusions and recommendations.

*Section 5—Assessment of CHP+ Health Plan Follow-Up on Prior Recommendations* provides, by EQR activity, a health plan-specific assessment of the extent to which the health plans were able to follow up on and complete any recommendations or corrective actions required as a result of the prior year's EQR activities.

## Scope of EQR Activities

The CHP+ health plans were subject to three federally mandated EQR activities and two optional activities. As set forth in 42 CFR §438.358, the mandatory activities were:

- **Assessment of compliance with CHIP managed care regulations (compliance with regulations).** Assessment of compliance with regulations was designed to determine the health plans' compliance with their contracts with the State and with State and federal managed care regulations. HSAG determined compliance through review of four standard areas developed based on federal managed care regulations and contract requirements.
- **Validation of performance measures.** To assess the accuracy of the performance measures reported by or on behalf of the health plans, each health plan's licensed HEDIS auditor validated each of the performance measures selected by the Department for review. The validation also determined the extent to which performance measures calculated by the health plans followed specifications required by the Department.
- **Validation of performance improvement projects.** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.

The optional activities conducted for the CHP+ health plans were:

- **CAHPS survey.** HSAG conducted surveys and reported results for all CHP+ MCOs on behalf of the Department. No CAHPS survey was conducted for Colorado's dental PAHP, Delta Dental.

- **Validation of network adequacy.** HSAG reviewed Colorado's existing network adequacy standards and obtained network information from the managed care entities and the Department to analyze and assess the Department's network needs and establish standardized provider category definitions across the CHP+ health plans.

## Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the CHP+ health plans in each of the domains of quality of, timeliness of, and access to care and services.

### Quality

The Centers for Medicare & Medicaid Services (CMS) defines “quality” in the final rule at 42 CFR §438.320 as follows: “Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement.”<sup>2-1</sup>

### Timeliness

NCQA defines “timeliness” relative to utilization decisions as follows: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”<sup>2-2</sup> NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO—e.g., processing appeals and providing timely care.

### Access

CMS defines “access” in the final 2016 regulations at 42 CFR §438.320 as follows: “Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for

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<sup>2-1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

<sup>2-2</sup> National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.

the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services).”<sup>2-3</sup>

## Methodology

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

### ***Assessment of Compliance With CHIP Managed Care Regulations***

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance based on federal healthcare regulations. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. HSAG developed a strategy and monitoring tools to review compliance with these standards and managed care contract requirements related to each standard. HSAG also reviewed the health plans’ administrative records to evaluate compliance related to member appeals and grievances.

### Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies all recognize that having standards is only the first step in promoting safe and effective healthcare. Making sure that the standards are followed is the second step. The objective of each site review was to provide meaningful information to the Department and the health plans regarding:

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

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<sup>2-3</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

## Technical Methods of Data Collection

To assess for health plans' compliance with regulations, HSAG conducted the five activities described in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.<sup>2-4</sup> Table 2-2 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

**Table 2-2—Protocol Activities Performed for Assessment of Compliance With Regulations**

For this step,	HSAG completed the following activities:
<b>Activity 1:</b>	<b>Establish Compliance Thresholds</b>
	<p>Before the site review to assess compliance with federal managed care regulations and managed care contract requirements:</p> <ul style="list-style-type: none"> <li>• HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies.</li> <li>• HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, and on-site agendas, and to set review dates.</li> <li>• HSAG submitted all materials to the Department for review and approval.</li> <li>• HSAG conducted training for all site reviewers to ensure consistency in scoring across health plans.</li> </ul>
<b>Activity 2:</b>	<b>Perform Preliminary Review</b>
	<ul style="list-style-type: none"> <li>• HSAG attended the Department's Integrated Quality Improvement Committee (IQIC) meetings and provided group technical assistance and training, as needed.</li> <li>• Prior to the scheduled date of the on-site portion of the review, HSAG notified the health plans in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site record reviews. Thirty days prior to the review, the health plans provided documentation for the desk review, as requested.</li> <li>• Documents submitted for the desk review and the on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plans' section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. Each health plan also submitted a list of all CHP+ (1) individual providers credentialed between July 1, 2018, and December 31, 2018; (2) individual providers recertified between July 1, 2018, and December 31, 2018; and (3) all organizations with which the health plan had an agreement between July 1, 2018,</li> </ul>

<sup>2-4</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Sept 19, 2018.

For this step,	HSAG completed the following activities:
	<p>and December 31, 2018. HSAG used a random sampling technique to select records for review during the site visit.</p> <ul style="list-style-type: none"> <li>The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation, if needed, as well as an interview guide for HSAG's use during the on-site portion of the review.</li> </ul>
<b>Activity 3:</b>	<b>Conduct Site Visit</b>
	<ul style="list-style-type: none"> <li>During the on-site portion of the review, HSAG met with the health plans' key staff members to obtain a complete picture of the health plans' compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plans' performance.</li> <li>HSAG reviewed a sample of administrative records related to credentialing and recredentialing to evaluate implementation of federal managed care regulations and State contract requirements.</li> <li>Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original-source documents that were confidential or proprietary or were requested as a result of the pre-on-site document review or on-site interview.)</li> <li>At the close of the on-site portion of the site review, HSAG met with the health plan's staff and Department personnel to provide an overview of preliminary findings.</li> </ul>
<b>Activity 4:</b>	<b>Compile and Analyze Findings</b>
	<ul style="list-style-type: none"> <li>HSAG used the site review report template to compile the findings and incorporate information from the pre-on-site and on-site review activities.</li> <li>HSAG analyzed the findings.</li> <li>HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.</li> </ul>
<b>Activity 5:</b>	<b>Report Results to the State</b>
	<ul style="list-style-type: none"> <li>HSAG populated the report template.</li> <li>HSAG submitted the site review report to the health plan and the Department for review and comment.</li> <li>HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report.</li> <li>HSAG distributed the final report to the health plan and the Department.</li> </ul>



## Description of Data Obtained

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

- Committee meeting agendas, minutes, and reports
- Policies and procedures
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Member handbook and informational materials
- Staff training materials and documentation of training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (processing of grievances and appeals)
- Interviews with key health plan staff members conducted on-site

## How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ MCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains. Each standard may involve assessment of more than one domain due to the combination of individual requirements in each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality of, timeliness of, or access to care and services provided by the MCOs. Table 2-3 depicts assignment of the standards to the domains.

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

Compliance Review Standards	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓		✓
Standard IV—Member Rights and Protections	✓		
Standard VIII—Credentialing and Recredentialing	✓	✓	
Standard X—Quality Assessment and Performance Improvement	✓		



## Validation of Performance Measures

### Objectives

The primary objectives of the PMV process were to:

- Evaluate the accuracy of performance measure data collected by the health plan.
- Determine the extent to which the specific performance measures calculated by the health plan (or on behalf of the health plan) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

### Technical Methods of Data Collection

The Department required that each health plan undergo a HEDIS Compliance Audit performed by an NCQA-certified HEDIS compliance auditor (CHCA) contracted with an NCQA-licensed organization. CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012,<sup>2-5</sup> identifies key types of data that should be reviewed. HEDIS Compliance Audits meet the requirements of the CMS protocol. Therefore, HSAG requested copies of the FAR for each health plan and aggregated several sources of HEDIS-related data to confirm that the health plans met the HEDIS IS compliance standards and had the ability to report HEDIS data accurately.

The following processes/activities constitute the standard practice for HEDIS audits regardless of the auditing firm. These processes/activities follow NCQA's *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*.<sup>2-6</sup>

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.
- Detailed review of the health plan's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- On-site meetings at the health plan's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification.

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<sup>2-5</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/externalquality-review/index.html>. Accessed on: Oct 10, 2018.

<sup>2-6</sup> National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

- Programming logic review and inspection of dated job logs.
- Computer database and file structure review.
- Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS measures.
- Re-abstraction of a sample of medical records selected by the auditors, with a comparison of results to the health plan's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the health plan's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS 2018 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) completed by the health plan and/or its contractor.

The health plans were responsible for obtaining and submitting their respective HEDIS FARs. The auditor's responsibility was to express an opinion on the health plan's performance based on the auditor's examination, using procedures that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the health plans, it did review the audit reports produced by the other licensed audit organizations. Through review of each health plan's FAR, HSAG determined that all licensed organizations followed NCQA's methodology in conducting their HEDIS Compliance Audits.

### Description of Data Obtained

As identified in the HEDIS audit methodology, key data sources were obtained and reviewed to ensure that data were validated in accordance with CMS' requirements and to confirm that only valid results were included in this report. Table 2-4 outlines HEDIS audit activities and steps reviewed by HSAG, along with the corresponding data sources.

**Table 2-4—Description of Data Sources Reviewed**

Data Reviewed	Source of Data
<b>Pre-On-Site Visit/Meeting</b> —This was the initial conference call or meeting between the HEDIS compliance auditor and the health plan staff. HSAG verified that key HEDIS topics such as timeliness and on-site review dates were addressed by the licensed organizations.	HEDIS 2019 FAR
<b>Roadmap Review</b> —This review provided the health plan's HEDIS compliance auditors with background information on policies, processes, and data in preparation for on-site validation activities. The health plans were required to complete the Roadmap to provide their lead auditor audit team with the necessary information to begin validation activities. HSAG looked for evidence in the final report that the licensed HEDIS auditor completed a thorough review of all components of the Roadmap.	HEDIS 2019 FAR

Data Reviewed	Source of Data
<b>Certified Measure Review</b> —If any health plan used a vendor whose measures were certified by NCQA to calculate that health plan's measure rates, HSAG verified that the certification was available and that all required measures developed by the vendor were certified by NCQA.	HEDIS 2019 FAR and Measure Certification Reports
<b>Source Code Review</b> —HSAG ensured that the licensed HEDIS auditor reviewed the programming language for calculating any HEDIS measures that did not undergo NCQA's measure certification process. Source code review was used to determine compliance with the performance measure definitions, including accurate numerator and denominator identification, sampling, and algorithmic compliance (to determine if rate calculations were performed correctly, medical record and administrative data were combined appropriately, and numerator events were counted accurately).	HEDIS 2019 FAR
<b>Survey Vendor</b> —If the health plan used a survey vendor to perform the CAHPS surveys, HSAG verified that an NCQA-certified survey vendor was used. A certified survey vendor must be used if the health plan performed a CAHPS survey as part of HEDIS reporting.	HEDIS 2019 FAR
<b>CAHPS Sample Frame Validation</b> —HSAG validated that the licensed organizations performed detailed evaluations of the source code used to access and manipulate data for CAHPS sample frames. This validation reviewed the source code to ensure that data were correctly queried in the output files, and HSAG conducted a detailed review of the survey eligibility file elements, including the healthcare organization's name, product line, product, unique member ID, and subscriber ID, as well as the member name, gender, telephone number, date of birth, mailing address, continuous enrollment history, and prescreen status code (if applicable).	HEDIS 2019 FAR
<b>Supplemental Data Validation</b> —If the health plan used any supplemental data for reporting, the HEDIS compliance auditor must validate the supplemental data according to NCQA guidelines. HSAG verified that the NCQA-required processes were followed to validate the supplemental databases.	HEDIS 2019 FAR
<b>Convenience Sample Validation</b> —Per NCQA guidelines, the HEDIS auditor reviews a small number of processed medical records to uncover potential problems that may require corrective action early in the medical record review (MRR) process. A convenience sample must be prepared unless the auditor determines that a health plan is exempt. NCQA allows organizations to be exempt from the convenience sample if they participated in a HEDIS audit the previous year and passed MRR validation, if the current MRR process has not changed significantly from the previous year, and if the health plan did not report hybrid measures that the auditor determines to be at risk of inaccurate reporting. HSAG verified that the HEDIS auditors determined whether or not the health plans were required to undergo a convenience sample validation. HSAG also verified that if a convenience sample validation was not required by the HEDIS auditor the specific reasons were documented.	HEDIS 2019 FAR

Data Reviewed	Source of Data
<b>Medical Record Review</b> —The HEDIS auditors are required to perform a more extensive validation of medical records reviewed, which is conducted late in the abstraction process. This validation ensures that the review process was executed as planned and that the results are accurate. HSAG reviewed whether or not the auditor performed a re-review of a minimum random sample of 16 medical records for each measure group and the exclusions group to ensure the reliability and validity of the data collected.	HEDIS 2019 FAR
<b>Interactive Data Submission System (IDSS) Review</b> —The health plans are required to complete NCQA's IDSS for the submission of audited rates to NCQA. The auditor finalizes the IDSS by completing the audit review and entering an audit result. This process verifies that the auditor validated all activities that culminated in a rate by the health plans. The auditor locks the IDSS so that no information can be changed. HSAG verified that the auditors completed the IDSS review process. In a situation where the health plans did not submit the rates via IDSS, HSAG validated the accuracy of the rates submitted by the health plans in a data submission template created by HSAG.	HEDIS 2019 IDSS

Table 2-5 identifies the key validation elements reviewed by HSAG. HSAG identified whether or not each health plan was compliant with the key elements as described by the licensed HEDIS auditor organization in the FAR and the IDSS. As presented in Table 2-5, a check mark symbol indicates that the licensed organization conducted the corresponding audit activity according to the HEDIS methodology. Some activities were conducted by other companies, such as NCQA-certified software or survey vendors, which contracted with the health plans. In these instances, the name of the company which performed the required task is listed.

**Table 2-5—Validation Activities**

	COA	DHMP	FHP	Kaiser	RMHP
<b>Licensed HEDIS Auditor Organization</b>	HealthcareData Company, LLC	Attest Health Care Advisors	DTS Group	DTS Group	DTS Group
<b>Pre-On-Site Visit Call/Meeting</b>	✓	✓	✓	✓	✓
<b>Roadmap Review</b>	✓	✓	✓	✓	✓
<b>Software Vendor</b>	Centauri Health Solutions	Cotiviti	Change Healthcare	None used	Inovalon, Inc.
<b>Source Code/Certified Measure Review</b>	✓	✓	✓	✓	✓
<b>Supplemental Data Validation</b>	✓	✓	Supplemental data were not used	✓	✓
<b>Medical Record Review</b>	Medical record review data were not used	✓	✓	✓	✓
<b>IDSS Review</b>	✓	✓	✓	✓	✓

The preceding table indicates that audits conducted for the health plans included all required validation activities. The health plans used NCQA-licensed organizations to perform the HEDIS audits.

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

## How Conclusions Were Drawn

### IS Standards Review

Health plans must be able to demonstrate compliance with IS standards. Health plans' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine health plan compliance with the HEDIS Compliance Audit Standards. The IS standards are listed as follows:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry
- IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity

In the measure results tables presented in Section 3, HEDIS 2017, 2018, and 2019 measure rates are presented for measures deemed *Reportable (R)* by the NCQA-licensed audit organization according to NCQA standards. With regard to the final measure rates for HEDIS 2017, 2018, and 2019, a measure result of *Small Denominator (NA)* indicates that the health plan followed the specifications, but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate (BR)* indicates that the calculated rate was materially biased and therefore is not presented in this report. A measure result of *Not Reported (NR)* indicates that the health plan chose not to report the measure.

### Performance Measure Results

The MCOs' HEDIS measure results were evaluated based on statistical comparisons between the current year's rates and the prior year's rates, where available, as well as on comparisons against the national benchmarks, where appropriate. In the performance measure results tables, rates shaded green with one caret (^) indicate statistically significant improvement in performance from HEDIS 2018 to HEDIS 2019. Rates shaded red with two carets (^) indicate statistically significant declines in performance from HEDIS 2018 to HEDIS 2019. Throughout the performance measure results sections in this report, references to "significant" changes in performance are noted; these instances refer to statistically

significant differences between performance from HEDIS 2018 to HEDIS 2019. Performance comparisons are based on the Chi-square test of proportions with results deemed significant with a  $p$ -value  $<0.05$ . However, caution should be exercised when interpreting results of the significance testing, given that significant changes may not necessarily be clinically significant. To limit the impact of this, a change will not be considered significant unless the change was at least 3 percentage points. Note that statistical testing could not be performed on the utilization-based measures within the Use of Services domain given that variances were not available in the IDSS for HSAG to use for statistical testing.

The statewide average presented in this report is a weighted average of the rates for each MCO, weighted by each MCO's eligible population for the measure. This results in a statewide average similar to an actual statewide rate because, rather than counting each MCO equally, the size of each MCO is taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

$$\text{Statewide Average} = \frac{P_1 R_1 + P_2 R_2}{P_1 + P_2}$$

Where  $P_1$  = the eligible population for MCO 1

$R_1$  = the rate for MCO 1

$P_2$  = the eligible population for MCO 2

$R_2$  = the rate for MCO 2

Measure results, where available, for HEDIS 2019 were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2018. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicators were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2018 since these indicators are not published in Quality Compass.

For the measures in the Use of Services domain (i.e., *Ambulatory Care*, *Inpatient Utilization—General Hospital/Acute Care*, and *Antibiotic Utilization*), HSAG did not perform significance testing because variances were not provided in the IDSS files; therefore, differences in rates are reported without significance testing. In addition, higher or lower rates do not necessarily indicate better or worse performance for the measures in the Use of Services domain.

In the performance measure results tables, an em dash (—) indicates that the rate is not presented in this report as the Department did not require the MCOs to report this rate for the respective HEDIS submission or NCQA recommended a break in trending in HEDIS 2018 or HEDIS 2019. This symbol may also indicate that a percentile ranking was not determined, either because the HEDIS 2019 measure rate was not reportable or because the measure did not have an applicable benchmark.



Additionally, the following logic determined the high- and low-performing measure rates discussed within the results:

- High performers are measures for which the statewide average is high compared to national benchmarks and performance is trending positively. These measures are those:
  - Ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2018.
  - Ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2018.
- Low performers are measures for which statewide performance is low compared to national percentiles or performance is toward the middle compared to national percentiles but declining over time. These measures are those:
  - Below the 25th percentile.
  - Ranked between the 25th and 49th percentiles with significant decline in performance from HEDIS 2018.

According to the Department's guidance, all measure rates presented in this report for the MCOs are based on administrative data only. The Department required that all HEDIS 2017, HEDIS 2018, and 2019 measures be reported using the administrative methodology only. However, FHP still reported certain measures to NCQA using the hybrid methodology. The hybrid measures' results are found in Table A-1 in Appendix A. When reviewing HEDIS measure results, the following items should be considered:

- MCOs that were able to obtain supplemental data or capture more complete data will generally report higher rates when using the administrative methodology. As a result, the HEDIS measure rates presented in this report for measures with a hybrid option may be more representative of data completeness rather than a measure of performance. Additionally, caution should be exercised when comparing administrative measure results to national benchmarks or to prior years' results that were established using administrative and/or medical record review data, as results likely underestimate actual performance. Table 2-6 presents the measures provided in the report that could be reported using the hybrid methodology.

**Table 2-6—HEDIS Measures That Can Be Reported Using the Hybrid Methodology**

Hybrid Measures
<i>Childhood Immunization Status</i>
<i>Immunizations for Adolescents</i>
<i>Well-Child Visits in the First 15 Months of Life</i>
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
<i>Adolescent Well-Care Visits</i>
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>
<i>Prenatal and Postpartum Care</i>

- National HEDIS percentiles are not available for the CHIP population; therefore, comparison of the CHIP+ MCOs' rates to Medicaid percentiles should be interpreted with caution.

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHIP+ MCOs, HSAG assigned each of the components reviewed for PMV to one or more of these three domains. This assignment to domains is depicted in Table 2-7.

**Table 2-7—Assignment of Activities to Performance Domains**

Performance Measures	Quality	Timeliness	Access
<b><i>Pediatric Care Measures</i></b>			
<i>Childhood Immunization Status</i>	✓		
<i>Immunizations for Adolescents</i>	✓		
<i>Well-Child Visits in the First 15 Months of Life</i>	✓		
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	✓		
<i>Adolescent Well-Care Visits</i>	✓		
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>	✓		
<i>Appropriate Testing for Children With Pharyngitis</i>	✓		
<b><i>Access to Care Measures</i></b>			
<i>Prenatal and Postpartum Care*</i>	✓	✓	✓
<i>Children's and Adolescents' Access to Primary Care Practitioners</i>			✓
<i>Annual Dental Visit**</i>			✓
<b><i>Preventive Screening Measures</i></b>			
<i>Chlamydia Screening in Women</i>	✓		
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	✓		
<b><i>Mental/Behavioral Health Measures</i></b>			
<i>Antidepressant Medication Management</i>	✓		
<i>Follow-Up Care for Children Prescribed ADHD Medication</i>	✓	✓	✓
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i>	✓		
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents</i>	✓		
<b><i>Respiratory Conditions Measures</i></b>			
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	✓		
<i>Medication Management for People With Asthma</i>	✓		
<i>Asthma Medication Ratio</i>	✓		



Performance Measures	Quality	Timeliness	Access
<b>Use of Services Measures</b>			
<i>Ambulatory Care (Per 1,000 Member Months)</i>	NA	NA	NA
<i>Inpatient Utilization—General Hospital/Acute Care</i>	NA	NA	NA
<i>Antibiotic Utilization</i>	NA	NA	NA

\* CHP+ SMCN was required to report just one measure, Prenatal and Postpartum Care.

\*\* Delta Dental was required to report just one measure, Annual Dental Visit.

NA indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).

## Validation of Performance Improvement Projects

### Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

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

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

### Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.<sup>1-7</sup>

<sup>1-7</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Jan 23, 2019.

Over time, HSAG identified that while the health plans had designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few health plans had achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.<sup>1-8</sup> The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects health plans to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement.

PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that given the pace of quality improvement science development and the prolific use of PDSA cycles in modern improvement projects within healthcare settings, a new approach was needed.

HSAG developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held technical assistance sessions with the health plans to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus on the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, FMEA, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the health plan summarizes key findings and outcomes and presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

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<sup>1-8</sup> Langley GL, Moen R, Nolan KM, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: <http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>. Accessed on: Mar 26, 2019.

## Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from each health plan's module submission form. In FY 2018–2019, these forms provided detailed information about the PIPs and the activities completed in Module 1 and Module 2.

Following HSAG's rapid-cycle PIP process, the health plans submit each module according to the approved timeline. Following the initial validation of each module, HSAG provides feedback in the validation tools. If validation criteria are not achieved, the health plan has the opportunity to seek technical assistance from HSAG. The health plan resubmits the modules until all validation criteria are met. This process ensures that the PIP methodology is sound prior to the health plan progressing to intervention testing.

## How Conclusions Were Drawn

During validation, HSAG determines if criteria for each module are *Achieved*. Any validation criteria not applicable (*NA*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- **High confidence** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the health plan accurately summarized the key findings.
- **Confidence** = The PIP was methodologically sound, the SMART Aim was achieved, and the health plan accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- **Low confidence** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- **Reported PIP results were not credible** = The PIP methodology was not executed as approved.

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ health plans, HSAG assigned each of the components reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, the Department required all health plans to choose a specific PIP topic related to the global topic of access to care; therefore, all PIP topics were also assigned to the access domain. This assignment to domains is shown in Table 2-8.

**Table 2-8—Assignment of PIPs to the Quality, Timeliness, and Access to Care Domains**

Health Plan	Performance Improvement Projects	Quality	Timeliness	Access
COA	<i>Well-Child Visits for Members 10–14 Years of Age</i>	✓		✓
DHMP	<i>Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age</i>	✓		✓
FHP	<i>Well-Child Visits in the 6<sup>th</sup> Through 14<sup>th</sup> Years of Life</i>	✓		✓
Kaiser	<i>Improving CHP+ Adolescent Well-Visit Adherence</i>	✓		✓
RMHP	<i>Improving CHP+ Adolescent Well-Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18</i>	✓		✓
Delta Dental	<i>Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year</i>	✓		✓

## CAHPS Surveys

### Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information about members' healthcare experiences.

### Technical Methods of Data Collection

HSAG administered the *CAHPS 5.0 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set for the CHP+ population. The survey includes a set of standardized items (48 items for the *CAHPS 5.0 Child Medicaid Health Plan Survey* without the Children with Chronic Conditions [CCC] measurement set) that assess members' perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed for member selection and survey distribution. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. HSAG aggregated data from survey respondents into a database for analysis.

The survey questions were categorized into nine measures of experience that included four global ratings and five composite measures. The global ratings reflected members' overall experience with their personal doctors, specialists, all healthcare, and health plans. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). For any case where a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

For each of the four global ratings, the percentage of respondents who chose the top ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the CAHPS survey fell into one of the following two categories: (1) “Never,” “Sometimes,” “Usually,” and “Always;” or (2) “No” and “Yes.” A positive or top-box response for the composites was defined as a response of “Usually/Always” or “Yes.” The percentage of top-box responses is referred to as a global proportion for the composite measures.

## Description of Data Obtained

HSAG administered the *CAHPS 5.0 Child Medicaid Health Plan Survey* with the HEDIS supplemental item set for the CHP+ population and stratified the results by the five CHP+ health plans. HSAG followed NCQA methodology when calculating the results.

## How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the CHP+ health plans, HSAG assigned each of the components reviewed for CAHPS to one or more of these three domains. This assignment to the domains is depicted in Table 2-9.

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

CAHPS Topics	Quality	Timeliness	Access
<i>Getting Needed Care</i>	✓		✓
<i>Getting Care Quickly</i>	✓	✓	
<i>How Well Doctors Communicate</i>	✓		
<i>Customer Service</i>	✓		
<i>Shared Decision Making</i>	✓		
<i>Rating of Personal Doctor</i>	✓		
<i>Rating of Specialist Seen Most Often</i>	✓		
<i>Rating of All Health Care</i>	✓		
<i>Rating of Health Plan</i>	✓		

## **Validation of Network Adequacy**

### **Objectives**

Medicaid and CHIP managed care regulations that were released in May 2016 stated that validation of network adequacy shall commence no later than one year from the issuance of the associated EQR protocol (42 CFR §438.358(b)(1)(iv)). In preparation of the release of the validation of network adequacy protocol, the Department collaborated with HSAG to support a review of current network adequacy documentation and processes; prepare a provider crosswalk for use in future network adequacy validation tasks; and conduct a baseline PCA of the provider networks for all CHP+ health plans.

The provider crosswalk was designed to use provider types, specialties, credentials, and/or taxonomy codes from the Department's and the plans' existing provider data to establish standard definitions for identifying categories of managed care providers (e.g., physician and non-physician PCPs). The primary focus of the PCA was to assess the distribution of providers affiliated with each health plan for the Department's selected provider categories.

### **Technical Methods of Data Collection**

HSAG used a desk review approach to collect documentation and provider data from the Department and participating CHP+ health plans (including the dental PAHP). The Department supplied HSAG with provider network documentation and standards, including the plans' network adequacy contract requirements and quarterly network adequacy reports. In addition, the Department supplied data for all ordering, referring, servicing, and billing providers active with the Department (i.e., registered in interChange). Concurrent with the Department's data extract, each plan completed a brief Data Structure Questionnaire with targeted information regarding its provider data structure(s) and methods for classifying providers. Finally, each CHP+ health plan submitted provider network data using a standardized data requirements document approved by the Department.

### **Description of Data Obtained**

Qualitative data for the study included the Department's provider network documentation and the plans' self-reported Data Structure Questionnaire responses.

Quantitative data for the study included provider-level network data from the Department and each CHP+ health plan, including data values with provider attributes for type (e.g., NP), specialty (e.g., family medicine), credentials (e.g., licensed clinical social worker), and/or taxonomy code. However, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the plans and a lack of consistent use of taxonomy codes by the Department.

Of note, the Department has not directed the plans to use standard categorization criteria when producing quarterly network adequacy reports, and the Department is unable to identify the CHP+

health plan and/or fee-for-service (FFS) affiliation(s) for each provider, resulting in a reliance on the plans' provider data for this study.

### How Conclusions Were Drawn

Following development of the study methodology, the Department approved the following high-level provider categories applicable to CHP+ health plans and aligned with the minimum provider categories identified in Section 42 438.68 of the federal network adequacy standard requirement:

- Facility-Level Providers
  - Hospitals, pharmacies, imaging services, and laboratories
- Prenatal Care and Women's Health Services
  - Individual providers, FQHCs, RHCs, CMHCs, and birthing centers
- PCPs
  - Individual general and pediatric providers, FQHCs and RHCs, CMHCs and school-based health clinics (SBHCs)
- Physical Health Specialists
  - Individual general and pediatric providers, FQHCs and RHCs
- Ancillary Physical Health Services
  - Audiology, optometry, podiatry, and occupational/physical/speech therapy
- Behavioral Health Specialists
  - Individual physician and non-physician providers, FQHCs, RHCs, and CMHCs
  - Mental hospitals and psychiatric residential treatment facilities
  - Substance abuse facilities and licensed addiction counselors
- Primary and Specialty Dental Services (CHP+ dental PAHP only)

Detailed provider categories within these high-level groups guided subsequent data review and provider crosswalk development, and HSAG mapped the plans' provider data attributes into preliminary provider crosswalks (i.e., documents describing the logic and data values that would identify providers attributed to each Department-approved category).

HSAG then reconciled the preliminary crosswalk results and collaborated with the Department to review the resulting provider category definitions and finalize the crosswalks. HSAG applied the results of the provider crosswalk to the plans' provider data to conduct the PCA, generating plan-specific frequency counts of total and unique providers for each provider category.

As the study was designed to provide a baseline for future network adequacy validation tasks using existing provider network data and documentation, the plans were not given the opportunity to submit additional information on their providers following the PCA.



## ***Aggregating and Analyzing Statewide Data***

For each health plan, HSAG analyzed the results obtained from each mandatory and optional EQR activity conducted in FY 2018–2019. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about quality of, timeliness of, or access to care and services for each health plan independently as well as related to statewide improvement.



### 3. Evaluation of Colorado's CHP+ Health Plans

#### Colorado Access (COA)

##### *Assessment of Compliance With CHIP Managed Care Regulations*

Table 3-1 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2018–2019.

**Table 3-1—Summary of COA Scores for the FY 2018–2019 Standards Reviewed**

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
Standard IV—Member Rights and Protections	8	8	7	1	0	0	88%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
<b>Totals</b>	<b>68</b>	<b>68</b>	<b>65</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>96%</b>

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

Table 3-2 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

**Table 3-2—Summary of COA Scores for the FY 2018–2019 Record Reviews**

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	86	86	0	14	100%
Recredentialing	90	82	82	0	8	100%
<b>Totals</b>	<b>190</b>	<b>168</b>	<b>168</b>	<b>0</b>	<b>22</b>	<b>100%</b>

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

## COA: Strengths

COA's care coordination policies and associated procedures addressed provision of care coordination for all members through either the PCP or COA care coordination staff members and included: criteria for making referrals to and ensuring coordination of services among providers; providing continuity of care for members transitioning between settings of care; and coordinating with multiple providers, agencies, and community organizations for members with complex needs. PCPs were responsible for coordinating care unless the member was identified to COA case management through a health risk assessment (HRA) or referral for assistance with coordinating complex physical, behavioral, and/or social support needs. COA conducted an HRA shortly after enrollment for all CHP+ members and used results of the initial HRA to stratify members into levels of need for care management. COA care managers developed a service or treatment plan for members with complex problems, serious health conditions, or special health care needs (SHCN) and shared results of the assessment and intervention plans with other entities involved in the member's care. COA allowed direct access to specialists within COA's provider network and arranged through single case agreements an ongoing course of treatment for members with SHCN requiring access to out-of-network specialists.

COA maintained written policies and procedures that addressed member rights afforded to members and member responsibilities. COA distributed the rights to members, employees, and providers through the Evidence of Coverage booklet, Member Benefits Handbook Summary, provider manual, new provider orientation, newsletters, and the COA website. COA had a robust process for monitoring customer service calls to identify any issues of dissatisfaction that may indicate a member rights violation. COA also maintained numerous policies and procedures that addressed nondiscrimination, communication with members with limited English proficiency, cultural awareness strategies, member materials readability guidelines, disability rights, and compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements. COA delineated required advance directive information within its policies, provider manual, and on the COA member and provider websites.

COA's credentialing and recredentialing policies and procedures were well-written, comprehensive, and compliant with NCQA standards and guidelines. COA demonstrated that staff members were credentialing and recredentialing providers and organizations in a manner consistent with written procedures. Credentialing and recredentialing files demonstrated review of all NCQA-required information. COA had a process for ongoing review of Office of Inspector General (OIG) and System for Award Management (SAM) queries. COA also delegated credentialing and recredentialing to several contracted organizations. HSAG reviewed delegation agreements and monitoring processes to ensure adequate oversight of delegated entities. COA retained the right to approve, suspend, or terminate providers approved by any of its delegated entities.

COA's Quality Assessment and Performance Improvement (QAPI) program description defined a robust corporate-wide QAPI program and included a description of COA's organizational structure, goals and objectives, committee composition and roles, and comprehensive QAPI program components. The program description addressed all required QAPI components, including CAHPS measures, HEDIS measures, PIPs, utilization measures, quality of care concerns, clinical guidelines, and care management. The CHP+ PIP met the required design parameters. COA's quality management (QM) department

collaborated with all programmatic areas within COA to drive improvement activities and to collect and distribute data to providers. COA demonstrated through the CHP+ HMO Annual Quality Report that the results, analysis, interventions for improvement, and all CHP+ quality improvement activities were reported to the Department. On-site, COA demonstrated a dashboard of numerous data elements used to monitor and detect over- or underutilization of services. COA's Quality Improvement Committee (QIC) reviewed both quarterly and annual CHP+ quality performance reports. COA had policies and procedures for adopting clinical practice guidelines (CPGs) in compliance with requirements and had CPGs in place for specific CHP+ health conditions as required by the Department. COA provided evidence that CPGs are available to members and providers on the COA website. Staff members described processes for ensuring that decisions in other program areas are consistent with clinical guidelines. COA demonstrated that it has a fully integrated health information system (HIS) and that complete data are stored in its enterprise data warehouse (EDW). Utilization, claims, grievances and appeals, and enrollment and disenrollment data from the EDW could be aggregated, analyzed, and reported to support corporate operations and the QAPI program. The claims processing and retrieval system enabled electronic monthly submission of CHP+ encounter data to the State in the required format. COA's claim and transaction systems applied automated edits and logic to ensure accuracy, timeliness, completeness, and consistency of claims data received from providers. COA reported that manual review is used when necessary to ensure accurate and complete encounter data.

#### **COA: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations**

HSAG identified no opportunities for improvement that resulted in required actions related to Standard III—Coordination and Continuity of Care and Standard VIII—Credentialing and Recredentialing.

#### ***Standard IV—Member Rights and Protections***

COA's Member Rights and Responsibilities policy directed the reader to the State's rights and responsibilities listed in the Medicaid Managed Care Program section of the CCR. The CCR does not include the complete list of federally-defined member rights. COA was required to:

- Ensure that all required member rights are accounted for within its Member Rights and Responsibilities policy.

#### ***Standard X—Quality Assessment and Performance Improvement***

COA did not demonstrate that its QAPI program included evaluation of the quality and appropriateness of care provided to members with SHCN. In addition, while the CHP+ HMO Annual Quality Report documented summary results of all quality initiatives undertaken in the FY, neither the report nor the QIC minutes documented statements or conclusions regarding the overall effectiveness of the QAPI program or any of its component activities. COA was required to:

- Implement mechanisms to assess the quality and appropriateness of care furnished to CHP+ members with SHCN.
- Implement an annual process for evaluating the impact and effectiveness of the CHP+ QAPI program.

### COA: Trended Performance for Compliance With Regulations

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

**Table 3-3—Compliance With Regulations Trended Performance for COA**

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	88%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	91%	100%
<b>Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*</b>	<b>92%</b>	<b>100%</b>
<b>Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*</b>	<b>80%</b>	<b>88%</b>
Standard V—Member Information (2014–2015, 2017–2018)	91%	100%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	77%	95%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	100%	100%
<b>Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*</b>	<b>94%</b>	<b>100%</b>
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	NA
<b>Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*</b>	<b>100%</b>	<b>89%</b>

\*Bold text indicates standards reviewed by HSAG during FY 2018–2019.

Trending scores over the past six years indicate that COA improved performance in seven of the 10 standards, with the greatest improvement (18 percentage points) observed in Standard VI—Grievance and Appeal System. In one standard area, Standard VII—Provider Participation and Program Integrity, COA maintained 100 percent compliance across review cycles. COA experienced an 11 percent decline from its previous 100 percent performance in Standard X—Quality Assessment and Performance Improvement. Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as “NA” for CHP+ health plans in FY 2017–2018, there are no comparable results for Standard IX. HSAG cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods. Overall, COA scores demonstrate strong understanding of and compliance with federal managed care regulations and State contract requirements.

## Validation of Performance Measures

### Compliance With IS Standards

According to COA's 2019 HEDIS Compliance Audit Report, COA was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted COA's HEDIS performance measure reporting.

### Performance Measure Results

Table 3-4 shows the performance measure results for COA for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

**Table 3-4—Performance Measure Results for COA**

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>				
<b><i>Childhood Immunization Status<sup>1</sup></i></b>				
Combination 2	65.92%	62.30%	71.58%^	25th–49th
Combination 3	63.67%	60.82%	69.58%^	25th–49th
Combination 4	59.71%	58.71%	66.86%^	25th–49th
Combination 5	56.67%	53.96%	63.21%^	50th–74th
Combination 6	38.97%	41.29%	49.53%^	75th–89th
Combination 7	53.76%	52.38%	61.32%^	50th–74th
Combination 8	37.12%	39.92%	48.23%^	75th–89th
Combination 9	35.80%	37.59%	45.64%^	75th–89th
Combination 10	34.35%	36.54%	44.58%^	75th–89th
<b><i>Immunizations for Adolescents</i></b>				
Combination 1 (Meningococcal, Tdap)	70.39%	70.24%	76.30%^	25th–49th
Combination 2 (Meningococcal, Tdap, HPV)	—	31.71%	38.90%^	75th–89th
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>				
Zero Visits*	2.17%	1.36%	6.36%^^	<10th
Six or More Visits	61.96%	59.86%	47.27%^^	<10th
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b>				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.48%	69.32%	68.50%	25th–49th
<b><i>Adolescent Well-Care Visits</i></b>				
Adolescent Well-Care Visits	48.88%	48.34%	49.87%	25th–49th
<b><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></b>				
BMI Percentile Documentation—Total <sup>1</sup>	3.85%	5.25%	9.27%^	<10th
Counseling for Nutrition—Total	2.08%	2.94%	5.11%	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Counseling for Physical Activity—Total</i>	0.78%	1.06%	3.14%	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
<i>Appropriate Testing for Children With Pharyngitis</i>	84.93%	88.07%	84.60%^^	50th–74th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
<i>Ages 12 to 24 Months</i>	91.23%	94.65%	90.30%^^	<10th
<i>Ages 25 Months to 6 Years</i>	86.24%	85.90%	84.52%	25th–49th
<i>Ages 7 to 11 Years</i>	91.63%	89.74%	87.98%	25th–49th
<i>Ages 12 to 19 Years</i>	92.18%	90.90%	87.78%^^	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
<i>Ages 16 to 20 Years</i>	32.72%	32.11%	32.27%	<10th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	0.24%	0.06%	0.08%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
<i>Effective Acute Phase Treatment</i>	NA	NA	NA	—
<i>Effective Continuation Phase Treatment</i>	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication<sup>2</sup></b>				
<i>Initiation Phase</i>	0.00%	0.00%	0.00%	<10th
<i>Continuation and Maintenance Phase</i>	0.00%	0.00%	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
<i>Total</i>	—	29.59%	30.49%	25th–49th
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents<sup>*1</sup></b>				
<i>Total</i>	4.05%	6.67%	3.23%	25th–49th
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	89.63%	92.12%	93.25%	50th–74th
<b>Medication Management for People With Asthma<sup>1</sup></b>				
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	51.18%	65.41%	58.41%	50th–74th
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	48.31%	55.77%	50.00%	25th–49th
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	27.56%	34.59%	36.28%	75th–89th
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	26.97%	27.88%	23.33%	25th–49th
<b>Asthma Medication Ratio<sup>1</sup></b>				
<i>Ages 5 to 11 Years</i>	87.50%	80.58%	83.19%	≥90th
<i>Ages 12 to 18 Years</i>	74.74%	72.07%	75.79%	≥90th



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Use of Services†</b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
Emergency Department (ED) Visits*	26.48	26.36	26.90	≥90th
Outpatient Visits <sup>1</sup>	224.38	221.11	218.12	<10th
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
Discharges per 1,000 Member Months (Total Inpatient)	0.96	0.99	1.03	<10th
Average Length of Stay (Total Inpatient)	3.64	3.74	3.43	<10th
Discharges per 1,000 Member Months (Medicine)	0.66	0.67	0.74	<10th
Average Length of Stay (Medicine)	2.88	2.85	2.97	<10th
Discharges per 1,000 Member Months (Surgery)	0.26	0.28	0.25	<10th
Average Length of Stay (Surgery)	5.79	6.00	4.90	<10th
Discharges per 1,000 Member Months (Maternity)	0.09	0.09	0.09	<10th
Average Length of Stay (Maternity)	2.41†	3.05†	2.58†	<10th
<b>Antibiotic Utilization*</b>				
Average Scripts Per Member Per Year (PMPY) for Antibiotics	0.46	0.42	0.35	≥90th
Average Days Supplied per Antibiotic Script	10.94	10.88	10.87	<10th
Average Scripts PMPY for Antibiotics of Concern	0.16	0.14	0.12	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.77%	34.12%	33.71%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

<sup>2</sup> Due to changes in the technical specifications for this measure in 2018, NCQA recommends trending between 2018 and prior years be considered with caution.

— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017.

Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

## COA: Strengths

The following HEDIS 2019 measure rates were determined to be high performers for COA (i.e., ranked at or above the 75th percentile without a significant decline in performance from HEDIS 2018 or ranked between the 50th and 74th percentiles with significant improvement in performance from HEDIS 2018):

- *Childhood Immunization Status—Combinations 5–10*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Medication Management for People With Asthma—Medication Compliance 75%—Ages 5 to 11 Years*
- *Asthma Medication Ratio—Ages 5 to 11 Years and Ages 12 to 18 Years*

For HEDIS 2019, COA demonstrated strong performance with children and adolescents receiving vaccinations by ranking above the 50th percentile for seven of 11 (63.6 percent) measure rates and demonstrating significant improvement for all 11 measure rates. Additionally, the MCO demonstrated appropriate management of members with asthma, particularly for children ages 5 to 11 years.

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

The following HEDIS 2019 measure rates were determined to be low performers for COA (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant decline in performance from HEDIS 2018):

- *Well-Child Visits in the First 15 Months of Life—Zero Visits and Six or More Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months and Ages 12 to 19 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

COA's performance demonstrated opportunities to improve access to the appropriate providers and services for children and adolescents, as evidenced by the rates for well-child/well-care visits, *Children and Adolescents' Access to Primary Care Practitioners*, and *Chlamydia Screening in Women* falling below the 50th percentile. The MCO should work with the Department and providers to identify the causes for the low access to care and preventive screening rates (e.g., are the issues related to barriers to accessing care, a lack of family planning service providers, or the need for improved provider training or community outreach and education) and implement strategies to improve the care for young members.



## Validation of Performance Improvement Projects

Table 3-5 presents the FY 2018–2019 validation findings for COA's PIP.

**Table 3-5—Validation Findings for the *Well-Child Visits for Members 10–14 Years of Age* PIP**

Module 1—PIP Initiation	
<b>Narrowed Focus Population</b>	Members 10 through 14 years of age attributed to Metro Community Provider Network (MCPN).
<b>SMART Aim Statement</b>	By June 30, 2020, increase the percentage of well child visits among members 10–14 years of age attributed to MCPN, from 25.28% to 37.18%.
Module 2—SMART Aim Data Collection	
<b>SMART Aim Measure</b>	The percentage of members 10 through 14 years of age attributed to MCPN during the rolling 12-month measurement period who each received a preventive or wellness visit during the measurement period.
<b>SMART Aim Data Collection Plan</b>	<ul style="list-style-type: none"> <li>• <b>Data Source:</b> Administrative claims.</li> <li>• <b>Methodology:</b> Monthly data collection using a rolling 12-month measurement period.</li> </ul>

### COA: Strengths

COA selected a PIP topic focused on increasing the rate of well-child visits among members 10 through 14 years of age. The CHP+ health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that COA designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. COA has progressed to Module 3, where the health plan will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, COA will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ health plan will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As COA continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.

- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ health plan progresses through the steps for determining and testing interventions.

## CAHPS Survey

### Findings

Table 3-6 shows the results achieved by COA for FY 2016–2017 through FY 2018–2019.

**Table 3-6—Question Summary Rates and Global Proportions for COA**

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
<i>Getting Needed Care</i>	85.6%	85.3%	87.7%
<i>Getting Care Quickly</i>	90.1%	92.4%	90.5%
<i>How Well Doctors Communicate</i>	95.2%	95.4%	94.8%
<i>Customer Service</i>	86.9%	83.7%	81.9%
<i>Shared Decision Making</i>	83.5% <sup>+</sup>	74.8% <sup>+</sup>	79.6% <sup>+</sup>
<i>Rating of Personal Doctor</i>	73.5%	76.2%	78.0%
<i>Rating of Specialist Seen Most Often</i>	70.2% <sup>+</sup>	78.9% <sup>+</sup>	77.1% <sup>+</sup>
<i>Rating of All Health Care</i>	67.2%	69.1%	67.7%
<i>Rating of Health Plan</i>	61.4%	61.3%	69.3%

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

### COA: Strengths

For COA's CHP+ population, one measure rate increased substantially between FY 2017–2018 and FY 2018–2019:

- Rating of Health Plan* (8 percentage points)

Three of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- Getting Needed Care*
- Shared Decision Making*
- Rating of Personal Doctor*

For COA's CHP+ population, two measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Specialist Seen Most Often* (6.9 percentage points)
- *Rating of Health Plan* (7.9 percentage points)

Four of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Rating of Personal Doctor*
- *Rating of All Health Care*

#### **COA: Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS**

For COA's CHP+ population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019.

Five of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*

For COA's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.

Three of the measures showed slight rate decreases between FY 2016–2017 and FY 2018–2019:

- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

COA experienced no substantial rate decreases in FY 2018–2019 compared to the previous year. However, five measurement rates showed slight decreases. HSAG recommends that COA prioritize analysis of what may be driving the decrease in rates from FY 2017–2018 to FY 2018–2019. HSAG offers the following recommendations that COA could consider based on population needs and health plan resources.

The *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care* measures could be impacted by many variables, including members' timely access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. COA could consider the following recommendations:

- Conducting evaluations to assess staff members' and providers' customer service skills and developing training programs designed to address issues found related to both staff members and providers.
- Developing an ongoing tracking mechanism that captures why members called customer service and identifies the most common questions and concerns expressed by members. With this information, COA should develop training directed at those findings to ensure that customer service representatives, call center staff members, and clinic-based reception area staff members have the information and resources needed to address the most common concerns.
- Enhancing weekly or monthly team meetings to include evaluating staff performance during calls in which the content or request was difficult and providing peer support as needed.
- Expanding the frequency and diversity of training by coordinating cultural competency trainings with other health plans.
- Querying members regarding their communication preferences and using the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increasing follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.

## Validation of Network Adequacy

### COA: Strengths

COA's Provider Data Structure Questionnaire responses noted that COA updates its provider data using the providers' triennial recredentialing information. COA reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider. COA also reported conducting a regular review of providers' location information to ensure compliance with the health plan's address standardization specifications.

COA's data included provider specialty values conveying the licensure status of addiction counselors, allowing HSAG to accurately classify providers into applicable BH provider categories.

COA identified prenatal care (PNC) providers as individuals with obstetrics/gynecology (OB/GYN) or nurse midwifery specialties, but also included selected family medicine practitioners who offer OB/GYN services.

## **COA: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy**

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. COA also did not indicate that it uses the National Plan and Provider Enumeration System (NPPES) Registry, the American Board of Medical Specialties board certification database, or the providers' CHCP applications to validate providers' type and specialty information.

Although COA consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, COA did not restrict these data indicators by degree or credential. Further, COA reported that it does not collect providers' taxonomy codes and COA's data included similar, but not identical, data values for the provider type and specialty fields. These factors complicated HSAG's efforts to map COA's provider data to the Department's provider categories.

As the first comprehensive review of COA's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing COA's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, COA should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

## Denver Health Medical Plan, Inc. (DHMP)

### Assessment of Compliance With CHIP Managed Care Regulations

Table 3-7 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2018–2019.

**Table 3-7—Summary of DHMP Scores for the FY 2018–2019 Standards Reviewed**

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	6	3	1	0	60%
Standard IV—Member Rights and Protections	8	8	8	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	32	30	30	0	0	2	100%
Standard X—Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
<b>Totals</b>	<b>68</b>	<b>66</b>	<b>60</b>	<b>5</b>	<b>1</b>	<b>2</b>	<b>91%</b>

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

Table 3-8 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

**Table 3-8—Summary of DHMP Scores for the FY 2018–2019 Record Reviews**

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	85	85	0	15	100%
Recredentialing	90	84	84	0	6	100%
<b>Totals</b>	<b>190</b>	<b>169</b>	<b>169</b>	<b>0</b>	<b>21</b>	<b>100%</b>

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

## DHMP: Strengths

DHMP care coordination for CHP+ members was primarily delivered through the system-wide care coordination resources, tools, and programs of the Denver Health and Hospitals Authority (DHHA) clinic delivery system. Documents submitted delineated criteria for making referrals among various programs and providers. DHHA had mechanisms to coordinate care between different settings of care, with services provided through external entities, and with community and social support organizations. DHHA's Care Management program and/or its designated pediatric specialty clinic staff members had a process to conduct comprehensive needs assessments and develop service plans for members with SHCN. DHMP allowed members with SHCN to directly access specialists through a standing referral or a preauthorized number of visits. Care coordination assessments, plans, interventions, and referrals were documented and communicated through the Epic electronic health record (EHR) system, available to all DHHA providers and care coordination staff members, as well as approved external provider entities.

DHMP's policies and procedures that addressed member rights and protections included a list of all federally mandated CHP+ member rights, which were also well-articulated in the CHP+ member handbook and provider manual. DHMP policies and procedures addressed providing DHMP staff members and providers initial and annual training regarding member rights. DHMP had robust policies, procedures, and organizational practices to ensure members' privacy and confidentiality rights under HIPAA. Policies and procedures adequately addressed federal regulations related to advance directives, and DHMP's website included information regarding advance directives.

DHMP had a well-defined credentialing and recredentialing program that met all NCQA standards. On-site record reviews confirmed that DHMP implemented processes compliant with all NCQA credentialing and recredentialing requirements for practitioners and organizational providers. DHMP conducted ongoing monitoring of federal exclusion databases to ensure practitioners and providers had not been excluded from federal healthcare participation. DHMP had a delegation agreement with DHHA for credentialing and recredentialing practitioners that served CHP+ members through DHHA clinics and facilities. DHMP demonstrated that it provided oversight to ensure the quality and completeness of DHHA's credentialing and recredentialing activities.

DHMP's Quality Improvement (QI) Program Description and QI Impact Analysis demonstrated that it had a comprehensive QAPI program in place. The QAPI program was conducted in partnership with DHHA and addressed the availability and adequacy of services, CPGs, continuity and coordination of care, investigation of quality of care complaints, PIPs, HEDIS measures, and CAHPS measures. DHMP demonstrated that all CHP+ QAPI activities and data were reported to the Department as required. DHMP had policies and procedures for adopting CPGs in compliance with requirements and had practice guidelines in place for specific CHP+ health conditions as required by the Department. DHMP distributed practice guidelines to providers through the DHHA intranet, targeted mailings, and the DHMP website. HIS documents demonstrated that DHMP had access to a robust, enterprise-wide DHHA information system with well-integrated components, allowing DHMP to access all necessary data for management of the health plan. DHMP claims systems electronically and manually verified claims data received from providers for completeness, coding accuracy and appropriateness, and service authorizations. DHMP monthly submitted electronic batch encounter data to the Department in required formats.



## **DHMP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations**

HSAG identified no opportunities for improvement that resulted in required actions related to Standard IV—Member Rights and Protections and Standard VIII—Credentialing and Recredentialing.

### ***Standard III—Coordination and Continuity of Care***

DHMP did not have a process in place to ensure that all newly enrolled CHP+ members needing continuity of care were identified and that services to prevent disruption in care were provided as needed. DHMP did not have an active mechanism to ensure that each CHP+ member has an ongoing source of primary care—e.g., a PCP. DHMP also did not have procedures in place to conduct an initial assessment of each new CHP+ member's needs that included all State-required initial assessment elements. While DHHA's Care Management program included a comprehensive assessment of members with SHCN when members were referred to the Care Management program, mechanisms were unclear regarding how CHP+ members with SHCN were identified and referred to DHHA's Care Management program. DHMP was required to:

- Define and implement procedures for providing continuity of care for newly enrolled CHP+ members to prevent disruption in the provision of medically necessary services.
- Implement mechanisms to ensure that each CHP+ member has an ongoing source of primary care and that DHMP provides information to the member on how to contact his or her PCP.
- Implement a mechanism to conduct an initial screening of each CHP+ member's health needs within 90 days of enrollment. The initial screening must include assessment of mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health needs.
- Ensure that each member with SHCN is consistently identified and receives a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

### ***Standard X—Quality Assessment and Performance Improvement***

DHMP did not demonstrate that it has a mechanism for detection or analysis of under- or overutilization of services as a component of the QAPI program. While DHMP had operational processes targeted toward enhancing the quality of care delivered to individual members with SHCN, DHMP did not demonstrate that it periodically assesses the overall quality of care being delivered to members with SHCN. DHMP was required to:

- Incorporate mechanisms to detect both under- and overutilization of services into its QAPI program.
- Develop and implement mechanisms within its QAPI program to assess the overall quality and appropriateness of care provided to CHP+ members with SHCN.



## DHMP: Trended Performance for Compliance With Regulations

Table 3-9 displays DHMP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

**Table 3-9—Compliance With Regulations Trended Performance for DHMP**

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	85%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	81%	92%
<b>Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*</b>	<b>100%</b>	<b>60%</b>
<b>Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*</b>	<b>100%</b>	<b>100%</b>
Standard V—Member Information (2014–2015, 2017–2018)	91%	83%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	81%	91%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	100%	79%
<b>Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*</b>	<b>98%</b>	<b>100%</b>
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	NA
<b>Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*</b>	<b>93%</b>	<b>89%</b>

*\*Bold text indicates standards reviewed by HSAG during FY 2018–2019.*

Trending scores over the past six years indicate that DHMP improved performance in four of the 10 standards: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VI—Grievance and Appeal System, and Standard VIII—Credentialing and Recredentialing, with approximately a 10 percentage point increase in three of those standards. In two standard areas, Standard IV—Member Rights and Protections and Standard X—Credentialing and Recredentialing, DHMP maintained consistent compliance at or near 100 percent. DHMP experienced slight declines in performance—less than 10 percent—in two standards, Standard V—Member Information and Standard X—Quality Assessment and Performance, and experienced substantial declines in Standard III—Coordination and Continuity of Care (40 percentage points) and Standard VII—Provider Participation and Program Integrity (21 percentage points). Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as “NA” for CHP+ health plans in FY 2017–2018, there are no comparable results for Standard IX. HSAG cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods.

## Validation of Performance Measures

### Compliance With IS Standards

According to DHMP's 2019 HEDIS Compliance Audit Report, DHMP was fully compliant with all IS standards relevant to the scope of the PMV performed by the health plan's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted DHMP's HEDIS performance measure reporting.

### Performance Measure Results

Table 3-10 shows the performance measure results for DHMP for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

**Table 3-10—Performance Measure Results for DHMP**

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>				
<b><i>Childhood Immunization Status<sup>1</sup></i></b>				
<i>Combination 2</i>	73.28%	BR	67.46%	10th–24th
<i>Combination 3</i>	73.28%	BR	65.87%	25th–49th
<i>Combination 4</i>	73.28%	BR	65.87%	25th–49th
<i>Combination 5</i>	67.24%	BR	57.94%	25th–49th
<i>Combination 6</i>	53.45%	BR	46.03%	50th–74th
<i>Combination 7</i>	67.24%	BR	57.94%	25th–49th
<i>Combination 8</i>	53.45%	BR	46.03%	50th–74th
<i>Combination 9</i>	50.86%	BR	41.27%	50th–74th
<i>Combination 10</i>	50.86%	BR	41.27%	75th–89th
<b><i>Immunizations for Adolescents</i></b>				
<i>Combination 1 (Meningococcal, Tdap)</i>	72.06%	68.81%	82.24%^	50th–74th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	49.54%	55.92%	≥90th
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>				
<i>Zero Visits*</i>	6.78%	NA	15.15%	<10th
<i>Six or More Visits</i>	6.78%	NA	63.64%	25th–49th
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	59.48%	46.64%	64.74%^	10th–24th
<b><i>Adolescent Well-Care Visits</i></b>				
<i>Adolescent Well-Care Visits</i>	41.37%	37.64%	45.30%^	10th–24th
<b><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></b>				
<i>BMI Percentile Documentation—Total<sup>1</sup></i>	7.94%	17.71%	21.80%^	<10th
<i>Counseling for Nutrition—Total</i>	1.46%	6.41%	7.93%	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Counseling for Physical Activity—Total</i>	0.80%	1.40%	6.65%^	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
<i>Appropriate Testing for Children With Pharyngitis</i>	83.87%	NA	83.33%	50th–74th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
<i>Ages 12 to 24 Months</i>	93.98%	69.03%	90.36%^	<10th
<i>Ages 25 Months to 6 Years</i>	71.52%	57.24%	73.58%^	<10th
<i>Ages 7 to 11 Years</i>	85.65%	81.33%	86.93%^	10th–24th
<i>Ages 12 to 19 Years</i>	85.48%	78.05%	82.04%	10th–24th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
<i>Ages 16 to 20 Years</i>	56.06%	39.74%	47.22%	25th–49th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	0.00%	0.00%	0.00%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
<i>Effective Acute Phase Treatment</i>	NA	NA	NA	—
<i>Effective Continuation Phase Treatment</i>	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
<i>Initiation Phase</i>	NA	NA	NA	—
<i>Continuation and Maintenance Phase</i>	NA	NA	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
<i>Total</i>	—	NA	NA	—
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</b>				
<i>Total</i>	NA	NA	NA	—
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	91.40%	100.00%	100.00%	≥90th
<b>Medication Management for People With Asthma</b>				
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<b>Asthma Medication Ratio</b>				
<i>Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 18 Years</i>	NA	NA	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Use of Services†</b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
ED Visits*	18.09	18.43	21.49	≥90th
Outpatient Visits <sup>1</sup>	117.49	123.51	135.56	<10th
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
Discharges per 1,000 Member Months (Total Inpatient)	0.88	0.69	0.82	<10th
Average Length of Stay (Total Inpatient)	2.80	4.25	3.07	<10th
Discharges per 1,000 Member Months (Medicine)	0.65	0.49	0.60	<10th
Average Length of Stay (Medicine)	2.68	2.90	2.59	<10th
Discharges per 1,000 Member Months (Surgery)	0.21	0.18	0.17	<10th
Average Length of Stay (Surgery)	2.92†	8.07†	5.07†	<10th
Discharges per 1,000 Member Months (Maternity)	0.03	0.02	0.09	<10th
Average Length of Stay (Maternity)	6.00†	2.00†	2.00†	<10th
<b>Antibiotic Utilization*</b>				
Average Scripts PMPY for Antibiotics	0.13	0.09	0.14	≥90th
Average Days Supplied per Antibiotic Script	10.47	12.07	11.28	<10th
Average Scripts PMPY for Antibiotics of Concern	0.03	0.02	0.03	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	26.07%	23.31%	24.04%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017. Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate. BR (Biased Rate) indicates that the reported rate was invalid; therefore, the rate is not presented.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

## DHMP: Strengths

The following HEDIS 2019 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for DHMP:

- *Childhood Immunization Status—Combination 10*

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

DHMP showed strong performance with vaccinating children and adolescents for HEDIS 2019 by ranking above the 50th percentile for six of 11 (54.5 percent) measure rates and by demonstrating improvement and exceeding the 90th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measure indicator. Additionally, the MCO continued to demonstrate strength ensuring providers are not overusing inappropriate treatments for members with respiratory infections and not screening young women unnecessarily for cervical cancer.

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

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for DHMP:

- *Childhood Immunization Status—Combination 2*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years*

Despite demonstrating significant improvement for seven of 11 (63.6 percent) measure rates determined to be low performers for HEDIS 2019, DHMP continued to demonstrate opportunities to improve access to preventive care and services for children and adolescents. The MCO and the Department should identify the factors contributing to the low rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source challenges) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.<sup>3-16</sup>

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<sup>3-16</sup> American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Accessed on: Jul 16, 2019.

## Validation of Performance Improvement Projects

Table 3-11 presents the FY 2018–2019 validation findings for DHMP's PIP.

**Table 3-11—Validation Findings for the *Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age* PIP**

Module 1—PIP Initiation	
<b>Narrowed Focus Population</b>	Members 15 through 18 years of age attributed to Webb Pediatrics Patient-Centered Medical Home (PCMH).
<b>SMART Aim Statement</b>	By June 30, 2020, increase the percentage of Denver Health CHP+ Members aged 15–18 assigned to the Webb Pediatrics PCMH who attend at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner year from 54.36% to 66.44%.
Module 2—SMART Aim Data Collection	
<b>SMART Aim Measure</b>	The percentage of Denver Health CHP+ members ages 15 through 18 as of the last day of each rolling 12-month measurement period assigned to the Webb Pediatrics PCMH, and who attended at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner within each rolling 12-month measurement period.
<b>SMART Aim Data Collection Plan</b>	<ul style="list-style-type: none"> <li><b>Data Source:</b> Administrative claims and electronic medical record (EMR) data.</li> <li><b>Methodology:</b> Monthly data collection using a rolling 12-month measurement period.</li> </ul>

### DHMP: Strengths

DHMP selected a PIP topic focused on increasing the rate of well-care visits among members 15 through 18 years of age. The CHP+ health plan has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that DHMP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. DHMP has progressed to Module 3, where the CHP+ health plan will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, DHMP will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ health plan will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As DHMP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on



impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.

- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ health plan progresses through the steps for determining and testing interventions.

## CAHPS Survey

### Findings

Table 3-12 shows the results achieved by DHMP for FY 2016–2017 through FY 2018–2019.

**Table 3-12—Question Summary Rates and Global Proportions for DHMP**

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
<i>Getting Needed Care</i>	75.8%	83.5%	79.7%
<i>Getting Care Quickly</i>	80.6%	88.4%	85.0%
<i>How Well Doctors Communicate</i>	96.5%	95.6%	94.4%
<i>Customer Service</i>	81.4%	84.4%	87.8%
<i>Shared Decision Making</i>	74.8% <sup>+</sup>	72.5% <sup>+</sup>	72.8% <sup>+</sup>
<i>Rating of Personal Doctor</i>	80.3%	84.6%	75.7%
<i>Rating of Specialist Seen Most Often</i>	77.4% <sup>+</sup>	84.1% <sup>+</sup>	85.3% <sup>+</sup>
<i>Rating of All Health Care</i>	67.8%	70.2%	69.2%
<i>Rating of Health Plan</i>	67.4%	65.3%	65.4%

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

### DHMP: Strengths

For DHMP's CHP+ population, no measure rates increased substantially between FY 2017–2018 and FY 2018–2019.

Four of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Customer Service*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

For DHMP's CHP+ population, two measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Customer Service* (6.4 percentage points)
- *Rating of Specialist Seen Most Often* (7.9 percentage points)

Three of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Rating of All Health Care*

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

For DHMP's CHP+ population, one measure rate decreased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of Personal Doctor* (8.9 percentage points)

Four of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

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

For DHMP's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.



Four of the measures showed slight rate decreases between FY 2016–2017 and FY 2018–2019:

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

DHMP experienced one substantial score decrease in FY 2018–2019 compared to the previous year. Additionally, four measure rates showed slight decreases compared to the previous year. HSAG recommends that DHMP prioritize analysis of what may be driving the decrease in the *Rating of Personal Doctor* rate from FY 2017–2018 to FY 2018–2019. However, to improve member perception for this measure, and others that demonstrated a decrease from FY 2017–2018 to FY 2018–2019, HSAG offers the following recommendations for DHMP to consider based on population needs and health plan resources.

The *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of all Health Care* measures could be impacted by many variables, including members' timely access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. HSAG recommends that DHMP:

- Conduct evaluations to assess staff members' and providers' customer service skills, and develop training programs designed to address issues found for both staff members and providers.
- Query members regarding their communication preferences and use the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Ensure continued ongoing communication to remind members, providers, and call center staff members of timeliness access standards and where to access after-hours care.
- Consider expanding the contracted provider network for primary care as well as specialists.
- Consider further expanding use of walk-in clinics and services and provide members and families ongoing reminders of where to access walk-in care.
- Evaluate the effectiveness of current processes for telephonic or other technology-based communications with members that provide intermittent interventions, when needed, to decrease the need for formal appointments with providers.
- Evaluate scheduling mechanisms related to CHP+ timely access to appointment standards, perhaps including assessment and training of schedulers to assess the urgency of an appointment request; and providing schedulers with CHP+ specific information to direct members to alternative sources of service when appropriate.

- Develop provider training forums or procedures that encourage providers to verify or ensure that members understand communications.
- Explore creative mechanisms for member engagement, such as expanding member advisory committees, developing community-based member committees, or offering member mentorship programs.
- Coordinate with community organizations to enhance disease management programs; and offer health education and support related to chronic conditions (i.e., asthma, diabetes, and weight management) to children, youth, and families.

## **Validation of Network Adequacy**

### **DHMP: Strengths**

DHMP's Provider Data Structure Questionnaire responses noted that DHMP updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPES Registry, the American Board of Medical Specialties board certification database, and the providers' CHCP applications. DHMP noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the DHMP data system, these individual providers were not listed on provider network rosters. DHMP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

DHMP reported including Denver Public Health within its provider network, facilitating identification of providers who serve members with clinical conditions of public health importance.

### **DHMP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy**

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although DHMP noted using the self-reported provider specialty information to identify PCPs or PNC providers, DHMP did not restrict these data indicators by degree or credential. Additionally, DHMP's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map DHMP's provider data to the Department's provider categories. Further, DHMP reported that panel capacity information was not available in its provider data system, though DHMP did not state whether such information may be obtained during the PCPs' application or credentialing process. Finally, provider data submitted by DHMP included no records for substance abuse treatment facilities.

As the first comprehensive review of DHMP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing DHMP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, DHMP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

## Friday Health Plans of Colorado (FHP)

### Assessment of Compliance With CHIP Managed Care Regulations

Table 3-13 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2018–2019.

**Table 3-13—Summary of FHP Scores for the FY 2018–2019 Standards Reviewed**

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	9	9	7	2	0	0	78%
Standard IV—Member Rights and Protections	8	8	7	1	0	0	88%
Standard VIII—Credentialing and Recredentialing	32	28	24	4	0	4	86%
Standard X—Quality Assessment and Performance Improvement	18	18	15	1	2	0	83%
<b>Totals</b>	<b>67</b>	<b>63</b>	<b>53</b>	<b>8</b>	<b>2</b>	<b>4</b>	<b>84%</b>

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

Table 3-14 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

**Table 3-14—Summary of FHP Scores for the FY 2018–2019 Record Reviews**

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	93	90	3	7	97%
Recredentialing	90	87	87	0	3	100%
<b>Totals</b>	<b>190</b>	<b>180</b>	<b>177</b>	<b>3</b>	<b>10</b>	<b>98%</b>

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

### FHP: Strengths

FHP integrated CHP+ members into its medical management and services coordination processes applicable to all FHP lines of business. FHP's HRA, administered to members on enrollment, included all required screening indicators to identify CHP+ members with SHCN and/or in need of continuity of care or coordination services. FHP reported that its small CHP+ population included very few members with ongoing complex medical or behavioral needs. FHP provided evidence that it performed a comprehensive assessment, developed a service plan for members identified as having special needs, and shared the assessment and service plan with providers and other entities involved in the member's care. The provider manual instructed providers to share results of assessments and members' treatment plans with other providers. Due to the small CHP+ population, staff members stated that FHP widely uses interpersonal interactions and relationships with providers and other entities to manage care for CHP+ members.

FHP's Member Rights and Responsibilities policy and procedure required all employees and providers to comply with all applicable federal and State laws related to member rights and listed specific CHP+ member rights. FHP included member rights in the CHP+ member handbook and provider manual. FHP requires that all employees participate in member rights training at time of hire. FHP notified providers about their responsibility to take member rights into account when furnishing services via the provider contract and provider manual. Customer service staff members participated in weekly meetings to identify and address any issues related to member rights. FHP had a robust HIPAA privacy policy and procedure for ensuring appropriate protection of personal health information. FHP had a well-written, comprehensive desktop procedure that addressed requirements related to advance directives and staff and member education related to advance directives. FHP demonstrated that it conducts annual CHP+ chart reviews that include review of advance directive requirements.

FHP's Credentialing Plan was compliant with NCQA requirements and guidelines and delineated the types of practitioners and facilities subject to credentialing and recredentialing, the criteria for joining

the FHP network, and credentialing verification sources used. FHP delegated no NCQA-required credentialing and recredentialing activities. The Credentialing Plan described the roles of credentialing staff members, the medical director, and the credentialing committee. FHP provided evidence of processes for ongoing monitoring for practitioner Medicare and Medicaid sanctions, complaints, and quality issues between recredentialing cycles.

FHP's Quality Assurance Plan demonstrated that FHP has an ongoing comprehensive QAPI program applicable to CHP+ members. FHP had many resources dedicated to QAPI activities: an established organizational structure, established organizational processes related to each component of the program, and oversight of the program by two quality improvement committees. Due to the relatively small CHP+ population, FHP integrated CHP+ members into all of its health plan-wide QAPI activities. Physician Advisory Committee minutes confirmed that QAPI program components included peer review, medical record review, credentialing, review of authorization outcomes, assessment of quality of care concerns, review of grievance and appeal activity, and clinical input into quality improvement activities. FHP participated in PIPs, HEDIS performance measures, and CAHPS surveys, which were compliant with all related requirements. The Quality Management Program Committee (QMPC) reviewed results of member surveys, grievances, and HEDIS measures and initiated internal corrective action plans as indicated. The Quality Assurance Plan outlined well-defined criteria for annual evaluation of overall effectiveness of the QAPI program. FHP had processes for adopting CPGs in compliance with requirements and had practice guidelines in place for specific CHP+ health conditions as required by the Department. FHP disseminated practice guidelines to members and providers through its website. FHP demonstrated that its HIS collects, integrates, analyzes, and reports data in compliance with federal managed care requirements. FHP's claims processing systems collect all required data to enable monthly encounter data submission to the Department in the required format. FHP employed automated system edits and manual screenings of claims data from providers to ensure accuracy, timeliness, completeness, and coding logic of claim information. FHP's HIS adequately performed all required health information functions.

## **FHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations**

### ***Standard III—Coordination and Continuity of Care***

FHP's policies and procedures outlined processes for ensuring delivery of care and coordination of services but did not address the requirement that all CHP+ members or family members consent to the medical treatment plan. In addition, while FHP preferred to coordinate care with other healthcare plans through the member's provider, FHP did not have procedures to directly coordinate services being received by CHP+ members with other managed care and FFS health plans or when the member is transitioning between health plans. FHP was required to:

- Define procedures to ensure that CHP+ members and/or authorized family members are involved in treatment planning and consent to any medical treatment.
- Develop and implement procedures to directly coordinate services being received by CHP+ members with other managed care and FFS health plans when indicated.

#### ***Standard IV—Member Rights and Protections***

FHP's Notification of Advance Directives desktop procedure included no provisions for providing information regarding advance directives to an adult member's family or surrogate if the member is incapacitated at the time of initial enrollment. FHP was required to:

- Convert its desktop procedure into a more formal policy and procedure and revise its processes to include provisions for providing information regarding advance directives to an adult CHP+ member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder.

#### ***Standard VIII—Credentialing and Recredentialing***

While FHP's credentialing and recredentialing policies and procedures described processes that were consistent with NCQA Standards and Guidelines, on-site record reviews documented several cases in which FHP did not comply with its policies and procedures. Examples included: accepting a provider into the network prior to receiving the provider applicant's signed attestation, accepting providers into the network prior to federal sanction information being received, and failing to recredential organizational providers within the required 36-month time frame. In addition, while review of organizational credentialing files demonstrated that FHP adhered to the requirement for using CMS or State quality reviews in lieu of site visits, this process was not documented in FHP's Credentialing Plan. FHP was required to:

- Ensure that staff members collect signed attestations from provider applicants prior to accepting the provider into the network.
- Ensure that a provider is not accepted into the network prior to information from federal exclusion databases being received and reviewed.
- Ensure that staff members recredential organizational providers every 36 months.
- Revise its credentialing process documentation to include the NCQA requirements related to on-site quality assessment for unaccredited organizational providers.

#### ***Standard X—Quality Assessment and Performance Improvement***

While FHP applied internal operational processes—i.e., coordination of services—to enhance the quality and appropriateness of care for individual CHP+ members with SHCN, FHP had no mechanism within its QAPI program to assess the overall quality and appropriateness of care furnished to these members. While FHP has a well-defined approach for adopting and disseminating CPGs in compliance with requirements, FHP did not demonstrate having an internal process for ensuring that other decisions to which the guidelines apply are consistent with adopted practice guidelines. While FHP demonstrated having the capability to produce on-demand utilization data trending reports, HSAG found no evidence that these types of reports were reviewed or that data were sufficiently analyzed within the QAPI program to determine potential under- or overutilization of services. FHP was required to:



- Implement a mechanism within its QAPI program to periodically assess quality and appropriateness of care for members with SHCN.
- Define and implement a process to ensure that utilization management (UM) decisions, member education materials, and other areas to which practice guidelines apply are consistent with adopted practice guidelines.
- Define and implement mechanisms within the QAPI program to systematically detect and determine concerns regarding both underutilization and overutilization of services.

### FHP: Trended Performance for Compliance With Regulations

Table 3-15 displays FHP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

**Table 3-15—Compliance With Regulations Trended Performance for FHP**

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	71%	91%
Standard II—Access and Availability (2013–2014, 2016–2017)	73%	79%
<b>Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*</b>	<b>50%</b>	<b>78%</b>
<b>Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*</b>	<b>80%</b>	<b>88%</b>
Standard V—Member Information (2014–2015, 2017–2018)	74%	92%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	27%	82%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	69%	93%
<b>Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*</b>	<b>77%</b>	<b>86%</b>
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	60%	NA
<b>Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*</b>	<b>73%</b>	<b>83%</b>

\*Bold text indicates standards reviewed by HSAG during FY 2018–2019.

Trending scores over the past six years indicate that FHP improved performance in nine of the 10 standards, with the greatest improvement (55 percentage points) observed in Standard VI—Grievance and Appeal System and substantial improvements (18 percentage points to 28 percentage points) in Standard I—Coverage and Authorization, Standard III—Coordination and Continuity of Care, Standard V—Member Information, and Standard VII—Provider Participation and Program Integrity. FHP also demonstrated improvement (10 percentage points or less) in four additional standards: Standard II—Access and Availability, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as “NA” for CHP+ health plans in FY 2017–2018, there are no comparable results for Standard IX. HSAG

cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods. Over the six-year cycle of compliance reviews, FHP has consistently demonstrated increased understanding and implementation of compliance with managed care regulations.

## Validation of Performance Measures

### Compliance With IS Standards

According to FHP's 2019 HEDIS Compliance Audit Report, FHP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted FHP's HEDIS performance measure reporting.

### Performance Measure Results

Table 3-16 shows the performance measure results for FHP for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

**Table 3-16—Performance Measure Results for FHP**

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>				
<b><i>Childhood Immunization Status<sup>1</sup></i></b>				
<i>Combination 2</i>	4.08%	7.84%	4.76%	<10th
<i>Combination 3</i>	4.08%	5.88%	4.76%	<10th
<i>Combination 4</i>	2.04%	3.92%	4.76%	<10th
<i>Combination 5</i>	0.00%	0.00%	4.76%	<10th
<i>Combination 6</i>	2.04%	3.92%	0.00%	<10th
<i>Combination 7</i>	0.00%	0.00%	4.76%	<10th
<i>Combination 8</i>	0.00%	1.96%	0.00%	<10th
<i>Combination 9</i>	0.00%	0.00%	0.00%	<10th
<i>Combination 10</i>	0.00%	0.00%	0.00%	<10th
<b><i>Immunizations for Adolescents</i></b>				
<i>Combination 1 (Meningococcal, Tdap)</i>	14.81%	15.94%	26.32%	<10th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	5.80%	12.28%	<10th
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>				
<i>Zero Visits*</i>	NA	NA	NA	—
<i>Six or More Visits</i>	NA	NA	NA	—



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	42.18%	43.72%	55.62%^	<10th
<b>Adolescent Well-Care Visits</b>				
Adolescent Well-Care Visits	28.92%	25.05%	37.65%^	10th–24th
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
BMI Percentile Documentation—Total <sup>1</sup>	1.53%	1.69%	9.70%^	<10th
Counseling for Nutrition—Total	3.44%	5.92%	4.65%	<10th
Counseling for Physical Activity—Total	4.01%	3.38%	6.26%	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
Appropriate Testing for Children With Pharyngitis	74.07%	77.55%	81.16%	50th–74th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
Ages 12 to 24 Months	79.41%	NA	NA	—
Ages 25 Months to 6 Years	65.12%	65.33%	71.90%	<10th
Ages 7 to 11 Years	72.61%	73.58%	87.18%^	10th–24th
Ages 12 to 19 Years	76.50%	80.49%	86.43%	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
Ages 16 to 20 Years	NA	13.95%	NA	—
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.00%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
Total	—	NA	NA	—
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</b>				
Total	NA	NA	NA	—
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
Appropriate Treatment for Children With Upper Respiratory Infection	83.72%	87.72%	92.63%	50th–74th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Medication Management for People With Asthma</b>				
Medication Compliance 50%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
<b>Asthma Medication Ratio</b>				
Ages 5 to 11 Years	NA	NA	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
<b>Use of Services†</b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
ED Visits*	15.26	15.98	17.33	≥90th
Outpatient Visits <sup>1</sup>	176.00	175.38	166.81	<10th
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
Discharges per 1,000 Member Months (Total Inpatient)	0.81	0.65	0.37	<10th
Average Length of Stay (Total Inpatient)	2.56†	2.13†	2.33†	<10th
Discharges per 1,000 Member Months (Medicine)	0.54	0.45	0.21	<10th
Average Length of Stay (Medicine)	2.25†	2.36†	2.00†	<10th
Discharges per 1,000 Member Months (Surgery)	0.27	0.16	0.17	<10th
Average Length of Stay (Surgery)	3.17†	1.50†	1.50†	<10th
Discharges per 1,000 Member Months (Maternity)	NA	0.08	0.00	<10th
Average Length of Stay (Maternity)	NA	2.00†	NA	—
<b>Antibiotic Utilization*</b>				
Average Scripts PMPY for Antibiotics	0.50	0.97	12.00	<10th
Average Days Supplied per Antibiotic Script	12.39	16.68	99.95	<10th
Average Scripts PMPY for Antibiotics of Concern	0.20	0.41	2.32	<10th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	39.01%	41.62%	19.35%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017.

Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

## FHP: Strengths

The following HEDIS 2019 measure rate was determined to be a high performer (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for FHP:

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

FHP continued to demonstrate strong performance in ensuring young women were not unnecessarily screened for cervical cancer, with the *Non-Recommended Cervical Cancer Screening in Adolescent Females* rate exceeding the 90th percentile. Additionally, the MCO demonstrated improvement from the prior year and ranked above the 50th percentile for measures related to the appropriate testing and treatment of respiratory infections.

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

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for FHP:

- *Childhood Immunization Status—Combinations 2–10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years and Ages 7 to 11 Years*

FHP's performance demonstrated opportunities to improve access to preventive care and services for children and adolescents, with the reportable rates for well-child/well-care visits and *Children and Adolescents' Access to Primary Care Practitioners* below the 50th percentile. Further, all *Childhood Immunization Status*, *Immunizations for Adolescents*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* rates were below the 10th percentile for HEDIS 2019, indicating the MCO should work with the Department and providers to identify the causes for the low rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source challenges) and ensure children and adolescents receive

comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.<sup>3-17</sup>

## Validation of Performance Improvement Projects

Table 3-17 presents the FY 2018–2019 validation findings for FHP's PIP.

**Table 3-17—Validation Findings for the *Well-Child Visits in the 6th Through 14th Years of Life* PIP**

Module 1—PIP Initiation	
<b>Narrowed Focus Population</b>	Members 6 through 14 years of age attributed to San Luis Valley Health.
<b>SMART Aim Statement</b>	By 6/30/2020, we will increase the percentage of members who meet the eligibility requirements during the measurement period receiving their well-child exam at San Luis Valley Health between the ages of 6 to 14 from 38% to 45%.
Module 2—SMART Aim Data Collection	
<b>SMART Aim Measure</b>	The percentage of members 6 through 14 years of age attributed to San Luis Valley Health during the rolling 12-month measurement period who each received a preventive or wellness visit during the measurement period.
<b>SMART Aim Data Collection Plan</b>	<ul style="list-style-type: none"> <li>• <b>Data Source:</b> Administrative claims.</li> <li>• <b>Methodology:</b> Monthly data collection using a rolling 12-month measurement period.</li> </ul>

## FHP: Strengths

FHP selected a PIP topic focused on increasing the rate of well-child visits among members 6 through 14 years of age. The MCO has passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that FHP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. FHP has progressed to Module 3, where the MCO will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, FHP will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ MCO will eventually use PDSA cycles to test

<sup>3-17</sup> American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Accessed on: Jul 16, 2019.

and refine interventions to achieve the goal for the project. As FHP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ MCO progresses through the steps for determining and testing interventions.

## CAHPS Surveys

### Findings

Table 3-18 shows the results achieved by FHP for FY 2016–2017 through FY 2018–2019.

**Table 3-18—Question Summary Rates and Global Proportions for FHP**

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
<i>Getting Needed Care</i>	87.9%	86.1%	90.1% <sup>+</sup>
<i>Getting Care Quickly</i>	93.7%	89.9%	91.0% <sup>+</sup>
<i>How Well Doctors Communicate</i>	96.5%	95.3%	92.9%
<i>Customer Service</i>	76.9% <sup>+</sup>	82.0% <sup>+</sup>	84.0% <sup>+</sup>
<i>Shared Decision Making</i>	81.8% <sup>+</sup>	84.6% <sup>+</sup>	80.4% <sup>+</sup>
<i>Rating of Personal Doctor</i>	66.4%	62.3%	71.0%
<i>Rating of Specialist Seen Most Often</i>	62.5% <sup>+</sup>	67.6% <sup>+</sup>	71.1% <sup>+</sup>
<i>Rating of All Health Care</i>	54.5%	52.2%	50.6%
<i>Rating of Health Plan</i>	46.7%	47.4%	55.2%

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

### FHP: Strengths

For FHP's CHP+ population, two measure rates increased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of Personal Doctor* (8.7 percentage points)
- *Rating of Health Plan* (7.8 percentage points)

Four of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Rating of Specialist Seen Most Often*

For FHP's CHP+ population, three measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Customer Service* (7.1 percentage points)
- *Rating of Specialist Seen Most Often* (8.6 percentage points)
- *Rating of Health Plan* (8.5 percentage points)

Two of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

- *Getting Needed Care*
- *Rating of Personal Doctor*

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

For FHP's CHP+ population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019.

Three of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

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

For FHP's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.

Four of the measures showed slight rate decreases between FY 2016–2017 and FY 2018–2019:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of All Health Care*

FHP experienced no substantial rate decreases in FY 2018–2019 compared to the previous year. However, three measurement rates showed slight decreases. HSAG recommends that FHP prioritize analysis of what may be driving the decrease in rates from FY 2017–2018 to FY 2018–2019. HSAG offers the following recommendations that FHP could consider based on population needs and health plan resources.

The *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of All Health Care* measures could be impacted by many variables, including members' timely access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. FHP could consider the following recommendations:

- Conduct evaluations to assess staff members' and providers' customer service skills, and develop training programs designed to address issues found related to both staff members and providers.
- Expanding the frequency and diversity of training by coordinating cultural competency trainings with other health plans.
- Query members regarding their communication preferences and use the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Exploring creative mechanisms for member engagement, such as expanding member advisory committees, developing community-based member committees, or offering member mentorship programs.



## **Validation of Network Adequacy**

### **FHP: Strengths**

FHP's Provider Data Structure Questionnaire responses noted that FHP updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPES Registry, the American Board of Medical Specialties board certification database, and the providers' CHCP applications. While providers with single case agreements were identified within the FHP data system, these individual providers were not listed on provider network rosters. FHP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

### **FHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy**

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although FHP noted using the self-reported provider specialty information to identify PCPs or PNC providers, FHP did not restrict these data indicators by degree or credential. Additionally, FHP's data included similar, but not identical, data values for the provider specialty fields, complicating HSAG's efforts to map FHP's provider data to the Department's provider categories. Further, FHP reported that panel capacity information was not available in its provider data system, though FHP did not state whether such information may be obtained during the PCPs' application or credentialing process. Finally, provider data submitted by FHP included no records for substance abuse treatment facilities, no provider type values, and offered limited specialty values for facility-level providers (e.g., hospitals).

As the first comprehensive review of FHP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing FHP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, FHP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.



## Kaiser Permanente Colorado (Kaiser)

### Assessment of Compliance With CHIP Managed Care Regulations

Table 3-19 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2018–2019.

**Table 3-19—Summary of Kaiser Scores for the FY 2018–2019 Standards Reviewed**

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	8	2	0	0	80%
Standard IV—Member Rights and Protections	8	8	7	1	0	0	88%
Standard VIII—Credentialing and Recredentialing	32	30	30	0	0	2	100%
Standard X—Quality Assessment and Performance Improvement	18	18	16	2	0	0	89%
<b>Totals</b>	<b>68</b>	<b>66</b>	<b>61</b>	<b>5</b>	<b>0</b>	<b>2</b>	<b>92%</b>

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

Table 3-20 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

**Table 3-20—Summary of Kaiser Scores for the FY 2018–2019 Record Reviews**

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	96	96	0	4	100%
Recredentialing	90	87	87	0	3	100%
<b>Totals</b>	<b>190</b>	<b>183</b>	<b>183</b>	<b>0</b>	<b>7</b>	<b>100%</b>

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

## Kaiser: Strengths

All CHP+ members received healthcare services through Kaiser's employed and affiliate specialists and hospital provider network. Kaiser demonstrated that it has system-wide resources dedicated to care coordination, which included numerous primary care clinic-based services supplemented by the pediatric care coordination and complex case management programs. Care managers coordinated with multiple providers, agencies, and community organizations, as indicated, and demonstrated processes for active coordination of services between multiple settings of care. Kaiser had a process in place to outreach to new members to ensure that each member has an ongoing source of primary care and to conduct an initial needs assessment. Pediatric care coordination and complex case management programs had procedures to conduct comprehensive assessments, develop a service plan, and coordinate needed services for members with SHCN. Kaiser used its HealthConnect EHR system as the primary mechanism for documenting and communicating referrals, assessments, and treatment or service plans to all network providers. Kaiser had a process for allowing all members to self-refer and directly access any internal Kaiser specialist and for staff members to arrange for long-term approvals and referrals to out-of-network specialists when required.

Kaiser's policies and procedures and internal documents that addressed member rights and protections included all federally mandated CHP+ member rights. Member rights were also well-articulated in the CHP+ member handbook and the provider manual. Kaiser had processes for ensuring that member written communications were provided in alternative formats and easy-to-understand language. Kaiser also had robust policies, procedures, and organizational practices to ensure privacy and confidentiality rights under HIPAA. In addition, policies and procedures adequately addressed federal regulations related to advance directives, and information regarding advance directives was available on Kaiser's website.

Kaiser demonstrated that it had a well-defined credentialing and recredentialing program that was compliant with all NCQA standards and guidelines for credentialing practitioners and assessing contracted organizational providers. Kaiser had delegation agreements with the Kaiser Permanente Medical Group for credentialing and recredentialing practitioners and organizational providers associated with Kaiser's clinics and facilities and with University Physicians, Incorporated. Kaiser provided evidence of adequate oversight to ensure the quality and completeness of both medical groups' credentialing and recredentialing activities.

Kaiser's system-wide QAPI documents described a multilevel, extensive process for oversight and analysis of the quality of services furnished to CHP+ members. The QAPI program specific to CHP+ members focused on CHP+ PIPs, CHP+ HEDIS measures, CAHPS data, quality of care concerns, and grievances and appeals. Kaiser's CHP+ PIP met the required design parameters. Kaiser trended quarterly grievance and appeal data and quality of care concerns. CHP+ members were also included in the system-wide Kaiser QAPI program, which included QAPI measures and initiatives applicable to the entire Kaiser population. The regional Service, Quality, and Resource Management Committee (SQRMC) provided oversight of the integrated patient care quality program. Kaiser demonstrated that the SQRMC annually evaluated the structure and effectiveness of the integrated patient care quality program. Kaiser had policies and procedures for the development of CPGs in compliance with

requirements and had adopted practice guidelines for specific CHP+ health conditions as required by the Department. Guidelines were posted for clinicians on the internal website and were embedded into the automated “smart-sets” in the EHR. Staff members stated that members could access clinical care guidelines during treatment visits to a clinic or through the Kaiser website. Documents submitted described multiple data systems that collect data from various clinical and business points of contact throughout the Kaiser system, exchanging information with external providers and organizations, and compiling data in the system-wide data warehouse. Kaiser’s HIS integrated claims data from multiple sources for adjudication of the claim. Kaiser applied automated and manual claims edits to verify completeness, accuracy, coding appropriateness, logic, and consistency of claims, and submitted monthly encounter data to the Department in required formats.

### **Kaiser: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations**

HSAG identified no opportunities for improvement that resulted in required actions related to Standard VIII—Credentialing and Recredentialing.

#### ***Standard III—Coordination and Continuity of Care***

While Kaiser provided information indicating that it has various points of service through which the need for continuity of care for newly enrolled members may be identified, HSAG found potential gaps in the processes to identifying a member to a provider that would ensure provision of necessary services for continuity of care. In addition, while Kaiser had mechanisms for conducting an initial screening of each new member’s needs, the assessment did not include all CHP+ contract-required categories of need. Kaiser was required to:

- Enhance procedures for providing continuity of care to newly enrolled members to ensure that any member identified as having continuity of care needs receives timely follow-up by providers or staff members to prevent disruption in provision of services.
- Define and implement a process to conduct an initial assessment of each new member’s needs (within 90 days of enrollment) that incorporates screening for all CHP+ required categories of need—mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems.

#### ***Standard IV—Member Rights and Protections***

The description of member rights in member and provider materials related to the member’s right to “receive information in accordance with information requirements (42 CFR §438.10)” did not articulate requirements about *how* member information must be presented by the MCO—i.e., in a language and format that would be best understood by the member. Kaiser was required to:

- Clarify the statement of member rights in member and provider materials to state that members have the right to receive information from the MCO in plain language, in English or an alternative

language if preferred by the member, and in a way that takes the member's communication needs into consideration.

### Standard X—Quality Assessment and Performance Improvement

While Kaiser described tracking multiple utilization indicators throughout the delivery system, Kaiser did not produce evidence that the described utilization tracking processes resulted in an assessment or determination of over- or underutilization of specific services as a component of the QAPI program. Kaiser was required to:

- Provide evidence that mechanisms to detect over- and underutilization of services are incorporated into the QAPI program and analyzed as such.

### Kaiser: Trended Performance for Compliance With Regulations

Table 3-21 displays Kaiser's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

**Table 3-21—Compliance With Regulations Trended Performance for Kaiser**

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	91%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	95%	93%
<b>Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*</b>	<b>75%</b>	<b>80%</b>
<b>Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*</b>	<b>60%</b>	<b>88%</b>
Standard V—Member Information (2014–2015, 2017–2018)	52%	100%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	65%	68%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	88%	87%
<b>Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*</b>	<b>100%</b>	<b>100%</b>
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	NA
<b>Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*</b>	<b>67%</b>	<b>89%</b>

*\*Bold text indicates standards reviewed by HSAG during FY 2018–2019.*

Trending scores over the past six years indicate that Kaiser substantially improved performance in three standards: Standard IV—Member Rights and Protections (28 percentage points), Standard V—Member Information (48 percentage points), and Standard X—Quality Assessment and Improvement (22 percentage points). Kaiser also demonstrated slight improvement (5 percentage points or less) in three additional standards: Standard I—Coverage and Authorization of Services, Standard III—Coordination and Continuity of Care, and Standard VI—Grievance and Appeal System. Although Kaiser demonstrated

slight improvement in Standard VI—Grievance and Appeal System, results remained consistently low (from 65 percentage points to 68 percentage points) over the two review periods. Kaiser maintained consistent compliance (variance of 2 percentage points or less) in Standard II—Access and Availability, Standard VII—Provider Participation and Program Integrity, and Standard VIII—Credentialing and Recredentialing. Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as “NA” to CHP+ MCOs in FY 2017–2018, there are no comparable results for Standard IX. HSAG cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods.

## Validation of Performance Measures

### Compliance With IS Standards

According to Kaiser’s 2019 HEDIS Compliance Audit Report, Kaiser was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO’s licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted Kaiser’s performance measure reporting.

### Performance Measure Results

Table 3-22 shows the performance measure results for Kaiser for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

**Table 3-22—Performance Measure Results for Kaiser**

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>				
<b><i>Childhood Immunization Status<sup>1</sup></i></b>				
<i>Combination 2</i>	79.34%	70.85%	69.46%	10th–24th
<i>Combination 3</i>	78.93%	70.17%	67.36%	25th–49th
<i>Combination 4</i>	78.93%	69.15%	66.95%	25th–49th
<i>Combination 5</i>	72.31%	62.03%	62.76%	50th–74th
<i>Combination 6</i>	50.41%	43.73%	41.84%	50th–74th
<i>Combination 7</i>	72.31%	61.02%	62.34%	50th–74th
<i>Combination 8</i>	50.41%	43.39%	41.84%	50th–74th
<i>Combination 9</i>	47.11%	39.32%	40.59%	50th–74th
<i>Combination 10</i>	47.11%	38.98%	40.59%	50th–74th
<b><i>Immunizations for Adolescents</i></b>				
<i>Combination 1 (Meningococcal, Tdap)</i>	86.02%	82.30%	82.84%	50th–74th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	53.98%	56.44%	≥90th
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>				
<i>Zero Visits*</i>	2.53%	2.91%	2.02%	25th–49th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Six or More Visits</i>	67.09%	66.02%	73.74%	75th–89th
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	67.99%	59.35%	65.44%^	10th–24th
<b>Adolescent Well-Care Visits</b>				
<i>Adolescent Well-Care Visits</i>	59.26%	41.18%	45.24%^	10th–24th
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
<i>BMI Percentile Documentation—Total<sup>1</sup></i>	94.10%	97.29%	98.57%	≥90th
<i>Counseling for Nutrition—Total</i>	97.18%	95.57%	96.18%	≥90th
<i>Counseling for Physical Activity—Total</i>	97.18%	95.57%	96.18%	≥90th
<b>Appropriate Testing for Children With Pharyngitis</b>				
<i>Appropriate Testing for Children With Pharyngitis</i>	96.58%	96.37%	94.20%	≥90th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
<i>Ages 12 to 24 Months</i>	87.43%	87.44%	97.22%^	75th–89th
<i>Ages 25 Months to 6 Years</i>	79.56%	75.76%	83.25%^	10th–24th
<i>Ages 7 to 11 Years</i>	87.93%	86.56%	86.81%	10th–24th
<i>Ages 12 to 19 Years</i>	87.81%	88.45%	88.26%	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
<i>Ages 16 to 20 Years</i>	48.46%	41.43%	45.51%	10th–24th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	0.27%	0.17%	0.00%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
<i>Effective Acute Phase Treatment</i>	NA	NA	NA	—
<i>Effective Continuation Phase Treatment</i>	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
<i>Initiation Phase</i>	NA	NA	45.16%	50th–74th
<i>Continuation and Maintenance Phase</i>	NA	NA	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
<i>Total</i>	—	NA	NA	—
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</b>				
<i>Total</i>	NA	NA	NA	—
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	98.91%	99.01%	96.94%	≥90th



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Medication Management for People With Asthma</b>				
Medication Compliance 50%—Ages 5 to 11 Years	NA	46.67%	NA	—
Medication Compliance 50%—Ages 12 to 18 Years	NA	NA	NA	—
Medication Compliance 75%—Ages 5 to 11 Years	NA	23.33%	NA	—
Medication Compliance 75%—Ages 12 to 18 Years	NA	NA	NA	—
<b>Asthma Medication Ratio</b>				
Ages 5 to 11 Years	NA	93.33%	NA	—
Ages 12 to 18 Years	NA	NA	NA	—
<b>Use of Services†</b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
ED Visits*	2.98	11.54	18.86	≥90th
Outpatient Visits <sup>1</sup>	179.23	151.08	133.57	<10th
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
Discharges per 1,000 Member Months (Total Inpatient)	0.64	0.62	0.49	<10th
Average Length of Stay (Total Inpatient)	3.35	3.51	3.67	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.49	0.46	0.40	<10th
Average Length of Stay (Medicine)	3.04	3.34	2.29	<10th
Discharges per 1,000 Member Months (Surgery)	0.15	0.12	0.08	<10th
Average Length of Stay (Surgery)	4.36†	4.24†	10.50†	<10th
Discharges per 1,000 Member Months (Maternity)	0.00	0.07	0.01	<10th
Average Length of Stay (Maternity)	NA	3.20†	3.00†	<10th
<b>Antibiotic Utilization*</b>				
Average Scripts PMPY for Antibiotics	0.28	0.26	0.19	≥90th
Average Days Supplied per Antibiotic Script	12.32	12.15	12.47	<10th
Average Scripts PMPY for Antibiotics of Concern	0.08	0.05	0.05	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	28.27%	19.57%	24.21%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017.

Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

## Kaiser: Strengths

The following HEDIS 2019 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for Kaiser:

- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*
- *Appropriate Testing for Children With Pharyngitis*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

For HEDIS 2019, Kaiser demonstrated strong performance with children and adolescents receiving vaccinations by ranking above the 50th percentile for eight of 11 (72.7 percent) measure rates and exceeding the 90th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* indicator. Additionally, the MCO continued to demonstrate the appropriate management of members with respiratory infections and ensuring young women are not being screened unnecessarily for cervical cancer.

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

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for Kaiser:

- *Childhood Immunization Status—Combination 2*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years and Ages 7 to 11 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

Kaiser demonstrated opportunities to improve the access to appropriate providers and services for members 2 years of age and older, as evidenced by the following measure rates falling below the 50th percentile: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Adolescent Well-Care*



*Visits; Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years; and Chlamydia Screening in Women—Ages 16 to 20 Years.* The MCO should work with the Department and providers to identify the causes for the low rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or the need for improved community outreach and education) and implement strategies to improve the preventive care for these members.

## Validation of Performance Improvement Projects

Table 3-23 presents the FY 2018–2019 validation findings for Kaiser's PIP.

**Table 3-23—Validation Findings for the *Improving CHP+ Adolescent Well-Visit Adherence* PIP**

Module 1—PIP Initiation	
<b>Narrowed Focus Population</b>	Members aged 15–18 years attributed to Aurora Centrepont Medical Office Building.
<b>SMART Aim Statement</b>	By June 30, 2020, increase the percentage of individuals with a well visit in the previous 12 months among continuously-enrolled CHP+ members aged 15–18 years who are linked to the Aurora Centrepont Medical Office Building from 34.3% to 47.3%.
Module 2—SMART Aim Data Collection	
<b>SMART Aim Measure</b>	Percentage of Child Health Plan Plus members linked to Kaiser Permanente's Aurora Centrepont Medical Offices and ages 15 through 18 as of the last day of the 12th month of the measurement year with at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the 12-month rolling measurement period.
<b>SMART Aim Data Collection Plan</b>	<ul style="list-style-type: none"> <li>• <b>Data Source:</b> Kaiser Permanente's Common Membership System and electronic medical records.</li> <li>• <b>Methodology:</b> Monthly data collection based on a rolling 12-month measurement period.</li> </ul>

## Kaiser: Strengths

Kaiser selected a PIP topic focused on increasing the rate of well-check visits among members 15 through 18 years of age. The CHP+ MCO passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that Kaiser designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. Kaiser has progressed to Module 3, where the CHP+ MCO will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, Kaiser will have the opportunity to analyze existing processes related to improving the well-care visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ MCO will eventually use PDSA cycles to test and refine interventions to achieve the goal for the project. As Kaiser continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ MCO progresses through the steps for determining and testing interventions.

## CAHPS Surveys

### Findings

Table 3-24 shows the results achieved by Kaiser for FY 2016–2017 through FY 2018–2019.

**Table 3-24—Question Summary Rates and Global Proportions for Kaiser**

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
<i>Getting Needed Care</i>	88.0%	84.5%	85.5%
<i>Getting Care Quickly</i>	92.0%	88.8%	90.8%
<i>How Well Doctors Communicate</i>	96.7%	95.7%	97.8%
<i>Customer Service</i>	85.1%	86.0%	86.5%
<i>Shared Decision Making</i>	80.4% <sup>+</sup>	88.2% <sup>+</sup>	84.9% <sup>+</sup>
<i>Rating of Personal Doctor</i>	72.9%	74.5%	78.1%
<i>Rating of Specialist Seen Most Often</i>	62.5% <sup>+</sup>	75.7% <sup>+</sup>	73.3% <sup>+</sup>
<i>Rating of All Health Care</i>	67.5%	68.1%	67.2%
<i>Rating of Health Plan</i>	61.0%	61.1%	60.9%

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

## Kaiser: Strengths

For Kaiser's CHP+ population, no measure rates increased substantially between FY 2017–2018 and FY 2018–2019.

Five of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Personal Doctor*

For Kaiser's CHP+ population, two measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Personal Doctor* (5.2 percentage points)
- *Rating of Specialist Seen Most Often* (10.8 percentage points)

Three of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

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

For Kaiser's CHP+ population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019.

Four of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

For Kaiser's CHP+ population, no measure rates decreased substantially between FY 2016–2017 and FY 2018–2019.

Four of the measures showed slight rate decreases between FY 2016–2017 and FY 2018–2019:

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

Kaiser experienced no substantial rate decreases in FY 2018–2019 compared to the previous year; however, for the measure rates that showed slight decreases compared to the previous year, HSAG offers the following recommendations for Kaiser to consider based on population needs and MCO resources.

The *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan* measures could be impacted by many variables, including members' timely access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, whether a member receives the services as the member perceives is needed, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. HSAG recommends that Kaiser consider the following:

- Continue to carefully monitor and evaluate the provider network, considering the total number of practitioners providing services to all payor sources, provider workloads, and available capacity for children and youth at various clinic locations within the network.
- Evaluate the effectiveness of current processes for telephonic or other technology-based communications with members that provide intermittent interventions, when needed, to decrease the need for formal appointments with providers.
- Evaluate scheduling mechanisms related to CHP+ timely access to appointment standards, perhaps including assessment and training of schedulers to assess the urgency of an appointment request; and providing schedulers with CHP+ specific information to direct members to alternative sources of service when appropriate.
- Evaluate PCP to specialist referral patterns and consider expanding contracted specialist relationships.
- Ensure continued ongoing communication to remind members, providers, and call center staff members of timeliness access standards and where to access after-hours care.
- Consider further expanding use of walk-in clinics and services and provide members and families ongoing reminders of where to access walk-in care.
- Coordinate with community organizations to enhance disease management programs; and offer health education and support related to chronic conditions (i.e., asthma, diabetes, and weight management) to children, youth, and families.

## **Validation of Network Adequacy**

### **Kaiser: Strengths**

Kaiser's Provider Data Structure Questionnaire responses noted that Kaiser updates its provider data using the providers' triennial recredentialing information and validates providers' type and specialty information against the following public data verification resources: the NPPES Registry, the American Board of Medical Specialties board certification database, and the providers' CHCP applications. DHMP noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the Kaiser data system, these individual providers were not listed on provider network rosters. Kaiser reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

### **Kaiser: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy**

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although Kaiser noted using the self-reported provider specialty information to identify PCPs or PNC providers, Kaiser did not restrict these data indicators by degree or credential. Additionally, Kaiser's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map Kaiser's provider data to the Department's provider categories. Further, Kaiser reported that panel capacity information was not available in its provider data system, though Kaiser did not state whether such information may be obtained during the PCPs' application or credentialing process. Finally, provider data submitted by Kaiser included no provider type values and offered limited specialty values for facility-level providers (e.g., hospitals).

As the first comprehensive review of Kaiser's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing Kaiser's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, Kaiser should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

## Rocky Mountain Health Plans (RMHP)

### Assessment of Compliance With CHIP Managed Care Regulations

Table 3-25 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2018–2019.

**Table 3-25—Summary of RMHP Scores for the FY 2018–2019 Standards Reviewed**

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score* (% of Met Elements)
Standard III—Coordination and Continuity of Care	10	10	8	2	0	0	80%
Standard IV—Member Rights and Protections	8	8	7	1	0	0	88%
Standard VIII—Credentialing and Recredentialing	32	32	32	0	0	0	100%
Standard X—Quality Assessment and Performance Improvement	18	18	15	3	0	0	83%
<b>Totals</b>	<b>68</b>	<b>68</b>	<b>62</b>	<b>6</b>	<b>0</b>	<b>0</b>	<b>91%</b>

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

Table 3-26 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall record review score for FY 2018–2019.

**Table 3-26—Summary of RMHP Scores for the FY 2018–2019 Record Reviews**

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score* (% of Met Elements)
Credentialing	100	91	91	0	9	100%
Recredentialing	90	86	86	0	4	100%
<b>Totals</b>	<b>190</b>	<b>177</b>	<b>177</b>	<b>0</b>	<b>13</b>	<b>100%</b>

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

## RMHP: Strengths

RMHP's Care Coordination policy and procedure defined a comprehensive care management program to assist members with access to needed services. RMHP's care coordination program included coordinating with the members' providers, assisting in referrals to specialists and community-based organizations, providing complex care coordination for members receiving services from multiple providers and agencies, involving members and family members in treatment and service planning, and providing continuity of care for newly enrolled members. RMHP used available medical, behavioral, and social support needs data and information from intake screenings and comprehensive needs assessments to stratify all members into four tiers of need to determine potential care coordination interventions. RMHP provided evidence of well-integrated program staff members, as well as 10 additional integrated care coordination teams distributed regionwide, to provide care coordination services in local communities. Customer service staff members had procedures for conducting outreach welcome calls to all newly enrolled members to explain the benefits of the plan, assist members with selecting a PCP, conduct initial intake screenings, and identify member continuity of care needs. If intake screenings indicated that a member may have coordination or continuity of care needs, customer service staff members referred the member to care management staff members for follow-up and further assessment. RMHP care coordination staff members assumed the lead coordinator role for all members with complex needs and had policies and procedures for ensuring transitions of care between settings, coordinating with other health plans when applicable, and coordinating with community organizations and agencies. All documentation of member-specific care management information, including health needs assessments and service plans, was entered and maintained in the Essette care management software, which enabled secure sharing of care coordination files among designated health entities in the region. Provider service agreements and the provider manual outlined requirements for maintaining and sharing medical records with other providers in a HIPAA-compliant manner. RMHP's comprehensive care coordination program and integrated staff members and procedures ensured that all CHP+ members had access to care coordination services appropriate to their needs.

RMHP policies and procedures delineated the member rights and responsibilities and included methods for the distribution of these rights to members and providers. The CHP+ member booklet and RMHP website identified the full list of member rights. RMHP required, through its provider contracts, that providers take these member rights into account when furnishing services. RMHP had procedures for monitoring member calls to customer service to identify any issue of dissatisfaction that could be related to a rights issue. RMHP addressed advance directive information within its policies, the CHP+ benefits booklet, and the RMHP provider manual. RMHP policies, staff procedures, and mandatory in-service trainings addressed compliance with federal and State laws pertaining to member rights, including HIPAA privacy requirements.

RMHP's policies and procedures related to the initial credentialing and recredentialing of providers and organizations were well-organized, thorough, and compliant with NCQA credentialing and recredentialing standards and guidelines. Credentialing and recredentialing record reviews demonstrated that staff members were credentialing and recredentialing providers and health delivery organizations in a manner consistent with the written procedures and all NCQA-required standards. RMHP staff members described a process for monthly review of OIG and SAM queries. RMHP provided evidence



of a facility site evaluation tool and assessment survey to evaluate organizations that had not had a State site survey and were not currently accredited. RMHP delegated credentialing and recredentialing to several contracted organizations and provided audit reports demonstrating oversight of delegated providers. Delegation agreements described required credentialing activities, responsibilities, and reporting requirements, and delineated remedies should the delegate fall short of its obligations.

RMHP's Quality Improvement Program description, corporate QI work plan, and monthly committee meeting minutes demonstrated a multidisciplinary, multidepartmental comprehensive QAPI program. The program was supported by three primary oversight committees and included routine reporting, analysis of results, and planned interventions for quality improvement initiatives. Components of the Quality Improvement Program (QIP) included, but were not limited to, CHP+ PIPs, CHP+ HEDIS measures, and CAHPS data. The CHP+ PIP met the required design parameters. The annual QIP impact analysis included an assessment of quality improvement effectiveness within each major area of activity. RMHP staff members also described the Practice Transformation Program, which was designed to coach and assist providers in improving quality of care and performance within individual practices. RMHP adopted CPGs in compliance with requirements and had practice guidelines in place for CHP+ specific health conditions as required by the Department. RMHP distributed CPGs to providers and members through the RMHP website and staff members stated that select practice guidelines were distributed to individual practices through the Practice Transformation Program. RMHP's HIS documents outlined a highly integrated multi-component data system for collecting, processing, and reporting claims as well as clinical and operational information. RMHP collected information from providers in standardized formats. Claims data received from providers were verified for completeness and accuracy through three separate and increasingly detailed electronic editing applications, with additional manual review as necessary. RMHP's policies and procedures described the process for monthly claims submission to the Department in required formats.

### **RMHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance With Regulations**

HSAG identified no opportunities for improvement that resulted in required actions related to Standard VIII—Credentialing and Recredentialing.

### ***Standard III—Coordination and Continuity of Care***

While RMHP demonstrated having a variety of member communications intended to ensure that each member selects a PCP, RMHP did not have a routine mechanism to inform a CHP+ member of how to contact his or her designated PCP. While RMHP demonstrated mechanisms to conduct an initial intake screening of all newly enrolled CHP+ members, the intake screening implemented during the compliance review period did not include assessment for BH needs, functional problems, or other complex health needs, as required by the Department. RMHP was required to:

- Implement a mechanism to inform each member how to contact his or her PCP for ongoing coordination of healthcare services.

- Implement an expanded intake assessment that addresses all required components of the health screening defined by the Department.

#### ***Standard IV—Member Rights and Protections***

While RMHP provided education to providers and adult members regarding advance directives, RMHP did not have provisions for educating the community at large regarding advance directives. RMHP was required to:

- Develop provisions for community education regarding advance directives, including what constitutes an advance directive; emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment; and description of applicable State law concerning advance directives.

#### ***Standard X—Quality Assessment and Performance Improvement***

RMHP did not demonstrate that it reviewed and analyzed utilization measures to detect over- or underutilization as a component of the QAPI program. In addition, while the QAPI program description addressed mechanisms in place to manage the care needed by individual members with SHCN, the intent of the care management activities was not to assess the quality of care provided to CHP+ members with SHCN. While RMHP verbally described a process for ensuring UM decisions were consistent with CPGs, written procedures and processes did not articulate accountabilities for ensuring consistency of UM guidelines with CPGs, nor was a process outlined to ensure that member education materials or other operational activities were consistent with applicable CPGs. RMHP was required to:

- Define and implement mechanisms to systematically detect and determine, as a component of its QAPI program, concerns regarding both underutilization and overutilization of services by CHP+ members.
- Develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care furnished to CHP+ members with SHCN.
- Enhance internal procedures and defined accountabilities to ensure that decisions for UM, member education, coverage of services, and other areas to which CPGs apply are consistent with adopted guidelines.

## RMHP: Trended Performance for Compliance With Regulations

Table 3-27 displays RMHP's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

**Table 3-27—Compliance With Regulations Trended Performance for RMHP**

Standard and Applicable Review Years	Previous Review	Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	85%	97%
Standard II—Access and Availability (2013–2014, 2016–2017)	86%	100%
<b>Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)*</b>	<b>100%</b>	<b>80%</b>
<b>Standard IV—Member Rights and Protections (2015–2016, 2018–2019)*</b>	<b>80%</b>	<b>88%</b>
Standard V—Member Information (2014–2015, 2017–2018)	52%	100%
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	77%	82%
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	94%	93%
<b>Standard VIII—Credentialing and Recredentialing (2015–2016, 2018–2019)*</b>	<b>100%</b>	<b>100%</b>
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	NA
<b>Standard X—Quality Assessment and Performance Improvement (2015–2016, 2018–2019)*</b>	<b>100%</b>	<b>83%</b>

*\*Bold text indicates standards reviewed by HSAG during FY 2018–2019.*

Trending scores over the past six years indicate that RMHP improved performance in five of the 10 standards, with the greatest increase (48 percentage points) in Standard V—Member Information and moderate increases (12 to 14 percentage points) in Standard I—Coverage and Authorization and Standard II—Access and Availability. RMHP demonstrated a slight increase (less than 10 percentage points) in performance in Standard IV—Member Rights and Protections and Standard VI—Grievance and Appeal System. RMHP experienced declines of at or near 20 percentage points in performance for Standard III—Coordination and Continuity of Care and Standard X—Quality Assessment and Performance Improvement. In two standard areas, Standard VII—Provider Participation and Program Integrity and Standard VIII—Credentialing and Recredentialing, RMHP maintained consistent performance above 90 percent. Due to HSAG scoring Standard IX—Subcontracts and Delegation requirements as “NA” to CHP+ MCOs in FY 2017–2018, there are no comparable results for Standard IX. HSAG cautions that, over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of compliance monitoring tools—may have impacted comparability of the compliance results over review periods.

## Validation of Performance Measures

### Compliance With IS Standards

According to RMHP's 2019 HEDIS Compliance Audit Report, RMHP was fully compliant with all IS standards relevant to the scope of the PMV performed by the MCO's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor identified no issues that impacted RMHP's HEDIS performance measure reporting.

### Performance Measure Results

Table 3-28 shows the performance measure results for RMHP for HEDIS 2017 through HEDIS 2019, along with the percentile rankings for each HEDIS 2019 rate.

**Table 3-28—Performance Measure Results for RMHP**

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>				
<b><i>Childhood Immunization Status<sup>1</sup></i></b>				
<i>Combination 2</i>	58.27%	64.80%	57.08%	<10th
<i>Combination 3</i>	55.91%	62.40%	57.08%	<10th
<i>Combination 4</i>	54.33%	60.40%	54.42%	<10th
<i>Combination 5</i>	51.57%	54.40%	54.87%	10th–24th
<i>Combination 6</i>	43.31%	41.20%	41.15%	50th–74th
<i>Combination 7</i>	50.39%	53.20%	52.21%	10th–24th
<i>Combination 8</i>	42.13%	41.20%	39.38%	25th–49th
<i>Combination 9</i>	40.16%	36.40%	39.82%	50th–74th
<i>Combination 10</i>	39.37%	36.40%	38.05%	50th–74th
<b><i>Immunizations for Adolescents</i></b>				
<i>Combination 1 (Meningococcal, Tdap)</i>	49.61%	60.87%	57.67%	<10th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	13.71%	18.33%	<10th
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>				
<i>Zero Visits*</i>	3.00%	5.00%	0.00%^	≥90th
<i>Six or More Visits</i>	23.00%	29.00%	15.79%^^	<10th
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	63.66%	68.75%	67.68%	25th–49th
<b><i>Adolescent Well-Care Visits</i></b>				
<i>Adolescent Well-Care Visits</i>	43.69%	47.07%	49.19%	25th–49th
<b><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></b>				
<i>BMI Percentile Documentation—Total<sup>1</sup></i>	4.44%	4.38%	4.83%	<10th
<i>Counseling for Nutrition—Total</i>	19.04%	21.52%	23.00%	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Counseling for Physical Activity—Total</i>	1.29%	3.51%	5.50%	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
<i>Appropriate Testing for Children With Pharyngitis</i>	78.26%	80.27%	77.64%	25th–49th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
<i>Ages 12 to 24 Months</i>	91.26%	93.48%	94.68%	25th–49th
<i>Ages 25 Months to 6 Years</i>	82.13%	83.49%	82.81%	10th–24th
<i>Ages 7 to 11 Years</i>	86.72%	86.90%	88.00%	25th–49th
<i>Ages 12 to 19 Years</i>	87.34%	86.82%	87.04%	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
<i>Ages 16 to 20 Years</i>	23.31%	31.93%	33.57%	<10th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	0.00%	0.00%	0.00%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
<i>Effective Acute Phase Treatment</i>	NA	NA	NA	—
<i>Effective Continuation Phase Treatment</i>	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication<sup>2</sup></b>				
<i>Initiation Phase</i>	NA	47.06%	53.33%	75th–89th
<i>Continuation and Maintenance Phase</i>	NA	NA	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
<i>Total</i>	—	NA	NA	—
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</b>				
<i>Total</i>	NA	NA	NA	—
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	95.41%	95.80%	93.68%	50th–74th
<b>Medication Management for People With Asthma</b>				
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<b>Asthma Medication Ratio</b>				
<i>Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 18 Years</i>	NA	NA	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Use of Services†</b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
ED Visits*	18.26	18.26	18.38	≥90th
Outpatient Visits <sup>1</sup>	212.07	218.41	211.60	<10th
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
Discharges per 1,000 Member Months (Total Inpatient)	0.73	0.89	0.75	<10th
Average Length of Stay (Total Inpatient)	3.01	4.11	4.37	50th–74th
Discharges per 1,000 Member Months (Medicine)	0.45	0.59	0.49	<10th
Average Length of Stay (Medicine)	2.57	3.29	3.27	<10th
Discharges per 1,000 Member Months (Surgery)	0.27	0.28	0.21	<10th
Average Length of Stay (Surgery)	3.71	5.91	7.46†	<10th
Discharges per 1,000 Member Months (Maternity)	0.02	0.03	0.10	<10th
Average Length of Stay (Maternity)	4.00†	2.50†	2.33†	<10th
<b>Antibiotic Utilization*</b>				
Average Scripts PMPY for Antibiotics	0.40	0.40	0.39	≥90th
Average Days Supplied per Antibiotic Script	10.49	10.18	10.20	<10th
Average Scripts PMPY for Antibiotics of Concern	0.15	0.14	0.14	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	38.64%	35.07%	35.98%	75th–89th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

<sup>2</sup> Due to changes in the technical specifications for this measure in 2018, NCQA recommends trending between 2018 and prior years be considered with caution.

— Indicates that comparisons to benchmarks are not appropriate or the MCOs were not required to report this measure for 2017. Additionally, this symbol may also indicate that NCQA recommended a break in trending in 2018; therefore, the 2017 rates are not displayed.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.



## RMHP: Strengths

The following HEDIS 2019 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for RMHP:

- *Well-Child Visits in the First 15 Months of Life—Zero Visits*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

For HEDIS 2019, RMHP demonstrated strong performance ensuring children received at least one well-child visit by exceeding the 90th percentile for the *Well-Child Visits in the First 15 Months of Life—Zero Visits* indicator. Additionally, the MCO continued to demonstrate strength ensuring that young women were not screened unnecessarily for cervical cancer.

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

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for RMHP:

- *Childhood Immunization Status—Combinations 2–5 and 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*

RMHP's performance demonstrated opportunities to improve access to care and services for children and adolescents, with all but one rate for the well-child/well-care visits measures (*Well-Child Visits in the First 15 Months of Life—Zero Visits*) and all rates for the *Children and Adolescents' Access to Primary Care Practitioners* measure below the 50th percentile. Further, rates for *Immunizations for Adolescents*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, *Chlamydia Screening in Women*, and eight of 11 (72.7 percent) *Childhood Immunization Status* indicators were below the 50th percentile for HEDIS 2019. The MCO should work with the Department and providers to identify the causes for the low rates for these measures (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source



challenges) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.<sup>3-18</sup>

## Validation of Performance Improvement Projects

Table 3-29 presents the FY 2018–2019 validation findings for RMHP's PIP.

**Table 3-29—Validation Findings for the *Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18* PIP**

Module 1—PIP Initiation	
<b>Narrowed Focus Population</b>	Members 15 through 18 years of age attributed to Mountain Family Health Center.
<b>SMART Aim Statement</b>	By 6/30/2020, increase the percentage of well-child visits among CHP+ Members at Mountain Family Health Center 15 through 18 years of age, from 42.39% to 53.26%.
Module 2—SMART Aim Data Collection	
<b>SMART Aim Measure</b>	The percentage of members 15 through 18 years of age attributed to Mountain Family Health Center during the rolling 12-month measurement period who received a preventive or wellness visit during the measurement period.
<b>SMART Aim Data Collection Plan</b>	<ul style="list-style-type: none"> <li>• <b>Data Source:</b> Administrative claims.</li> <li>• <b>Methodology:</b> Monthly data collection using a rolling 12-month measurement period.</li> </ul>

## RMHP: Strengths

RMHP selected a PIP topic focused on increasing the rate of well-child visits among members 15 to 18 years of age. The CHP+ MCO passed Module 1 and Module 2 and achieved all validation criteria for the first two modules of the PIP. The validation findings suggest that RMHP designed a methodologically sound project, and was successful in building quality improvement teams and establishing collaborative partnerships. RMHP has progressed to Module 3, where the CHP+ MCO will determine potential interventions to test for the PIP.

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

In the next phase of the PIP, RMHP will have the opportunity to analyze existing processes related to improving the well-child visit rate at the level of the narrowed focus and identify process gaps or flaws that can be addressed through interventions. The CHP+ MCO will eventually use PDSA cycles to test

<sup>3-18</sup> American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Accessed on: Jul 16, 2019.

and refine interventions to achieve the goal for the project. As RMHP continues through the rapid-cycle PIP modules, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- The intended effect of the intervention should be determined before testing begins to ensure a sound data collection plan for the intervention evaluation. Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ MCO progresses through the steps for determining and testing interventions.

## CAHPS Surveys

### Findings

Table 3-30 shows the results achieved by RMHP for FY 2016–2017 through FY 2018–2019.

**Table 3-30—Question Summary Rates and Global Proportions for RMHP**

Measure	FY 2016–2017 Score	FY 2017–2018 Score	FY 2018–2019 Score
<i>Getting Needed Care</i>	88.2%	88.4%	90.1%
<i>Getting Care Quickly</i>	92.5%	91.8%	93.3%
<i>How Well Doctors Communicate</i>	97.3%	97.9%	97.1%
<i>Customer Service</i>	86.2% <sup>+</sup>	83.9%	87.9%
<i>Shared Decision Making</i>	76.2% <sup>+</sup>	84.2% <sup>+</sup>	84.8% <sup>+</sup>
<i>Rating of Personal Doctor</i>	77.6%	72.8%	71.2%
<i>Rating of Specialist Seen Most Often</i>	77.5% <sup>+</sup>	80.5% <sup>+</sup>	82.9% <sup>+</sup>
<i>Rating of All Health Care</i>	66.6%	67.2%	67.7%
<i>Rating of Health Plan</i>	60.6%	63.2%	68.3%

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

### RMHP: Strengths

For RMHP's CHP+ population, one measure rate increased substantially between FY 2017–2018 and FY 2018–2019:

- *Rating of Health Plan* (5.1 percentage points)

Six of the measures demonstrated slight increases between FY 2017–2018 and FY 2018–2019:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*

For RMHP's CHP+ population, three measure rates increased substantially between FY 2016–2017 and FY 2018–2019:

- *Shared Decision Making* (8.6 percentage points)
- *Rating of Specialist Seen Most Often* (5.4 percentage points)
- *Rating of Health Plan* (7.7 percentage points)

Four of the measures demonstrated slight increases between FY 2016–2017 and FY 2018–2019:

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

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

For RMHP's CHP+ population, no measure rates decreased substantially between FY 2017–2018 and FY 2018–2019.

Two of the measures showed slight rate decreases between FY 2017–2018 and FY 2018–2019:

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

For RMHP's CHP+ population, one measure rate decreased substantially between FY 2016–2017 and FY 2018–2019:

- *Rating of Personal Doctor* (6.4 percentage points)

One of the measures showed a slight rate decrease between FY 2016–2017 and FY 2018–2019:

- *How Well Doctors Communicate*

RMHP experienced no substantial rate decreases in FY 2018–2019 compared to the previous year. However, two measurement rates showed slight decreases. The *How Well Doctors Communicate* and the *Rating of Personal Doctor* measures could be impacted by many variables, including members' access to care, providers' cultural competency or communication methods regarding treatment recommendations or medication, or whether the member feels treated with courtesy and respect by customer service staff members and/or providers. HSAG offers the following for RMHP to consider based on population needs and MCO resources:

- Expand the frequency and diversity of training by coordinating cultural competency trainings with community organizations.
- Query members regarding their communication preferences and use the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increase follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Coordinate with community organizations to enhance disease management programs; and offer health education and support related to chronic conditions (i.e., asthma, diabetes, and weight management) to children, youth, and families.

## Validation of Network Adequacy

### RMHP: Strengths

RMHP's Provider Data Structure Questionnaire responses noted that RMHP validated providers' type and specialty information against the following public data verification resources: NPES Registry, the American Board of Medical Specialties board certification database, and the providers' CHCP applications. RMHP noted that it validated self-reported provider information against data listed in the provider's CHCP application. While providers with single case agreements were identified within the RMHP data system, these individual providers were not listed on provider network rosters. RMHP reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

RMHP reported assigning providers a PCP indicator if the practicing specialty included adolescent, family, geriatric, internal, pediatric, or OB/GYN specialties. RMHP also reported using a status

confirmation process to identify and verify provider directory notations for providers with a PCP-like specialty who did not wish to serve as a PCP. RMHP reported conducting monthly outreach to PCPs to verify demographic, location, and panel capacity information.

RMHP identified PNC providers as individuals with an OB/GYN or nurse midwifery specialty, but also included selected family medicine practitioners who offer OB/GYN services.

### **RMHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Network Adequacy**

During this review, HSAG noted that when each health plan identified group and/or facility-level providers, many of the health plans included no provider type values for facilities such as hospitals, pharmacies, or multi-specialty practices, indicating that each health plan may handle records for these categories of providers using different methods than used for the individual-level providers. Although RMHP consistently noted using the self-reported provider specialty information to identify PCPs or PNC providers, RMHP did not restrict these data indicators by degree or credential. Additionally, RMHP's data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map RMHP's provider data to the Department's provider categories. RMHP's data submission reflected physician-level taxonomy codes for NPs' provider records; because these NPs had no NP taxonomy codes, HSAG was unable to assign these providers to applicable PCA categories. Finally, provider data submitted by RMHP included no records for substance abuse treatment facilities.

As the first comprehensive review of RMHP's provider networks, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing RMHP's compliance with network adequacy standards. HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. Therefore, RMHP should assess available data values in its provider data systems and standardize available data value options to ensure complete and accurate data are used for assessments of network adequacy.

## Delta Dental of Colorado (Delta Dental)

### *Assessment of Compliance With CHIP Managed Care Regulations*

Due to a contract end date of July 1, 2019, FY 2018–2019 was both the initial and final year for review of Delta Dental's compliance with CHP+ managed care requirements; therefore, the compliance review was conducted in a readiness format, which included abbreviated versions of nine different standards. HSAG found that Delta Dental was compliant with 15 of 27 total requirements and that 12 of 27 requirements were either partially met or not met. HSAG provided recommendations for improvement for those elements that were either partially met or not met.

### **Delta Dental Summary of Compliance**

- Delta Dental developed a website that includes CHP+ program information, a downloadable summary of children's dental benefits, a secure member portal, printable copies of the CHP+ Evidence of Coverage benefits booklet and provider directory, and a link to the Health First Colorado CHP+ website portal.
- Delta Dental made oral interpretation services in all languages available to its providers and members.
- Delta Dental's website provider directory listed provider name, group affiliation, address, telephone number, specialty, and stated that all providers accepted new members.
- Delta Dental used multiple methods to communicate important information to providers, including provider contracts and two dental provider handbooks.
- Delta Dental had recently implemented GeoAccess mapping specific to the providers serving the CHP+ member population and a process to ensure that providers are enrolled with the State as CHP+ providers.
- Delta Dental's policies and processes for initial and ongoing provider credentialing were compliant with State and federal requirements.
- Delta Dental covered dental services needed to evaluate and stabilize an emergency dental condition, regardless of whether or not the services were provided in network.
- Within the written delegation agreements, Delta Dental included contract language specifying the delegated activities or obligations and related reporting responsibilities and assigned a staff member responsible for each delegation agreement.
- Delta Dental's CHP+ compliance officer described the compliance program in detail. Employees were trained on compliance issues and fraud, waste, and abuse (FWA). Delta Dental routinely monitored provider claims for potential FWA, with follow-up as indicated, and had processes for collecting and reporting overpayments to the Department.
- Delta Dental had processes to ensure that member care was coordinated as needed between settings of care and among various provider types, particularly for members with complex cases.

- Delta Dental participated in required PIPs and also used claims data to conduct an analysis of overutilization.
- Delta Dental demonstrated having a fully integrated HIS that included utilization data, grievances and appeals, membership enrollment history, provider demographic files, and reporting functions. The dental plan's claims system was able to collect all necessary data elements, verified for accuracy, to enable mechanized claims processing and to submit reports to the Department in required formats.

### Delta Dental Summary of Opportunities for Improvement

- Delta Dental did not provide notification on its website of the availability of member materials in large print or alternative formats, and critical written materials failed to include taglines in non-English languages.
- Delta Dental's website included a significant number of readability and contrast errors when tested with the WAVE accessibility tool to determine compliance with Americans with Disabilities Act requirements.
- Delta Dental did not include all required elements within the paper or electronic form of the provider directory.
- Delta Dental had not yet adopted dental practice guidelines and did not communicate details about the grievance and appeal system to providers.
- Delta Dental's processes for authorization of initial and ongoing dental services did not align with Medicaid managed care regulations, including defined authorization time frames and procedures, notice of adverse benefit determination letters being sent to the member, and member appeal rights.
- Delta Dental's Complaint Handling policy was not compliant with all federal and State regulations for disposition of a grievance, including time frames for resolving a grievance and providing the member with written acknowledgement of a grievance.
- Delta Dental's CHP+ appeals procedures were not in alignment with all Medicaid managed care regulations, including timelines for processing appeals. Procedures also defined a "reconsideration" process that allowed for a second level of appeal (not permitted per Medicaid managed care regulations).
- Delta Dental did not include all required elements within the delegation subcontracts, including: provision for revocation or remedies; agreement to comply with applicable laws and regulations; and State, CMS, or Department of Health and Human Services inspector general right-to-audit requirements. In addition, Delta Dental did not have policies or procedures governing the oversight and monitoring of the delegates' performance.
- Delta Dental did not incorporate directors, officers, partners, employees, subcontractors, or owners within its monthly search of federal exclusion lists.
- Delta Dental did not have a method to ensure that each member had a provider or provider group as an ongoing source of primary dental care or responsible for coordinating the member's dental services.
- Delta Dental did not have a comprehensive QAPI program that incorporated all required components.



## Validation of Performance Measures

An independent review was performed on Delta Dental's claims and enrollment data from July 2018 through April 2019; however, this review was not a HEDIS compliance audit, therefore, rates submitted by Delta Dental were not validated rates.

### Performance Measure Results

Table 3-31 shows the performance measure results for Delta Dental. Of note, the Department provided the number of members eligible to receive dental services through the CHP+ dental PAHP and Delta Dental provided the count of members who had at least one dental visit during FY 2018–2019. Subsequently, HSAG calculated the rate for the *Annual Dental Visit* measure.

**Table 3-31—Performance Measure Results for Delta Dental**

Performance Measure	HEDIS 2019 Rate	Percentile Ranking
<i>Annual Dental Visit</i> <sup>1</sup>		
Total	37.09%	10th–24th

<sup>1</sup> The age range for this measure rate was modified to less than 1 year old to age 19 during the measurement period (i.e., July 2018–June 2019). Therefore, the reader should exercise caution when comparing the rate to benchmarks generated for ages 2 to 20 years during calendar year 2017.

The *Annual Dental Visit—Total* rate fell below the 25th percentile for HEDIS 2019, indicating opportunities to improve the number of preventive dental visits for members.

## Validation of Performance Improvement Projects

Table 3-32 displays the FY 2018–2019 validation findings Delta Dental's PIP.

**Table 3-32—Validation Findings for the Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year PIP**

Module 1—PIP Initiation	
Narrowed Focus Population	Members 3 through 5 years of age who reside in the Greeley area.
SMART Aim Statement	By June 30, 2020, increase the percentage of CHP+ members who reside in the Greeley area who utilized any service among the 3–5-year-old age group from 35.96% to 38%.
Module 2—SMART Aim Data Collection	
SMART Aim Measure	The percentage of members 3 through 5 years of age who reside in the Greeley area and utilized any dental service during the rolling 12-month measurement period.
SMART Aim Data Collection Plan	<ul style="list-style-type: none"> <li><b>Data Source:</b> Administrative claims.</li> <li><b>Methodology:</b> Monthly data collection using a rolling 12-month measurement period.</li> </ul>

## Delta Dental: Strengths

Delta Dental selected a PIP topic focused on increasing dental service utilization among members 3 through 5 years of age. The MCO passed Module 1 and Module 2 and achieved all validation criteria for the PIP. The validation findings suggest that the MCO developed a methodologically sound project design and established a PIP team with appropriate membership to achieve the goal for improvement.

## Delta Dental: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

Completion of Module 1 and Module 2 concluded Delta Dental's PIP submissions for validation as the MCO's contract with the Department to provide dental services for CHP+ members ended June 30, 2019. After the MCO completed and passed Module 1 and Module 2 in April 2019, the Department and HSAG agreed that Delta Dental had fulfilled the FY 2018–2019 PIP validation requirements. The remainder of the FY would not have allowed time for the MCO to complete and submit subsequent modules of the PIP for validation. HSAG recommends the following strategies for Delta Dental, which can be applied to general quality improvement efforts beyond the rapid-cycle PIP:

- When planning a test of change or intervention, think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- Determine the best method for identifying the intended effect of an intervention prior to testing it. The intended effect of the intervention should be known beforehand to help determine a sound data collection plan for the intervention evaluation measure(s).
- When testing a new intervention, make a prediction of expected results in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. Discussing predicted results will help keep the theory for improvement at the forefront for all involved in the project.
- Key driver diagrams should be developed when an improvement project is initiated and should be updated regularly to incorporate knowledge gained and lessons learned through PDSA cycles.

## Validation of Network Adequacy

Delta Dental's Provider Data Structure Questionnaire responses noted that Delta Dental validated providers' type and specialty information against the following public data verification resources: the NPPE Registry, the American Board of Medical Specialties board certification database, and the provider's CHCP applications. Delta Dental reported performing a formal data validation to ensure that its data systems contained current contracting status, demographics, practice locations, practice accommodations(s), and panel capacity for each contracted provider.

Delta Dental's provider data extract for the study contained key limitations, suggesting the data did not accurately reflect Delta Dental's complete provider network. For example, data included no attribute values for provider groups or practices, indicating that group-level provider records, if available, may be identified using other network database elements. Delta Dental also noted that it does not permit services to be offered by out-of-network providers (i.e., using single case agreements or similar approaches).

As the first comprehensive review of Delta Dental's provider network, the current study established a foundation upon which the Department can build robust managed care network adequacy expectations and processes for overseeing compliance with network adequacy standards for the CHP+ dental PAHP.

As Delta Dental's contract with the Department ended June 30, 2019, HSAG provides no recommendations for Delta Dental in this report.

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

### Assessment of Compliance With CHIP Managed Care Regulations

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

Description of Standard	COA	DHMP	FHP	Kaiser	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services (2016–2017)	94%	94%	91%	94%	97%	94%
Standard II—Access and Availability (2016–2017)	100%	92%	79%	93%	100%	93%
<b>Standard III—Coordination and Continuity of Care (2018–2019)</b>	<b>100%</b>	<b>60%</b>	<b>78%</b>	<b>80%</b>	<b>80%</b>	<b>80%</b>
<b>Standard IV—Member Rights and Protections (2018–2019)</b>	<b>88%</b>	<b>100%</b>	<b>88%</b>	<b>88%</b>	<b>88%</b>	<b>90%</b>
Standard V—Member Information (2017–2018)	100%	83%	92%	100%	100%	95%
Standard VI—Grievance and Appeal System (2017–2018)	95%	91%	82%	68%	82%	84%
Standard VII—Provider Participation and Program Integrity (2017–2018)	100%	79%	93%	87%	93%	90%
<b>Standard VIII—Credentialing and Recredentialing (2018–2019)</b>	<b>100%</b>	<b>100%</b>	<b>86%</b>	<b>100%</b>	<b>100%</b>	<b>97%</b>
Standard IX—Subcontracts and Delegation (2017–2018)	NA	NA	NA	NA	NA	NA
<b>Standard X—Quality Assessment and Performance Improvement (2018–2019)</b>	<b>89%</b>	<b>89%</b>	<b>83%</b>	<b>89%</b>	<b>83%</b>	<b>87%</b>

Note: Bold text indicates standards that HSAG reviewed during FY 2018–2019.

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

Record Reviews	COA	DHMP	FHP	Kaiser	RMHP	Statewide Average
Appeals (2017–2018)	93%	83%	100%	NA	83%	90%
<b>Credentialing (2018–2019)</b>	<b>100%</b>	<b>100%</b>	<b>97%</b>	<b>100%</b>	<b>100%</b>	<b>99%</b>
Denials (2016–2017)	100%	0%	98%	100%	97%	90%
Grievances (2017–2018)	100%	NA	100%	75%	85%	89%
<b>Recredentialing (2018–2019)</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Note: Bold text indicates standards that HSAG reviewed during FY 2018–2019.

NA: DHMP reported no CHP+ member grievances and Kaiser reported no CHP+ member appeals during the FY 2017–2018 review period.

## ***Statewide Conclusions and Strengths Related to Compliance With Regulations***

For the four standards reviewed in FY 2018–2019, the CHP+ MCOs demonstrated compliance in many areas. All or most (three or more) CHP+ MCOs demonstrated the following strengths:

- Maintained robust and comprehensive policies, procedures, and program descriptions for Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and QAPI.
- Maintained processes for comprehensive care management to assist CHP+ members with access to needed services, including assisting with referrals, coordinating with multiple providers and agencies for members with complex care needs, and coordinating services with community organizations, as indicated.
- Had processes to ensure continuity of care for newly enrolled CHP+ members.
- Had processes for allowing CHP+ members direct access to specialists in or out of network.
- Had procedures for conducting intake screenings and comprehensive needs assessments and for developing related care coordination service plans for CHP+ members.
- Had care coordination processes for ensuring transition of care between multiple settings of care or between health plans.
- Had multi-disciplinary teams of care coordinators distributed throughout the service area or delivery system.
- Maintained care coordination documentation systems to enable collecting and secure sharing of members' care coordination information.
- Maintained policies and systems for compliance with HIPAA privacy regulations for sharing member records and ensuring confidentiality of CHP+ member information.
- Maintained policies and provider and member communications outlining required member rights.
- Provided staff member and provider trainings related to CHP+ member rights.
- Demonstrated processes for monitoring member customer service calls to identify and address any issues related to member rights.
- Maintained policies and provider and member communications addressing the required components and provisions for advance directives.
- Maintained credentialing and recredentialing policies and procedures compliant with NCQA requirements and demonstrated implementation of those procedures consistent with NCQA standards and guidelines.
- Delegated provider credentialing and recredentialing activities to large provider organizations and demonstrated oversight of delegate credentialing and recredentialing performance.
- Demonstrated conducting monthly screening of all providers against federal exclusion databases.
- Maintained comprehensive QAPI programs that included CHP+ PIPs, HEDIS measures, CAHPS surveys, and various other quality oversight measures and analysis.
- Had processes to conduct annual evaluation of the effectiveness of QAPI activities.

- Had processes to adopt and distribute to providers and members CPGs and had adopted clinical guidelines for all CHP+ health conditions required by the Department.
- Demonstrated having integrated multi-component HISs for collecting, processing, and reporting of claims, clinical, and operational information.
- Had processes for ensuring claims data received from providers were verified for accuracy and completeness.
- Had processes for submitting claims data monthly to the Department in required formats.

### Statewide Conclusions and Recommendations Related to Compliance With Regulations

For CHP+ MCOs, the most common required actions (involving three or more MCOs) were the following:

- Ensure that the intake screening of each CHP+ member's needs includes all Department-required categories of assessment—mental health, high-risk health problems, functional problems, language or comprehension barriers, other complex health problems.
- Implement mechanisms within the QAPI program for review and analysis of data to detect over- or underutilization of services.
- Develop and implement mechanisms within the QAPI program to assess the quality and appropriateness of care furnished to members with SHCN.

### Validation of Performance Measures

In Table 4-3, plan-specific and statewide weighted averages are presented for the CHP+ MCOs for HEDIS 2019. Given that the MCOs varied in membership size, the statewide average rate for each measure was weighted based on the MCOs' eligible populations. For the MCOs with rates reported as *Small Denominator (NA)*, the numerators, denominators, and eligible populations were included in the calculations of the statewide rate.

**Table 4-3—MCO and Statewide Results**

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
<b>Pediatric Care</b>						
<b>Childhood Immunization Status</b>						
<i>Combination 2</i>	71.58%	67.46%	4.76%	69.46%	57.08%	66.78%
<i>Combination 3</i>	69.58%	65.87%	4.76%	67.36%	57.08%	65.16%
<i>Combination 4</i>	66.86%	65.87%	4.76%	66.95%	54.42%	63.13%
<i>Combination 5</i>	63.21%	57.94%	4.76%	62.76%	54.87%	59.76%
<i>Combination 6</i>	49.53%	46.03%	0.00%	41.84%	41.15%	45.31%

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
<i>Combination 7</i>	61.32%	57.94%	4.76%	62.34%	52.21%	58.20%
<i>Combination 8</i>	48.23%	46.03%	0.00%	41.84%	39.38%	44.29%
<i>Combination 9</i>	45.64%	41.27%	0.00%	40.59%	39.82%	42.27%
<i>Combination 10</i>	44.58%	41.27%	0.00%	40.59%	38.05%	41.39%
<b>Immunizations for Adolescents</b>						
<i>Combination 1 (Meningococcal, Tdap)</i>	76.30%	82.24%	26.32%	82.84%	57.67%	73.33%
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	38.90%	55.92%	12.28%	56.44%	18.33%	39.02%
<b>Well-Child Visits in the First 15 Months of Life</b>						
<i>Zero Visits*</i>	6.36%	15.15%	NA	2.02%	0.00%	5.06%
<i>Six or More Visits</i>	47.27%	63.64%	NA	73.74%	15.79%	48.28%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>						
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	68.50%	64.74%	55.62%	65.44%	67.68%	67.34%
<b>Adolescent Well-Care Visits</b>						
<i>Adolescent Well-Care Visits</i>	49.87%	45.30%	37.65%	45.24%	49.19%	48.23%
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>						
<i>BMI Percentile Documentation—Total</i>	9.27%	21.80%	9.70%	98.57%	4.83%	22.71%
<i>Counseling for Nutrition—Total</i>	5.11%	7.93%	4.65%	96.18%	23.00%	21.46%
<i>Counseling for Physical Activity—Total</i>	3.14%	6.65%	6.26%	96.18%	5.50%	17.58%
<b>Appropriate Testing for Children With Pharyngitis</b>						
<i>Appropriate Testing for Children With Pharyngitis</i>	84.60%	83.33%	81.16%	94.20%	77.64%	84.99%
<b>Access to Care</b>						
<b>Prenatal and Postpartum Care<sup>^</sup></b>						
<i>Timeliness of Prenatal Care</i>	—	—	—	—	—	55.13%
<i>Postpartum Care</i>	—	—	—	—	—	45.01%
<b>Children and Adolescents' Access to Primary Care Practitioners</b>						
<i>Ages 12 to 24 Months</i>	90.30%	90.36%	NA	97.22%	94.68%	92.33%
<i>Ages 25 Months to 6 Years</i>	84.52%	73.58%	71.90%	83.25%	82.81%	82.93%
<i>Ages 7 to 11 Years</i>	87.98%	86.93%	87.18%	86.81%	88.00%	87.66%
<i>Ages 12 to 19 Years</i>	87.78%	82.04%	86.43%	88.26%	87.04%	87.14%
<b>Preventive Screening</b>						
<b>Chlamydia Screening in Women</b>						
<i>Ages 16 to 20 Years</i>	32.27%	47.22%	NA	45.51%	33.57%	36.52%



Performance Measures	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
<b><i>Non-Recommended Cervical Cancer Screening in Adolescent Females*</i></b>						
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	0.08%	0.00%	0.00%	0.00%	0.00%	0.04%
<b><i>Mental/Behavioral Health</i></b>						
<b><i>Antidepressant Medication Management</i></b>						
<i>Effective Acute Phase Treatment</i>	NA	NA	NA	NA	NA	55.00%
<i>Effective Continuation Phase Treatment</i>	NA	NA	NA	NA	NA	37.50%
<b><i>Follow-Up Care for Children Prescribed ADHD Medication</i></b>						
<i>Initiation Phase</i>	0.00%	NA	NA	45.16%	53.33%	15.21%
<i>Continuation and Maintenance Phase</i>	NA	NA	NA	NA	NA	20.00%
<b><i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i></b>						
<i>Total</i>	30.49%	NA	NA	NA	NA	38.98%
<b><i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</i></b>						
<i>Total</i>	3.23%	NA	NA	NA	NA	4.04%
<b><i>Respiratory Conditions</i></b>						
<b><i>Appropriate Treatment for Children With Upper Respiratory Infection</i></b>						
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	93.25%	100.00%	92.63%	96.94%	93.68%	94.09%
<b><i>Medication Management for People With Asthma</i></b>						
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	58.41%	NA	NA	NA	NA	59.75%
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	50.00%	NA	NA	NA	NA	51.64%
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	36.28%	NA	NA	NA	NA	33.96%
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	23.33%	NA	NA	NA	NA	27.05%
<b><i>Asthma Medication Ratio</i></b>						
<i>Ages 5 to 11 Years</i>	83.19%	NA	NA	NA	NA	82.63%
<i>Ages 12 to 18 Years</i>	75.79%	NA	NA	NA	NA	71.32%
<b><i>Use of Services†</i></b>						
<b><i>Ambulatory Care (Per 1,000 Member Months)</i></b>						
<i>ED Visits*</i>	26.90	21.49	17.33	18.86	18.38	23.83
<i>Outpatient Visits</i>	218.12	135.56	166.81	133.57	211.60	195.91
<b><i>Inpatient Utilization—General Hospital/Acute Care</i></b>						
<i>Discharges per 1,000 Member Months (Total Inpatient)</i>	1.03	0.82	0.37	0.49	0.75	0.88
<i>Average Length of Stay (Total Inpatient)</i>	3.43	3.07	2.33†	3.67	4.37	3.51

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP	Statewide Weighted Average
<i>Discharges per 1,000 Member Months (Medicine)</i>	0.74	0.60	0.21	0.40	0.49	0.63
<i>Average Length of Stay (Medicine)</i>	2.97	2.59	2.00†	2.29	3.27	2.89
<i>Discharges per 1,000 Member Months (Surgery)</i>	0.25	0.17	0.17	0.08	0.21	0.21
<i>Average Length of Stay (Surgery)</i>	4.90	5.07†	1.50†	10.50†	7.46†	5.50
<i>Discharges per 1,000 Member Months (Maternity)</i>	0.09	0.09	0.00	0.01	0.10	0.07
<i>Average Length of Stay (Maternity)</i>	2.58†	2.00†	NA	3.00†	2.33†	2.49
<b>Antibiotic Utilization*</b>						
<i>Average Scripts PMPY for Antibiotics</i>	0.35	0.14	12.00	0.19	0.39	0.33
<i>Average Days Supplied per Antibiotic Script</i>	10.87	11.28	99.95	12.47	10.20	16.86
<i>Average Scripts PMPY for Antibiotics of Concern</i>	0.12	0.03	2.32	0.05	0.14	0.11
<i>Percentage of Antibiotics of Concern of All Antibiotic Scripts</i>	33.71%	24.04%	19.35%	24.21%	35.98%	31.91%

\* For this indicator, a lower rate indicates better performance.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

^ The SMCN is the only CHP+ MCO required to report the Prenatal and Postpartum Care measure.

† For measures in the Use of Services domain, higher or lower rates did not necessarily denote better or poorer performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

## Statewide Strengths

The following HEDIS 2019 measure rates were determined to be high performers (i.e., ranked at or above the 75th percentile, without significant declines in performance from HEDIS 2018; or ranked between the 50th and 74th percentiles, with significant improvements in performance from HEDIS 2018) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 6, 8, 9, and 10*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Asthma Medication Ratio—Ages 5 to 11 Years and Ages 12 to 18 Years*

At the statewide level, vaccinations for children and adolescents—driven by high influenza, rotavirus, and HPV vaccination rates—were identified as a statewide strength for HEDIS 2019. Additionally, the State continued to demonstrate strength by not screening young women unnecessarily for cervical cancer and by ensuring providers appropriately treat members with respiratory infections.

## **Statewide Opportunities for Improvement and Recommendations Related to Health Plan Performance Measure Results**

The following HEDIS 2019 measure rates were determined to be low performers (i.e., fell below the 25th percentile; or ranked between the 25th and 49th percentiles, with significant declines in performance from HEDIS 2018) for the CHP+ statewide weighted average:

- *Childhood Immunization Status—Combinations 2, 3, and 4*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits and Six or More Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, and Ages 7 to 11 Years*
- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Statewide performance for HEDIS 2019 demonstrated opportunities to improve the access to preventive care and services for members, including chlamydia screening and follow-up care for members prescribed ADHD medications.

## Validation of Performance Improvement Projects

Table 4-4 shows the FY 2018–2019 statewide PIP results for the CHP+ health plans.

**Table 4-4—FY 2018–2019 PIP Results for the CHP+ Health Plans**

Health Plan	PIP Topic	Module Status	Validation Status
COA	<i>Well-Child Visits for Members 10–14 Years of Age</i>	Completed Module 1 and Module 2	NA*
DHMP	<i>Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15–18 Years of Age</i>	Completed Module 1 and Module 2	NA*
FHP	<i>Well-Child Visits in the 6th Through 14th Years of Life</i>	Completed Module 1 and Module 2	NA*
Kaiser	<i>Improving CHP+ Adolescent Well-Visit Adherence</i>	Completed Module 1 and Module 2	NA*
RMHP	<i>Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15–18</i>	Completed Module 1 and Module 2	NA*
Delta Dental	<i>Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year</i>	Completed Module 1 and Module 2	NA*

\*NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2018–2019 validation cycle.

During FY 2018–2019, the CHP+ health plans initiated new rapid-cycle PIPs focusing on topics approved by the Department. The PIPs addressed the following topic areas:

- Well-child visits
- Adolescent well-care visits
- Dental service utilization

The PIPs run on an 18-month schedule and will continue into the next FY. The PIPs will be evaluated on outcomes and receive a final validation status after the CHP+ health plans complete all five modules of the rapid-cycle PIP process and submit final documentation for validation. One exception to this progression is the Delta Dental PIP. Delta Dental’s PIP will not progress beyond Module 1 and Module 2 because the PAHP’s contract with the Department to deliver dental services for CHP+ members ended at the end of FY 2018–2019.

During the FY 2018–2019 validation cycle, the CHP+ health plans received training and technical assistance on the rapid-cycle PIP process and developed the foundation of the projects in the first two modules of the process. The CHP+ health plans submitted documentation on Module 1 and Module 2

for a total of six PIPs. HSAG provided feedback to the CHP+ health plans on the initial submissions and the CHP+ health plans revised the module documentation and resubmitted Module 1 and Module 2 until all criteria were achieved. The CHP+ health plans passed Module 1 and Module 2, achieving all validation criteria for the first two modules for all six PIPs.

### ***Statewide Conclusions and Recommendations for PIPs***

The FY 2018–2019 validation findings for all six PIPs suggested that all CHP+ health plans designed methodologically sound projects addressing Department-approved rapid-cycle PIP topics. The CHP+ health plans used data to identify a narrowed focus for each project, established PIP teams to include necessary internal and external partners, defined a goal for improvement, and designed a measure and data collection plan to evaluate progress toward achieving the goal. In the next FY, the CHP+ health plans will continue to progress through the rapid-cycle PIP modules, analyzing processes and developing and testing interventions to achieve the goal for improvement defined in Module 1. As the CHP+ health plans continue working on the PIPs, HSAG recommends the following:

- Complete process map(s) to thoroughly illustrate current processes and identify all existing failure modes that can be addressed through interventions. Prioritize identified failure modes based on impact to achieving the goal for the project and develop interventions to address the highest priority failure modes.
- Make a prediction in the *Plan* step of each PDSA cycle and discuss the basis for the prediction with all PIP team members and partners. The shared prediction will help keep the theory for improvement at the forefront for everyone involved in the project.
- Clearly define and track intervention evaluation measure(s) throughout testing to evaluate if the intended effect of the intervention was achieved. Refine the intervention, as needed, based on frequent assessments of intervention evaluation measure results.
- Regularly update the key driver diagram for the PIP to incorporate knowledge gained and lessons learned as the CHP+ health plan progresses through the steps for determining and testing interventions.

## CAHPS Surveys

### Statewide Results for CAHPS

The statewide averages presented in Table 4-5 are derived from the combined results of the five CHP+ MCOs. Table 4-5 shows the FY 2018–2019 plan-level and statewide average results for each CAHPS measure.

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

Measure	COA	DHMP	FHP	Kaiser	RMHP	Statewide Average
<i>Getting Needed Care</i>	87.7%	79.7%	90.1% <sup>+</sup>	85.5%	90.1%	87.1%
<i>Getting Care Quickly</i>	90.5%	85.0%	91.0% <sup>+</sup>	90.8%	93.3%	90.5%
<i>How Well Doctors Communicate</i>	94.8%	94.4%	92.9%	97.8%	97.1%	95.4%
<i>Customer Service</i>	81.9%	87.8%	84.0% <sup>+</sup>	86.5%	87.9%	84.0%
<i>Shared Decision Making</i>	79.6% <sup>+</sup>	72.8% <sup>+</sup>	80.4% <sup>+</sup>	84.9% <sup>+</sup>	84.8% <sup>+</sup>	80.4%
<i>Rating of Personal Doctor</i>	78.0%	75.7%	71.0%	78.1%	71.2%	76.6%
<i>Rating of Specialist Seen Most Often</i>	77.1% <sup>+</sup>	85.3% <sup>+</sup>	71.1% <sup>+</sup>	73.3% <sup>+</sup>	82.9% <sup>+</sup>	77.9%
<i>Rating of All Health Care</i>	67.7%	69.2%	50.6%	67.2%	67.7%	67.1%
<i>Rating of Health Plan</i>	69.3%	65.4%	55.2%	60.9%	68.3%	67.1%

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

### Statewide Conclusions and Recommendations for CAHPS

Each member experience measure displayed substantial or slight increases of member and family perceptions regarding quality of care and services between FY 2017–2018 and FY 2018–2019 in three or more MCOs except *How Well Doctors Communicate* and *Rating of All Health Care*. *Rating of Health Plan* increased in four of the five MCOs, and in three of those substantially: COA, FHP, and RMHP. Also, four of five plans' ratings showed improvements in *Getting Needed Care* and *Customer Service*. *Rating of Personal Doctor* increased in three of the five CHP+ MCOs, and in one of three MCOs substantially, FHP. Also, three of five MCOs' ratings showed improvements in *Getting Care Quickly*, *Shared Decision Making*, and *Rating of Specialist Seen Most Often*. *How Well Doctors Communicate* and *Rating of All Health Care* increased in only one of the five CHP+ MCOs. Only one measure, *Rating of Specialist Seen Most Often*, had two CHP+ MCO rates substantially higher than the statewide average.



One of the five CHP+ MCOs, COA, had no rates substantially lower than the statewide average. One MCO, FHP, had four rates substantially lower than the statewide average rates; one MCO, DHMP, had three rates substantially lower than the statewide average rate; and two MCOs, RMHP and Kaiser, had only one rate substantially lower than the statewide average rate. For two measures—*Rating of Personal Doctor* and *Rating of Health Plan*—two health plans had rates substantially lower than the statewide averages. For five measures—*Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*—only one health plan had a rate substantially lower than the statewide averages. The Department may want to consider statewide initiatives or studies to further evaluate the key drivers that impact these rates.

## Validation of Network Adequacy

### Statewide Results

The Department actively participated in the network adequacy activities, supplying network process documentation and provider data from the interChange data system. However, provider data in interChange supports FFS data processes (e.g., processing healthcare claims) and has no mechanism to capture data on a provider's FFS and/or health plan affiliation(s). Additionally, the Department reported that it does not routinely collect the health plans' provider network data files and does not require health plans to use a standardized set of definitions for identifying specific provider categories. Furthermore, the structure in which interChange maintains provider data affects the availability and completeness of provider attributes. Providers' degree, title, and/or credentialing information is required for selected provider types when enrolling in interChange (e.g., providers or facilities must submit documentation confirming that they meet the criteria for the given provider type). Consequently, providers' degree, title, and/or credentialing information is not captured in separate interChange data elements but may be inferred based on the provider type.

Each health plan participated in the network adequacy activities, supplying documentation and provider data to HSAG. While all health plans reported on their approaches for collecting and maintaining their provider data, specific activities varied by health plan. Each health plan reported that it identifies group and/or facility-level providers, though many health plans included no provider type values for facilities (e.g., hospitals or multi-specialty practices), indicating that each health plan handles records differently for these provider categories compared to data for the individual-level providers. Additionally, not every health plan reported that it collects providers' taxonomy code(s), limiting the use of this provider attribute when creating a standardized crosswalk of provider category definitions. Finally, each health plan's provider data included similar, but not identical, data values for the provider type and specialty fields, complicating HSAG's efforts to map the provider data to the Department's provider categories (i.e., generate provider crosswalks). Disparities in provider data elements available from the Department and the health plans also prevented HSAG from reliably identifying the same provider from both the interChange and the health plans' data sets.



## Statewide Conclusions and Recommendations

The health plans' data completeness and consistency affected the range of attribute combinations recommended for each provider category in the provider crosswalks. When HSAG determined that a health plan's data was missing provider type values or contained overly broad specialty information (e.g., a specialty of "Nurse Practitioner"), HSAG may have required taxonomy, degree, or credential data to determine whether the provider could be counted in a specific PCA category. Behavioral health provider categories for the CHP+ MCOs required licensure information (e.g., licensed clinical social workers), and the CHP+ health plans generally had sufficient provider attribute data to assign potential providers to the Department's approved provider categories. However, for other provider types, many health plans' data did not contain sufficiently detailed provider attributes, and HSAG was unable to determine subspecialties for non-physician providers (e.g., NPs or PAs). While these health plans collected detailed subspecialty information for physicians, similar information was not reported for the non-physician providers.

PCA results illustrated the need for standardized provider category definitions when conducting network adequacy assessments to ensure consistent analytic results across health plans. The PCA results also reinforced the need for the health plans to evaluate the level of specificity available in their provider data systems. Additionally, interChange provider data include hospitals, FQHCs, RHCs, and CMHCs; however, the health plans may not have these providers counted in the PCA due to the way in which these providers are reflected in the health plans' data.

As the first comprehensive investigation into the health plans' provider networks, the current study established a foundation from which to build robust managed care network adequacy expectations and processes for overseeing the health plans' compliance with network adequacy standards. As such, HSAG offers the following recommendations to improve network adequacy data and oversight:

- To facilitate future network adequacy validation, the Department should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the health plan. The Department should also develop standardized quarterly network adequacy reporting templates for each health plan type. To ensure consistent reporting within each health plan type, templates should include the following minimum information:
  - A description of the expected file format and minimum content, as well as which content should be reported using data tables versus narrative text or maps
    - Content should allow the health plan to demonstrate compliance with federal network adequacy requirements under 42 CFR §438.206<sup>4-19</sup> and reporting requirements under 42 CFR §438.207<sup>4-20</sup>

<sup>4-19</sup> Availability of Services, 42 CFR §438.206. Available at [https://gov.ecfr.io/cgi-bin/text-idx?SID=94387567351b1f2780e32505a0d8a864&mc=true&node=se42.4.438\\_1206&rgn=div8](https://gov.ecfr.io/cgi-bin/text-idx?SID=94387567351b1f2780e32505a0d8a864&mc=true&node=se42.4.438_1206&rgn=div8). Accessed on May 20, 2019.

<sup>4-20</sup> Assurances of Adequate Capacity and Services, 42 CFR §438.207. Available at [https://gov.ecfr.io/cgi-bin/retrieveECFR?gp=&SID=94387567351b1f2780e32505a0d8a864&mc=true&r=SECTION&n=se42.4.438\\_1207](https://gov.ecfr.io/cgi-bin/retrieveECFR?gp=&SID=94387567351b1f2780e32505a0d8a864&mc=true&r=SECTION&n=se42.4.438_1207). Accessed on May 20, 2019.

- Definitions for all required provider categories and instructions for reporting any additional provider categories defined by the health plan
- Methodology information for any expected calculations
  - For example, time/distance calculations should be based on driving distances between each member and the nearest applicable provider
- Templates for any expected data tables, including definitions for each cell that the health plan is expected to populate
- While developing the provider crosswalks, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the health plans and a lack of consistent use of taxonomy codes by the Department. The Department should collaborate with the health plans to ensure consistent data collection for these crucial provider data fields for all provider data.
- HSAG's PCA identified numerous spelling variations and/or special characters for the health plans' data values for provider type, specialty, and credentials. The health plans should assess available data values in their provider data systems and standardize available data value options.

## 5. Assessment of CHP+ Health Plan Follow-Up on Prior Recommendations

### Colorado Access (COA)

#### *Assessment of Compliance With CHIP Managed Care Regulations*

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable*). COA had no required actions related to Standard V—Member Information or Standard VII—Provider Participation and Program Integrity.

For Standard VI—Grievance and Appeal System, COA had one required action:

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

COA submitted its initial corrective action plan proposal on February 25, 2018, and following Department approval completed implementation of all planned interventions on December 3, 2018.

#### *Validation of Performance Measures*

HSAG recommended that COA work to ensure that members receive follow-up care for children receiving antipsychotic medications, childhood immunizations, and nutrition counseling for children and adolescents.

To follow up on these recommendations related to the FY 2017–2018 PMV, COA responded with the following:

- Interventions related to children receiving antipsychotic medications in the coming year (e.g., messaging to the provider network about the clinical necessity for this service, billing codes, etc.) in an effort to improve future HEDIS scores.
- Childhood immunization status increased an average of 6.94 percentage points for all measure indicators, with the minimum increase being just over 4 percentage points and the largest just over 9 percentage points. These increases are due to 104 new site locations for Safeway pharmacies and 48 sites for CVS and Target, with a total of 848 new sites going live between 2017 and 2018.
- COA regularly engages members in regard to their nutrition; one example is the HeLP program (Healthy Living Program), a grant funded by the Colorado Department of Public Health and Environment and in partnership with the Colorado Department of Pediatrics, Section of Nutrition, which has been running for the last two years.

## Validation of Performance Improvement Projects

In FY 2017–2018, COA closed out a PIP focused on improving the percentage of members with a chronic medical or mental illness who received care management outreach within 90 days of their 19th birthday. At the conclusion of COA’s PIP, HSAG recommended the following:

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

With the initiation of a new rapid-cycle PIP in FY 2018–2019, COA developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG’s rapid-cycle PIP process, COA will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, COA will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, COA will report final SMART Aim measure results and develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess COA’s progress toward addressing the prior recommendations in the next FY’s PIP validation.

## CAHPS Surveys

To follow up on recommendations related to FY 2017–2018 CAHPS, COA reported engaging in the following quality improvement initiatives:

- As part of COA’s PIP for well-visits for 10–14 year old members, COA has incorporated a study that looks at how effective the clinic is at scheduling a well-visit at the time that a member is already in the office as well as no-show rates for appointments scheduled as a result of the clinic’s enhanced telephone outreach to members.
- COA partners with provider groups to designate them as Enhanced Clinical Partner Primary Care Providers. COA offers an enhanced per-member-per-month payment to these providers who deliver required enhanced services including: (1) have weekly availability of appointments on a weekend and/or on a weekday outside of typical workday hours (Monday–Friday, 7:30 a.m.–5:30 p.m.) or school hours for SBHCs, and (2) provide 24/7 phone coverage with access to a clinician that can assess the degree of the member’s health need.
- COA has implemented a standard call monitoring program that audits staff members’ customer service and soft skills weekly. Also, COA continuously gauges members’ experience of care from the customer service department through a Net Promoter System survey. Members of the customer

service department have individualized professional development plans to increase customer service skills. Additionally, the customer service department continues to assess providers' customer service skills through the evaluation of grievances submitted by members.

### ***Validation of Network Adequacy***

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

## **Denver Health Medical Plan, Inc. (DHMP)**

### ***Assessment of Compliance With CHIP Managed Care Regulations***

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable*).

For Standard V—Member Information, DHMP had two required actions:

- Revise its member handbook to include accurate time frames for filing grievances and appeals and requesting a State fair hearing.
- Revise its member handbook to inform members how to access benefits available under the State plan but not covered by DHMP.

For Standard VI—Grievance and Appeal System, DHMP had two required actions:

- Ensure that written notices of appeal resolutions are in formats and language that may be easily understood by members.
- Ensure that all providers and subcontractors are provided with information about the grievance, appeal, and State fair hearing system upon entering into contracts with DHMP.

For Standard VII—Provider Participation and Program Integrity, DHMP had three required actions:

- Have mechanisms for screening provider claims for potential fraud, waste, or abuse, reporting to the Department all overpayments related to potential fraud, and reporting to the Department changes in a network provider's circumstances that may affect the provider's ability to participate in the managed care program.
- Have documented procedures for notifying the Department of prohibited affiliations, ownership and control, and any excess capitation payments made.
- Have mechanisms for ensuring that network providers report and return overpayments to DHMP and that DHMP reports recovery of overpayments to the Department.

DHMP submitted its initial corrective action plan proposal on February 26, 2018, and following Department approval completed implementation of all planned interventions on June 5, 2019.

### ***Validation of Performance Measures***

HSAG recommended that DHMP work to ensure that members receive medications necessary to treat their conditions and that providers appropriately monitor members receiving long-term medications.

To follow up on these recommendations, DHMP responded with the following:

- The pharmacy department reviews all prior authorization (PA) requests quarterly by number of requests and top requested drugs by cost to regularly evaluate if continued PA is appropriate, to identify drugs that should be added to the formulary or to determine if modifications to the formulary UM in place is needed.
- An annual Pharmacy Member Survey is performed regarding pharmacy benefits and experience using the pharmacy network.
- The Drug Utilization Review (DUR) Committee works with DHMP staff members that administer Denver Health Medicaid Choice to oversee and improve members' quality of clinical care and safety.

HSAG also recommended that DHMP work to ensure that members have access to care and receive these services.

To follow up on these recommendations, DHMP responded with the following:

- The marketing department produces and distributes annual quick reference guides to educate members about how and where to receive care, which are mailed to all members.
- An annual Pharmacy Member Survey is performed regarding pharmacy benefits and experience using the pharmacy network. This survey also provides members the opportunity to leave specific comments or request follow up from the health plan.
- Integrated the use of quarterly reporting through the appointment center that shows the number of appointments that Medicaid member's access for PCPs and specialists. This report helps to identify any potential gaps in services or appointment times.

## ***Validation of Performance Improvement Projects***

In FY 2017–2018, DHMP closed out a PIP focused on improving the follow-up visit rate for members with asthma who visited an ED, urgent care, or an inpatient facility. At the conclusion of DHMP’s PIP, HSAG recommended the following:

- Consider using other quality improvement tools, such as a process map or FMEA, to isolate barriers or gaps within processes that may not have been previously identified.
- Continue to conduct ongoing evaluations of each intervention and make data-driven decisions regarding revising, continuing, or discontinuing interventions.
- For improvement strategies that were deemed successful, DHMP should develop a plan for sustaining and spreading the success beyond the life of the PIP.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, DHMP developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG’s rapid-cycle PIP process, DHMP will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, DHMP will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, DHMP will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess DHMP’s progress toward addressing the prior recommendations in the next FY’s PIP validation.

## ***CAHPS Surveys***

To follow up on recommendations related to FY 2017–2018 CAHPS, DHMP reported engaging in the following quality improvement initiatives:

- DHMP continues to improve their quality assurance and training program for staff members. DHMP monitors 10 calls per representative per month and identifies trends for team training and individual issues for one-on-one training. Trainings are conducted each month.
- To address opportunities for improvement with customer service, DHMP runs a report through Customer Relationship Management (CRM) that documents the reasons for incoming calls and common themes that were captured by customer service representatives. As new trends are identified, DHMP provides additional information, refresher training, or new training for new issues identified to customer service representatives.
- DHMP conducted an Annual Member Experience Survey and asked members specific questions about their communication preferences (e.g., information in member handbook was clear, know where to find and get materials, understand DHMP’s policies and procedures). DHMP set a top-box goal of 75 percent for each of the questions and two questions exceeded the goal, while three questions fell short of the goal. DHMP’s website offers members options to view the site in different formats to meet their needs (e.g., larger font size, line spacing, color contrast). DHMP’s marketing department will evaluate the areas that performed below the target top-box rates during



the annual web review process and review opportunities for member education on DHMP's policies and procedures.

- DHMP uses a report generated quarterly through the appointment center that shows the number of appointments that Medicaid members access for specialists. The report helps DHMP identify any potential gaps in services or appointment times. In addition, DHHA began an initiative over a year ago to increase availability for new patient appointments in specialist care clinic visits.
- DHMP's marketing department creates and distributes member newsletters quarterly, which contain content to educate members about various health topics and community and plan resources (e.g., same-day care options, the Denver Health NurseLine, recipes, Denver Public Health).

### **Validation of Network Adequacy**

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

## **Friday Health Plans of Colorado (FHP)**

### **Assessment of Compliance With CHIP Managed Care Regulations**

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable*).

For Standard V—Member Information, FHP had one required action:

- Ensure that the member handbook is written in Spanish and available to members upon request.

For Standard VI—Grievance and Appeal System, FHP had four required actions:

- Correct the Grievance and Appeal policy, CHP+ member handbook, and notices of denial to CHP+ members to address requirements related to denial of an expedited appeal request.
- Include specific information in the Grievance and Appeal policy regarding the time frame for member requests for continued benefits during an appeal or State fair hearing.
- Correct the defined criteria for how long requested benefits will continue during an appeal or State fair hearing to comply with revised CHP+ federal regulations.
- Correct grievance and appeal information in the provider manual to similarly reflect all required changes in the Grievance and Appeal policy and procedures.

For Standard VII—Provider Participation and Program Integrity, FHP had one required action:

- Develop written policies and procedures that address provider retention.

FHP submitted its initial corrective action plan proposal on April 9, 2018, and following Department approval completed implementation of all planned interventions on May 6, 2019.

### ***Validation of Performance Measures***

HSAG recommended that FHP work to ensure that members have access to primary care, childhood immunizations, weight assessment and counseling, and child and adolescent well-care services.

To follow up on these recommendations, FHP responded with the following:

- FHP developed a list of reports that will be reviewed on a quarterly process looking at under- and overutilization of services. In this review, the QMPC will be reviewing the results and making recommendations for quality improvement related to access to primary care and services and the utilization of such services.

### ***Validation of Performance Improvement Projects***

In FY 2017–2018, FHP closed out a PIP focused on improving the transition from primary care to BH follow-up care for adolescents 12 to 17 years of age who screened positive for depression. At the conclusion of FHP's PIP, HSAG recommended the following:

- Revisit the causal/barrier analysis and quality improvement processes at least annually to reevaluate barriers and develop new, active interventions, as needed.
- Evaluate the effectiveness of each individual intervention and make data-driven decisions based on the evaluation results.
- Develop a plan to spread or sustain any improvement achieved through the PIP process.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, FHP developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG's rapid-cycle PIP process, FHP will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, FHP will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, FHP will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess FHP's progress toward addressing the prior recommendations in the next FY's PIP validation.

## CAHPS Surveys

To follow up on recommendations related to FY 2017–2018 CAHPS, FHP reported engaging in the following quality improvement initiatives:

- Through its provider relations department, FHP is working on a demographic update that looks at the following to ensure demographic accuracy:
  - General information (e.g., National Provider Identifier (NPI), location address, phone number, fax number, hours, languages, and remit address [if different from service location])
  - Provider newsletter correspondence
  - Credential information
  - Contract information
  - Claims/billing information
  - Medical records information
  - Roster information
- FHP has confirmed that providers are currently leaving slots open for same-day appointments and have incorporated evening and Saturday hours for scheduling purposes. Additionally, FHP is exploring the possibility of offering clinics on Saturdays for certain services (e.g., well-child visits).
- FHP provides Teladoc services to members that deliver additional resources when it is not feasible for members to attend a face-to-face appointment.
- FHP continues to offer many cultural competency trainings to its providers.
- FHP has translated and offers member-specific communication templates in Spanish. FHP provides these Spanish materials to members upon request.

## Validation of Network Adequacy

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

## Kaiser Permanente Colorado (Kaiser)

### *Assessment of Compliance With CHIP Managed Care Regulations*

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable*). Kaiser had no required actions related to Standard V—Member Information.

For Standard VI—Grievance and Appeal System, Kaiser had seven required actions:

- Three required actions regarding CHP+ member written communications related to grievances: acknowledgement of receipt of a grievance, written disposition of the grievance, and ensure including all required information in the grievance disposition letter.
- Two required actions regarding CHP+ appeal communications: ensure that the resolution letter may be easily understood by the member and that it includes circumstances in which the member may be held liable for the cost of continued benefits pending the outcome of an appeal.
- Revise the appeals policy and CHP+ member handbook to specify that the representative of a deceased member's estate is a party to the State fair hearing process.
- Correct the defined criteria for how long requested benefits will continue during an appeal or State fair hearing to comply with revised CHP+ federal regulations.

For Standard VII—Provider Participation and Program Integrity, Kaiser had one required action:

- Develop a written policy for retention of providers.

Kaiser submitted its initial corrective action plan proposal on April 6, 2018, and following Department approval completed implementation of all planned interventions on March 19, 2019.

### *Validation of Performance Measures*

HSAG recommended that Kaiser work to ensure that members have access to child and adolescent well-care services and medication management for children receiving asthma medications.

To follow up on these recommendations related to the FY 2017–2018 PMV, Kaiser responded with the following:

- Kaiser created new workflows that were developed since the release of the asthma care coordinator roles (registered nurses [RNs]). These new workflows contain the following initiatives:
  - Chronic obstructive pulmonary disease (COPD) patients are being followed by the care management registered nurses/team post-ED visit and/or hospitalization.

- Adult and pediatric asthma patients are being followed by allergy RNs/teams post-ED visit and/or hospitalization.
- Follow-up outreach calls are made within 24–48 hours post-discharge.
- Asthma medication refills are being processed by primary care teams after refill authorization requests (RARs) are sent from the pharmacy refill team.

### ***Validation of Performance Improvement Projects***

In FY 2017–2018, Kaiser closed out a PIP focused on improving BH follow-up for CHP+ members 13–17 years of age who screened positive for depression with a PCP. At the conclusion of Kaiser’s PIP, HSAG recommended the following:

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

With the initiation of a new rapid-cycle PIP in FY 2018–2019, Kaiser developed the foundation for a project that will address the prior recommendations. In Module 4, Kaiser will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, Kaiser will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess Kaiser’s progress toward addressing the prior recommendations in the next FY’s PIP validation.

### ***CAHPS Surveys***

To follow up on recommendations related to FY 2017–2018 CAHPS, Kaiser reported engaging in the following quality improvement initiatives:

- Kaiser continues to hire providers based on the following year’s expected membership. Additionally, Kaiser has increased access due to its staffing model through a variety and number of appointment slot times, as well as the availability of telehealth visits. In order to provide quality specialty care for its pediatric members, Kaiser has established key relationships with the highest quality pediatric specialty care providers in Colorado.
- Kaiser has focused on making significant improvements to its online scheduling and improving the functionality of its systems. Kaiser has expanded access in every medical office and community through convenient care. Kaiser continues to offer services such as a Nurse Advice Line 24/7, Chat with a Doctor online, Chat with a Financial Counselor online, Chat with a Pharmacist online, and scheduled telephone and video visits. Also, Kaiser has extended providers’ office hours and offers Saturday hours, as well as urgent care within certain medical offices and locations, which has increased the percentage of Kaiser’s same-day appointments available.
- To effectively determine member-specific forms of communication, Kaiser continues to have a Best Practice Alert (BPA) for race, ethnicity, and language preference. Kaiser allows members to choose

how they would like to receive information: 1) in-person, 2) video, or 3) phone. Kaiser utilizes pop-up screens in each department if the member's preferences have not been updated.

### ***Validation of Network Adequacy***

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado's health plans.

## **Rocky Mountain Health Plans (RMHP)**

### ***Assessment of Compliance With CHIP Managed Care Regulations***

In FY 2016–2017, HSAG reviewed four standards: Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation (scored *Not Applicable*). RMHP had no required actions related to Standard V—Member Information.

For Standard VI—Grievance and Appeal System, RMHP had four required actions:

- Ensure that each member receives a written acknowledgement of a grievance and a written acknowledgement of an appeal within two days of receipt.
- Ensure that each grievance and each appeal is resolved and that a written notice of resolution is sent to the member within the required time frames.

For Standard VII—Provider Participation and Program Integrity, RMHP had one required action:

- Implement a method to verify whether services represented to have been delivered by network providers were actually received by members.

RMHP submitted its initial corrective action plan proposal on April 2, 2018, and following Department approval completed implementation of all planned interventions on January 7, 2019.

### ***Validation of Performance Measures***

HSAG recommended that RMHP work to ensure that members have access to care and receive access to adolescent primary care, well-child visits, and childhood immunization services.

To follow up on these recommendations, RMHP responded with the following:

- RMHP has information in member-facing educational materials that directs the member to contact customer service at the One-Call phone number, if/when there is a question related to benefits or services offered under its plan.

- RMHP focused on reaching CHP+ members with asthma aging out of the program in order to encourage them to schedule a visit with their provider before coverage ended.
- The RMHP QI department sends incentive mailings to CHP+ members to remind them to complete their scheduled childhood immunizations.

### ***Validation of Performance Improvement Projects***

In FY 2017–2018, RMHP closed out a PIP focused on improving the transition of care process for members with asthma who will be aging out of the CHP+ plan. At the conclusion of RMHP’s PIP, HSAG recommended the following:

- Regularly revisit its causal/barrier analysis and quality improvement processes to reevaluate barriers and consider new innovative impactful interventions.
- Consider using an FMEA, in addition to a process map, to isolate barriers that may not have been previously identified.
- Continue to conduct ongoing evaluations of each intervention and make data-driven decisions regarding revising, continuing, or discontinuing interventions.

With the initiation of a new rapid-cycle PIP in FY 2018–2019, RMHP developed the foundation for a project that will address the prior recommendations. In Module 3 of HSAG’s rapid-cycle PIP process, RMHP will use a process map and FMEA to identify gaps and failures acting as barriers to improvement. In Module 4, RMHP will design a robust intervention effectiveness measure and data collection process and will test and refine interventions through PDSA cycles. In Module 5, RMHP will develop a plan for sustaining and spreading successful interventions at the conclusion of the project. HSAG will continue to assess RMHP’s progress toward addressing the prior recommendations in the next FY’s PIP validation.

### ***CAHPS Surveys***

To follow up on recommendations related to FY 2017–2018 CAHPS, RMHP reported engaging in the following quality improvement initiatives:

- RMHP is a “Partner in Quality” with NCQA; therefore, RMHP practices that are PCMH have a requirement to offer expanded hours of availability, and RMHP supports practices in PCMH transformation. RMHP incentivizes practices for being a higher tiered practice in the RMHP Value-Based Tiered Payment Model. Tier 1 practices are required to be a PCMH. In addition, the Access Measures under the State Alternative Payment Model Program are monitored by the RMHP Practice Transformation Team.
- RMHP conducts a quarterly Provider Attributes survey. Implemented in November 2018, this survey template is sent to all network providers and requests any updates from the provider, including availability of hours. RMHP is developing a database to capture this information more



efficiently and allow RMHP to populate the print and online directories. This development should be fully incorporated by the end of August 2019.

- RMHP continually strives to ensure that its provider network is sufficient so that services are provided to members on a timely basis. RMHP uses a variety of means to educate providers about the various behavioral health and physical health appointment standards.
- RMHP surveys members annually regarding their experience with timeliness of appointments.
- RMHP provides members and providers access to the directory on its website where they can easily search for after-hours care and urgent care providers.

### ***Validation of Network Adequacy***

FY 2018–2019 was the first year that HSAG performed the validation of network adequacy activity for Colorado’s health plans.

### **Delta Dental of Colorado**

FY 2018–2019 was the first year that HSAG performed the EQR-related activities for Delta Dental. Therefore, no follow-up is reported.

## Appendix A. FHP Administrative and Hybrid Rates

Table A-1 shows FHP's rates for HEDIS 2019 for measures with a hybrid option, along with the percentile ranking for each HEDIS 2019 hybrid rate.

**Table A-1—HEDIS 2019 Administrative and Hybrid Performance Measure Results for FHP**

Performance Measures	Administrative Rate	Hybrid Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>			
<b><i>Childhood Immunization Status</i></b>			
<i>Combination 2</i>	4.76%	47.62%	<10th
<i>Combination 3</i>	4.76%	47.62%	<10th
<i>Combination 4</i>	4.76%	45.24%	<10th
<i>Combination 5</i>	4.76%	38.10%	<10th
<i>Combination 6</i>	0.00%	28.57%	10th–24th
<i>Combination 7</i>	4.76%	38.10%	<10th
<i>Combination 8</i>	0.00%	28.57%	10th–24th
<i>Combination 9</i>	0.00%	23.81%	<10th
<i>Combination 10</i>	0.00%	23.81%	10th–24th
<b><i>Immunizations for Adolescents</i></b>			
<i>Combination 1 (Meningococcal, Tdap)</i>	26.32%	38.60%	<10th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	12.28%	17.54%	<10th
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b>			
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	55.62%	58.58%	<10th
<b><i>Adolescent Well-Care Visits</i></b>			
<i>Adolescent Well-Care Visits</i>	37.65%	48.53%	25th–49th
<b><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></b>			
<i>BMI Percentile Documentation—Total</i>	9.70%	33.74%	<10th
<i>Counseling for Nutrition—Total</i>	4.65%	40.20%	<10th
<i>Counseling for Physical Activity—Total</i>	6.26%	37.98%	<10th



# CHP+

Child Health Plan *Plus*

## 2019 HEDIS Aggregate Report for Child Health Plan *Plus*

*October 2019*

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



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## 1. Executive Summary

### Introduction

The State of Colorado offers its residents a low-cost health insurance plan for qualified children age 18 and younger and pregnant women age 19 and older through its Child Health Plan *Plus* (CHP+) program, also known as the Children's Health Insurance Program (CHIP). As of the end of fiscal year (FY) 2018–2019, Colorado's CHP+ enrollment was 80,252 children and pregnant women.<sup>1-1</sup> The CHP+ services are coordinated through five managed care organizations (MCOs) and the State Managed Care Network (SMCN). Medical services covered by Colorado's CHP+ program include primary care, emergency/urgent care, hospital services, dental care, prescriptions, immunizations, maternity care, and mental/behavioral health care.

The CHP+ program is administered by Colorado's Department of Health Care Policy and Financing (the Department). Colorado's five CHP+ MCOs in FY 2018–2019 included Colorado Access (COA), Denver Health Medical Plan (DHMP), Friday Health Plans of Colorado (FHP), Kaiser Permanente Colorado (Kaiser), and Rocky Mountain Health Plans (RMHP). All counties in Colorado have a CHP+ MCO; however, the SMCN (the State's administrative service organization) is available for CHP+ eligible members prior to enrollment in an MCO, for all pregnant women, and as an alternative to managed care for members who request to receive service using a fee-for-service (FFS) payment strategy instead of choosing an MCO. The SMCN directly contracts with providers, hospitals, and ancillary services, and was only required to report one measure, *Prenatal and Postpartum Care*.

To evaluate performance levels and to provide an objective, comparative review of the Colorado CHP+ MCOs' quality-of-care outcomes and key performance measure rates, the Department required its MCOs to report results following the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) protocols.<sup>1-2</sup> The Department selected HEDIS performance measures from the standard Medicaid HEDIS 2019 reporting set to evaluate the MCOs' performance and for public reporting. For HEDIS 2019, the Department required that the MCOs report all HEDIS measures using the administrative methodology. This report includes rates calculated using only administrative data. Therefore, caution should be exercised when comparing results for measures with a hybrid option to national benchmarks, which were established using administrative and/or medical record review data.

In FY 2018–2019, each CHP+ MCO underwent an NCQA HEDIS Compliance Audit<sup>™</sup> through a licensed HEDIS audit organization in order to verify the processes used to report valid HEDIS rates.<sup>1-3</sup> All CHP+ MCOs submitted final measure rates and audit results to Health Services Advisory Group,

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<sup>1-1</sup> Colorado Department of Health Care Policy and Financing. Child Health Plan *Plus*. Available at: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>. Accessed on: Sept 19, 2019.

<sup>1-2</sup> HEDIS<sup>®</sup> is a registered trademark of the NCQA.

<sup>1-3</sup> NCQA HEDIS Compliance Audit<sup>™</sup> is a trademark of the NCQA.

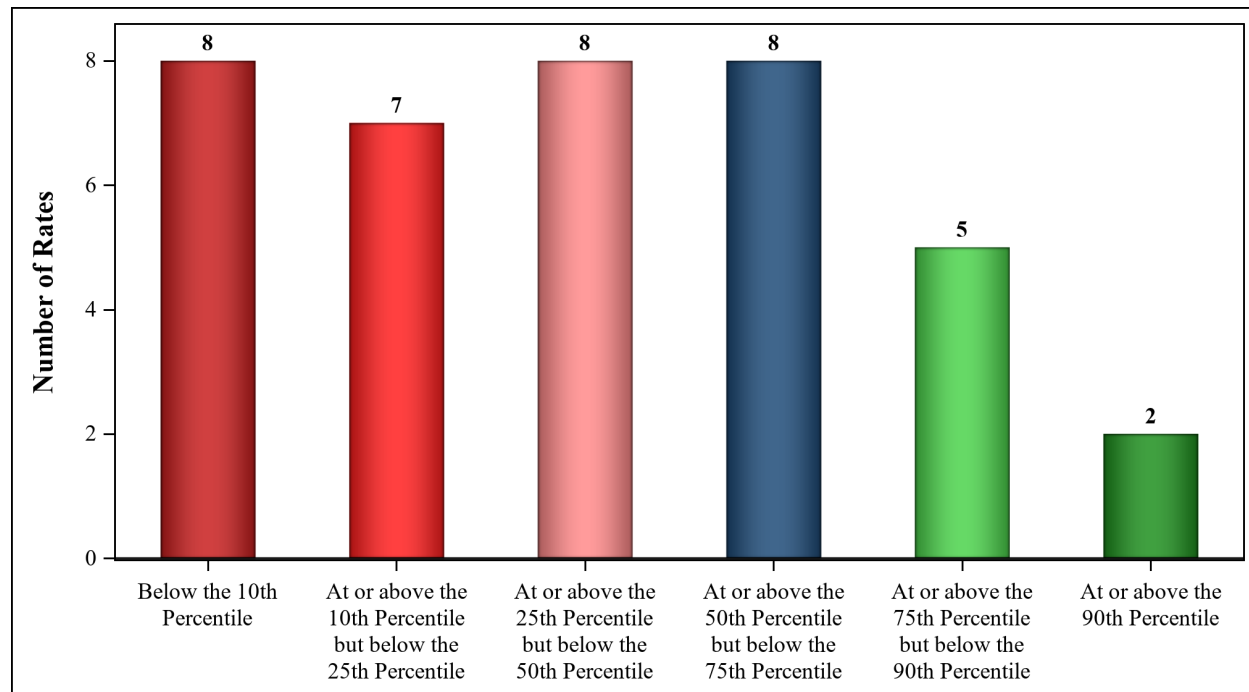


Inc. (HSAG), the Department’s external quality review organization (EQRO). HSAG examined the measures among the following domains of care: Pediatric Care, Access to Care and Preventive Screening, Mental/Behavioral Health, Respiratory Conditions, and Use of Services. Please see Appendix C for additional information on NCQA’s Information Systems (IS) standards and the audit findings for the CHP+ MCOs.<sup>1-4</sup> This report documents the results of HSAG’s analysis and recommendations for improvement, where appropriate.

## Summary of Performance

Figure 1-1 shows the Colorado CHP+ program’s performance on the HEDIS 2019 performance measure indicators that were comparable to NCQA’s Quality Compass® national Medicaid HMO percentiles for HEDIS 2018 (referred to throughout this report as percentiles).<sup>1-5</sup> Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicators were compared to NCQA’s Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2018 since these indicators are not published in Quality Compass. The bars represent the number of CHP+ statewide weighted averages that fell into each national Medicaid percentile range. The percentile range shows how the CHP+ statewide weighted average ranked nationally. Measures under the Use of Services domain are considered utilization-based measures rather than performance measures; therefore, they are not included in this figure.

**Figure 1-1—Colorado CHP+ Weighted Averages**



<sup>1-4</sup> NCQA. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

<sup>1-5</sup> Quality Compass® is a registered trademark of the NCQA.

The Colorado CHP+ weighted averages indicated low performance statewide compared to national standards for HEDIS 2019, as 23 of 38 (60.5 percent) measure rates fell below the 50th percentile.

## Detailed Statewide Performance

Table 1-1 shows the Colorado CHP+ weighted averages for HEDIS 2017 through HEDIS 2019 along with the percentile ranking for each HEDIS 2019 rate. Rates for HEDIS 2019 shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates for HEDIS 2019 shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.<sup>1-6</sup> For measures in the Use of Services domain, HSAG did not perform significance testing because variances were not provided in the Interactive Data Submission System (IDSS) files; therefore, differences in rates are reported here without significance testing. In addition, higher or lower rates do not necessarily indicate better or worse performance for the measures in the Use of Services domain.

**Table 1-1—Colorado CHP+ Weighted Averages**

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>				
<b><i>Childhood Immunization Status<sup>1</sup></i></b>				
<i>Combination 2</i>	65.30%	62.54%	66.78%^	10th–24th
<i>Combination 3</i>	63.61%	61.05%	65.16%^	10th–24th
<i>Combination 4</i>	61.14%	59.17%	63.13%^	10th–24th
<i>Combination 5</i>	57.33%	53.79%	59.76%^	25th–49th
<i>Combination 6</i>	41.61%	40.51%	45.31%^	50th–74th
<i>Combination 7</i>	55.57%	52.43%	58.20%^	25th–49th
<i>Combination 8</i>	40.34%	39.53%	44.29%^	50th–74th
<i>Combination 9</i>	38.50%	36.49%	42.27%^	75th–89th
<i>Combination 10</i>	37.59%	35.77%	41.39%^	75th–89th
<b><i>Immunizations for Adolescents</i></b>				
<i>Combination 1 (Meningococcal; Tetanus, Diphtheria Toxoids, and Acellular Pertussis [Tdap])</i>	67.55%	68.89%	73.33%^	25th–49th
<i>Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])</i>	—	33.79%	39.02%^	75th–89th

<sup>1-6</sup> Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05. A change in performance is considered statistically significant in this report if there was at least a 3-percentage point difference from HEDIS 2018 to HEDIS 2019.

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Well-Child Visits in the First 15 Months of Life</b>				
Zero Visits*	3.04%	2.63%	5.06%	<10th
Six or More Visits	48.01%	51.41%	48.28%	<10th
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.60%	64.97%	67.34%	25th–49th
<b>Adolescent Well-Care Visits</b>				
Adolescent Well-Care Visits	48.26%	45.09%	48.23%^	25th–49th
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
Body Mass Index (BMI) Percentile Documentation—Total <sup>1</sup>	16.67%	19.89%	22.71%	<10th
Counseling for Nutrition—Total	18.14%	20.12%	21.46%	<10th
Counseling for Physical Activity—Total	14.31%	15.87%	17.58%	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
Appropriate Testing for Children With Pharyngitis	84.35%	87.36%	84.99%	50th–74th
<b>Access to Care</b>				
<b>Prenatal and Postpartum Care<sup>2</sup></b>				
Timeliness of Prenatal Care	57.08%	58.29%	55.13%	—
Postpartum Care	42.50%	43.42%	45.01%	—
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
Ages 12 to 24 Months	90.02%	90.65%	92.33%	10th–24th
Ages 25 Months to 6 Years	82.88%	80.91%	82.93%	10th–24th
Ages 7 to 11 Years	88.99%	87.49%	87.66%	10th–24th
Ages 12 to 19 Years	89.39%	88.09%	87.14%	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
Ages 16 to 20 Years	35.31%	33.66%	36.52%	<10th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17%	0.07%	0.04%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management<sup>3</sup></b>				
Effective Acute Phase Treatment	NA	48.65%	55.00%	50th–74th
Effective Continuation Phase Treatment	NA	40.54%	37.50%	50th–74th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication<sup>3</sup></i></b>				
<i>Initiation Phase</i>	13.02%	21.84%	15.21%	<10th
<i>Continuation and Maintenance Phase</i>	20.00%	21.57%	20.00%	<10th
<b><i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i></b>				
<i>Total</i>	—	39.85%	38.98%	50th–74th
<b><i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents<sup>*1</sup></i></b>				
<i>Total</i>	3.37%	5.62%	4.04%	10th–24th
<b><i>Respiratory Conditions</i></b>				
<b><i>Appropriate Treatment for Children With Upper Respiratory Infection</i></b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	91.24%	93.84%	94.09%	75th–89th
<b><i>Medication Management for People With Asthma<sup>1</sup></i></b>				
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	49.43%	61.29%	59.75%	50th–74th
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	45.74%	51.75%	51.64%	25th–49th
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	25.86%	32.26%	33.96%	50th–74th
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	20.93%	24.48%	27.05%	25th–49th
<b><i>Asthma Medication Ratio<sup>1</sup></i></b>				
<i>Ages 5 to 11 Years</i>	85.80%	82.90%	82.63%	≥90th
<i>Ages 12 to 18 Years</i>	73.72%	74.03%	71.32%	75th–89th
<b><i>Use of Services</i></b>				
<b><i>Ambulatory Care (Per 1,000 Member Months)</i></b>				
<i>Outpatient Visits<sup>1</sup></i>	205.26	199.00	195.91	<10th
<i>Emergency Department (ED) Visits<sup>*</sup></i>	20.84	21.80	23.83	≥90th
<b><i>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></i></b>				
<i>Discharges per 1,000 Member Months (Total Inpatient)</i>	0.87	0.88	0.88	<10th
<i>Average Length of Stay (Total Inpatient)</i>	3.42	3.77	3.51	10th–24th
<i>Discharges per 1,000 Member Months (Medicine)</i>	0.60	0.60	0.63	<10th
<i>Average Length of Stay (Medicine)</i>	2.82	2.96	2.89	<10th
<i>Discharges per 1,000 Member Months (Surgery)</i>	0.24	0.24	0.21	<10th
<i>Average Length of Stay (Surgery)</i>	4.97	5.90	5.50	10th–24th
<i>Discharges per 1,000 Member Months (Maternity)</i>	0.06	0.07	0.07	<10th
<i>Average Length of Stay (Maternity)</i>	2.68	2.97	2.49	10th–24th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Antibiotic Utilization*</b>				
<i>Average Scripts Per Member Per Year (PMPY) for Antibiotics</i>	0.40	0.38	0.33	≥90th
<i>Average Days Supplied per Antibiotic Script</i>	11.06	11.36	16.86	<10th
<i>Average Scripts PMPY for Antibiotics of Concern</i>	0.13	0.12	0.11	≥90th
<i>Percentage of Antibiotics of Concern of All Antibiotic Scripts</i>	33.99%	33.02%	31.91%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

<sup>2</sup> The SMCN was the only MCO required to report the Prenatal and Postpartum Care measure. The rates were calculated using modified specifications; therefore, comparisons to national benchmarks were not performed for this measure.

<sup>3</sup> Due to changes in the technical specifications for this measure in 2018, NCQA recommends trending between 2018 and prior years be considered with caution.

— Indicates that the rate is not presented as the measure was not required to be reported during HEDIS 2017 or comparisons to benchmarks are not appropriate. This symbol may also indicate that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

## Summary of Performance by Domain

### Pediatric Care

Across the three measure rates related to well-care/well-child visits (i.e., *Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Adolescent Well-Care Visits*), only two MCOs reported a rate that exceeded the 50th percentile (RMHP for *Well-Child Visits in the First 15 Months of Life—Zero Visits* and Kaiser for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*). This demonstrates opportunities to increase the number of comprehensive visits for infants, children, and adolescents. The MCOs and the Department should identify the factors contributing to the low rates for the well-child/well-care visits (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source challenges) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.<sup>1-7</sup>

Of note, three of five (60.0 percent) MCOs were above the 75th percentile for *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* and four of five (80.0 percent) MCOs were above the 50th percentile for *Appropriate Testing for Children With Pharyngitis*, indicating statewide

<sup>1-7</sup> American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Accessed on: Jul 16, 2019.

strength for adolescents receiving necessary vaccinations and appropriate testing of pharyngitis in outpatient and ED settings.

### Access to Care and Preventive Screening

Overall, only one *Children and Adolescents' Access to Primary Care Practitioners* measure rate was above the 50th percentile (Kaiser's *Ages 12 to 24 Months* indicator), indicating all five MCOs have opportunities to improve access to care for children and adolescents. The Department should work with the MCOs and providers to identify barriers in access to care (e.g., transportation/distance to and from the doctor's office, limited provider office hours, difficulty navigating the healthcare system, prolonged wait times for getting an appointment, or prolonged wait times once at the provider's office).<sup>1-8</sup>

Increasing the access to care for members may also have a positive impact on the quality of preventive care received, such as the *Chlamydia Screening in Women* measure, for which all MCOs demonstrated poor performance. Chlamydia is the most common sexually transmitted disease in the United States, and improvement of MCO performance in this measure could positively impact the quality of care for a substantial number of CHP+ members. The MCOs and the Department should ensure providers are aware of the importance of screening for chlamydia and increase the number of resources available to providers and members (e.g., one-on-one provider trainings, providing lists of members overdue for a screening, or newsletters targeting chlamydia screening rates) to support the screenings.<sup>1-9,1-10</sup> Conversely, all MCOs exceeded the 90th percentile for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure.

### Mental/Behavioral Health

For HEDIS 2019, neither DHMP nor FHP had any reportable rates within the Mental/Behavioral Health domain. Kaiser and RMHP demonstrated strong performance for young members newly prescribed ADHD medication that received a follow-up care visit within 30 days, with opportunities for improvement noted for COA in the same measure. None of COA's eligible members received a follow-up visit after being prescribed ADHD medication. Monitoring of children on ADHD medications is necessary to ensure that the clinical benefits are achieved and to make any necessary dosage/prescription adjustments to control and prevent side effects (e.g., increased activity, negative mood, headaches).<sup>1-11</sup> Additionally, COA's rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* fell below the 50th

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<sup>1-8</sup> MACPAC. *Chapter 4: Monitoring Access to Care in Medicaid*. Available at: <https://www.macpac.gov/wp-content/uploads/2017/03/Monitoring-Access-to-Care-in-Medicaid.pdf>. Accessed on: Aug 14, 2019.

<sup>1-9</sup> Centers for Disease Control and Prevention. *Chlamydia*. Available at: <https://www.cdc.gov/std/stats17/chlamydia.htm>. Accessed on: Jul 16, 2019.

<sup>1-10</sup> National Prevention Information Network. *Strategies and Incentives from Health Plans to Increase Chlamydia Screening Rates*. Available at: <https://npin.cdc.gov/publication/strategies-and-incentives-health-plans-increase-chlamydia-screening-rates>. Accessed on: Aug 26, 2019.

<sup>1-11</sup> Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). *Managing Medication for Children and Adolescents with ADHD*. Available at: [https://chadd.org/wp-content/uploads/2018/05/managing\\_medication.pdf](https://chadd.org/wp-content/uploads/2018/05/managing_medication.pdf). Accessed on: Jul 16, 2019.



percentile. Antipsychotic medication use is associated with adverse physical side effects (e.g., type 2 diabetes, cardiovascular disease), and children are more at risk for these side effects when they receive multiple antipsychotics.<sup>1-12</sup> COA and the Department should conduct root cause analyses for the low monitoring rates for members prescribed ADHD and/or antipsychotic medications to determine the nature and scope of the issue (e.g., are the issues related to barriers to accessing care or the need for improved provider training) and implement strategies to improve the care for these members.

## Respiratory Conditions

All MCOs were above the 50th percentile for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, demonstrating appropriate treatment of upper respiratory infections in the outpatient and ED settings. COA was the only MCO to have reportable rates for the remaining measures in the Respiratory Conditions domain, showing strength with the ratio of controller medications to reliever medications for children and adolescents. Conversely, opportunities for improvement exist with asthma medication compliance for members ages 12 to 18, with both rates falling below the 50th percentile. COA and the Department should focus efforts to identify the low rates of adherence to asthma medications (e.g., are the issues related to barriers to accessing pharmacies, provider prescribing patterns, or members not filling prescriptions) and implement strategies to increase the rates for members ages 12 to 18.

## Use of Services

Reported rates for the MCOs and CHP+ weighted averages for the Use of Services domain did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions regarding performance based on the reported utilization results. Nonetheless, combined with other performance metrics, the utilization results provide additional information that MCOs may use to assess barriers or patterns of utilization when evaluating improvement interventions.

## Limitations and Considerations

- Since all HEDIS 2019 measures were reported using the administrative methodology according to the Department's direction, MCOs that were able to obtain supplemental data or capture more complete data will generally report higher rates when using the administrative methodology. As a result, the rates presented in this report for measures with a hybrid option may be more representative of data completeness rather than a measure of performance.
- National HEDIS percentiles are not available for the CHIP population; therefore, comparison of the CHP+ MCOs' rates to Medicaid percentiles should be interpreted with caution.

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<sup>1-12</sup> Correll CU, Detraux J, De Lepeleire J, De Hert M. Effects of antipsychotics, antidepressants and mood stabilizers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder. *World Psychiatry*. 2015;14(2):119-36.



## 2. Reader's Guide

### Introduction

The reader's guide is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

### CHP+ MCO Names

Table 2-1 presents the CHP+ MCOs discussed within this report and their corresponding abbreviations.

**Table 2-1—2019 CHP+ MCO Names and Abbreviations**

CHP+ MCO Name	Abbreviation
Colorado Access	COA
Denver Health Medical Plan	DHMP
Friday Health Plans of Colorado	FHP
Kaiser Permanente Colorado	Kaiser
Rocky Mountain Health Plans	RMHP

### Summary of HEDIS 2019 Measures

Within this report, HSAG presents the statewide and MCO-specific performance on HEDIS measures selected by the Department for HEDIS 2019. The HEDIS measures selected by the Department were grouped into the following domains of care: Pediatric Care, Access to Care and Preventive Screening, Mental/Behavioral Health, Respiratory Conditions, and Use of Services.<sup>2-1</sup> While performance is reported primarily at the measure indicator level, grouping these measures into domains encourages the MCOs and the Department to consider the measures as a whole rather than in isolation and to develop the strategic changes required to improve overall performance.

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<sup>2-1</sup> The CHP+ SMCN was only required to report one measure, *Prenatal and Postpartum Care*. Additionally, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* was a required measure; however, because all five CHP+ MCOs had zero members in the eligible population for this measure, it was excluded from this report.

Table 2-2 shows the selected HEDIS 2019 measures and measure indicators that are presented within this report as well as the corresponding domains of care. Additional measure indicator rates are displayed within the appendices for more granular definitions of MCO performance for select measures. For example, the *Total* rates for the *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* measure are displayed in the Executive Summary and Section 5 of this report to provide an overall understanding of plan and statewide performance associated with antipsychotic medication use for members 1 to 17 years of age. *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* rates for *Ages 1 to 5*, *Ages 6 to 11*, and *Ages 12 to 17* are presented along with the *Total* in the appendices.

**Table 2-2—HEDIS 2019 Selected Measures**

Performance Measures
<b>Pediatric Care</b>
<i>Childhood Immunization Status—Combinations 2–10</i>
<i>Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)</i>
<i>Well-Child Visits in the First 15 Months of Life—Zero Visits and Six or More Visits</i>
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
<i>Adolescent Well-Care Visits</i>
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total</i>
<i>Appropriate Testing for Children With Pharyngitis</i>
<b>Access to Care and Preventive Screening</b>
<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*</i>
<i>Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years</i>
<i>Chlamydia Screening in Women—Ages 16 to 20 Years</i>
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>
<b>Mental/Behavioral Health</b>
<i>Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment</i>
<i>Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase</i>
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total</i>
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total</i>

Performance Measures
<b>Respiratory Conditions</b>
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>
<i>Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years and Ages 12 to 18 Years, and Medication Compliance 75%—Ages 5 to 11 Years and Ages 12 to 18 Years</i>
<i>Asthma Medication Ratio—Ages 5 to 11 Years and Ages 12 to 18 Years</i>
<b>Use of Services</b>
<i>Ambulatory Care (Per 1,000 Member Months)—ED Visits—Total and Outpatient Visits—Total</i>
<i>Inpatient Utilization—General Hospital/Acute Care</i>
<i>Antibiotic Utilization</i>

\* The CHP+ SMCN was only required to report one measure, Prenatal and Postpartum Care.

Of note, HEDIS technical measure descriptions are included throughout this report, which include age requirements for inclusion in the measure. In some instances, the HEDIS technical measure definition includes individuals who would not be eligible for the CHP+ program (i.e., some measures apply to adults who are age 18 and older; however, the CHP+ program is limited to individuals who are in the month of their 19th birthday or younger). Therefore, the measure results actually reflect a more limited age group than the HEDIS technical specification definition.

## Data Collection Method

According to the Department's guidance, all measure rates presented in this report for the MCOs are based on administrative data only. Please note, the hybrid data collection methodology was used by the MCOs to report rates for select measures prior to 2017. The administrative method requires that the MCOs identify the eligible population (i.e., the denominator) using administrative data, derived from claims and encounters. In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely using administrative and supplemental data collected during the reporting year. Supplemental data include immunization registry data, medical record review data from the prior year, etc. Medical records collected during the current year cannot be used to retrieve information. When using the administrative method, the entire eligible population becomes the denominator, and sampling is not allowed. In contrast, the hybrid method extracts a systematic sample of members and utilizes data from the medical record, along with administrative and supplemental data. The hybrid method generally produces higher rates because the completeness of documentation in the medical record exceeds what is typically captured in administrative data; however, the medical record review component of the hybrid method is considered more labor intensive. The data collection or calculation methods (i.e., administrative, hybrid) for each measure are described in detail by NCQA in the *HEDIS 2019 Volume 2 Technical Specifications*. Of note, FHP reported select measure rates for HEDIS 2019 using the administrative and hybrid methods. The hybrid rates are included in Appendix D.

## Data Sources and Measure Audit Results

MCO-specific performance displayed in this report was based on data elements obtained from the IDSS files or the Microsoft (MS) Excel files supplied by the MCOs contracted with the Department to provide CHP+ services. Prior to HSAG's receipt of the MCOs' IDSS files or MS Excel files, all the MCOs were required by the Department to have their HEDIS 2019 results examined and verified through an NCQA HEDIS Compliance Audit.

Through the audit process, each measure indicator rate reported by an MCO was assigned an NCQA-defined audit result. HEDIS 2019 measure indicator rates received one of seven predefined audit results: *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR)*, *No Benefit (NB)*, *Not Required (NQ)*, *Not Reported (NR)*, and *Unaudited (UN)*. The audit results are defined in the Glossary section.

Rates designated as *NA*, *BR*, *NB*, *NQ*, *NR*, or *UN* are not presented in this report. All measure indicator rates that are presented in this report have been verified as an unbiased estimate of the measure by the respective HEDIS auditor. Please see Appendix C for additional information on NCQA's Information System (IS) standards and the audit findings for the CHP+ MCOs.

## Differences in Calculations

The *Prenatal and Postpartum Care* measure was calculated using modified measure specifications to address the use of bundled service billing. Only the SMCN was required to report this measure. Of note, the SMCN's calculated rates did not undergo an NCQA HEDIS Compliance Audit.

In a case where a provider submitted a bundled service claim, but did not indicate the date when prenatal care was initiated, the following criteria were used as a proxy to determine the date when prenatal care was initiated to calculate the rate for *Timeliness of Prenatal Care*:

- Any visit with the same obstetrician/gynecologist (OB/GYN) who submitted the bundled service claim during the relevant time period.
- A claim for an obstetric ultrasound during the relevant time period.

In a case where a provider submitted a bundled service claim, but did not indicate the date when postpartum care was rendered, any visit with the same OB/GYN during the relevant time period was used as a proxy to determine the date when postpartum care was rendered to calculate the rate for *Postpartum Care*.

## Calculation of Statewide Averages

For all measures, HSAG collected the audited results, numerator, denominator, rate, audit designation, and eligible population data elements reported in the files submitted by the five CHP+ MCOs to calculate the statewide weighted averages. Given that the MCOs varied in membership size and demographic configuration, the statewide rate for a measure was the average rate weighted by each MCOs' eligible population for the measure. Weighting the rates by the eligible population sizes ensured that the rate for an MCO with 125,000 members, for example, had a greater impact on the overall Colorado CHP+ weighted average rate than the rate for an MCO with only 10,000 members. For the MCOs with rates reported as *NA* due to small denominators, the numerators, denominators, and eligible populations were still included in the calculations of the statewide weighted average. However, MCO rates reported as *BR*, *NB*, *NQ*, *NR*, or *UN* were excluded from the statewide weighted average calculation.

## Evaluating Measure Results

### National Benchmark Comparisons

#### Benchmark Data

HEDIS 2019 MCO rates and the statewide weighted average rates were compared to the corresponding national HEDIS benchmarks, which are expressed in percentiles of national performance for each measure. For comparative purposes, HSAG used the most recent data available from NCQA at the time of the production of this report to evaluate the HEDIS 2019 rates: NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2018. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%* measure indicator were compared to the NCQA's Audit Means and Percentiles for HEDIS 2018.

For some measures for which lower rates indicate better performance (i.e., *Well-Child Visits in the First 15 Months of Life—Zero Visits*, *Ambulatory Care—ED Visits*, and *Antibiotic Utilization*), HSAG inverted the percentiles to be consistently applied to these measures as with the other HEDIS measures. For example, the 10th percentile (a lower rate) was inverted to become the 90th percentile, indicating better performance.

Since national percentiles are not available specifically for the CHIP population, the CHP+ MCOs' rates as well as the Colorado CHP+ statewide weighted averages were compared to the national percentiles, which were composed of performance from all Medicaid plans. Therefore, comparisons of Colorado's CHP+ population measure indicator rates to the benchmarks should be interpreted with caution.

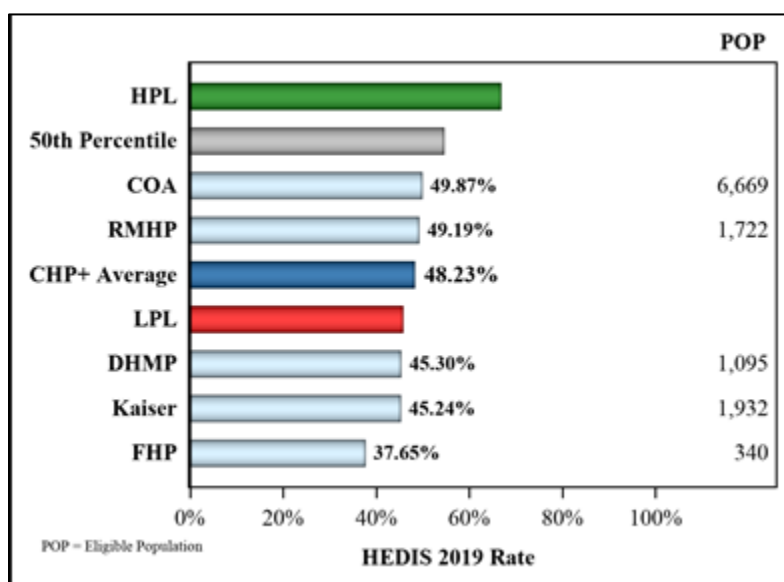
Additionally, benchmarking data (i.e., NCQA Quality Compass and NCQA Audit Means and Percentiles) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays.

## Figure Interpretation

For each performance measure indicator presented in this report, the horizontal bar graph figure positioned on the right side of the page presents each MCO's performance against the HEDIS 2019 Colorado CHP+ weighted average (i.e., the bar shaded darker blue) as well as the 50th percentile (i.e., the bar shaded gray), and the high (i.e., the bar shaded green) and low (i.e., the bar shaded red) performance levels.

For most performance measures, the high performance level (HPL) corresponds to the 90th percentile and the low performance level (LPL) corresponds to the 25th percentile. For measures such as *Well-Child Visits in the First 15 Months of Life—Zero Visits*, in which lower rates indicate better performance, the 10th percentile (rather than the 90th percentile) and the 75th percentile (rather than the 25th percentile) are considered the HPL and LPL, respectively. An example of the horizontal bar graph figure for one measure is shown in Figure 2-1.

**Figure 2-1—Sample Horizontal Bar Graph Figure**



## Percentile Rankings and Star Ratings

In addition to illustrating MCO-specific and statewide performance via side-by-side comparisons to national percentiles, benchmark comparisons are denoted within this report using the percentile ranking performance levels and star ratings defined below in Table 2-3.

**Table 2-3—Percentile Ranking Performance Levels**

Star Rating	Percentile Ranking	Performance Level
★★★★★	≥90th	At or above the 90th percentile
★★★★	75th–89th	At or above the 75th percentile but below the 90th percentile
★★★	50th–74th	At or above the 50th percentile but below the 75th percentile
★★	25th–49th	At or above the 25th percentile but below the 50th percentile
★	10th–24th	At or above the 10th percentile but below the 25th percentile
	<10th	Below the 10th percentile

Some measures in the Use of Services measure domain are designed to capture the frequency of services provided. Higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates and the associated percentile rankings are provided for informational purposes only.

Of note, MCO-specific and statewide rates were rounded to the second decimal place before performance levels were determined. As HSAG assigned percentile rankings and star ratings, an em dash (—) was presented to indicate when the measure did not have an applicable benchmark; therefore, the performance levels for these measures were not presented in this report.

## Trend Analysis

In addition to the percentile ranking and star rating results, HSAG also compared HEDIS 2019 Colorado CHP+ weighted averages and MCO-specific rates to the corresponding HEDIS 2018 rates. HSAG also evaluated the extent of changes observed in the rates between years. Year-over-year performance comparisons are based on the Chi-square test of statistical significance with a  $p$  value  $<0.05$ . However, caution should be exercised when interpreting results of the significance testing, given that statistically significant changes may not necessarily be clinically significant. To limit the impact of this, a change will not be considered statistically significant unless the change was at least 3 percentage points. Note that statistical testing could not be performed on the utilization-based measures under the Use of Services domain given that variances were not available in the IDSS for HSAG to use for statistical testing.

In general, results from statistical significance testing provide information on whether a change in the rate may suggest improvement or decline in performance. Throughout the report, references to “significant” changes in performance are noted; these instances refer to statistically significant differences between performance from HEDIS 2018 to HEDIS 2019. At the statewide level, if the



number of MCOs reporting *NR* or *BR* differs vastly from year to year, the statewide performance may not represent all of the contracted MCOs, and any changes observed across years may need to take this factor into consideration. Nonetheless, changes (regardless of whether they are significant) could be related to the following factors independent of any effective interventions designed to improve the quality of care:

- Substantial changes in measure specifications. The “Measure Changes Between HEDIS 2018 and HEDIS 2019” section lists measures with specification changes made by NCQA.
- Substantial changes in membership composition within the MCO.

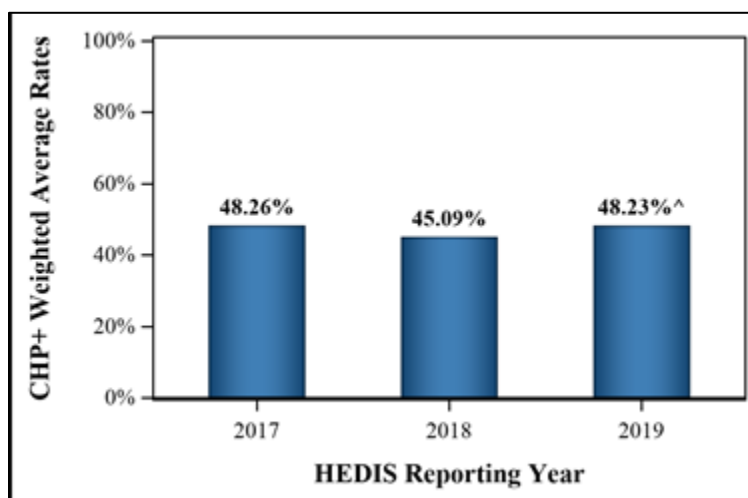
Similarly, caution should be exercised when comparing rates calculated administratively to national benchmarks that were calculated using the hybrid methodology.

### Figure Interpretation

Within the Executive Summary and Appendix B of this report, performance measure indicator rates and results of significance testing between HEDIS 2018 and HEDIS 2019 are presented in tabular format. HEDIS 2019 rates shaded green with one caret (^) indicate a significant improvement in performance from the previous year. HEDIS 2019 rates shaded red with two carets (^) indicate a significant decline in performance from the previous year.

For each performance measure indicator presented in this report, the vertical bar graph figure positioned on the left side of the page presents the HEDIS 2017, HEDIS 2018, and HEDIS 2019 Colorado CHP+ weighted averages, with significance testing performed between the HEDIS 2018 and HEDIS 2019 weighted averages. Within these figures, HEDIS 2019 rates with one caret (^) indicate a significant improvement in performance from HEDIS 2018. HEDIS 2019 rates with two carets (^) indicate a significant decline in performance from HEDIS 2018. An example of the vertical bar graph figure for measure indicators reported is shown in Figure 2-2.

**Figure 2-2—Sample Vertical Bar Graph Figure**



## Measure Changes Between HEDIS 2018 and HEDIS 2019

The following is a list of measures with technical specification changes that NCQA announced for HEDIS 2019.<sup>2-2,2-3</sup> These changes may have an effect on the HEDIS 2019 rates that are presented in this report.

### ***Childhood Immunization Status***

- Revised the measles, mumps, and rubella (MMR), varicella-zoster virus (VZV), and hepatitis A (HepA) numerators in the Administrative Specification to indicate that a vaccination administered on or between the child's first and second birthdays meets the numerator criteria.

### ***Immunizations for Adolescents***

- Updated meningococcal vaccine references.
- Added optional exclusions for the Tdap vaccine.

### ***Well-Child Visits in the First 15 Months of Life***

- Clarified that children who turn 15 months old during the measurement year are included in the measure.
- Clarified in the numerator to not count visits that occur after the member's 15-month birthday.
- Clarified the medical record requirements for health history, physical developmental history, mental developmental history, and health education/anticipatory guidance.
- Added a *Note* that includes examples of documentation that do not meet the criteria for the numerator.

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

- Clarified the medical record requirements for health history, physical developmental history, mental developmental history, and health education/anticipatory guidance.
- Added a *Note* that includes examples of documentation that do not meet the criteria for the numerator.

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<sup>2-2</sup> National Committee for Quality Assurance. *HEDIS® 2018, Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA Publication, 2017.

<sup>2-3</sup> National Committee for Quality Assurance. *HEDIS® 2018, Volume 2: Technical Update*. Washington, DC: NCQA Publication, 2017.

### **Adolescent Well-Care Visits**

- Clarified the medical record requirements for health history, physical developmental history, mental developmental history, and health education/anticipatory guidance.
- Added a *Note* that includes examples of documentation that do not meet the criteria for the numerator.

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

- Clarified in the *Notes* that services rendered for obesity or eating disorders may be used to meet criteria for the *Counseling for Nutrition* and *Counseling for Physical Activity* indicators.

### **Appropriate Testing for Children With Pharyngitis**

- Deleted the instructions for identifying ED/observation visits that result in an inpatient stay; refer to *General Guideline 44* for new instructions.

### **Prenatal and Postpartum Care**

- Deleted prenatal visits with internal organization codes for last menstrual period (LMP)/estimated date of delivery (EDD) and obstetrical history/risk assessment counseling from Decision Rule 3 of the Administrative specification. Internal organization codes are supplemental data and are in the scope of the hybrid specification.
- Clarified that documentation in the medical record of gestational age with either prenatal risk assessment and counseling/education or complete obstetrical history meets criteria for the *Timeliness of Prenatal Care* numerator.
- Clarified in the *Notes* that nonancillary services must be delivered by the required provider type.

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

- Added a *Note* to indicate that supplemental data can be used for only required exclusions for this measure.

### **Antidepressant Medication Management**

- Restructured the codes and value sets for identifying the required exclusions (step 2). Refer to the Value Set Directory for a detailed summary of changes.

### ***Follow-Up Care for Children Prescribed ADHD Medication***

- Clarified in the continuous enrollment of Rate 2 that members who switch product lines or products between the Rate 1 and Rate 2 continuous enrollment periods are only included in Rate 1.
- Restructured the codes and value sets for identifying the numerators. Refer to the Value Set Directory for a detailed summary of changes.

### ***Use of Multiple Concurrent Antipsychotics in Children and Adolescents***

- Revised the section to not include denied claims when identifying the eligible population or assessing the numerator.

### ***Appropriate Treatment for Children With Upper Respiratory Infection***

- Deleted the instructions for identifying ED/observation visits that result in an inpatient stay; refer to *General Guideline 44* for new instructions.
- Added a *Note* to indicate that supplemental data may not be used for this measure.

### ***Medication Management for People With Asthma***

- Incorporated telehealth into the measure specifications.
- Removed “Mast cell stabilizers” from the Asthma Controller Medications List.

### ***Asthma Medication Ratio***

- Incorporated telehealth into the measure specifications.
- Added instructions in step 4 of the numerator calculation to indicate that the ratio should be rounded to the nearest whole number using the .5 rule.
- Removed “Mast cell stabilizers” from the Asthma Controller Medications List.

### ***Ambulatory Care***

- Incorporated telehealth into the measure specification.
- Deleted the instructions for identifying ED/observation visits that result in an inpatient stay; refer to *General Guideline 44* for new instructions.

### ***Inpatient Utilization***

- Clarified that member months for maternity rates are reported for members 10–64 years of age.

## Glossary

Table 2-4 below provides definitions of terms, abbreviations, and acronyms used through this report.

**Table 2-4—Definition of Terms**

Term	Description
ADHD	Attention-deficit/hyperactivity disorder.
Audit Result	The HEDIS auditor's final determination, based on audit findings, of the appropriateness of the MCO to publicly report its HEDIS measure rates. Each measure indicator rate included in the HEDIS audit receives an audit result of <i>Reportable (R)</i> , <i>Small Denominator (NA)</i> , <i>Biased Rate (BR)</i> , <i>No Benefit (NB)</i> , <i>Not Required (NQ)</i> , <i>Not Reported (NR)</i> , and <i>Unaudited (UN)</i> .
ADMIN%	Percentage of the final hybrid measure rate that was derived administratively (e.g., claims data and immunization registry).
BMI	Body Mass Index.
BR	Biased Rate: indicates that the MCO's reported rate was invalid; therefore, the rate was not presented.
Continuous Enrollment Requirement	The minimum amount of time that a member must be enrolled in the MCO to be eligible for inclusion in a measure to ensure that the MCO has a sufficient amount of time to be held accountable for providing services to that member.
CHIP	Children's Health Insurance Program.
CHP+	Child Health Plan <i>Plus</i> , Colorado's program implementing the CHIP.
CVX	Vaccine administered codes.
Data Completeness	The degree to which occurring services/diagnoses appear in the MCO's administrative data systems.
Denominator	The number of members who meet all criteria specified in a measure for inclusion in the eligible population. When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.
DTaP	Diphtheria, tetanus toxoids, and acellular pertussis vaccine.
ED	Emergency department.
EDD	Estimated date of delivery.
EDI	Electronic data interchange; the direct computer-to-computer transfer of data.
Electronic Data	Data that are maintained in a computer environment versus a paper environment.
Encounter Data	Billing data received from a capitated provider. (Although the MCO does not reimburse the provider for each encounter, submission of encounter data allows the MCO to collect the data for future HEDIS reporting.)
EQR	External quality review.

Term	Description
Exclusions	Conditions outlined in HEDIS measure specifications that describe when a member should not be included in the denominator.
Final Audit Report	Following the MCO's completion of any corrective actions, an auditor completes the final audit report, documenting all final findings and results of the HEDIS audit. The final audit report includes a summary report, IS capabilities assessment, medical record review validation findings, measure results, and the auditor's audit opinion (the final audit statement).
Flu	Influenza vaccine.
FY	Fiscal year.
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.
HEDIS Repository	The data warehouse where all data used for HEDIS reporting are stored.
HepA	Hepatitis A vaccine.
HepB	Hepatitis B vaccine.
HiB	Haemophilus influenza type B vaccine.
HMO	Health maintenance organization.
HPL	High performance level. (For most performance measures, the Department defined the HPL as the most recent 90th percentile. For measures such as <i>Well-Child Visits in the First 15 Months of Life—Zero Visits</i> , in which lower rates indicate better performance, the 10th percentile [rather than the 90th percentile] is considered the HPL.)
HPV	Human papillomavirus vaccine.
HSAG	Health Services Advisory Group, Inc., the State's external quality review organization.
Hybrid Measures	Measures that can be reported using the hybrid method.
IDSS	The Interactive Data Submission System, a tool used to submit data to NCQA.
IPV	Inactivated polio virus vaccine.
IS	Information System; an automated system for collecting, processing, and transmitting data.
IS Standards	Information System (IS) standards; an NCQA-defined set of standards that measure how an organization collects, stores, analyzes, and reports medical, customer service, member, practitioner, and vendor data. <sup>2-4</sup>

<sup>2-4</sup> National Committee for Quality Assurance. HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5. Washington D.C.

Term	Description
IT	Information technology; the technology used to create, store, exchange, and use information in its various forms.
LPL	Low performance level. (For most performance measures, the Department defined the LPL as the most recent 25th national Medicaid percentile. For measures such as <i>Well-Child Visits in the First 15 Months of Life—Zero Visits</i> , in which lower rates indicate better performance, the 75th percentile [rather than the 25th percentile] is considered the LPL).
Material Bias	For most measures reported as a rate, any error that causes a $\pm 5$ percent difference in the reported rate is considered materially biased. For non-rate measures, any error that causes a $\pm 10$ percent difference in the reported rate or calculation is considered materially biased.
Medical Record Validation	The process that auditors follow to verify that the MCO's medical record abstraction meets industry standards and abstracted data are accurate.
Medicaid Percentiles	The NCQA national percentiles for each HEDIS measure for the Medicaid product line used to compare the MCO's performance and assess the reliability of the MCO's HEDIS rates.
MMR	Measles, mumps, and rubella vaccine.
MRR	Medical record review.
NA	<p>Small Denominator; indicates that the MCO followed the specifications but the denominator was too small (<math>&lt;30</math>) to report a valid rate, resulting in an NA designation.</p> <ul style="list-style-type: none"> <li>For effectiveness of care (EOC) and EOC-like measures, when the denominator is fewer than 30.</li> <li>For utilization measures that count member months, when the denominator is fewer than 360 member months.</li> <li>For all risk-adjusted utilization measures, except <i>PCR</i>, when the denominator is fewer than 150.</li> </ul>
NB	No Benefit; indicates that the required benefit to calculate the measure was not offered.
NCQA	The National Committee for Quality Assurance (NCQA) is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed health care delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.
NR	<p>Not Reported; indicates that the MCO chose not to report the required HEDIS measure indicator rate. This designation was assigned to rates during previous reporting years to indicate one of the following designations:</p> <p>The MCO chose not to report the required measure indicator rate, or the MCO's reported rate was invalid.</p>



Term	Description
Numerator	The number of members in the denominator who received all the services as specified in the measure.
NQ	Not Required; indicates that the MCO was not required to report this measure.
OB/GYN	Obstetrician/Gynecologist.
PCP	Primary care practitioner.
PCV	Pneumococcal conjugate vaccine.
POP	Eligible population.
PPC	Prenatal and Postpartum Care.
Provider Data	Electronic files containing information about physicians such as type of physician, specialty, reimbursement arrangement, and office location.
Retroactive Enrollment	When the effective date of a member's enrollment in the MCO occurs prior to the date that the MCO is notified of that member's enrollment. Medicaid members who are retroactively enrolled in the MCO may be excluded from a HEDIS measure denominator if the time period from the date of enrollment to the date of notification exceeds the measure's allowable gap specifications.
Revenue Codes	Cost codes for facilities to bill based on the categories of services, procedures, supplies, and materials.
RV	Rotavirus vaccine.
SMCN	State Managed Care Network.
Software Vendor	A third party, with source code certified by NCQA, that contracts with the MCO to write source code for HEDIS measures. (For the measures to be certified, the vendor must submit programming codes associated with the measure to NCQA for automated testing of program logic, and a minimum percentage of the measures must receive a "Pass" or "Pass With Qualifications" designation.)
The Department	The Colorado Department of Health Care Policy and Financing.
UN	Unaudited; indicates that the organization chose to report a measure that is not required to be audited.
URI	Upper respiratory infection.
Quality Compass	NCQA Quality Compass benchmark.
VZV	Varicella zoster virus (chicken pox) vaccine.

## 3. Pediatric Care

### Pediatric Care

The following section provides a detailed analysis of the Colorado CHP+ MCOs' performance within the Pediatric Care domain. The Pediatric Care domain encompasses the following measures/indicators:

- *Childhood Immunization Status—Combination 2—Combination 10*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits and Six or More Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Adolescent Well-Care Visits*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total*
- *Appropriate Testing for Children With Pharyngitis*

Please see the “Reader’s Guide” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendix A and Appendix B.

## Childhood Immunization Status

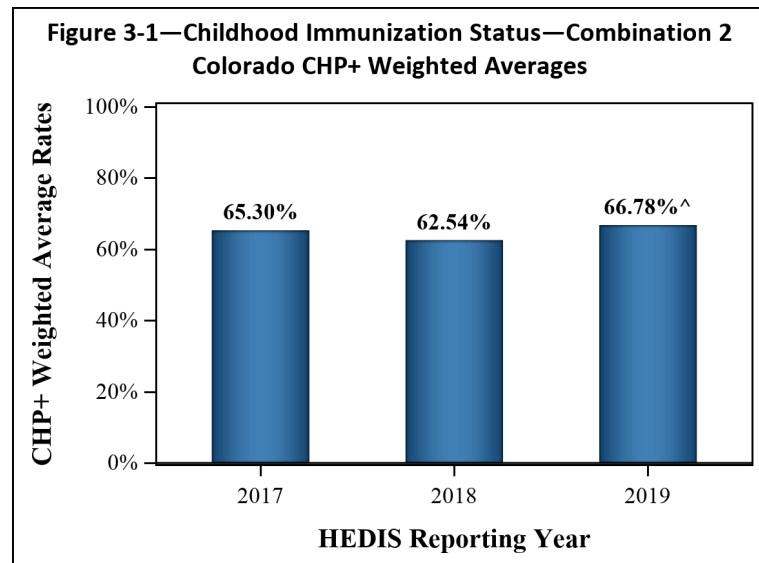
*Childhood Immunization Status* measures the percentage of members 2 years of age who received the following vaccinations on or before their second birthday. Table 3-1 displays the different antigens associated with various combinations.

**Table 3-1—Combination Vaccinations for Childhood Immunization Status**

Combination	Four DTaP	Three IPV	One MMR	Three HiB	Three HepB	One VZV	Four PCV	One HepA	Two or Three RV	Two Flu
<i>Combination 2</i>	✓	✓	✓	✓	✓	✓				
<i>Combination 3</i>	✓	✓	✓	✓	✓	✓	✓			
<i>Combination 4</i>	✓	✓	✓	✓	✓	✓	✓	✓		
<i>Combination 5</i>	✓	✓	✓	✓	✓	✓	✓		✓	
<i>Combination 6</i>	✓	✓	✓	✓	✓	✓	✓			✓
<i>Combination 7</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	
<i>Combination 8</i>	✓	✓	✓	✓	✓	✓	✓	✓		✓
<i>Combination 9</i>	✓	✓	✓	✓	✓	✓	✓		✓	✓
<i>Combination 10</i>	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

## Childhood Immunization Status—Combination 2

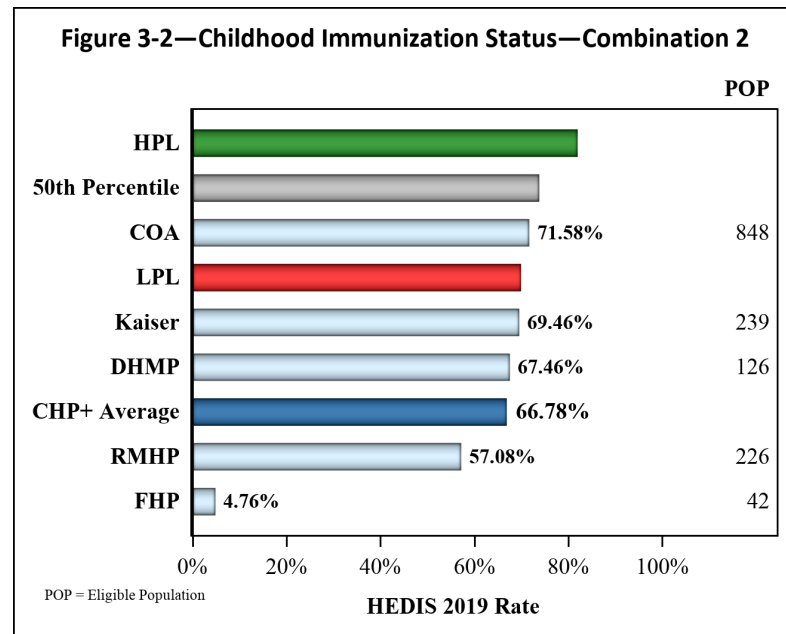
*Childhood Immunization Status—Combination 2* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, and one VZV.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

*One caret (^) indicates a significant improvement in performance from 2018 to 2019.*

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

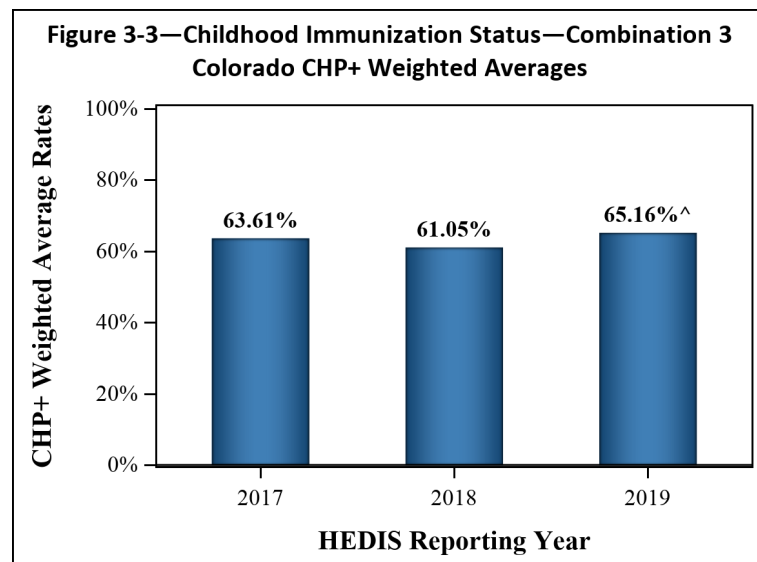


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

One MCO's rate was above the LPL but below the 50th percentile. Four MCO's rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 67 percentage points.

### Childhood Immunization Status—Combination 3

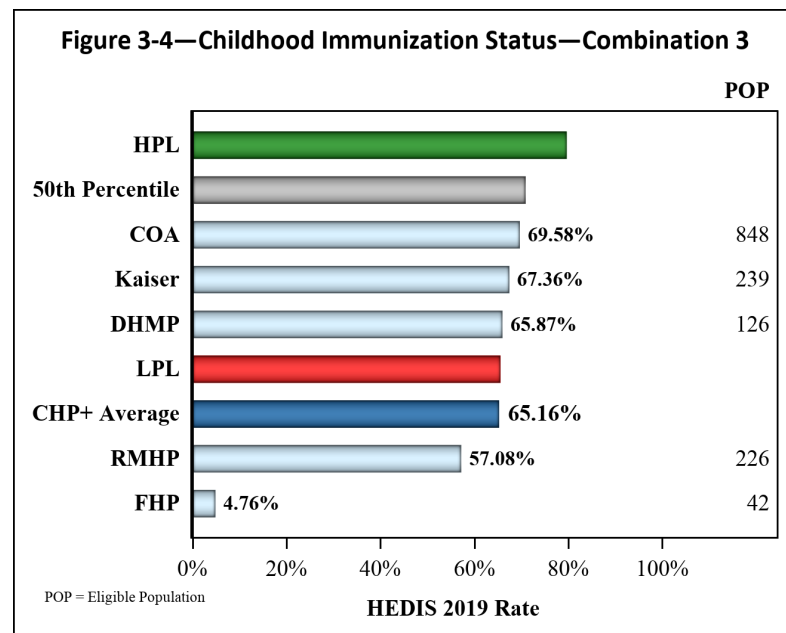
*Childhood Immunization Status—Combination 3* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, and four PCV.



Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

One caret (^) indicates a significant improvement in performance from 2018 to 2019.

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

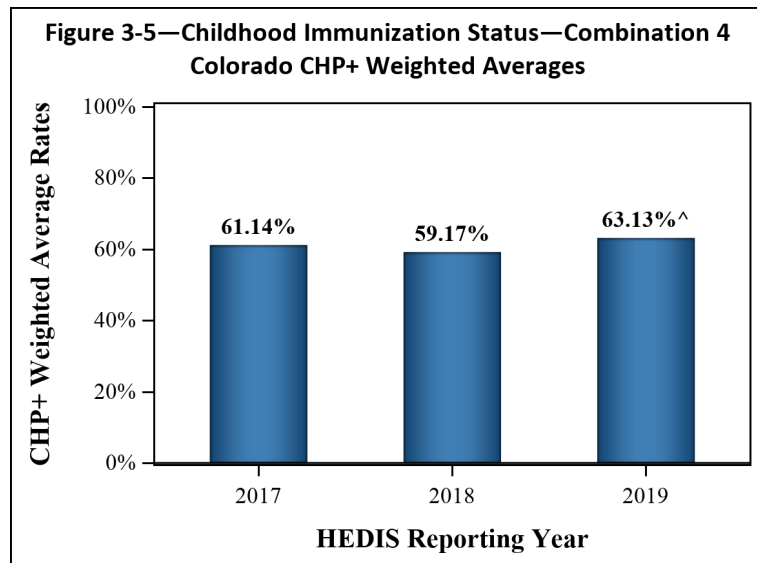


Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Three MCOs' rates were above the LPL but below the 50th percentile. Two MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 65 percentage points.

## Childhood Immunization Status—Combination 4

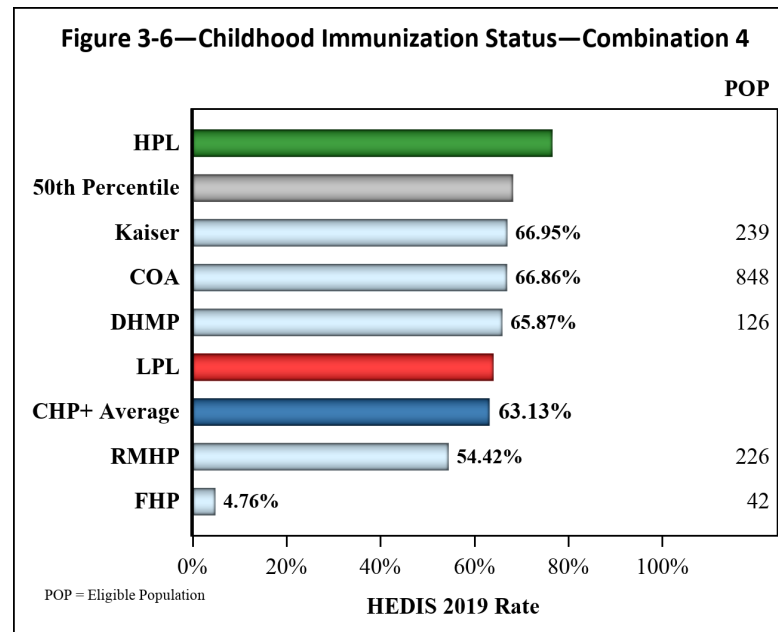
*Childhood Immunization Status—Combination 4* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, and one HepA.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

*One caret (^) indicates a significant improvement in performance from 2018 to 2019.*

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

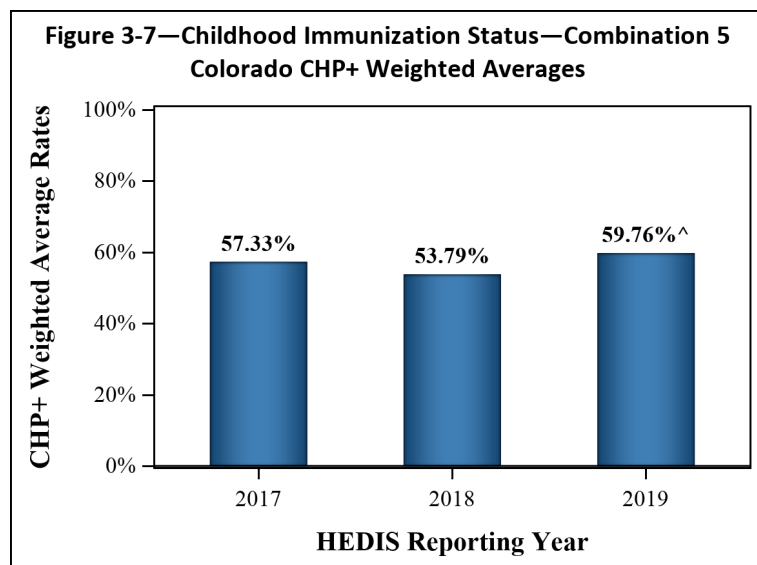


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

Three MCOs' rates were above the LPL but below the 50th percentile. Two MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 62 percentage points.

## Childhood Immunization Status—Combination 5

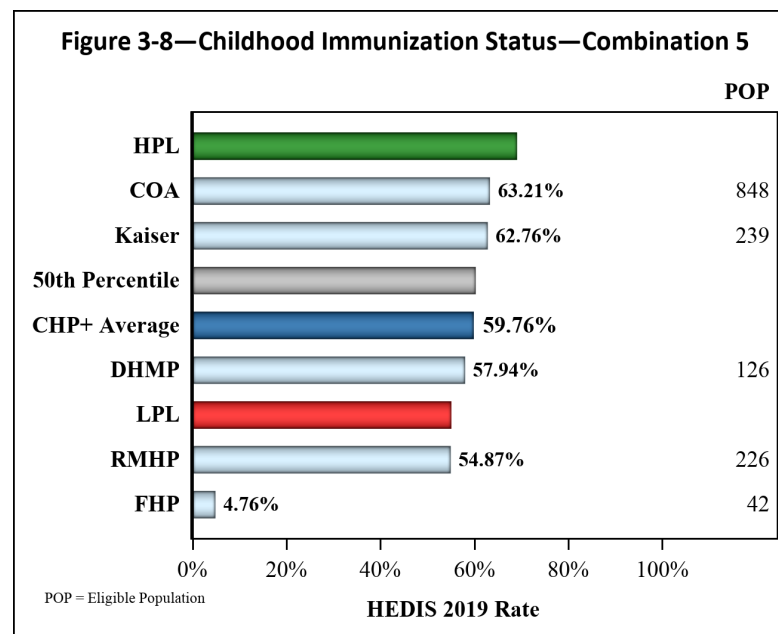
*Childhood Immunization Status—Combination 5* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, and two or three RV.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

*One caret (^) indicates a significant improvement in performance from 2018 to 2019.*

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.



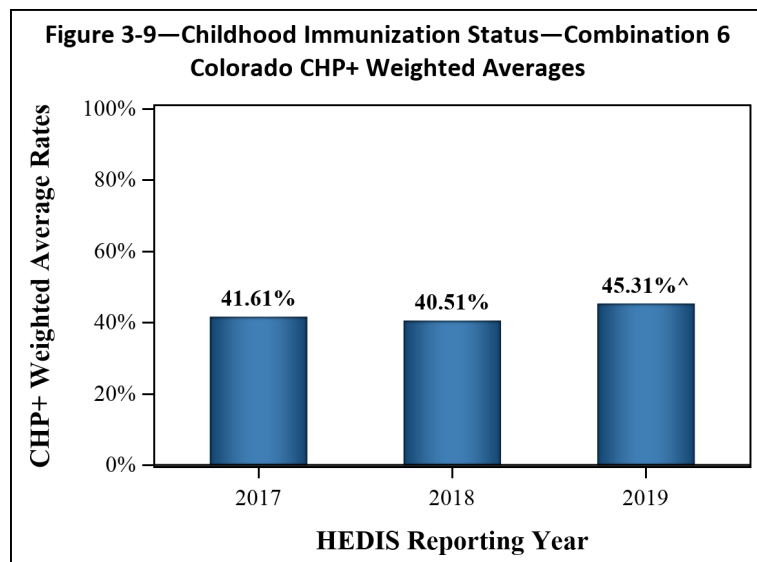
*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

Two MCOs' rates were above the 50th percentile but below the HPL. One MCO's rate and the Colorado CHP+ weighted average were above the LPL but below the 50th percentile. Two MCOs' rates fell below the LPL. MCO performance varied by approximately 58 percentage points.



## Childhood Immunization Status—Combination 6

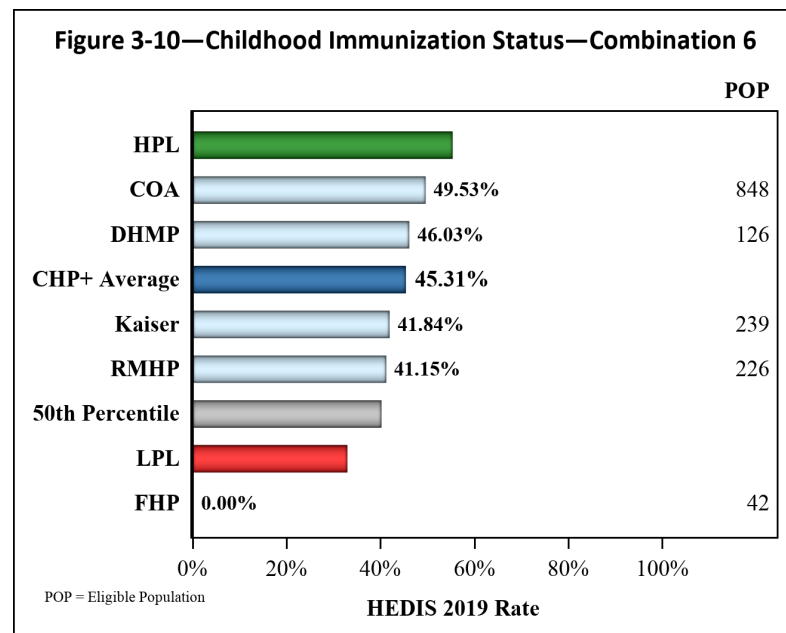
*Childhood Immunization Status—Combination 6* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, and two flu.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

*One caret (^) indicates a significant improvement in performance from 2018 to 2019.*

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

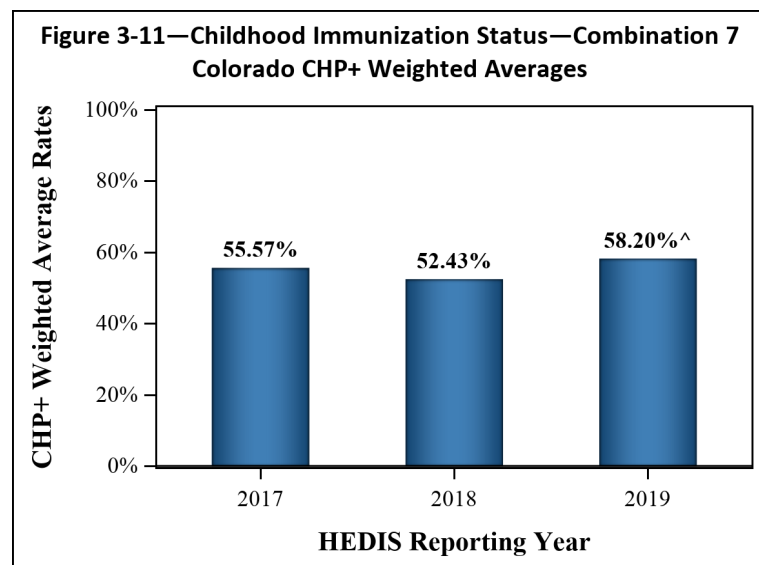


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

Four MCO's rates and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. One MCO's rate fell below the LPL. MCO performance varied by approximately 50 percentage points.

## Childhood Immunization Status—Combination 7

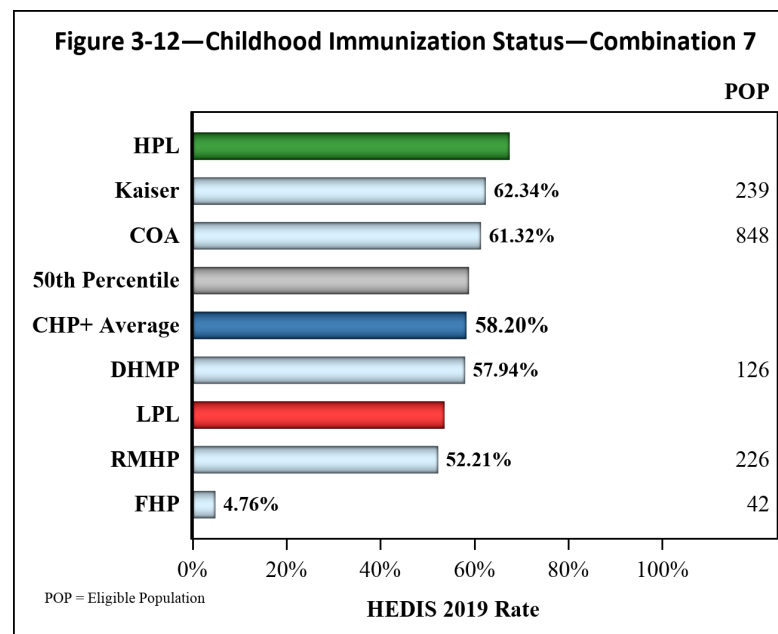
*Childhood Immunization Status—Combination 7* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, and two or three RV.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

*One caret (^) indicates a significant improvement in performance from 2018 to 2019.*

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

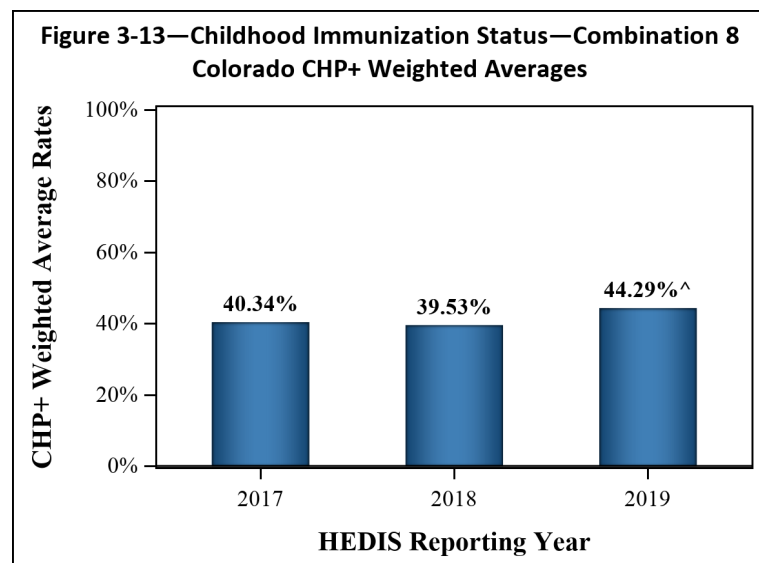


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

Two MCOs' rates were above the 50th percentile but below the HPL. One MCO's rate and the Colorado CHP+ weighted average were above the LPL but below the 50th percentile. Two MCOs' rates fell below the LPL. MCO performance varied by approximately 58 percentage points.

## Childhood Immunization Status—Combination 8

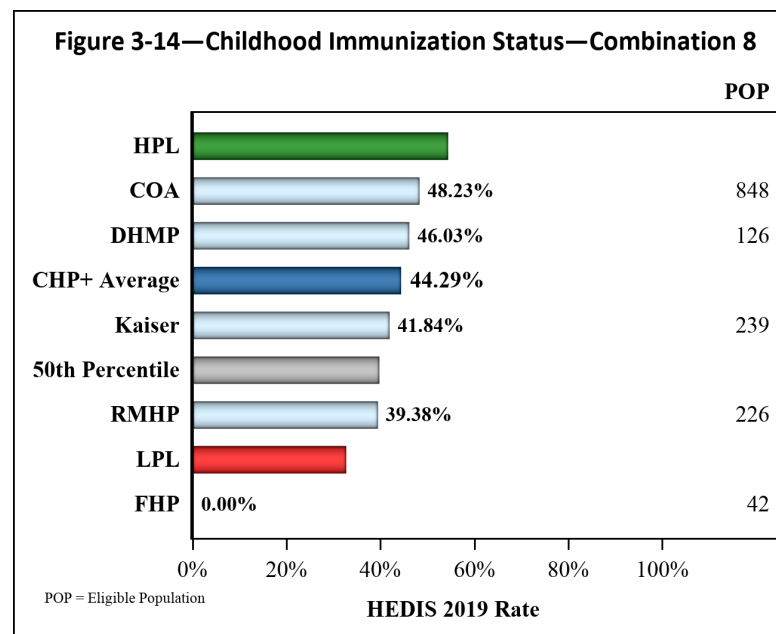
*Childhood Immunization Status—Combination 8* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, and two flu.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

*One caret (^) indicates a significant improvement in performance from 2018 to 2019.*

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

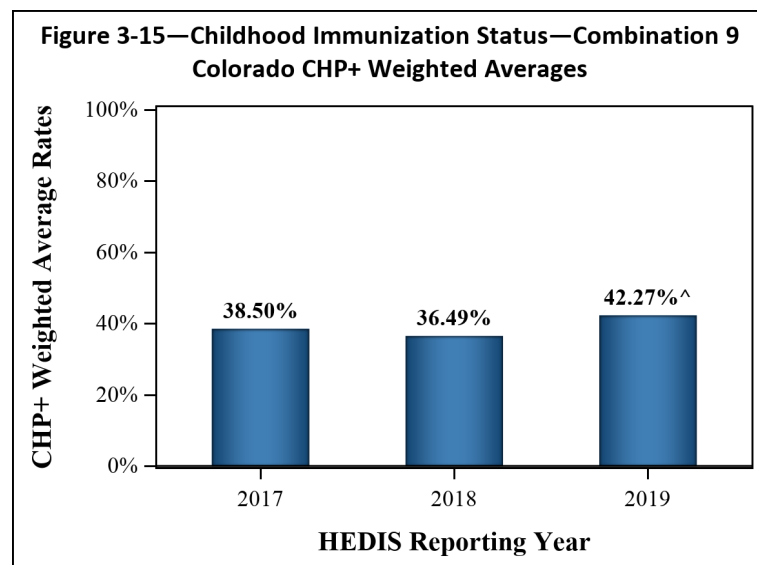


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

Three MCOs' rates and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. One MCO's rate was above the LPL but below the 50th percentile. One MCO's rate fell below the LPL. MCO performance varied by approximately 48 percentage points.

## Childhood Immunization Status—Combination 9

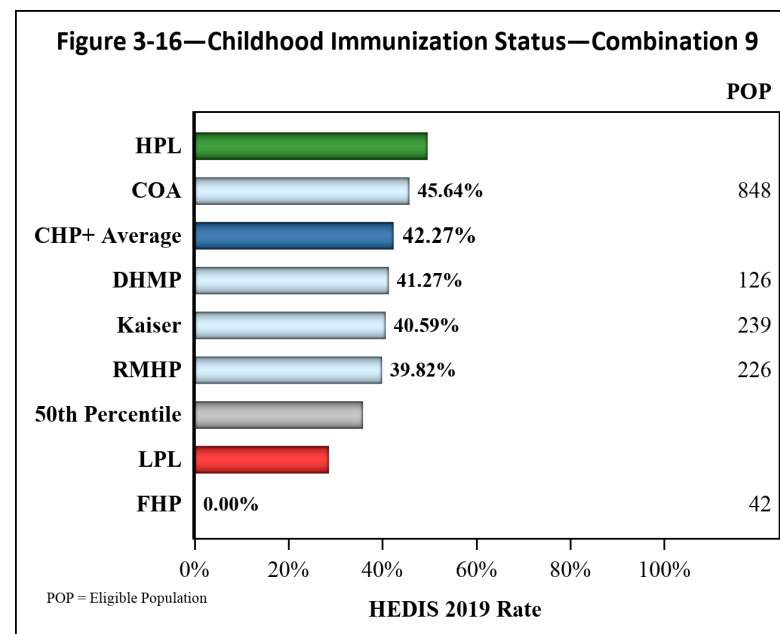
*Childhood Immunization Status—Combination 9* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, two or three RV, and two flu.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

*One caret (^) indicates a significant improvement in performance from 2018 to 2019.*

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

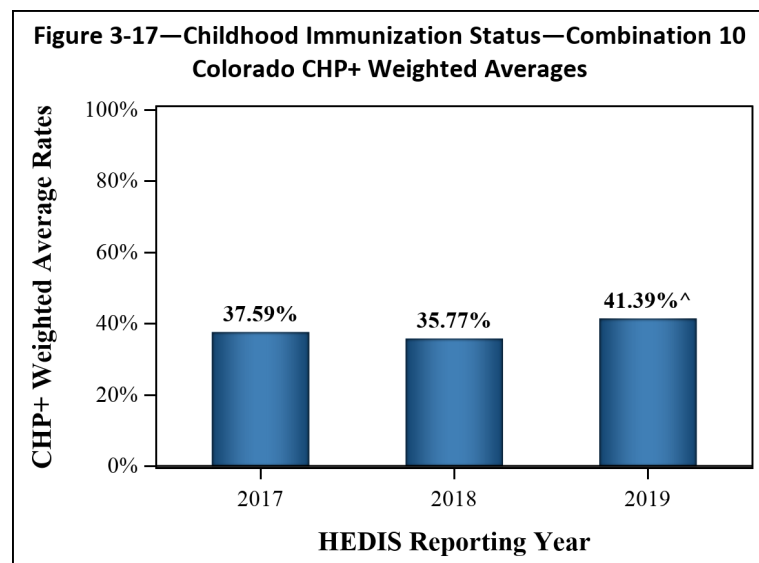


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

Four MCOs' rates and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. One MCO's rate fell below the LPL. MCO performance varied by approximately 46 percentage points.

## Childhood Immunization Status—Combination 10

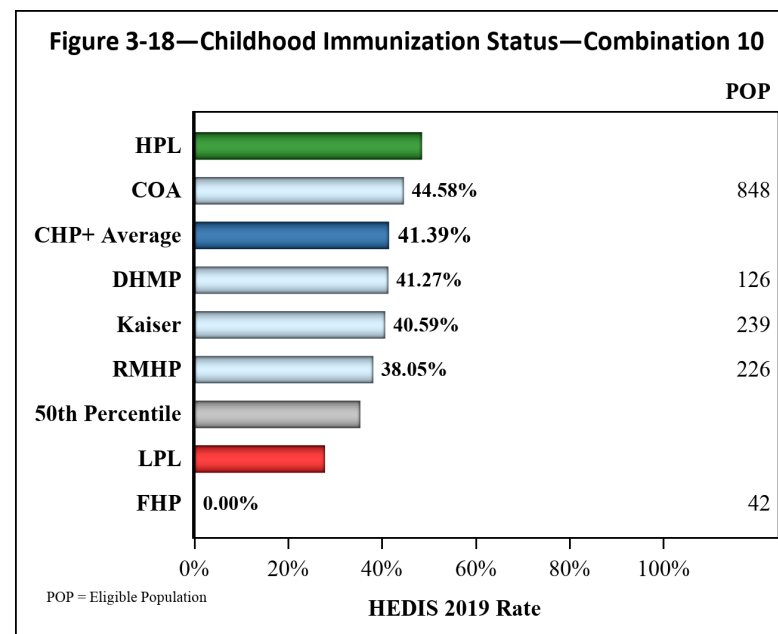
*Childhood Immunization Status—Combination 10* measures the percentage of members 2 years of age who received the following vaccines by their second birthday: four DTaP, three IPV, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two flu.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

*One caret (^) indicates a significant improvement in performance from 2018 to 2019.*

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

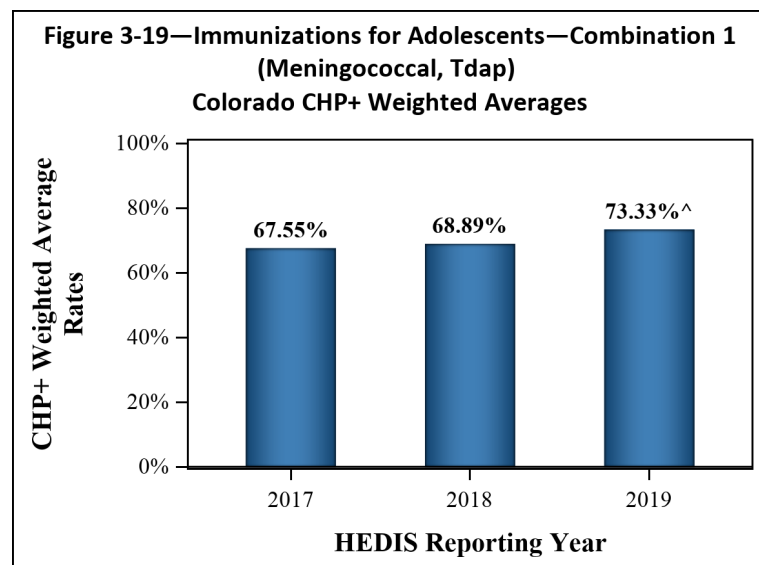


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

Four MCOs' rates and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. One MCO's rate fell below the LPL. MCO performance varied by approximately 45 percentage points.

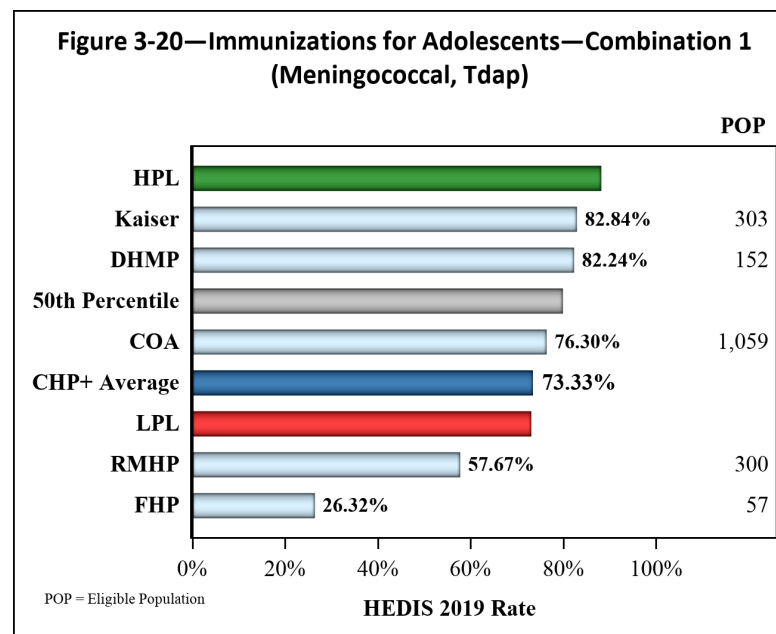
## Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)

*Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measures the percentage of members 13 years of age who had the following vaccines by their 13th birthday: one dose of meningococcal vaccine, and one Tdap vaccine.



One caret (^) indicates a significant improvement in performance from 2018 to 2019.

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

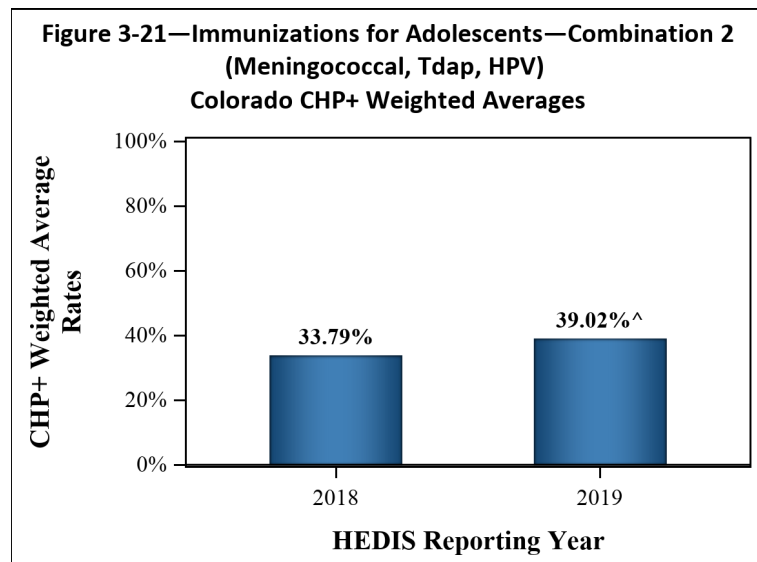


Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Two MCOs' rates were above the 50th percentile but below the HPL. One MCO's rate and the Colorado CHP+ weighted average were above the LPL but below the 50th percentile. Two MCOs' rates fell below the LPL. MCO performance varied by approximately 57 percentage points.

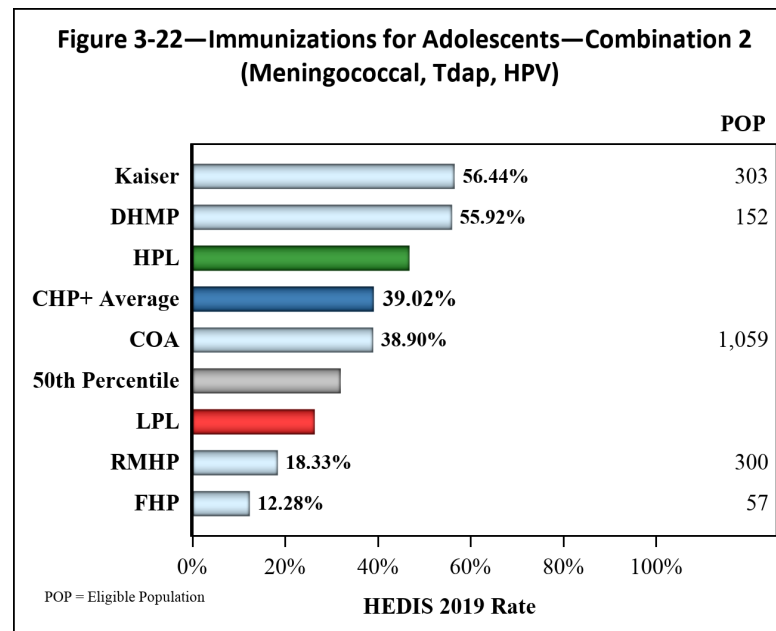
## Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)

*Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measures the percentage of members 13 years of age who had the following vaccines by their 13th birthday: one dose of meningococcal vaccine, one Tdap vaccine, and completed the HPV vaccine series.



One caret (^) indicates a significant improvement in performance from 2018 to 2019.

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

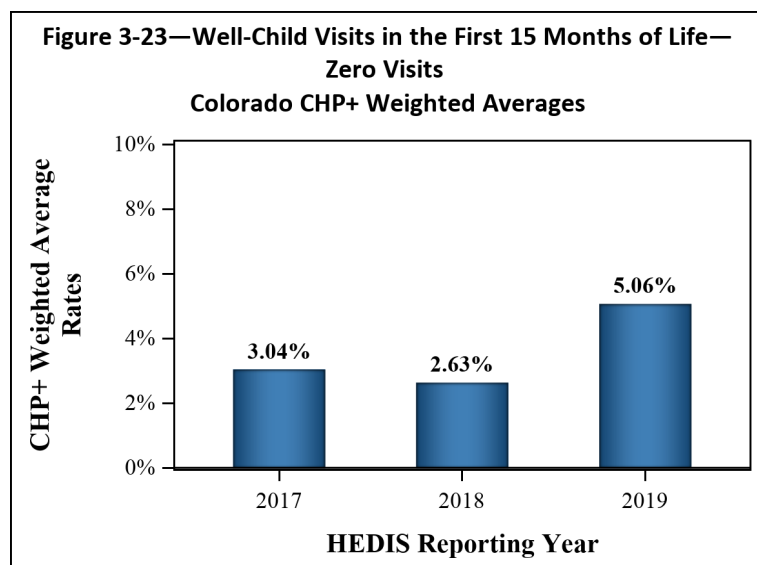


Two MCOs' rates exceeded the HPL. One MCO's rate and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. Two MCOs' rates fell below the LPL. MCO performance varied by approximately 44 percentage points.

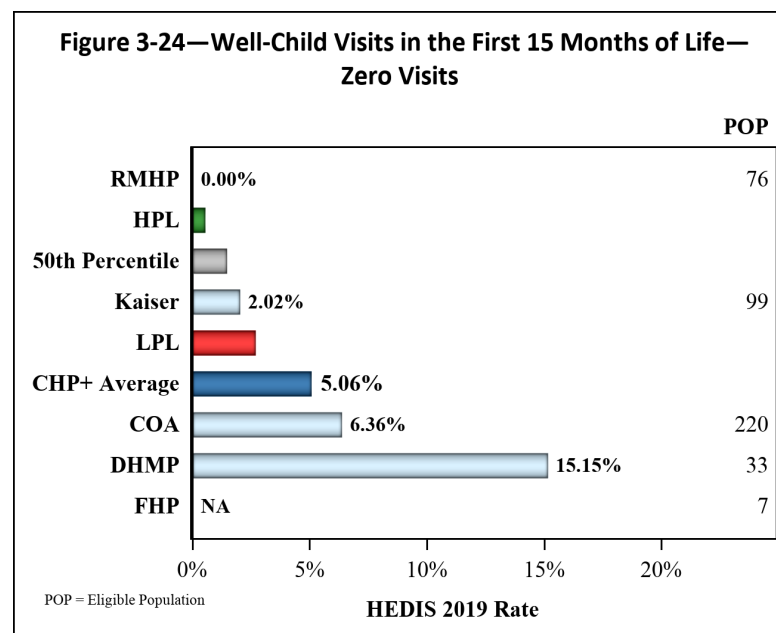


## Well-Child Visits in the First 15 Months of Life—Zero Visits

*Well-Child Visits in the First 15 Months of Life—Zero Visits* measures the percentage of members who turned 15 months of age during the measurement year who did not have a well-child visit with a PCP during their first 15 months of life. For this indicator, a lower rate indicates better performance.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

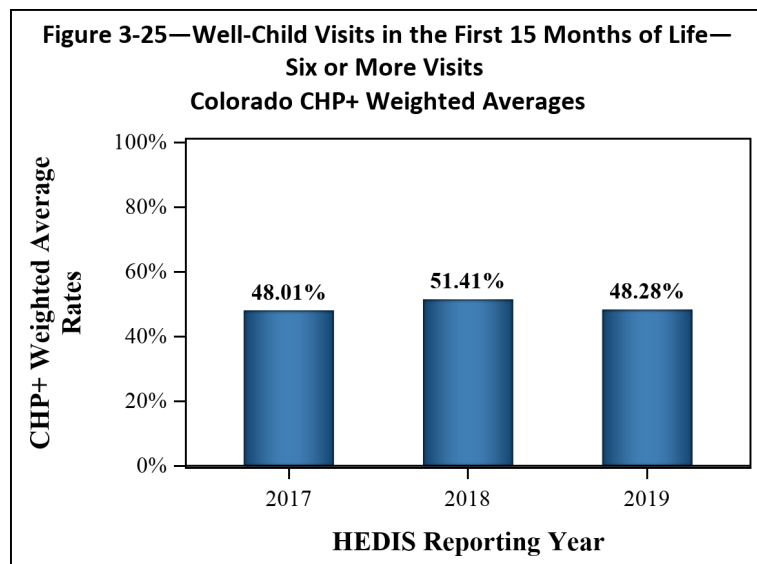


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate. Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

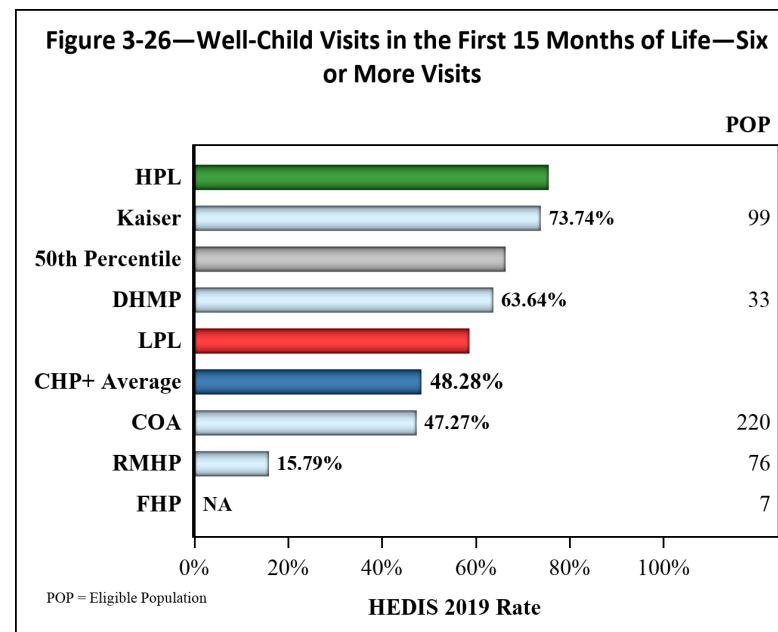
One MCO's rate exceeded the HPL. One MCO's rate was above the LPL but below the 50th percentile. Two MCO's rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 15 percentage points.

## Well-Child Visits in the First 15 Months of Life—Six or More Visits

*Well-Child Visits in the First 15 Months of Life—Six or More Visits* measures the percentage of members who turned 15 months of age during the measurement year who received six or more well-child visits with a PCP during their first 15 months of life.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

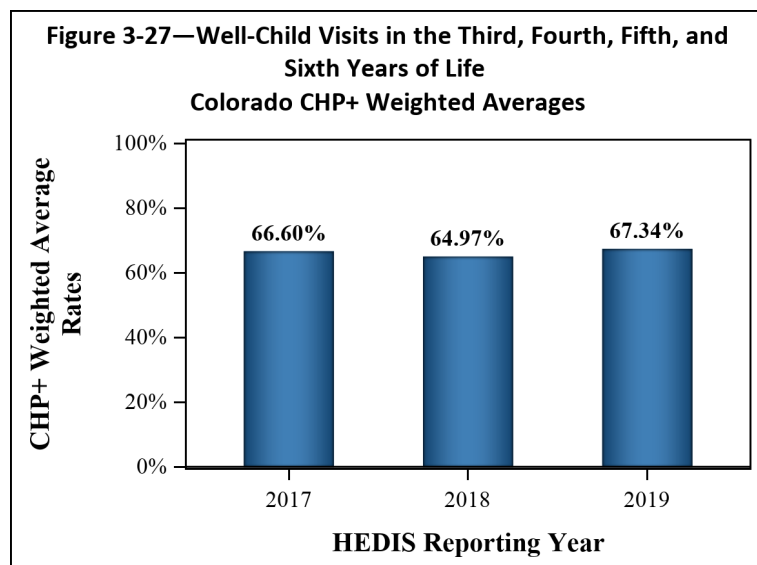


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate. Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

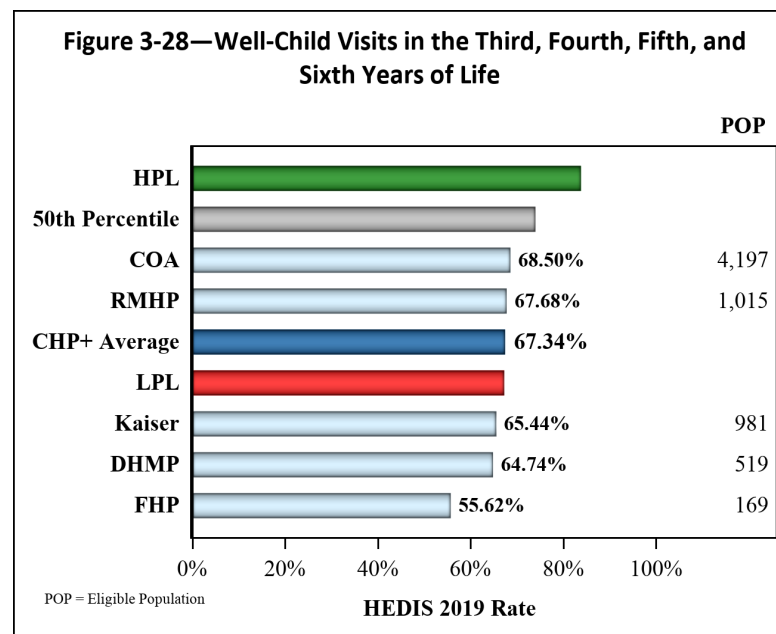
One MCO's rate was above the 50th percentile but below the HPL. One MCO's rate was above the LPL but below the 50th percentile. Two MCO's rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 58 percentage points.

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

*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures the percentage of members 3 to 6 years of age who received one or more well-child visits with a PCP during the measurement year.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

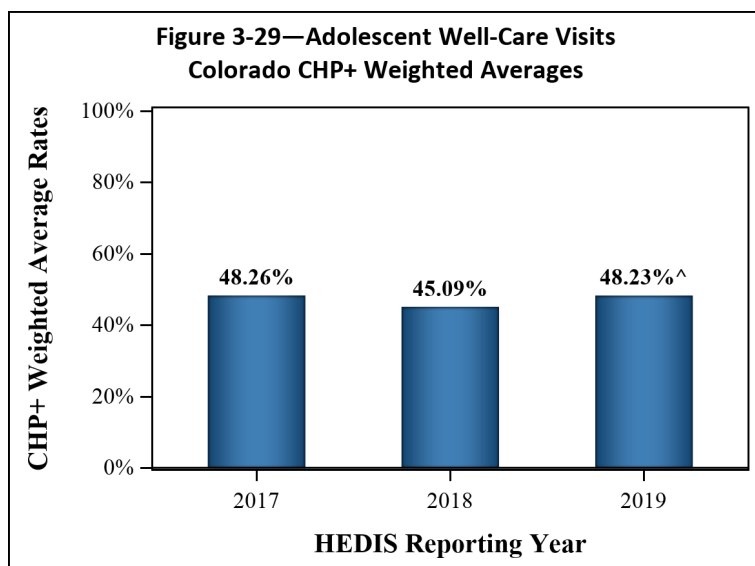


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

Two MCOs' rates and the Colorado CHP+ weighted average were above the LPL but below the 50th percentile. Three MCOs' rates fell below the LPL. MCO performance varied by approximately 13 percentage points.

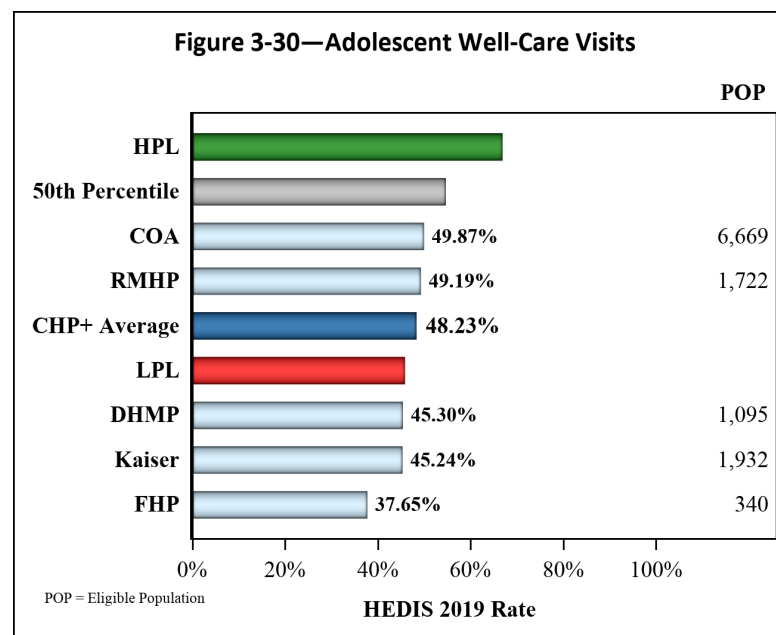
## Adolescent Well-Care Visits

*Adolescent Well-Care Visits* measures the percentage of members 12 to 21 years of age who received at least one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year.



One caret (^) indicates a significant improvement in performance from 2018 to 2019.

The Colorado CHP+ weighted average significantly improved from 2018 to 2019.

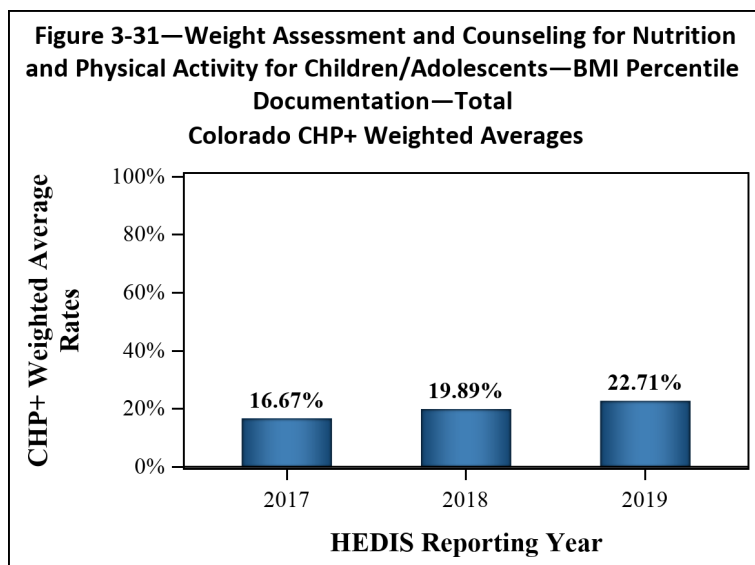


Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Two MCOs' rates and the Colorado CHP+ weighted average were above the LPL but below the 50th percentile. Three MCOs' rates fell below the LPL. MCO performance varied by approximately 12 percentage points.

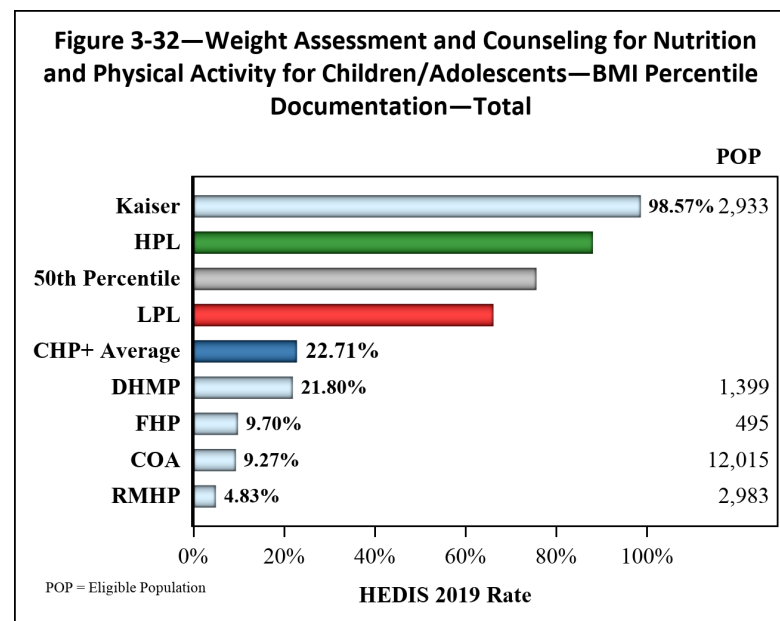
## Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total

*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of BMI percentile documentation during the measurement year.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

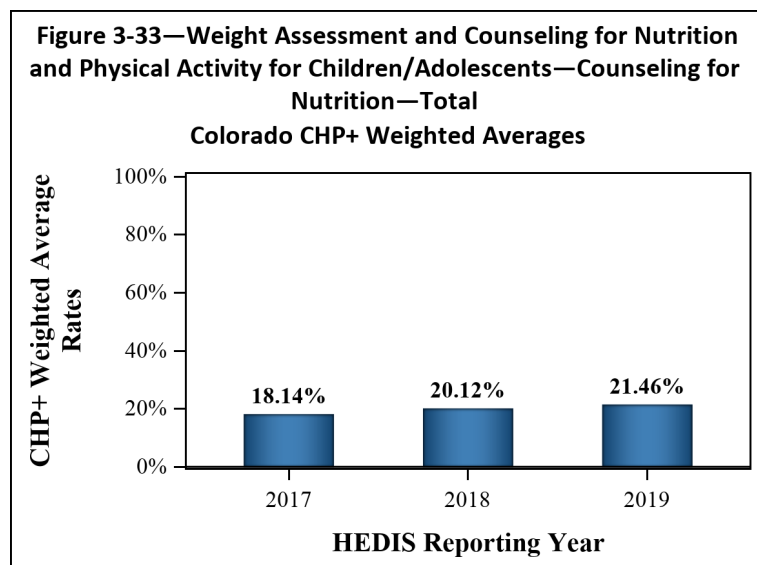


*Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.*

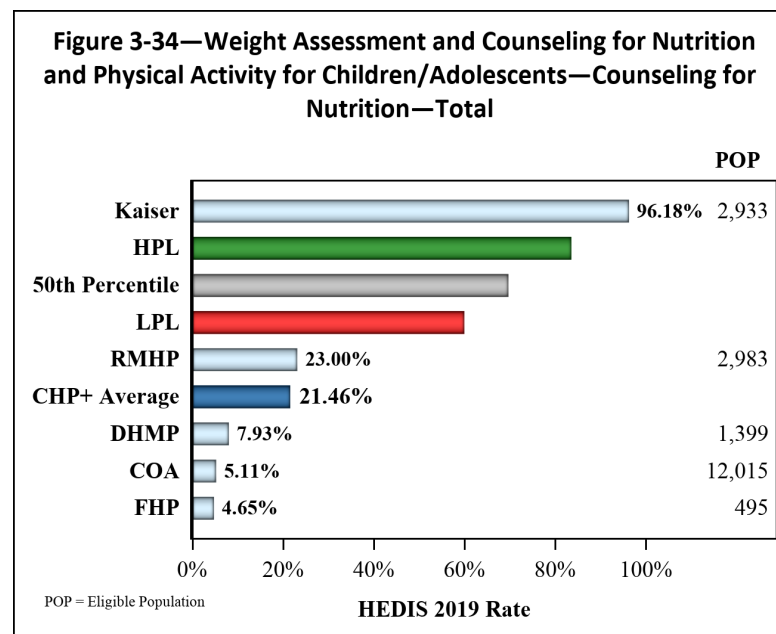
One MCO's rate exceeded the HPL. Four MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 94 percentage points.

## Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Nutrition—Total

*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and received counseling for nutrition during the measurement year.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

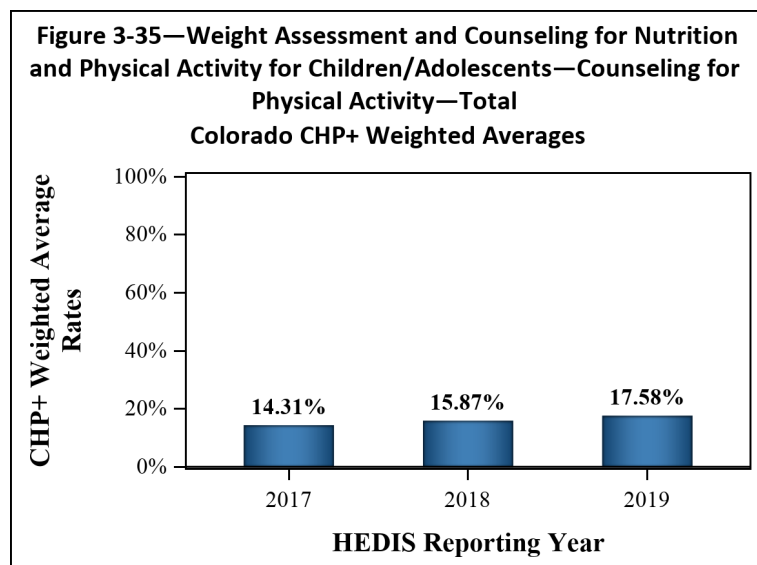


Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

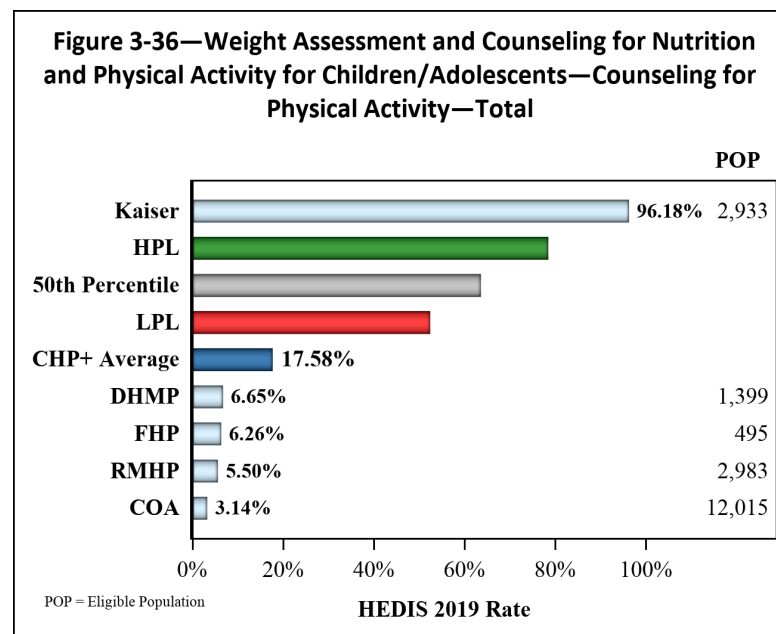
One MCO's rate exceeded the HPL. Four MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 92 percentage points.

## Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— Counseling for Physical Activity—Total

*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measures the percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and received counseling for physical activity during the measurement year.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



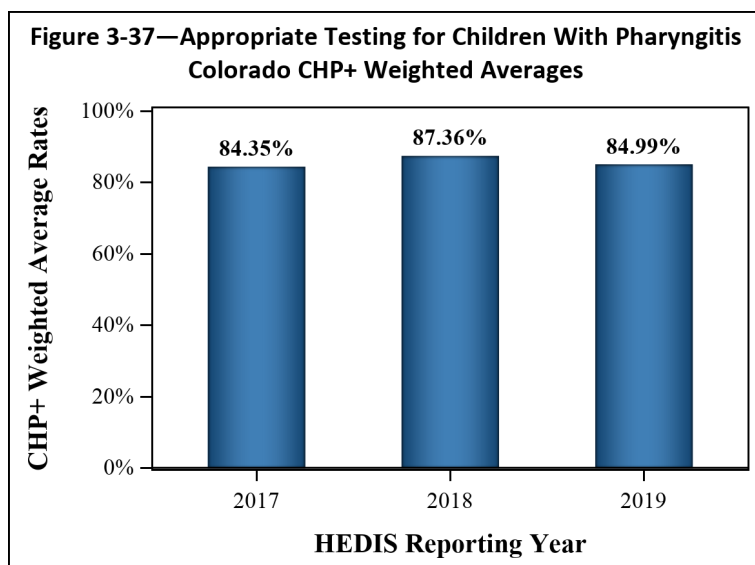
Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

One MCO's rate exceeded the HPL. Four MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 93 percentage points.

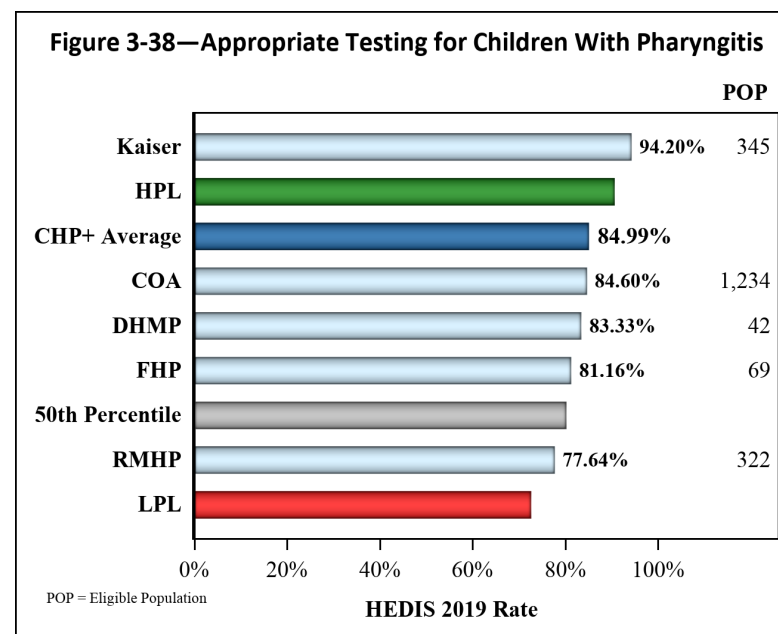


## Appropriate Testing for Children With Pharyngitis

*Appropriate Testing for Children With Pharyngitis* measures the percentage of members 3 to 18 years of age who were diagnosed with pharyngitis during an outpatient or ED visit, dispensed an antibiotic, and received a Group A streptococcus (strep) test for the episode.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



One MCO's rate exceeded the HPL. Three MCOs' rates and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. One MCO's rate was above the LPL but below the 50th percentile. MCO performance varied by approximately 17 percentage points.

## Summary of Findings

Table 3-2 presents the MCOs' performance ratings for each measure in the Pediatric Care domain. Performance ratings were assigned across five categories (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*).

**Table 3-2—Pediatric Care: Measure-Specific Performance Ratings**

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP
<b>Childhood Immunization Status</b>					
Combination 2	★★	★	★	★	★
Combination 3	★★	★★	★	★★	★
Combination 4	★★	★★	★	★★	★
Combination 5	★★★★	★★	★	★★★★	★
Combination 6	★★★★	★★★★	★	★★★★	★★★★
Combination 7	★★★★	★★	★	★★★★	★
Combination 8	★★★★	★★★★	★	★★★★	★★
Combination 9	★★★★	★★★★	★	★★★★	★★★★
Combination 10	★★★★	★★★★	★	★★★★	★★★★
<b>Immunizations for Adolescents</b>					
Combination 1 (Meningococcal, Tdap)	★★	★★★★	★	★★★★	★
Combination 2 (Meningococcal, Tdap, HPV)	★★★★	★★★★	★	★★★★	★
<b>Well-Child Visits in the First 15 Months of Life</b>					
Zero Visits*	★	★	—	★★	★★★★★
Six or More Visits	★	★★	—	★★★★	★
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★★	★	★	★	★★
<b>Adolescent Well-Care Visits</b>					
Adolescent Well-Care Visits	★★	★	★	★	★★
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>					
BMI Percentile Documentation—Total	★	★	★	★★★★★	★
Counseling for Nutrition—Total	★	★	★	★★★★★	★
Counseling for Physical Activity—Total	★	★	★	★★★★★	★
<b>Appropriate Testing for Children With Pharyngitis</b>					
Appropriate Testing for Children With Pharyngitis	★★★★	★★★★	★★★★	★★★★★	★★

\* For this indicator, a lower rate indicates better performance.

— Indicates that a percentile ranking was not determined because the rate was not reportable.

Table 3-3 presents a summary of the MCOs' overall performance for the measures in the Pediatric Care domain. The table shows the number of measures falling into each performance rating.

**Table 3-3—Pediatric Care: MCO-Specific Count of Measures by Performance Rating**

MCO Name	★★★★★	★★★★	★★★	★★	★
COA	0	5	3	6	5
DHMP	1	1	5	5	7
FHP	0	0	1	0	16
Kaiser	5	1	7	3	3
RMHP	1	0	3	4	11

Across the three measure rates related to well-care/well-child visits (i.e., *Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Adolescent Well-Care Visits*), only two MCOs reported a rate that exceeded the 50th percentile (RMHP for *Well-Child Visits in the First 15 Months of Life—Zero Visits* and Kaiser for *Well-Child Visits in the First 15 Months of Life—Six or More Visits*). This demonstrates opportunities to increase the number of comprehensive visits for infants, children, and adolescents. The MCOs and the Department should identify the factors contributing to the low rates for the well-child/well-care visits (e.g., are the issues related to barriers to accessing care, provider billing issues, or administrative data source challenges) and ensure children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' *Recommendations for Preventive Pediatric Health Care*.<sup>3-1</sup>

Of note, three of five (60.0 percent) MCOs were above the 75th percentile for *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* and four of five (80.0 percent) MCOs were above the 50th percentile for *Appropriate Testing for Children With Pharyngitis*, indicating strength for adolescents receiving necessary vaccinations and appropriate testing of pharyngitis in outpatient and ED settings.

<sup>3-1</sup> American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care*. Available at: [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). Accessed on: Jul 16, 2019.

## 4. Access to Care and Preventive Screening

### Access to Care and Preventive Screening

The following section provides a detailed analysis of the Colorado CHP+ MCOs' performance for the Access to Care and Preventive Screening domain. The Access to Care and Preventive Screening domain encompasses the following measures:

#### Access to Care

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*
- *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years*

#### Preventive Screening

- *Chlamydia Screening in Women—Ages 16 to 20 Years*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

Please see the “Reader’s Guide” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendix A and Appendix B.

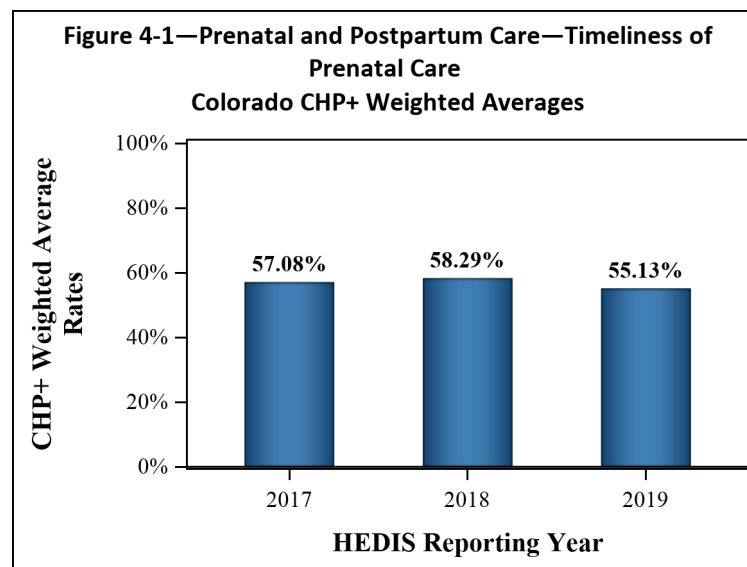
## Prenatal and Postpartum Care

*Prenatal and Postpartum Care* measures the percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these members, the measure assesses prenatal and postpartum care.

Only the SMCN was required to report *Prenatal and Postpartum Care*, and the remaining CHP+ MCOs were not required to report rates for this measure. Of note, the SMCN's calculated rates did not undergo an NCQA HEDIS Compliance Audit.

### Prenatal and Postpartum Care—Timeliness of Prenatal Care

*Prenatal and Postpartum Care—Timeliness of Prenatal Care* measures the percentage of deliveries of live births that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in the MCO.

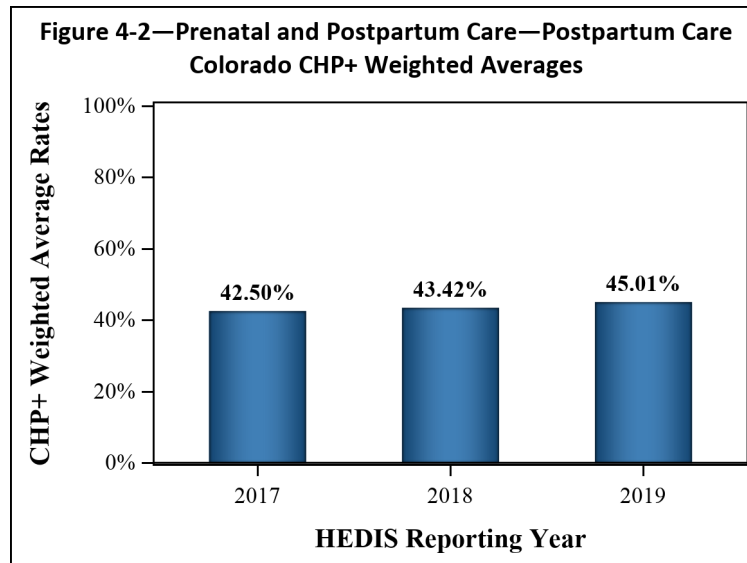


*The SMCN is the only CHP+ MCO required to report the Prenatal and Postpartum Care measure.*

The SMCN rate did not demonstrate a significant change from 2018 to 2019.

## Prenatal and Postpartum Care—Postpartum Care

*Prenatal and Postpartum Care—Postpartum Care* measures the percentage of deliveries of live births that had a postpartum visit on or between 21 and 56 days after delivery.

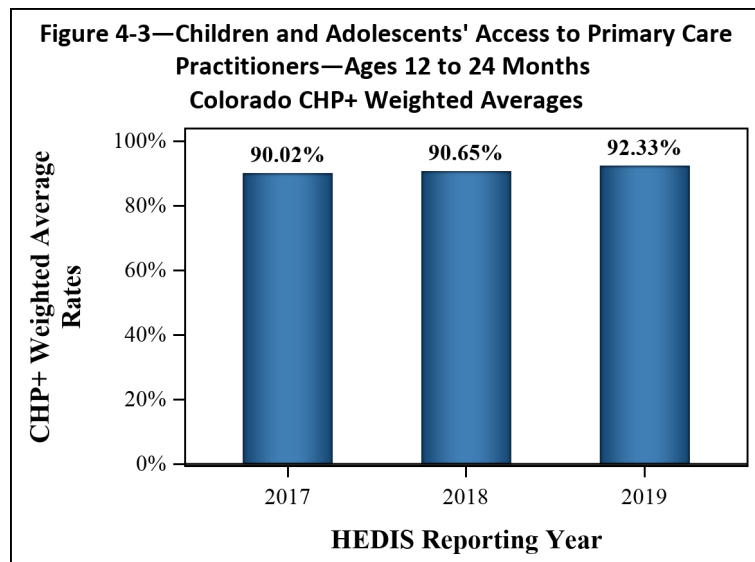


*The SMCN is the only CHP+ MCO required to report the Prenatal and Postpartum Care measure.*

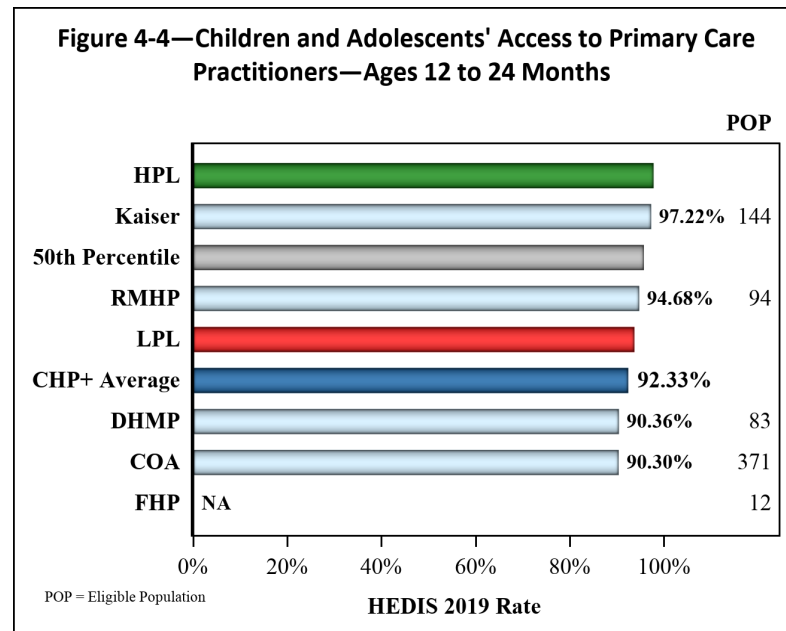
The SMCN rate did not demonstrate a significant change from 2018 to 2019.

## Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months

*Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* measures the percentage of members 12 to 24 months of age who had a visit with a PCP during the measurement year.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



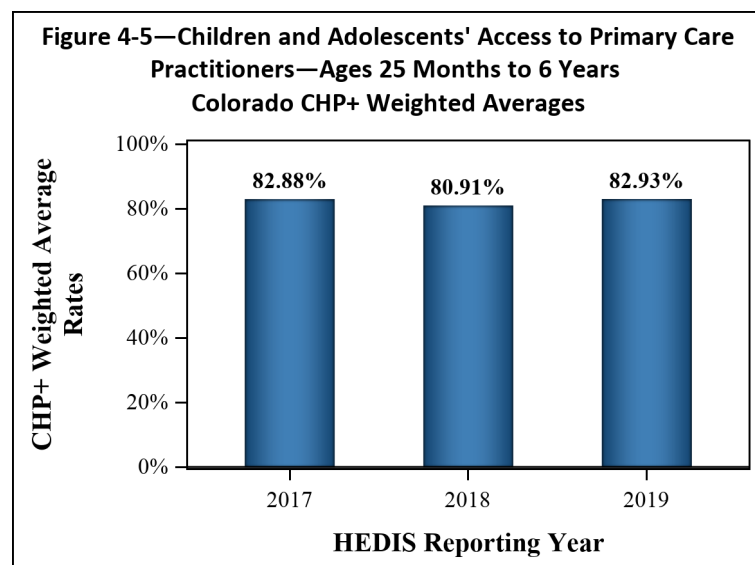
NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MCO's rate was above the 50th percentile but below the HPL. One MCO's rate was above the LPL but below the 50th percentile. Two MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 7 percentage points.

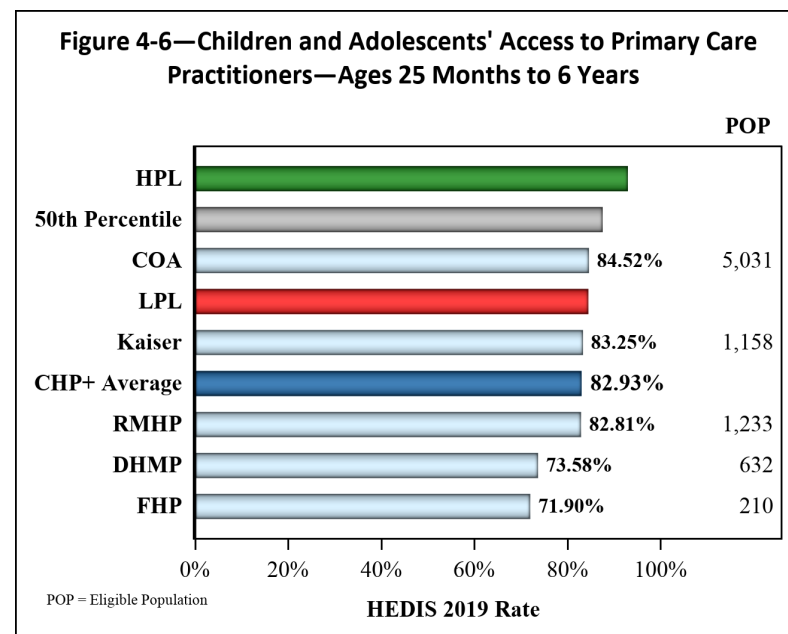


## Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years

*Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* measures the percentage of members 25 months to 6 years of age who had a visit with a PCP during the measurement year.



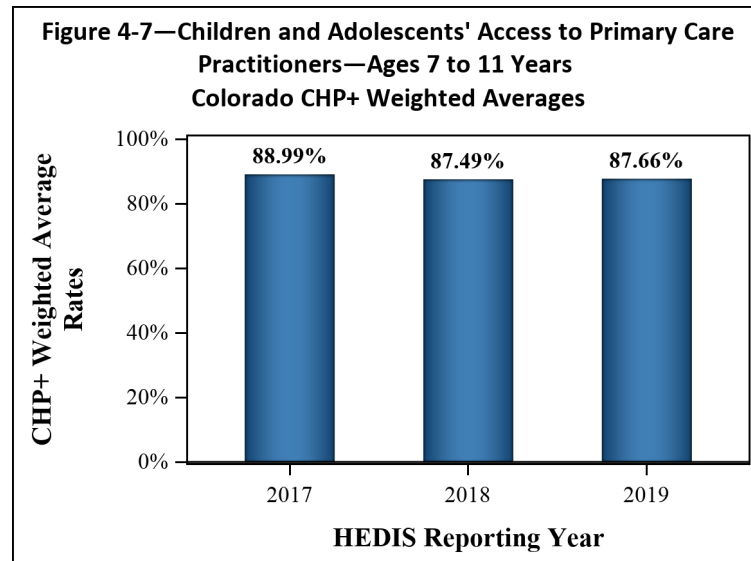
The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



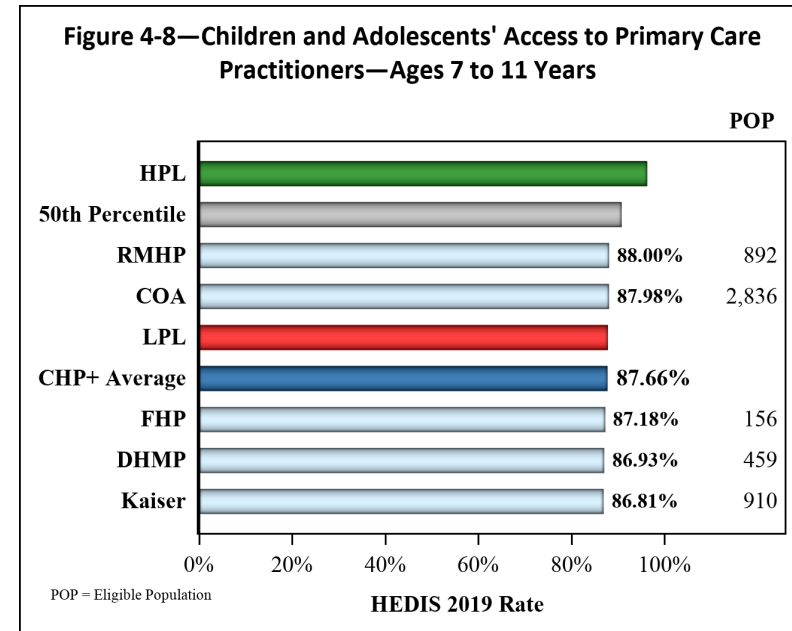
One MCO's rate was above the LPL but below the 50th percentile. Four MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 13 percentage points.

## Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years

*Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years* measures the percentage of members 7 to 11 years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year.



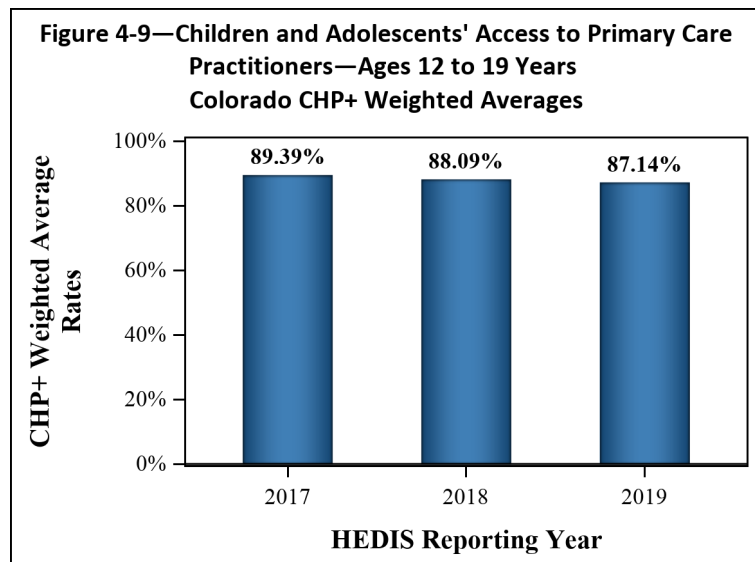
The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



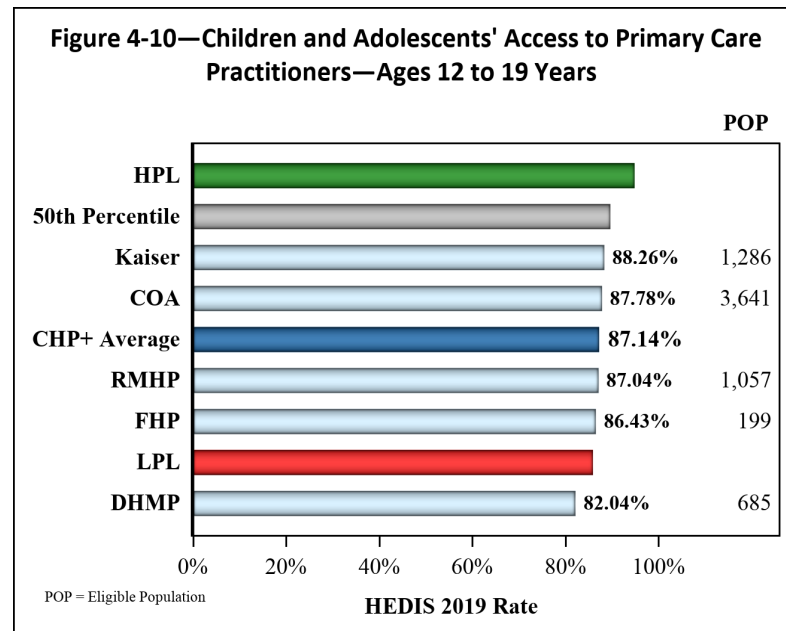
Two MCOs' rates were above the LPL but below the 50th percentile. Three MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 1 percentage point.

## Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years

*Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 19 Years* measures the percentage of members 12 to 19 years of age who had a visit with a PCP during the measurement year or the year prior to the measurement year.



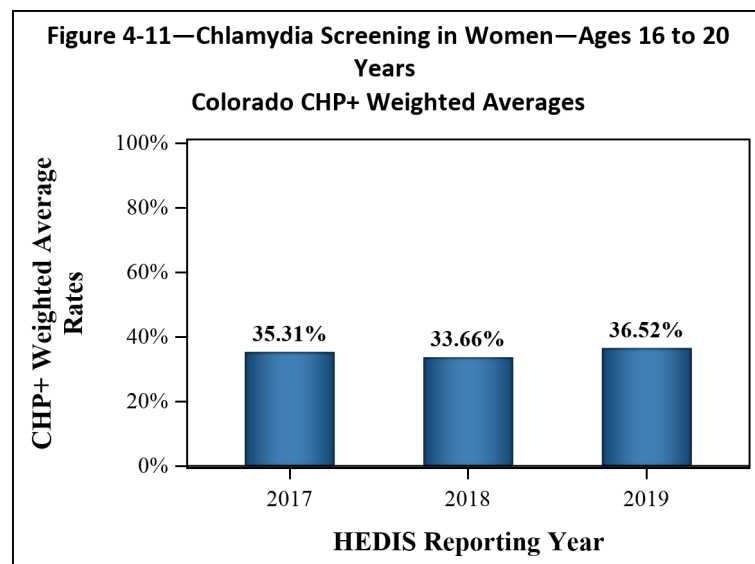
The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



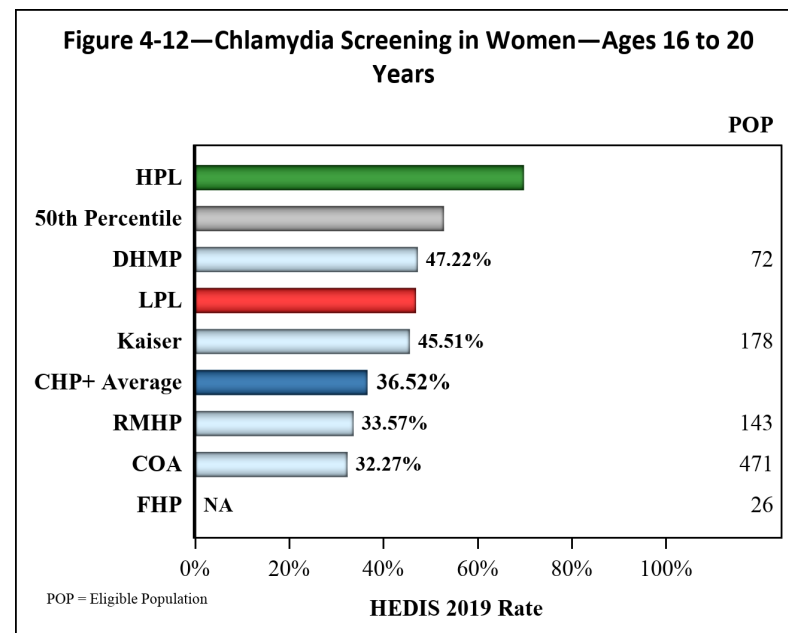
Four MCOs' rates and the CHP+ weighted average were above the LPL but below the 50th percentile. One MCO's rate fell below the LPL. MCO performance varied by approximately 6 percentage points.

## Chlamydia Screening in Women—Ages 16 to 20 Years

*Chlamydia Screening in Women—Ages 16 to 20 Years* measures the percentage of female members 16 to 20 years of age who were identified as being sexually active and received at least one test for chlamydia during the measurement year.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

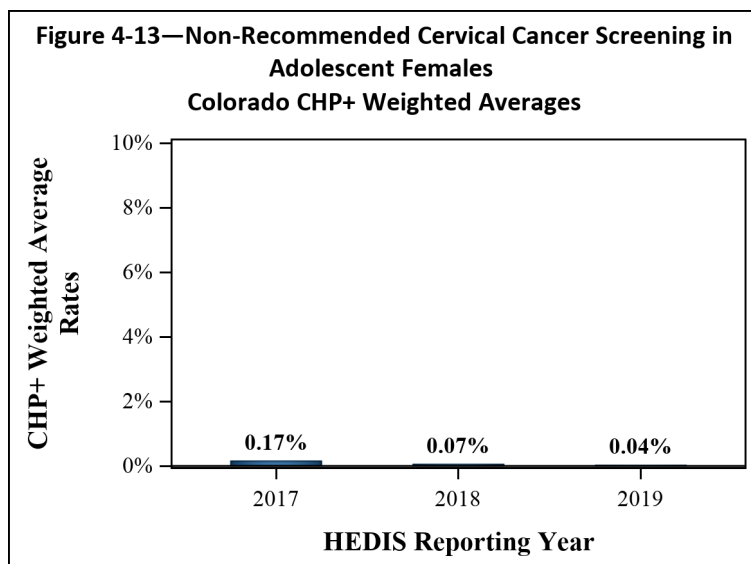


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

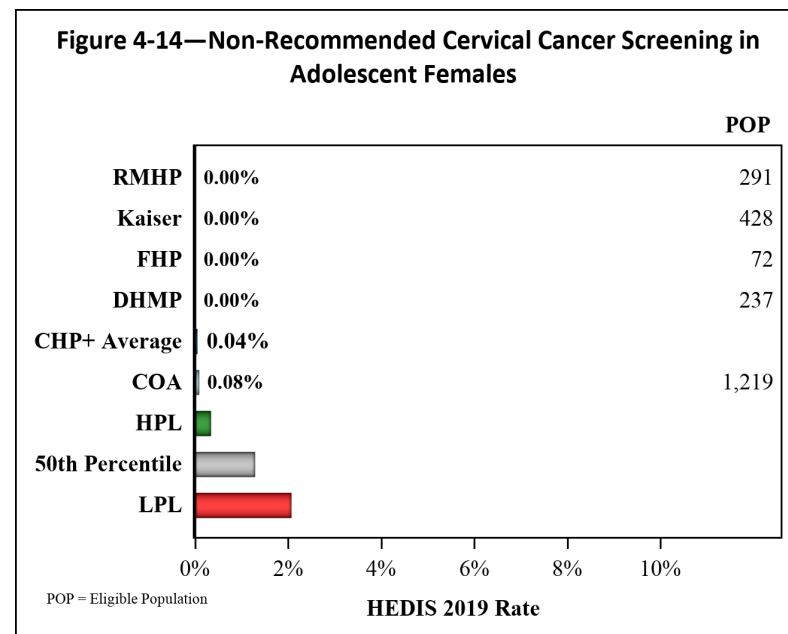
One MCO's rate was above the LPL but below the 50th percentile. Three MCOs' rates and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 15 percentage points.

## Non-Recommended Cervical Cancer Screening in Adolescent Females

*Non-Recommended Cervical Cancer Screening in Adolescent Females* measures the percentage of female members 16 to 20 years of age who were screened unnecessarily for cervical cancer. For this measure, a lower rate indicates better performance.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



All MCO rates and the Colorado CHP+ weighted average exceeded the HPL. MCO performance varied by less than one percentage point.

## Summary of Findings

Table 4-1 presents the MCOs' performance ratings for each measure in the Access to Care and Preventive Screening domain. Performance ratings were assigned across five categories (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*).

**Table 4-1—Access to Care and Preventive Screening: Measure-Specific Performance Ratings**

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP
<b>Access to Care</b>					
<b>Children and Adolescents' Access to Primary Care Practitioners</b>					
<i>Ages 12 to 24 Months</i>	★	★	—	★★★★★	★★
<i>Ages 25 Months to 6 Years</i>	★★	★	★	★	★
<i>Ages 7 to 11 Years</i>	★★	★	★	★	★★
<i>Ages 12 to 19 Years</i>	★★	★	★★	★★	★★
<b>Preventive Screening</b>					
<b>Chlamydia Screening in Women</b>					
<i>Ages 16 to 20 Years</i>	★	★★	—	★	★
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>					
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★

— Indicates that a percentile ranking was not determined because the rate was not reportable.

\* For this indicator, a lower rate indicates better performance.

Table 4-2 presents a summary of the MCOs' overall performance for the measures in the Access to Care and Preventive Screening domain with the number of measures falling into each performance rating.

**Table 4-2—Access to Care and Preventive Screening: MCO-Specific Count of Measures by Performance Rating**

MCO Name	★★★★★	★★★★	★★★	★★	★
<b>Access to Care</b>					
COA	0	0	0	3	1
DHMP	0	0	0	0	4
FHP	0	0	0	1	2
Kaiser	0	1	0	1	2
RMHP	0	0	0	3	1
<b>Preventive Screening</b>					
COA	1	0	0	0	1
DHMP	1	0	0	1	0
FHP	1	0	0	0	0
Kaiser	1	0	0	0	1
RMHP	1	0	0	0	1

Overall, only one *Children and Adolescents' Access to Primary Care Practitioners* measure rate was above the 50th percentile (Kaiser's *Ages 12 to 24 Months* indicator), indicating all five MCOs have opportunities to improve access to care for children and adolescents. The Department should work with the MCOs and providers to identify barriers in access to care (e.g., transportation/distance to and from the doctor's office, limited provider office hours, difficulty navigating the healthcare system, prolonged wait times for getting an appointment, or prolonged wait times once at the provider's office).<sup>4-1</sup>

Increasing the access to care for members may also have a positive impact on the quality of preventive care received, such as the *Chlamydia Screening in Women* measure, for which all MCOs demonstrated poor performance. Chlamydia is the most common sexually transmitted disease in the United States, and improvement of MCO performance in this measure could positively impact the quality of care for a substantial number of CHP+ members. The MCOs and the Department should ensure providers are aware of the importance of screening for chlamydia and increase the number of resources available to providers and members (e.g., one-on-one provider trainings, providing lists of members overdue for a screening, or newsletters targeting chlamydia screening rates) to support the screenings.<sup>4-2,4-3</sup> Conversely, all MCOs exceeded the 90th percentile for the *Non-Recommended Cervical Cancer Screening in Adolescent Females* measure.

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<sup>4-1</sup> MACPAC. *Chapter 4: Monitoring Access to Care in Medicaid*. Available at: <https://www.macpac.gov/wp-content/uploads/2017/03/Monitoring-Access-to-Care-in-Medicaid.pdf>. Accessed on: Aug 14, 2019.

<sup>4-2</sup> Centers for Disease Control and Prevention. *Chlamydia*. Available at: <https://www.cdc.gov/std/stats17/chlamydia.htm>. Accessed on: Jul 16, 2019.

<sup>4-3</sup> National Prevention Information Network. *Strategies and Incentives from Health Plans to Increase Chlamydia Screening Rates*. Available at: <https://npin.cdc.gov/publication/strategies-and-incentives-health-plans-increase-chlamydia-screening-rates>. Accessed on: Aug 26, 2019.



## 5. Mental/Behavioral Health

### Mental/Behavioral Health

The following section provides a detailed analysis of the Colorado CHP+ MCOs' performance for the Mental/Behavioral Health domain. The Mental/Behavioral Health domain encompasses the following measures/indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Please see the “Reader’s Guide” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendix A and Appendix B.

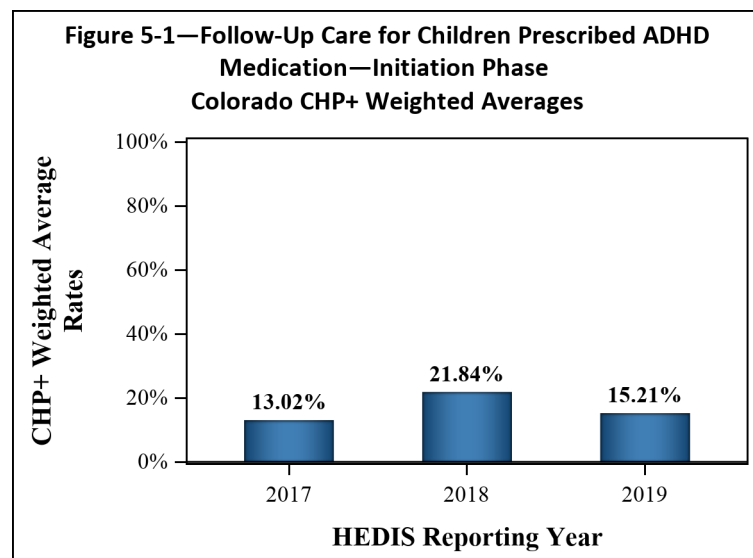
## ***Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment***

*Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment* measures the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment. Two rates are reported—*Effective Acute Phase Treatment* (remained on an antidepressant medication for at least 84 days [12 weeks]) and *Effective Continuation Phase Treatment* (remained on an antidepressant medication for at least 180 days [6 months]).

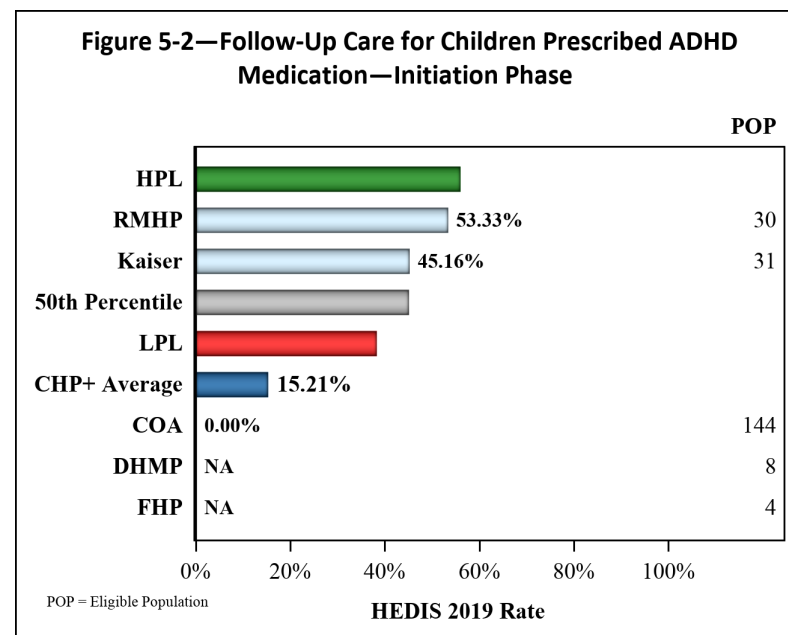
All the CHP+ MCOs followed the specifications for this performance measure, but the denominator was too small (<30) to report a valid rate, resulting in a *Small Denominator (NA)* audit designation; therefore, these rates are not presented in this report and the figures for this measure are not displayed. This is likely because this measure evaluates adults who are age 18 and older, and the CHP+ population is limited to individuals in the month of their 19th birthday or younger.

## Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase

*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measures the percentage of members 6 to 12 years of age who were newly prescribed ADHD medication and had a follow-up care visit within 30 days of the first ADHD medication being dispensed.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

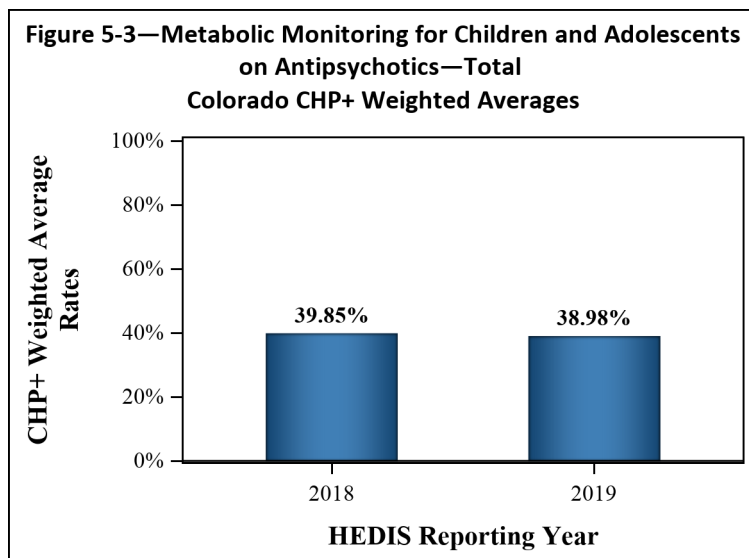
Two MCOs' rates were above the 50th percentile but below the HPL. One MCO's rate and the Colorado CHP+ weighted average fell below the LPL. MCO performance varied by approximately 53 percentage points.

### ***Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase***

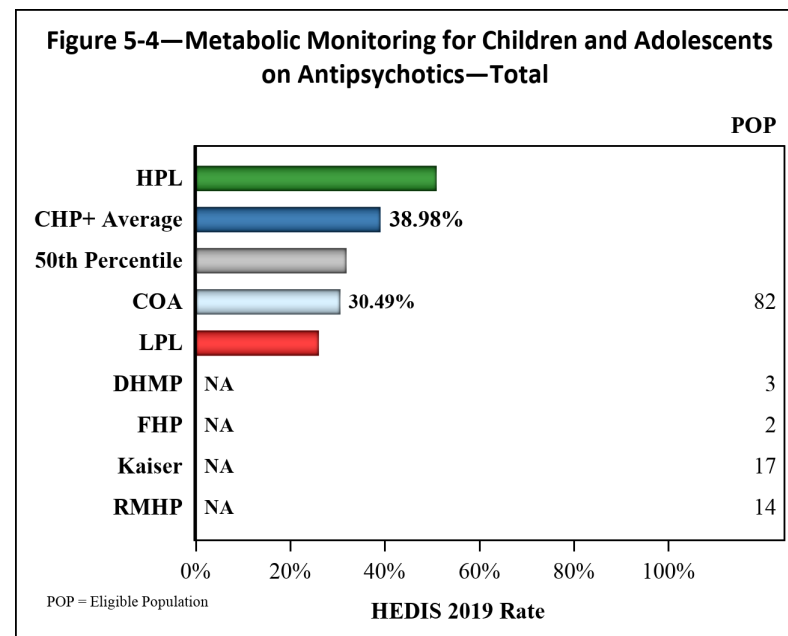
*Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measures the percentage of members 6 to 12 years of age who were newly prescribed ADHD medication, remained on the medication for at least 210 days, and had at least three follow-up care visits within a 10-month period, one of which was within 30 days of the first ADHD medication being dispensed. All the CHP+ MCOs followed the specifications for this performance measure, but the denominator was too small (<30) to report a valid rate, resulting in a *Small Denominator (NA)* audit designation; therefore, these rates are not presented in this report and the figures for this measure are not displayed.

## Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total

*Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total* measures the percentage of members 1 to 17 years of age who had two or more antipsychotic medication prescriptions and received metabolic testing.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

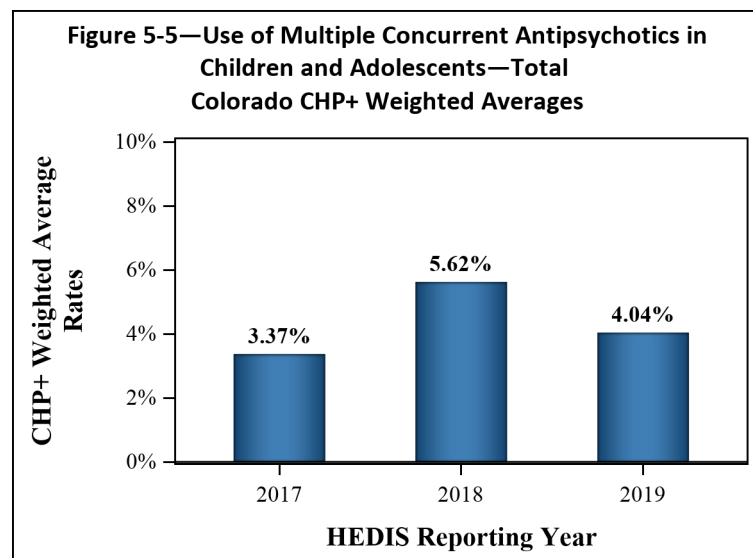


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

The Colorado CHP+ weighted average was above the 50th percentile but below the HPL. One MCO's rate was above the LPL but below the 50th percentile. None of the other MCOs had reportable rates for this measure indicator.

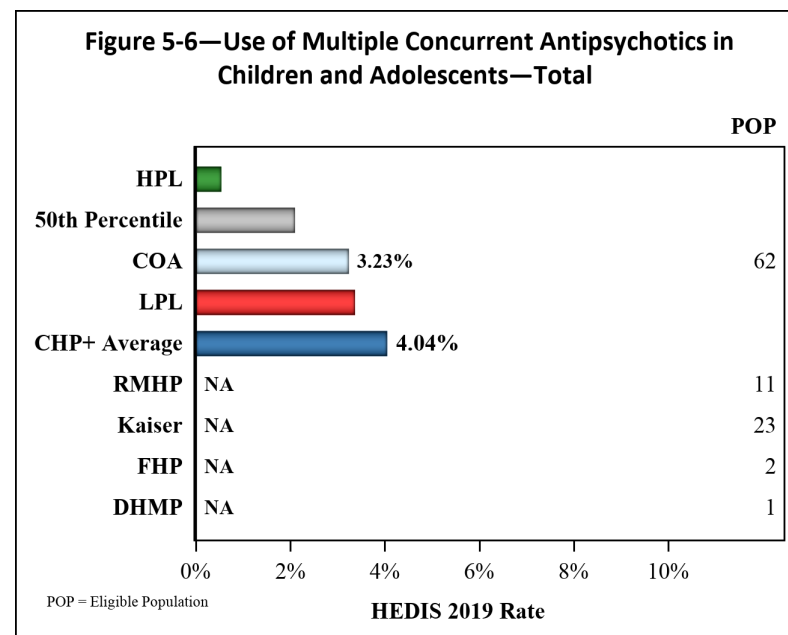
## Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total

*Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* measures the percentage of members 1 to 17 years of age who were on two or more concurrent antipsychotic medications for at least 90 consecutive days. For this indicator, a lower rate indicates better performance.



*Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.*

The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



*NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.*

One MCO's rate was above the LPL but below the 50th percentile. The Colorado CHP+ weighted average fell below the LPL. None of the other MCOs had reportable rates for this measure indicator.

## Summary of Findings

Table 5-1 presents the MCOs' performance ratings for each measure in the Mental/Behavioral Health domain. Performance ratings were assigned across five categories (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*).

**Table 5-1—Mental/Behavioral Health: Measure-Specific Performance Ratings**

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP
<b>Antidepressant Medication Management</b>					
<i>Effective Acute Phase Treatment</i>	—	—	—	—	—
<i>Effective Continuation Phase Treatment</i>	—	—	—	—	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>					
<i>Initiation Phase</i>	★	—	—	★★★★	★★★★★
<i>Continuation and Maintenance Phase</i>	—	—	—	—	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>					
<i>Total</i>	★★	—	—	—	—
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</b>					
<i>Total</i>	★★	—	—	—	—

\* For this indicator, a lower rate indicates better performance.

— Indicates that a percentile ranking was not determined because the rate was not reportable.

Table 5-2 presents a summary of the MCOs' overall performance for measures in the Mental/Behavioral Health domain.

**Table 5-2—Mental/Behavioral Health: MCO-Specific Count of Measures by Performance Rating**

MCO Name	★★★★★	★★★★	★★★	★★	★
COA	0	0	0	2	1
DHMP	0	0	0	0	0
FHP	0	0	0	0	0
Kaiser	0	0	1	0	0
RMHP	0	1	0	0	0

For HEDIS 2019, neither DHMP nor FHP had any reportable rates within the Mental/Behavioral Health domain. Kaiser and RMHP demonstrated strong performance for young members newly prescribed ADHD medication that received a follow-up care visit within 30 days, with opportunities for improvement noted for COA in the same measure. None of COA's eligible members received a follow-up visit after being prescribed ADHD medication. Monitoring of children on ADHD medications is necessary to ensure that the clinical benefits are achieved and to make any necessary dosage/prescription adjustments to control and prevent side effects (e.g., increased activity, negative mood, headaches).<sup>5-1</sup>

<sup>5-1</sup> Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD). *Managing Medication for Children and Adolescents with ADHD*. Available at: [https://chadd.org/wp-content/uploads/2018/05/managing\\_medication.pdf](https://chadd.org/wp-content/uploads/2018/05/managing_medication.pdf). Accessed on: Jul 16, 2019.

Additionally, COA's rates for *Metabolic Monitoring for Children and Adolescents on Antipsychotics* and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* fell below the 50th percentile. Antipsychotic medication use is associated with adverse physical side effects (e.g., type 2 diabetes, cardiovascular disease), and children are more at risk for these side effects when they receive multiple antipsychotics.<sup>5-2</sup> COA and the Department should conduct root cause analyses for the low monitoring rates for members prescribed ADHD and/or antipsychotic medications to determine the nature and scope of the issue (e.g., are the issues related to barriers to accessing care or the need for improved provider training) and implement strategies to improve the care for these members.

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<sup>5-2</sup> Correll CU, Detraux J, De Lepeleire J, De Hert M. Effects of antipsychotics, antidepressants and mood stabilizers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder. *World Psychiatry*. 2015;14(2):119-36.



## 6. Respiratory Conditions

### Respiratory Conditions

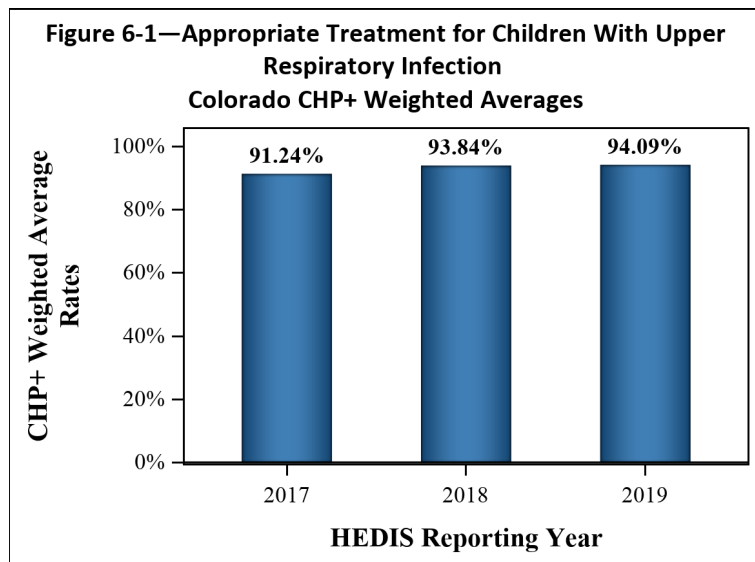
The following section provides a detailed analysis of the Colorado CHP+ MCOs' performance for the Respiratory Conditions domain. The Respiratory Conditions domain encompasses the following measures/indicators:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years and Ages 12 to 18 Years, and Medication Compliance 75%—Ages 5 to 11 Years and Ages 12 to 18 Years*
- *Asthma Medication Ratio—Ages 5 to 11 Years and Ages 12 to 18 Years*

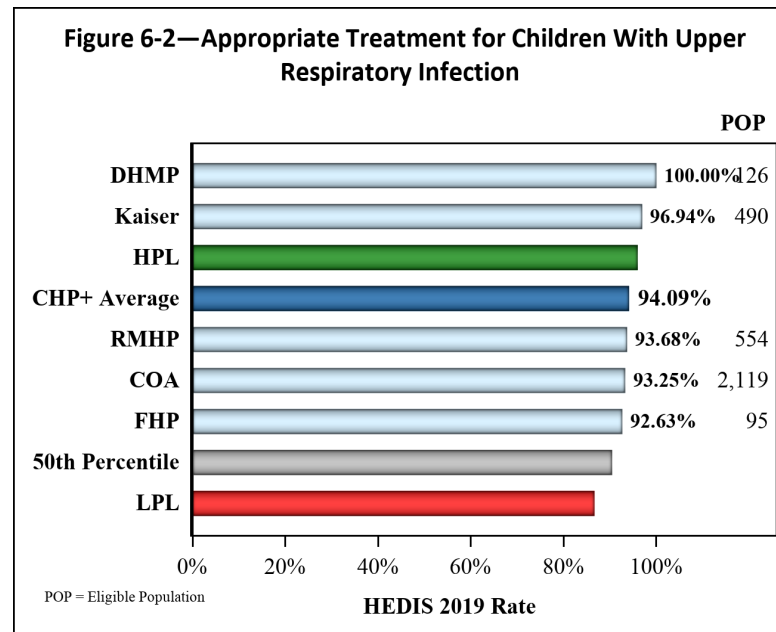
Please see the “Reader’s Guide” section for guidance on interpreting the figures presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendix A and Appendix B.

## Appropriate Treatment for Children With Upper Respiratory Infection

*Appropriate Treatment for Children With Upper Respiratory Infection* measures the percentage of members 3 months to 18 years of age diagnosed with an upper respiratory infection who were not dispensed an antibiotic prescription.



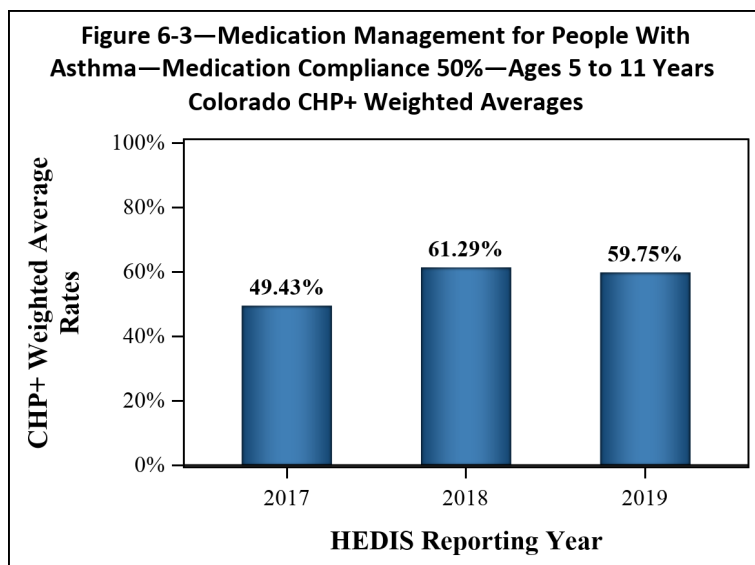
The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



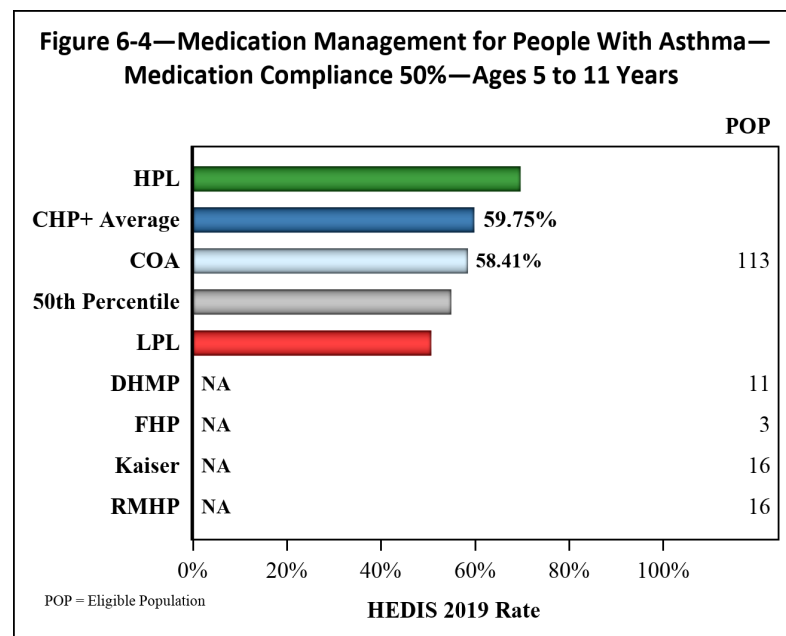
Two MCOs' rates exceeded the HPL. Three MCOs' rates and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. MCO performance varied by approximately 7 percentage points.

## Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years

*Medication Management for People With Asthma—Medication Compliance 50%—Ages 5 to 11 Years* measures the percentage of members 5 to 11 years of age identified as having persistent asthma and dispensed appropriate medications who remained on an asthma controller medication for at least 50 percent of the treatment period.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

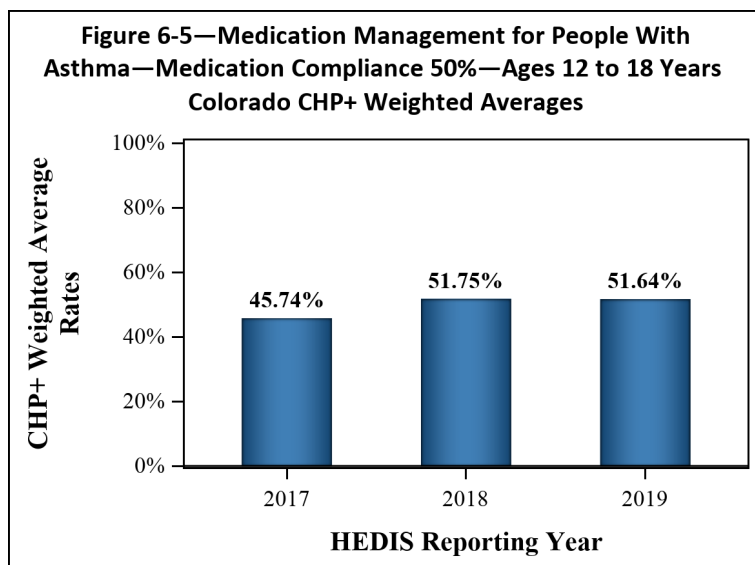


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

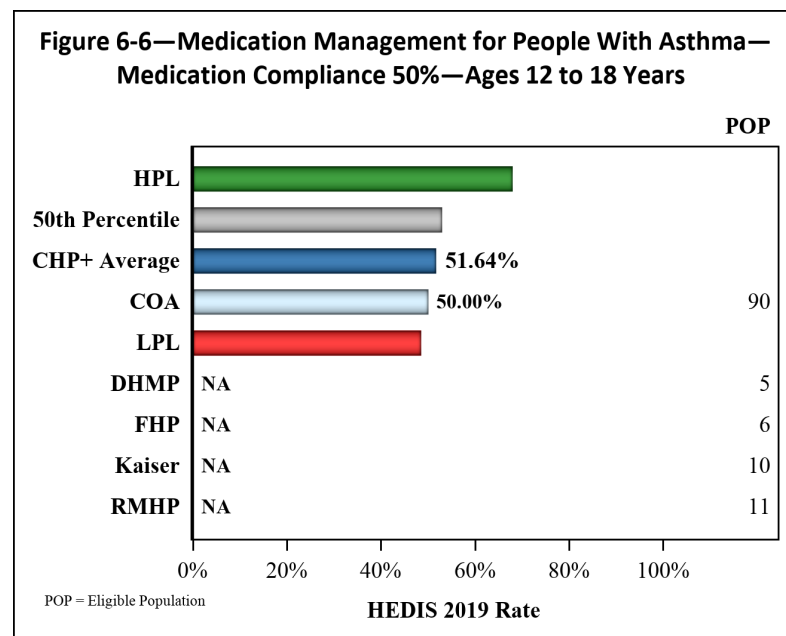
One MCO's rate and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. None of the other MCOs had reportable rates for this measure indicator.

## Medication Management for People With Asthma—Medication Compliance 50%—Ages 12 to 18 Years

*Medication Management for People With Asthma—Medication Compliance 50%—Ages 12 to 18 Years* measures the percentage of members 12 to 18 years of age identified as having persistent asthma and dispensed appropriate medications who remained on an asthma controller medication for at least 50 percent of the treatment period.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

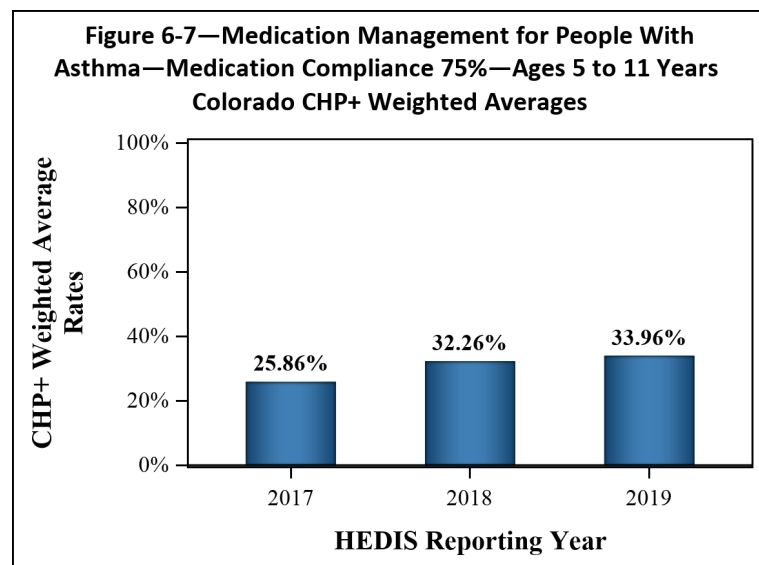


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

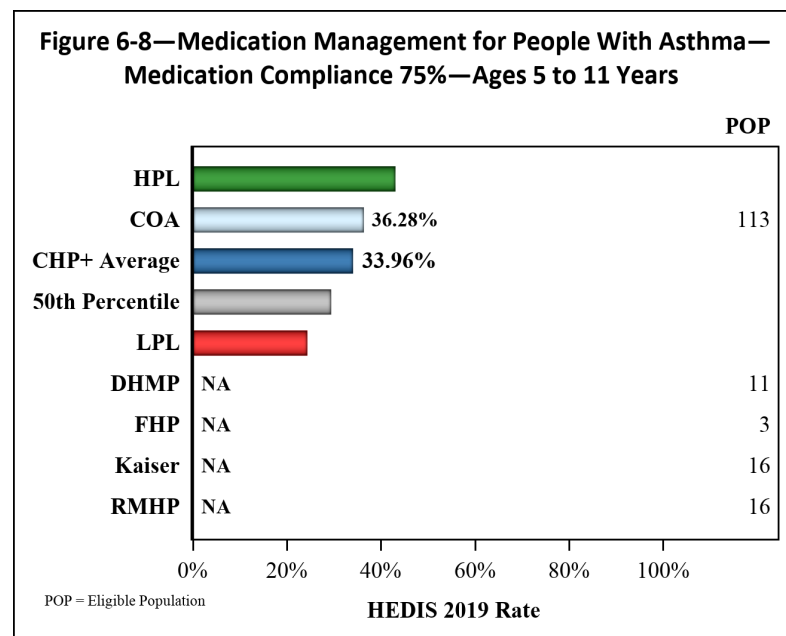
One MCO's rate and the Colorado CHP+ weighted average were above the LPL but below the 50th percentile. None of the other MCOs had reportable rates for this measure indicator.

## Medication Management for People With Asthma—Medication Compliance 75%—Ages 5 to 11 Years

*Medication Management for People With Asthma—Medication Compliance 75%—Ages 5 to 11 Years* measures the percentage of members 5 to 11 years of age identified as having persistent asthma and dispensed appropriate medications who remained on an asthma controller medication for at least 75 percent of the treatment period.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

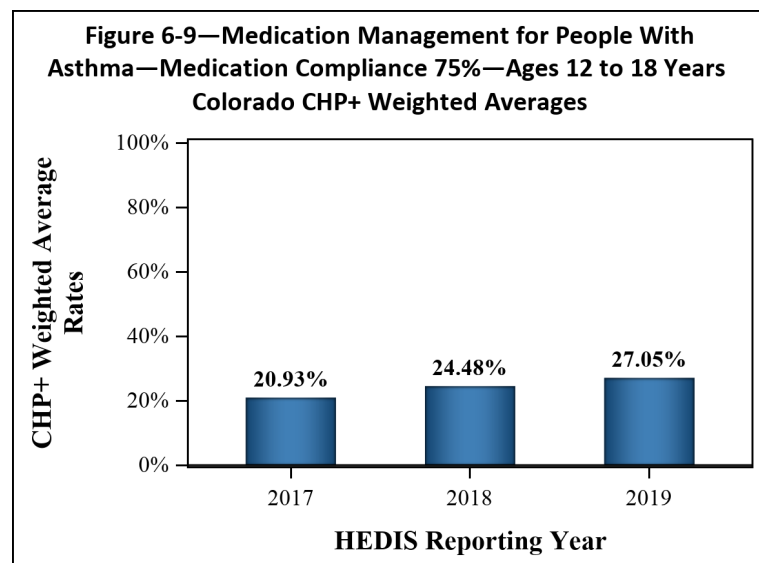


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

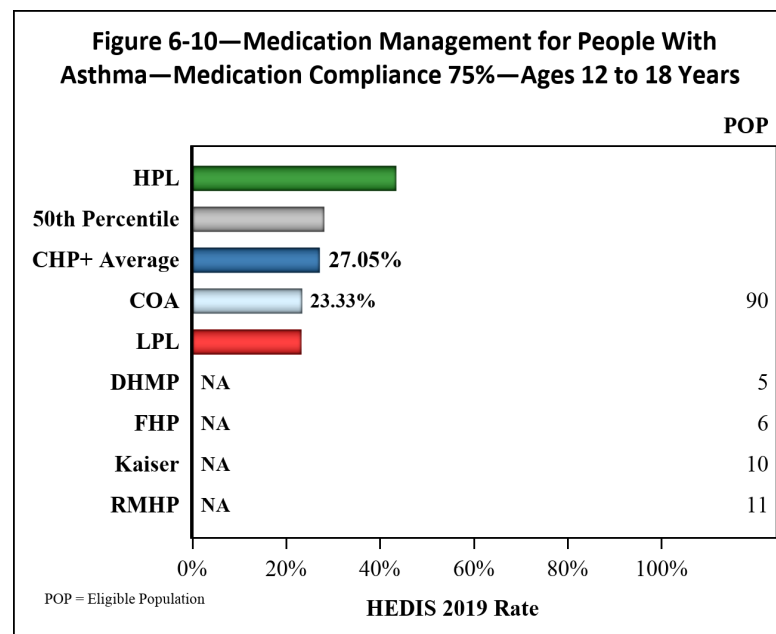
One MCO's rate and the Colorado CHP+ weighted average were above the 50th percentile but below the HPL. None of the other MCOs had reportable rates for this measure indicator.

## Medication Management for People With Asthma—Medication Compliance 75%—Ages 12 to 18 Years

*Medication Management for People With Asthma—Medication Compliance 75%—Ages 12 to 18 Years* measures the percentage of members 12 to 18 years of age identified as having persistent asthma and dispensed appropriate medications who remained on an asthma controller medication for at least 75 percent of the treatment period.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

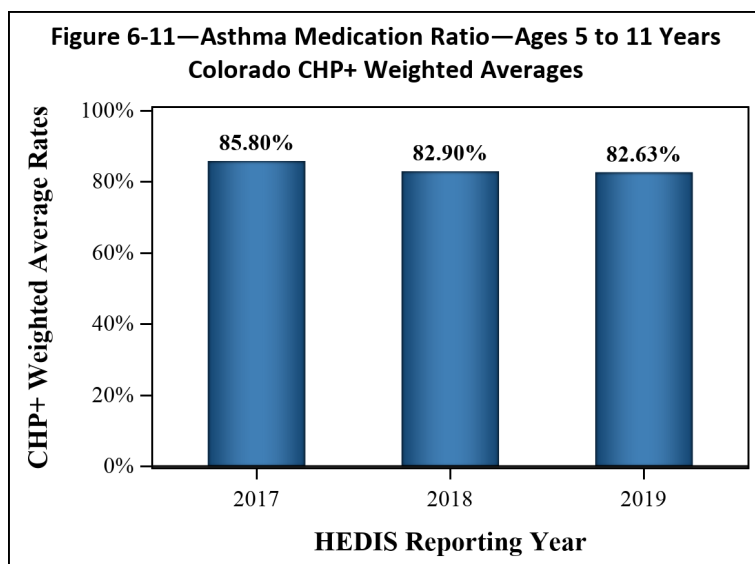


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

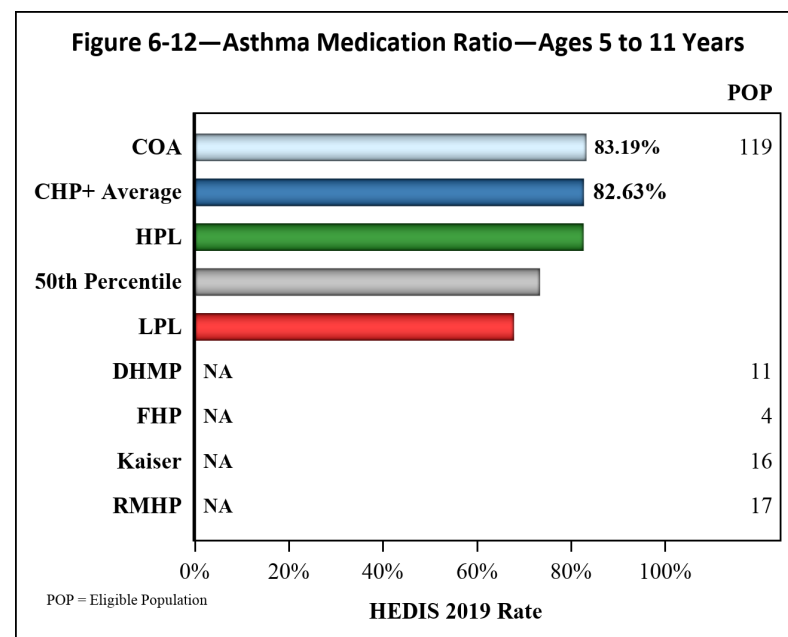
One MCO's rate and the Colorado CHP+ weighted average were above the LPL but below the 50th percentile. None of the other MCOs had reportable rates for this measure indicator.

## Asthma Medication Ratio—Ages 5 to 11 Years

*Asthma Medication Ratio—Ages 5 to 11 Years* measures the percentage of members 5 to 11 years of age identified as having persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.

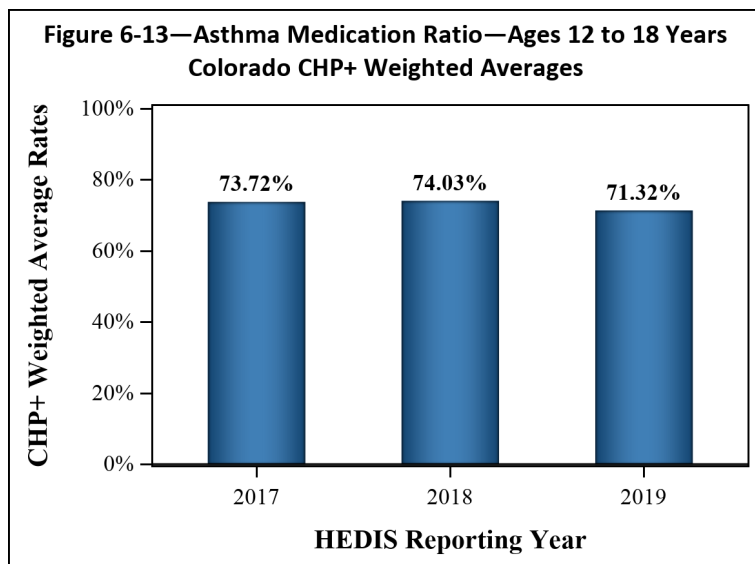


NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

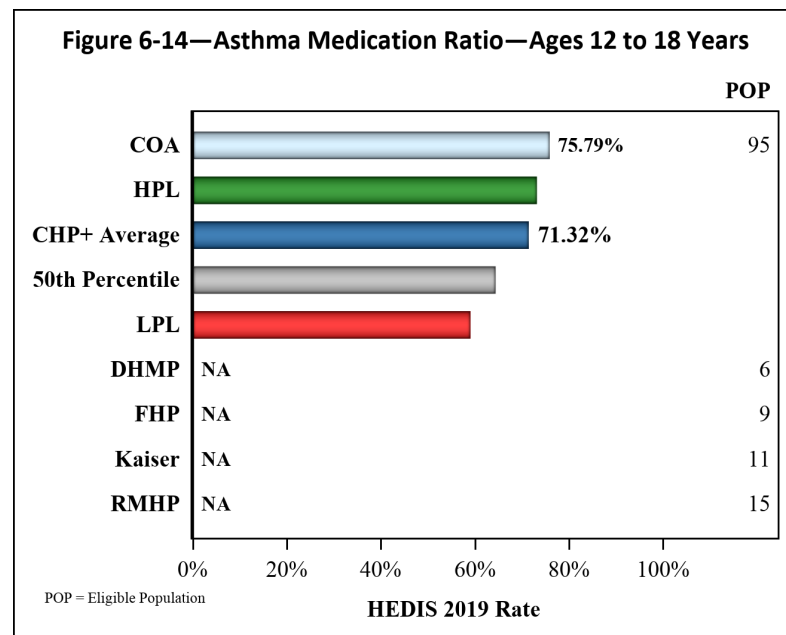
One MCO's rate and the Colorado CHP+ weighted average exceeded the HPL. None of the other MCOs had reportable rates for this measure indicator.

## Asthma Medication Ratio—Ages 12 to 18 Years

*Asthma Medication Ratio—Ages 12 to 18 Years* measures the percentage of members 12 to 18 years of age identified as having persistent asthma who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.



The Colorado CHP+ weighted average did not demonstrate a significant change from 2018 to 2019.



NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

One MCO's rate exceeded the HPL. The Colorado CHP+ weighted average was above the 50th percentile but below the HPL. None of the other MCOs had reportable rates for this measure indicator.



## Summary of Findings

Table 6-1 presents the MCOs' performance ratings for each measure in the Respiratory Conditions domain. Performance ratings were assigned across five categories (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*).

**Table 6-1—Respiratory Conditions: Measure-Specific Performance Ratings**

Performance Measures	COA	DHMP	FHP	Kaiser	RMHP
<b><i>Appropriate Treatment for Children With Upper Respiratory Infection</i></b>					
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	★★★	★★★★★	★★★	★★★★★	★★★
<b><i>Medication Management for People With Asthma</i></b>					
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	★★★	—	—	—	—
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	★★	—	—	—	—
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	★★★★★	—	—	—	—
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	★★	—	—	—	—
<b><i>Asthma Medication Ratio</i></b>					
<i>Ages 5 to 11 Years</i>	★★★★★	—	—	—	—
<i>Ages 12 to 18 Years</i>	★★★★★	—	—	—	—

— Indicates that a percentile ranking was not determined because the rate was not reportable.

Table 6-2 presents a summary of the MCOs' overall performance for measures in the Respiratory Conditions domain.

**Table 6-2—Respiratory Conditions: MCO-Specific Count of Measures by Performance Rating**

MCO Name	★★★★★	★★★★	★★★	★★	★
COA	2	1	2	2	0
DHMP	1	0	0	0	0
FHP	0	0	1	0	0
Kaiser	1	0	0	0	0
RMHP	0	0	1	0	0

All MCOs were above the 50th percentile for the *Appropriate Treatment for Children With Upper Respiratory Infection* measure, demonstrating appropriate treatment of upper respiratory infections in the outpatient and ED settings. COA was the only MCO to have reportable rates for the remaining measures in the Respiratory Conditions domain, showing strength with the ratio of controller medications to reliever medications for children and adolescents. Conversely, opportunities for improvement exist with asthma medication compliance for members ages 12 to 18, with both rates falling below the 50th percentile. COA and the Department should focus efforts to identify the low rates of adherence to asthma medications (e.g., are the issues related to barriers to accessing pharmacies, provider prescribing patterns, or members not filling prescriptions) and implement strategies to increase the rates for members ages 12 to 18.

## 7. Use of Services

### Use of Services

Within the Use of Services domain, HEDIS methodology requires that the rate be derived using only the administrative method. The Use of Services domain encompasses the following measures:

- *Ambulatory Care (Per 1,000 Member Months)—Outpatient Visits—Total and ED Visits—Total*
- *Inpatient Utilization—General Hospital/Acute Care—Total Inpatient—Total Discharges per 1,000 Member Months and Total Average Length of Stay, Medicine—Total Discharges per 1,000 Member Months and Total Average Length of Stay, Surgery—Total Discharges per 1,000 Member Months and Total Average Length of Stay, and Maternity—Total Discharges per 1,000 Member Months and Total Average Length of Stay*
- *Antibiotic Utilization—Total—Average Scripts PMPY for Antibiotics, Average Days Supplied per Antibiotic Script, Average Scripts PMPY for Antibiotics of Concern, and Percentage of Antibiotics of Concern of All Antibiotic Scripts*

All the MCOs were required to report these measures in HEDIS 2019. The MCOs' member months served as an eligible population proxy and were used when calculating the Colorado CHP+ weighted average. Table 7-1 displays the member months for each MCO and the CHP+ program. The largest contribution of member months came from the two categories of children between 1 and 9 years of age and between 10 and 19 years of age.

**Table 7-1—Colorado CHP+ Member Months for Calendar Year 2018**

Age	COA	DHMP	FHP	Kaiser	RMHP	Total CHP+
Less Than 1 Year	9,617	791	326	753	2,244	13,731
1–9 Years	292,607	38,069	11,958	66,652	63,767	473,053
10–19 Years	271,022	42,715	11,779	78,321	59,903	463,740
20–44 Years	31	91	0	5	0	127
<b>Total</b>	<b>573,277</b>	<b>81,666</b>	<b>24,063</b>	<b>145,731</b>	<b>125,914</b>	<b>950,651</b>

Rates displayed in the Use of Services domain are for informational purposes only; the rates do not indicate the quality and timeliness of, or access to, care and services. Therefore, exercise caution in connecting these data to the efficacy of the program, as many factors influence these data. HSAG recommends that MCOs review the Use of Services results to identify whether a rate is higher or lower than expected. Additional focused analyses related to the Use of Services domain may help to identify key drivers associated with the utilization patterns.

Please see the “Reader’s Guide” section for guidance on interpreting the tables presented within this section. For reference, additional analyses for each measure indicator are displayed in Appendix A and Appendix B.

## Ambulatory Care

The *Ambulatory Care (per 1,000 Member Months)* measure summarizes use of ambulatory care for *Outpatient Visits—Total* and *ED Visits—Total*. In this section, the results for the total age group are presented.

### Results

Table 7-2 shows *Outpatient Visits—Total* and *ED Visits—Total* per 1,000 member months for ambulatory care for all ages.

**Table 7-2—Ambulatory Care: Total Visits per 1,000 Member Months for Total Age Group**

MCO Name	Outpatient Visits	ED Visits*
COA	218.12	26.90
DHMP	135.56	21.49
FHP	166.81	17.33
Kaiser	133.57	18.86
RMHP	211.60	18.38
2019 Colorado CHP+ Weighted Average	195.91	23.83
2018 Colorado CHP+ Weighted Average	199.00	21.80
2017 Colorado CHP+ Weighted Average	205.26	20.84

\* For this indicator, a lower rate may indicate more favorable performance.

For the *ED Visits—Total* indicator, MCO performance varied with the lowest number of visits per 1,000 member months reported as 17.33 and the highest number of visits per 1,000 member months reported as 26.90.

## Inpatient Utilization—General Hospital/Acute Care

The *Inpatient Utilization—General Hospital/Acute Care* measure summarizes use of acute inpatient care and services in four categories: total inpatient, medicine, surgery, and maternity.

### Results

Table 7-3 shows the total discharges per 1,000 member months for all ages, which are presented for informational purposes only.

**Table 7-3—Inpatient Utilization—General Hospital/Acute Care: Total Discharges per 1,000 Member Months for Total Age Group<sup>1</sup>**

MCO Name	Total Inpatient	Medicine	Surgery	Maternity
COA	1.03	0.74	0.25	0.09
DHMP	0.82	0.60	0.17	0.09
FHP	0.37	0.21	0.17	0.00
Kaiser	0.49	0.40	0.08	0.01
RMHP	0.75	0.49	0.21	0.10
2019 Colorado CHP+ Weighted Average	0.88	0.63	0.21	0.07
2018 Colorado CHP+ Weighted Average	0.88	0.60	0.24	0.07
2017 Colorado CHP+ Weighted Average	0.87	0.60	0.24	0.06

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

Table 7-4 displays the total average length of stay for all ages, which are presented for informational purposes only.

**Table 7-4—Inpatient Utilization—General Hospital/Acute Care: Total Average Length of Stay for Total Age Group<sup>1</sup>**

MCO Name	Total Inpatient	Medicine	Surgery	Maternity
COA	3.43	2.97	4.90	2.58†
DHMP	3.07	2.59	5.07†	2.00†
FHP	2.33†	2.00†	1.50†	NA
Kaiser	3.67	2.29	10.50†	3.00†
RMHP	4.37	3.27	7.46†	2.33†
2019 Colorado CHP+ Weighted Average	3.51	2.89	5.50	2.49
2018 Colorado CHP+ Weighted Average	3.77	2.96	5.90	2.97
2017 Colorado CHP+ Weighted Average	3.42	2.82	4.97	2.68†

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

† Fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

## Antibiotic Utilization

Table 7-5 displays the results of the *Antibiotic Utilization* measure indicators, which are presented for informational purposes only for four categories: *Average Scripts PMPY for Antibiotics*; *Average Days Supplied per Antibiotic Script*; *Average Scripts PMPY Antibiotics of Concern*; and *Percentage of Antibiotics of Concern of All Antibiotic Scripts*. Of note, antibiotics of concern are those that are often prescribed unnecessarily or inappropriately and could increase the risk of antibiotic resistant infections. For this measure, a lower rate may indicate more favorable performance.

**Table 7-5—Antibiotic Utilization: Total for Total Age Group\***

MCO Name	Average Scripts PMPY for Antibiotics	Average Days Supplied per Antibiotic Script	Average Scripts PMPY for Antibiotics of Concern	Percentage of Antibiotics of Concern of All Antibiotic Scripts
COA	0.35	10.87	0.12	33.71%
DHMP	0.14	11.28	0.03	24.04%
FHP	12.00	99.95	2.32	19.35%
Kaiser	0.19	12.47	0.05	24.21%
RMHP	0.39	10.20	0.14	35.98%
2019 Colorado CHP+ Weighted Average	0.33	16.86	0.11	31.91%
2018 Colorado CHP+ Weighted Average	0.38	11.36	0.12	33.02%
2017 Colorado CHP+ Weighted Average	0.40	11.06	0.13	33.99%

\* For this measure, a lower rate may indicate more favorable performance.

## Summary of Findings

Reported rates for the MCOs and CHP+ weighted averages for the Use of Services domain did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions regarding performance based on the reported utilization results. Nonetheless, combined with other performance metrics, the utilization results provide additional information that MCOs may use to assess barriers or patterns of utilization when evaluating improvement interventions.

## Appendix A. Tabular Results for Measures by MCO

Appendix A presents tables showing results for the measures by MCO. Where applicable, the results provided for each measure include the eligible population and rate for each MCO as well as HEDIS 2017, 2018, and 2019 Colorado CHP+ weighted averages. Yellow shading with one caret (^) indicates the HEDIS 2019 MCO-specific rate or Colorado CHP+ weighted average ranked at or above the 50th percentile. Comparisons of Colorado's CHP+ population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution, as previously discussed in the body of this report.

### Pediatric Care Performance Measure Results

**Table A-1—Pediatric Care Performance Measure Results—MCO-Specific Rates and Colorado CHP+ Weighted Averages**

CHP+ Plan	Eligible Population	Rate
<i>Childhood Immunization Status<sup>1</sup></i>		
<b>DTaP</b>		
COA	848	75.83%
FHP	42	7.14%
DHMP	126	69.84%
Kaiser	239	71.13%
RMHP	226	68.14%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>71.44%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>69.02%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>71.93%</b>
<b>IPV</b>		
COA	848	86.44%
FHP	42	7.14%
DHMP	126	75.40%
Kaiser	239	87.03%
RMHP	226	84.07%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>82.98%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>80.23%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>80.89%</b>
<b>MMR</b>		
COA	848	86.44%
FHP	42	40.48%
DHMP	126	78.57%
Kaiser	239	81.17%

CHP+ Plan	Eligible Population	Rate
RMHP	226	77.88%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>82.31%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>82.05%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>83.57%</b>
<b><i>HiB</i></b>		
COA	848	87.03%
FHP	42	9.52%
DHMP	126	74.60%
Kaiser	239	87.87%
RMHP	226	76.99%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>82.38%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>80.75%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>81.31%</b>
<b><i>Hepatitis B</i></b>		
COA	848	85.61%
FHP	42	7.14%
DHMP	126	73.81%
Kaiser	239	88.70%
RMHP	226	79.65%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>81.97%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>78.81%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>79.34%</b>
<b><i>VZV</i></b>		
COA	848	84.32%
FHP	42	38.10%
DHMP	126	78.57%
Kaiser	239	81.59%
RMHP	226	80.97%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>81.57%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>79.84%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>81.31%</b>
<b><i>Pneumococcal Conjugate</i></b>		
COA	848	78.07%
FHP	42	7.14%
DHMP	126	69.05%
Kaiser	239	77.82%
RMHP	226	74.34%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>74.68%</b>

CHP+ Plan	Eligible Population	Rate
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>72.20%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>74.05%</b>
<b><i>Hepatitis A</i></b>		
COA	848	80.66%
FHP	42	52.38%
DHMP	126	80.16%
Kaiser	239	81.17%
RMHP	226	76.55%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>79.27%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>77.12%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>77.86%</b>
<b><i>Rotavirus</i></b>		
COA	848	76.18%^
FHP	42	4.76%
DHMP	126	66.67%
Kaiser	239	76.57%^
RMHP	226	75.66%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>73.33%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>66.56%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>69.11%</b>
<b><i>Influenza</i></b>		
COA	848	57.08%^
FHP	42	11.90%
DHMP	126	53.17%^
Kaiser	239	48.95%^
RMHP	226	54.42%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>53.75%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>48.54%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>49.22%</b>
<b><i>Combination 2</i></b>		
COA	848	71.58%
FHP	42	4.76%
DHMP	126	67.46%
Kaiser	239	69.46%
RMHP	226	57.08%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>66.78%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>62.54%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>65.30%</b>



CHP+ Plan	Eligible Population	Rate
<b>Combination 3</b>		
COA	848	69.58%
FHP	42	4.76%
DHMP	126	65.87%
Kaiser	239	67.36%
RMHP	226	57.08%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>65.16%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>61.05%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>63.61%</b>
<b>Combination 4</b>		
COA	848	66.86%
FHP	42	4.76%
DHMP	126	65.87%
Kaiser	239	66.95%
RMHP	226	54.42%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>63.13%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>59.17%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>61.14%</b>
<b>Combination 5</b>		
COA	848	63.21%^
FHP	42	4.76%
DHMP	126	57.94%
Kaiser	239	62.76%^
RMHP	226	54.87%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>59.76%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>53.79%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>57.33%</b>
<b>Combination 6</b>		
COA	848	49.53%^
FHP	42	0.00%
DHMP	126	46.03%^
Kaiser	239	41.84%^
RMHP	226	41.15%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>45.31%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>40.51%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>41.61%</b>

CHP+ Plan	Eligible Population	Rate
<b>Combination 7</b>		
COA	848	61.32%^
FHP	42	4.76%
DHMP	126	57.94%
Kaiser	239	62.34%^
RMHP	226	52.21%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>58.20%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>52.43%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>55.57%</b>
<b>Combination 8</b>		
COA	848	48.23%^
FHP	42	0.00%
DHMP	126	46.03%^
Kaiser	239	41.84%^
RMHP	226	39.38%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>44.29%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>39.53%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>40.34%</b>
<b>Combination 9</b>		
COA	848	45.64%^
FHP	42	0.00%
DHMP	126	41.27%^
Kaiser	239	40.59%^
RMHP	226	39.82%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>42.27%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>36.49%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>38.50%</b>
<b>Combination 10</b>		
COA	848	44.58%^
FHP	42	0.00%
DHMP	126	41.27%^
Kaiser	239	40.59%^
RMHP	226	38.05%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>41.39%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>35.77%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>37.59%</b>

CHP+ Plan	Eligible Population	Rate
<b>Immunizations for Adolescents</b>		
<b>Meningococcal</b>		
COA	1,059	78.09%
FHP	57	31.58%
DHMP	152	84.21%^
Kaiser	303	84.49%^
RMHP	300	60.67%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>75.41%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>71.03%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>69.48%</b>
<b>Tdap</b>		
COA	1,059	87.54%
FHP	57	56.14%
DHMP	152	85.53%
Kaiser	303	89.77%^
RMHP	300	84.67%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>86.32%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>82.47%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>81.55%</b>
<b>HPV</b>		
COA	1,059	41.17%^
FHP	57	14.04%
DHMP	152	57.24%^
Kaiser	303	58.42%^
RMHP	300	22.33%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>41.42%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>37.05%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>—</b>
<b>Combination 1 (Meningococcal, Tdap)</b>		
COA	1,059	76.30%
FHP	57	26.32%
DHMP	152	82.24%^
Kaiser	303	82.84%^
RMHP	300	57.67%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>73.33%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>68.89%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>67.55%</b>

CHP+ Plan	Eligible Population	Rate
<b><i>Combination 2 (Meningococcal, Tdap, HPV)</i></b>		
COA	1,059	38.90%^
FHP	57	12.28%
DHMP	152	55.92%^
Kaiser	303	56.44%^
RMHP	300	18.33%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>39.02%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>33.79%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>—</b>
<b><i>Well-Child Visits in the First 15 Months of Life</i></b>		
<b><i>Zero Visits*</i></b>		
COA	220	6.36%
FHP	7	NA
DHMP	33	15.15%
Kaiser	99	2.02%
RMHP	76	0.00%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>5.06%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>2.63%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>3.04%</b>
<b><i>Six or More Visits</i></b>		
COA	220	47.27%
FHP	7	NA
DHMP	33	63.64%
Kaiser	99	73.74%^
RMHP	76	15.79%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>48.28%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>51.41%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>48.01%</b>
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b>		
COA	4,197	68.50%
FHP	169	55.62%
DHMP	519	64.74%
Kaiser	981	65.44%
RMHP	1,015	67.68%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>67.34%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>64.97%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>66.60%</b>

CHP+ Plan	Eligible Population	Rate
<b><i>Adolescent Well-Care Visits</i></b>		
COA	6,669	49.87%
FHP	340	37.65%
DHMP	1,095	45.30%
Kaiser	1,932	45.24%
RMHP	1,722	49.19%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>48.23%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>45.09%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>48.26%</b>
<b><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></b>		
<b><i>BMI Percentile Documentation—Ages 3 to 11 Years<sup>1</sup></i></b>		
COA	7,590	7.47%
FHP	288	12.15%
DHMP	841	14.27%
Kaiser	1,777	98.82%^
RMHP	1,894	3.38%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>20.52%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>18.03%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>15.25%</b>
<b><i>BMI Percentile Documentation—Ages 12 to 17 Years<sup>1</sup></i></b>		
COA	4,425	12.36%
FHP	207	6.28%
DHMP	558	33.15%
Kaiser	1,156	98.18%^
RMHP	1,089	7.35%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>26.36%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>23.01%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>19.08%</b>
<b><i>BMI Percentile Documentation—Total<sup>1</sup></i></b>		
COA	12,015	9.27%
FHP	495	9.70%
DHMP	1,399	21.80%
Kaiser	2,933	98.57%^
RMHP	2,983	4.83%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>22.71%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>19.89%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>16.67%</b>

CHP+ Plan	Eligible Population	Rate
<b><i>Counseling for Nutrition—Ages 3 to 11 Years</i></b>		
COA	7,590	4.39%
FHP	288	4.17%
DHMP	841	2.14%
Kaiser	1,777	96.57%^
RMHP	1,894	23.76%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>20.41%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>19.06%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>17.68%</b>
<b><i>Counseling for Nutrition—Ages 12 to 17 Years</i></b>		
COA	4,425	6.35%
FHP	207	5.31%
DHMP	558	16.67%
Kaiser	1,156	95.59%^
RMHP	1,089	21.67%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>23.21%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>21.89%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>18.92%</b>
<b><i>Counseling for Nutrition—Total</i></b>		
COA	12,015	5.11%
FHP	495	4.65%
DHMP	1,399	7.93%
Kaiser	2,933	96.18%^
RMHP	2,983	23.00%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>21.46%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>20.12%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>18.14%</b>
<b><i>Counseling for Physical Activity—Ages 3 to 11 Years</i></b>		
COA	7,590	1.98%
FHP	288	0.00%
DHMP	841	1.66%
Kaiser	1,777	96.57%^
RMHP	1,894	4.96%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>15.93%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>14.47%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>13.05%</b>

CHP+ Plan	Eligible Population	Rate
<b><i>Counseling for Physical Activity—Ages 12 to 17 Years</i></b>		
COA	4,425	5.13%
FHP	207	14.98%
DHMP	558	14.16%
Kaiser	1,156	95.59%^
RMHP	1,089	6.43%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>20.34%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>18.23%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>16.44%</b>
<b><i>Counseling for Physical Activity—Total</i></b>		
COA	12,015	3.14%
FHP	495	6.26%
DHMP	1,399	6.65%
Kaiser	2,933	96.18%^
RMHP	2,983	5.50%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>17.58%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>15.87%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>14.31%</b>
<b><i>Appropriate Testing for Children With Pharyngitis</i></b>		
COA	1,234	84.60%^
FHP	69	81.16%^
DHMP	42	83.33%^
Kaiser	345	94.20%^
RMHP	322	77.64%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>84.99%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>87.36%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>84.35%</b>

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

— Indicates that NCQA recommended a break in trending; therefore, no prior year rates are displayed.

Yellow shading with one caret (^) indicates the rate was at or above the 50th percentile.

**Bold font indicates Colorado CHP+ weighted average values.**

## Access to Care and Preventive Screening Performance Measure Results

**Table A-2—Access to Care and Preventive Screening Performance Measure Results—MCO-Specific Rates and Colorado CHP+ Weighted Averages**

CHP+ Plan	Eligible Population	Rate
<i>Prenatal and Postpartum Care<sup>1</sup></i>		
<i>Timeliness of Prenatal Care</i>		
SMCN	702	55.13%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>55.13%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>58.29%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>57.08%</b>
<i>Postpartum Care</i>		
SMCN	702	45.01%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>45.01%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>43.42%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>42.50%</b>
<i>Children and Adolescents' Access to Primary Care Practitioners</i>		
<i>Ages 12 to 24 Months</i>		
COA	371	90.30%
FHP	12	NA
DHMP	83	90.36%
Kaiser	144	97.22%^
RMHP	94	94.68%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>92.33%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>90.65%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>90.02%</b>
<i>Ages 25 Months to 6 Years</i>		
COA	5,031	84.52%
FHP	210	71.90%
DHMP	632	73.58%
Kaiser	1,158	83.25%
RMHP	1,233	82.81%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>82.93%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>80.91%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>82.88%</b>
<i>Ages 7 to 11 Years</i>		
COA	2,836	87.98%
FHP	156	87.18%
DHMP	459	86.93%
Kaiser	910	86.81%



CHP+ Plan	Eligible Population	Rate
RMHP	892	88.00%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>87.66%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>87.49%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>88.99%</b>
<b><i>Ages 12 to 19 Years</i></b>		
COA	3,641	87.78%
FHP	199	86.43%
DHMP	685	82.04%
Kaiser	1,286	88.26%
RMHP	1,057	87.04%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>87.14%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>88.09%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>89.39%</b>
<b><i>Chlamydia Screening in Women<sup>2</sup></i></b>		
<b><i>Ages 16 to 20 Years</i></b>		
COA	471	32.27%
FHP	26	NA
DHMP	72	47.22%
Kaiser	178	45.51%
RMHP	143	33.57%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>36.52%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>33.66%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>35.31%</b>
<b><i>Non-Recommended Cervical Cancer Screening in Adolescent Females*</i></b>		
COA	1,219	0.08%^
FHP	72	0.00%^
DHMP	237	0.00%^
Kaiser	428	0.00%^
RMHP	291	0.00%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>0.04%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>0.07%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>0.17%</b>

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Since the Prenatal and Postpartum Care rates are calculated using a modified specification, comparisons to national benchmarks are not shown.

<sup>2</sup> Because the CHP+ population is limited to individuals ages 18 years and under, the HEDIS 2019 indicator rates for Ages 16 to 20 Years are the same as the measure indicator rates for the Total age grouping for this measure.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Yellow shading with one caret (^) indicates the rate was at or above the 50th percentile.

**Bold font indicates Colorado CHP+ weighted average values.**

## Mental/Behavioral Health Performance Measure Results

**Table A-3—Mental/Behavioral Health Performance Measure Results—MCO-Specific Rates and Colorado CHP+ Weighted Averages**

CHP+ Plan	Eligible Population	Rate
<b><i>Antidepressant Medication Management</i></b>		
<b><i>Effective Acute Phase Treatment</i></b>		
COA	21	NA
FHP	3	NA
DHMP	2	NA
Kaiser	5	NA
RMHP	9	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>55.00%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>48.65%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b><i>Effective Continuation Phase Treatment</i></b>		
COA	21	NA
FHP	3	NA
DHMP	2	NA
Kaiser	5	NA
RMHP	9	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>37.50%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>40.54%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b><i>Follow-Up Care for Children Prescribed ADHD Medication</i></b>		
<b><i>Initiation Phase</i></b>		
COA	144	0.00%
FHP	4	NA
DHMP	8	NA
Kaiser	31	45.16%^
RMHP	30	53.33%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>15.21%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>21.84%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>13.02%</b>
<b><i>Continuation and Maintenance Phase</i></b>		
COA	25	NA
FHP	0	NA
DHMP	0	NA
Kaiser	9	NA

CHP+ Plan	Eligible Population	Rate
RMHP	6	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>20.00%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>21.57%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>20.00%</b>
<b><i>Metabolic Monitoring for Children and Adolescents on Antipsychotics</i></b>		
<b><i>Ages 1 to 5 Years</i></b>		
COA	0	NA
FHP	0	NA
DHMP	0	NA
Kaiser	0	NA
RMHP	0	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>—</b>
<b><i>Ages 6 to 11 Years</i></b>		
COA	22	NA
FHP	0	NA
DHMP	0	NA
Kaiser	4	NA
RMHP	2	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>—</b>
<b><i>Ages 12 to 17 Years</i></b>		
COA	60	28.33%
FHP	2	NA
DHMP	3	NA
Kaiser	13	NA
RMHP	12	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>38.89%<sup>^</sup></b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>41.51%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>—</b>
<b><i>Total</i></b>		
COA	82	30.49%
FHP	2	NA
DHMP	3	NA
Kaiser	17	NA
RMHP	14	NA

CHP+ Plan	Eligible Population	Rate
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>38.98%<sup>^</sup></b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>39.85%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>—</b>
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents<sup>*,1</sup></i>		
<i>Ages 1 to 5 Years</i>		
COA	0	NA
FHP	0	NA
DHMP	0	NA
Kaiser	0	NA
RMHP	0	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<i>Ages 6 to 11 Years</i>		
COA	18	NA
FHP	0	NA
DHMP	0	NA
Kaiser	6	NA
RMHP	1	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>NA</b>
<i>Ages 12 to 17 Years</i>		
COA	44	4.55%
FHP	2	NA
DHMP	1	NA
Kaiser	17	NA
RMHP	10	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>5.41%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>7.14%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>4.05%</b>
<i>Total</i>		
COA	62	3.23%
FHP	2	NA
DHMP	1	NA
Kaiser	23	NA
RMHP	11	NA

CHP+ Plan	Eligible Population	Rate
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>4.04%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>5.62%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>3.37%</b>

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

— Indicates that the MCOs were not required to report this measure for HEDIS 2017.

Yellow shading with one caret (^) indicates the rate was at or above the 50th percentile.

**Bold font indicates Colorado CHP+ weighted average values.**

## Respiratory Conditions Performance Measure Results

**Table A-4—Respiratory Conditions Performance Measure Results—MCO-Specific Rates and Colorado CHP+ Weighted Averages**

CHP+ Plan	Eligible Population	Rate
<i><b>Appropriate Treatment for Children With Upper Respiratory Infection</b></i>		
COA	2,119	93.25%^
FHP	95	92.63%^
DHMP	126	100.00%^
Kaiser	490	96.94%^
RMHP	554	93.68%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>94.09%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>93.84%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>91.24%</b>
<i><b>Medication Management for People With Asthma</b></i>		
<i><b>Medication Compliance 50%—Ages 5 to 11 Years</b></i>		
COA	113	58.41%^
FHP	3	NA
DHMP	11	NA
Kaiser	16	NA
RMHP	16	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>59.75%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>61.29%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>49.43%</b>
<i><b>Medication Compliance 50%—Ages 12 to 18 Years</b></i>		
COA	90	50.00%
FHP	6	NA
DHMP	5	NA
Kaiser	10	NA
RMHP	11	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>51.64%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>51.75%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>45.74%</b>
<i><b>Medication Compliance 50%—Total</b></i>		
COA	203	54.68%
FHP	9	NA
DHMP	16	NA
Kaiser	27	NA
RMHP	27	NA

CHP+ Plan	Eligible Population	Rate
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>56.38%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>57.14%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>47.85%</b>
<b>Medication Compliance 75%—Ages 5 to 11 Years</b>		
COA	113	36.28%^
FHP	3	NA
DHMP	11	NA
Kaiser	16	NA
RMHP	16	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>33.96%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>32.26%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>25.86%</b>
<b>Medication Compliance 75%—Ages 12 to 18 Years</b>		
COA	90	23.33%
FHP	6	NA
DHMP	5	NA
Kaiser	10	NA
RMHP	11	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>27.05%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>24.48%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>20.93%</b>
<b>Medication Compliance 75%—Total</b>		
COA	203	30.54%
FHP	9	NA
DHMP	16	NA
Kaiser	27	NA
RMHP	27	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>31.21%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>28.88%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>23.76%</b>
<b>Asthma Medication Ratio</b>		
<b>Ages 5 to 11 Years</b>		
COA	119	83.19%^
FHP	4	NA
DHMP	11	NA
Kaiser	16	NA
RMHP	17	NA

CHP+ Plan	Eligible Population	Rate
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>82.63%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>82.90%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>85.80%</b>
<b><i>Ages 12 to 18 Years</i></b>		
COA	95	75.79%^
FHP	9	NA
DHMP	6	NA
Kaiser	11	NA
RMHP	15	NA
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>71.32%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>74.03%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>73.72%</b>
<b><i>Total</i></b>		
COA	214	79.91%^
FHP	13	NA
DHMP	17	NA
Kaiser	28	NA
RMHP	32	75.00%^
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>		<b>77.63%^</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>		<b>78.96%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>		<b>80.25%</b>

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Yellow shading with one caret (^) indicates the rate was at or above the 50th percentile.

**Bold font indicates Colorado CHP+ weighted average values.**



## Use of Services Measure Results

**Table A-5—Use of Services Measure Results—MCO-Specific Rates and Colorado CHP+ Weighted Averages**

CHP+ Plan	Rate
<b>Ambulatory Care (Per 1,000 Member Months)</b>	
<b>ED Visits—Age &lt;1 Year*</b>	
COA	45.44
FHP	21.47
DHMP	30.34
Kaiser	43.82
RMHP	26.74
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>40.86</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>41.99</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>36.04</b>
<b>ED Visits—Ages 1 to 9 Years*</b>	
COA	28.69
FHP	17.98
DHMP	25.56
Kaiser	20.45
RMHP	18.44
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>25.62</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>23.71</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>21.90</b>
<b>ED Visits—Ages 10 to 19 Years*</b>	
COA	24.32
FHP	16.55
DHMP	17.75
Kaiser	17.26
RMHP	18.00
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>21.51</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>19.11</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>19.03</b>
<b>ED Visits—Total*</b>	
COA	26.90
FHP	17.33
DHMP	21.49
Kaiser	18.86
RMHP	18.38

CHP+ Plan	Rate
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>23.83</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>21.80</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>20.84</b>
<i>Outpatient Visits—Age &lt;1 Year</i>	
COA	590.52
FHP	435.58
DHMP	404.55
Kaiser	363.88
RMHP	581.55
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>562.23</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>550.58</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>567.40</b>
<i>Outpatient Visits—Ages 1 to 9 Years</i>	
COA	226.03
FHP	170.35
DHMP	137.62
Kaiser	147.18
RMHP	214.09
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>204.79</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>208.40</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>212.96</b>
<i>Outpatient Visits—Ages 10 to 19 Years</i>	
COA	196.38
FHP	155.79
DHMP	129.04
Kaiser	119.78
RMHP	195.10
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>176.04</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>177.18</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>181.34</b>
<i>Outpatient Visits—Total</i>	
COA	218.12
FHP	166.81
DHMP	135.56
Kaiser	133.57
RMHP	211.60
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>195.91</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>199.00</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>205.26</b>

CHP+ Plan	Rate
<b><i>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></i></b>	
<b><i>Discharges per 1,000 Member Months (Total Inpatient)—Age &lt;1 Year</i></b>	
COA	4.16
FHP	0.00
DHMP	5.06
Kaiser	1.33
RMHP	2.23
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.73</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.13</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>3.41</b>
<b><i>Discharges per 1,000 Member Months (Total Inpatient)—Ages 1 to 9 Years</i></b>	
COA	1.00
FHP	9.20
DHMP	0.89
Kaiser	0.47
RMHP	0.55
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.86</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.86</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.86</b>
<b><i>Discharges per 1,000 Member Months (Total Inpatient)—Ages 10 to 19 Years</i></b>	
COA	0.96
FHP	0.50
DHMP	0.68
Kaiser	0.51
RMHP	0.90
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.84</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.82</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.77</b>
<b><i>Discharges per 1,000 Member Months (Total Inpatient)—Total</i></b>	
COA	1.03
FHP	0.37
DHMP	0.82
Kaiser	0.49
RMHP	0.75
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.88</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.88</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.87</b>

CHP+ Plan	Rate
<b><i>Days per 1,000 Member Months (Total Inpatient)—Age &lt;1 Year</i></b>	
COA	18.20
FHP	0.00
DHMP	7.59
Kaiser	1.33
RMHP	4.90
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>14.40</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>13.21</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>10.08</b>
<b><i>Days per 1,000 Member Months (Total Inpatient)—Ages 1 to 9 Years</i></b>	
COA	3.25
FHP	27.61
DHMP	2.34
Kaiser	1.05
RMHP	3.29
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>2.88</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.04</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.54</b>
<b><i>Days per 1,000 Member Months (Total Inpatient)—Ages 10 to 19 Years</i></b>	
COA	3.35
FHP	1.00
DHMP	2.60
Kaiser	2.46
RMHP	3.17
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.05</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.25</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>3.14</b>
<b><i>Days per 1,000 Member Months (Total Inpatient)—Total</i></b>	
COA	3.55
FHP	0.87
DHMP	2.52
Kaiser	1.81
RMHP	3.26
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.09</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.31</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.97</b>

CHP+ Plan	Rate
<i>Average Length of Stay (Total Inpatient)—Age &lt;1 Year</i>	
COA	4.38
FHP	NA
DHMP	1.50†
Kaiser	1.00†
RMHP	2.20†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.86</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>4.23</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.96</b>
<i>Average Length of Stay (Total Inpatient)—Ages 1 to 9 Years</i>	
COA	3.26
FHP	3.00†
DHMP	2.62
Kaiser	2.26
RMHP	6.00
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.36</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.55</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.94</b>
<i>Average Length of Stay (Total Inpatient)—Ages 10 to 19 Years</i>	
COA	3.48
FHP	2.00†
DHMP	3.83†
Kaiser	4.83
RMHP	3.52
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.62</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.96</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>4.10</b>
<i>Average Length of Stay (Total Inpatient)—Total</i>	
COA	3.43
FHP	2.33†
DHMP	3.07
Kaiser	3.67
RMHP	4.37
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.51</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.77</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>3.42</b>

CHP+ Plan	Rate
<i>Discharges per 1,000 Member Months (Medicine)—Age &lt;1 Year</i>	
COA	3.22
FHP	0.00
DHMP	5.06
Kaiser	1.33
RMHP	1.78
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>2.98</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>2.49</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.39</b>
<i>Discharges per 1,000 Member Months (Medicine)—Ages 1 to 9 Years</i>	
COA	0.83
FHP	3.07
DHMP	0.76
Kaiser	0.41
RMHP	0.36
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.70</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.67</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.69</b>
<i>Discharges per 1,000 Member Months (Medicine)—Ages 10 to 19 Years</i>	
COA	0.55
FHP	0.33
DHMP	0.37
Kaiser	0.40
RMHP	0.58
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.51</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.47</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.43</b>
<i>Discharges per 1,000 Member Months (Medicine)—Total</i>	
COA	0.74
FHP	0.21
DHMP	0.60
Kaiser	0.40
RMHP	0.49
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.63</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.60</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.60</b>

CHP+ Plan	Rate
<b><i>Days per 1,000 Member Months (Medicine)—Age &lt;1 Year</i></b>	
COA	12.79
FHP	0.00
DHMP	7.59
Kaiser	1.33
RMHP	4.46
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>10.44</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>9.24</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>6.53</b>
<b><i>Days per 1,000 Member Months (Medicine)—Ages 1 to 9 Years</i></b>	
COA	2.30
FHP	9.20
DHMP	1.97
Kaiser	0.80
RMHP	1.08
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>1.89</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>1.91</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>1.83</b>
<b><i>Days per 1,000 Member Months (Medicine)—Ages 10 to 19 Years</i></b>	
COA	1.69
FHP	0.59
DHMP	1.08
Kaiser	1.03
RMHP	2.07
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>1.55</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>1.38</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>1.34</b>
<b><i>Days per 1,000 Member Months (Medicine)—Total</i></b>	
COA	2.19
FHP	0.42
DHMP	1.56
Kaiser	0.93
RMHP	1.61
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>1.82</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>1.78</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>1.69</b>

CHP+ Plan	Rate
<b><i>Average Length of Stay (Medicine)—Age &lt;1 Year</i></b>	
COA	3.97
FHP	NA
DHMP	1.50†
Kaiser	1.00†
RMHP	2.50†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.50</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.71</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.73</b>
<b><i>Average Length of Stay (Medicine)—Ages 1 to 9 Years</i></b>	
COA	2.79
FHP	3.00†
DHMP	2.59†
Kaiser	1.96†
RMHP	3.00†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>2.71</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>2.86</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.66</b>
<b><i>Average Length of Stay (Medicine)—Ages 10 to 19 Years</i></b>	
COA	3.06
FHP	1.75†
DHMP	2.88†
Kaiser	2.61
RMHP	3.54
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.04</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>2.97</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>3.14</b>
<b><i>Average Length of Stay (Medicine)—Total</i></b>	
COA	2.97
FHP	2.00†
DHMP	2.59
Kaiser	2.29
RMHP	3.27
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>2.89</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>2.96</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.82</b>



CHP+ Plan	Rate
<b>Discharges per 1,000 Member Months (Surgery)—Age &lt;1 Year</b>	
COA	0.94
FHP	0.00
DHMP	0.00
Kaiser	0.00
RMHP	0.45
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.75</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.64</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>1.02</b>
<b>Discharges per 1,000 Member Months (Surgery)—Ages 1 to 9 Years</b>	
COA	0.17
FHP	6.13
DHMP	0.13
Kaiser	0.06
RMHP	0.19
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.16</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.19</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.18</b>
<b>Discharges per 1,000 Member Months (Surgery)—Ages 10 to 19 Years</b>	
COA	0.32
FHP	0.17
DHMP	0.21
Kaiser	0.10
RMHP	0.22
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.26</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.28</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.28</b>
<b>Discharges per 1,000 Member Months (Surgery)—Total</b>	
COA	0.25
FHP	0.17
DHMP	0.17
Kaiser	0.08
RMHP	0.21
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.21</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.24</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.24</b>

CHP+ Plan	Rate
<b><i>Days per 1,000 Member Months (Surgery)—Age &lt;1 Year</i></b>	
COA	5.41
FHP	0.00
DHMP	0.00
Kaiser	0.00
RMHP	0.45
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>3.95</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>3.98</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>3.55</b>
<b><i>Days per 1,000 Member Months (Surgery)—Ages 1 to 9 Years</i></b>	
COA	0.95
FHP	18.40
DHMP	0.37
Kaiser	0.26
RMHP	2.21
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.99</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>1.13</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.71</b>
<b><i>Days per 1,000 Member Months (Surgery)—Ages 10 to 19 Years</i></b>	
COA	1.42
FHP	0.00
DHMP	1.33
Kaiser	1.39
RMHP	0.87
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>1.30</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>1.66</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>1.64</b>
<b><i>Days per 1,000 Member Months (Surgery)—Total</i></b>	
COA	1.25
FHP	0.25
DHMP	0.87
Kaiser	0.86
RMHP	1.54
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>1.17</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>1.43</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>1.20</b>

CHP+ Plan	Rate
<b><i>Average Length of Stay (Surgery)—Age &lt;1 Year</i></b>	
COA	5.78†
FHP	NA
DHMP	NA
Kaiser	NA
RMHP	1.00†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>5.30†</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>6.22</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>3.50</b>
<b><i>Average Length of Stay (Surgery)—Ages 1 to 9 Years</i></b>	
COA	5.54
FHP	3.00†
DHMP	2.80†
Kaiser	4.25†
RMHP	11.75†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>6.23</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>6.00</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>4.03</b>
<b><i>Average Length of Stay (Surgery)—Ages 10 to 19 Years</i></b>	
COA	4.44
FHP	0.00†
DHMP	6.33†
Kaiser	13.63†
RMHP	4.00†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>5.08</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>5.81</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>5.85</b>
<b><i>Average Length of Stay (Surgery)—Total</i></b>	
COA	4.90
FHP	1.50†
DHMP	5.07†
Kaiser	10.50†
RMHP	7.46†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>5.50</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>5.90</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>4.97</b>

CHP+ Plan	Rate
<i>Discharges per 1,000 Member Months (Maternity)—Ages 10 to 19 Years</i>	
COA	0.09
FHP	0.00
DHMP	0.09
Kaiser	0.01
RMHP	0.10
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.08</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.07</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.06</b>
<i>Discharges per 1,000 Member Months (Maternity)—Total</i>	
COA	0.09
FHP	0.00
DHMP	0.09
Kaiser	0.01
RMHP	0.10
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.07</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.07</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.06</b>
<i>Days per 1,000 Member Months (Maternity)—Ages 10 to 19 Years</i>	
COA	0.23
FHP	0.00
DHMP	0.19
Kaiser	0.04
RMHP	0.23
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.19</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.21</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.16</b>
<i>Days per 1,000 Member Months (Maternity)—Total</i>	
COA	0.23
FHP	0.00
DHMP	0.19
Kaiser	0.04
RMHP	0.23
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.18</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.21</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.16</b>

CHP+ Plan	Rate
<b><i>Average Length of Stay (Maternity)—Ages 10 to 19 Years</i></b>	
COA	2.58†
FHP	NA
DHMP	2.00†
Kaiser	3.00†
RMHP	2.33†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>2.49</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>2.97</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.68</b>
<b><i>Average Length of Stay (Maternity)—Total</i></b>	
COA	2.58†
FHP	NA
DHMP	2.00†
Kaiser	3.00†
RMHP	2.33†
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>2.49</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>2.97</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>2.68†</b>
<b><i>Antibiotic Utilization*</i></b>	
<b><i>Average Scripts PMPY for Antibiotics—Ages 0 to 9 Years</i></b>	
COA	0.39
FHP	12.00
DHMP	0.16
Kaiser	0.21
RMHP	0.44
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.36</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.41</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.44</b>
<b><i>Average Scripts PMPY for Antibiotics—Ages 10 to 17 Years</i></b>	
COA	0.29
FHP	12.00
DHMP	0.11
Kaiser	0.16
RMHP	0.33
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.27</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.30</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.34</b>

CHP+ Plan	Rate
<i>Average Scripts PMPY for Antibiotics—Ages 18 to 34 Years</i>	
COA	0.40
FHP	12.00
DHMP	0.14
Kaiser	0.29
RMHP	0.49
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.37</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.44</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.38</b>
<i>Average Scripts PMPY for Antibiotics—Total</i>	
COA	0.35
FHP	12.00
DHMP	0.14
Kaiser	0.19
RMHP	0.39
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.33</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.38</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.40</b>
<i>Average Days Supplied per Antibiotic Script—Ages 0 to 9 Years</i>	
COA	9.89
FHP	89.62
DHMP	9.83
Kaiser	10.55
RMHP	9.64
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>12.64</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>10.15</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>9.98</b>
<i>Average Days Supplied per Antibiotic Script—Ages 10 to 17 Years</i>	
COA	12.34
FHP	115.10
DHMP	13.01
Kaiser	14.90
RMHP	10.81
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>15.93</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>12.64</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>12.73</b>

CHP+ Plan	Rate
<i>Average Days Supplied per Antibiotic Script—Ages 18 to 34 Years</i>	
COA	12.00
FHP	109.39
DHMP	14.15
Kaiser	13.85
RMHP	12.17
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>15.71</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>12.29</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>11.81</b>
<i>Average Days Supplied per Antibiotic Script—Total</i>	
COA	10.87
FHP	99.95
DHMP	11.28
Kaiser	12.47
RMHP	10.20
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>16.86</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>11.36</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>11.06</b>
<i>Average Scripts PMPY for Antibiotics of Concern—Ages 0 to 9 Years</i>	
COA	0.13
FHP	4.76
DHMP	0.04
Kaiser	0.04
RMHP	0.15
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.12</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.13</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.15</b>
<i>Average Scripts PMPY for Antibiotics of Concern—Ages 10 to 17 Years</i>	
COA	0.10
FHP	4.61
DHMP	0.02
Kaiser	0.04
RMHP	0.13
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.09</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.10</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.12</b>

CHP+ Plan	Rate
<i>Average Scripts PMPY for Antibiotics of Concern—Ages 18 to 34 Years</i>	
COA	0.14
FHP	3.43
DHMP	0.03
Kaiser	0.10
RMHP	0.17
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.13</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.14</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.13</b>
<i>Average Scripts PMPY for Antibiotics of Concern—Total</i>	
COA	0.12
FHP	2.32
DHMP	0.03
Kaiser	0.05
RMHP	0.14
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>0.11</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>0.12</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>0.13</b>
<i>Percentage of Antibiotics of Concern of All Antibiotic Scripts—Ages 0 to 9 Years</i>	
COA	33.49%
FHP	39.68%
DHMP	25.19%
Kaiser	21.27%
RMHP	33.74%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>32.39%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>32.85%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>34.28%</b>
<i>Percentage of Antibiotics of Concern of All Antibiotic Scripts—Ages 10 to 17 Years</i>	
COA	33.92%
FHP	38.39%
DHMP	22.12%
Kaiser	25.66%
RMHP	39.96%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>33.82%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>32.37%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>33.44%</b>



CHP+ Plan	Rate
<b>Percentage of Antibiotics of Concern of All Antibiotic Scripts—Ages 18 to 34 Years</b>	
COA	34.70%
FHP	28.57%
DHMP	24.62%
Kaiser	35.92%
RMHP	34.18%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>34.12%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>33.11%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>34.53%</b>
<b>Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total</b>	
COA	33.71%
FHP	19.35%
DHMP	24.04%
Kaiser	24.21%
RMHP	35.98%
<b>HEDIS 2019 Colorado CHP+ Weighted Average</b>	<b>31.91%</b>
<b>HEDIS 2018 Colorado CHP+ Weighted Average</b>	<b>33.02%</b>
<b>HEDIS 2017 Colorado CHP+ Weighted Average</b>	<b>33.99%</b>

\* For this indicator, a lower rate indicates better performance.

† Indicates that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

**Bold font indicates Colorado CHP+ weighted average values.**

## Appendix B. Trend Tables

Appendix B includes trend tables for the MCOs and the Colorado CHP+ weighted averages. Where applicable, measure rates for HEDIS 2017, 2018, and 2019 are presented.

HEDIS 2018 to 2019 performance comparisons are based on the Chi-square test of statistical significance with a  $p$  value  $<0.05$ . Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

### COA Trend Table

Table B-1—COA Trend Table

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>				
<b><i>Childhood Immunization Status<sup>1</sup></i></b>				
<i>DTaP</i>	73.84%	69.69%	75.83%^	25th–49th
<i>IPV</i>	84.54%	81.52%	86.44%^	10th–24th
<i>MMR</i>	85.20%	82.26%	86.44%^	10th–24th
<i>HiB</i>	83.75%	82.26%	87.03%^	25th–49th
<i>Hepatitis B</i>	82.30%	80.15%	85.61%^	10th–24th
<i>VZV</i>	81.51%	79.51%	84.32%^	10th–24th
<i>Pneumococcal Conjugate</i>	76.09%	72.65%	78.07%^	25th–49th
<i>Hepatitis A</i>	76.49%	76.24%	80.66%^	10th–24th
<i>Rotavirus</i>	71.20%	68.74%	76.18%^	75th–89th
<i>Influenza</i>	47.56%	49.84%	57.08%^	75th–89th
<i>Combination 2</i>	65.92%	62.30%	71.58%^	25th–49th
<i>Combination 3</i>	63.67%	60.82%	69.58%^	25th–49th
<i>Combination 4</i>	59.71%	58.71%	66.86%^	25th–49th
<i>Combination 5</i>	56.67%	53.96%	63.21%^	50th–74th
<i>Combination 6</i>	38.97%	41.29%	49.53%^	75th–89th
<i>Combination 7</i>	53.76%	52.38%	61.32%^	50th–74th
<i>Combination 8</i>	37.12%	39.92%	48.23%^	75th–89th
<i>Combination 9</i>	35.80%	37.59%	45.64%^	75th–89th
<i>Combination 10</i>	34.35%	36.54%	44.58%^	75th–89th
<b><i>Immunizations for Adolescents</i></b>				
<i>Meningococcal</i>	72.00%	72.28%	78.09%^	25th–49th
<i>Tdap</i>	84.91%	83.26%	87.54%^	25th–49th
<i>HPV</i>	—	34.54%	41.17%^	75th–89th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Combination 1 (Meningococcal, Tdap)</i>	70.39%	70.24%	76.30%^	25th–49th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	31.71%	38.90%^	75th–89th
<b>Well-Child Visits in the First 15 Months of Life</b>				
<i>Zero Visits*</i>	2.17%	1.36%	6.36%^^	<10th
<i>Six or More Visits</i>	61.96%	59.86%	47.27%^^	<10th
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	69.48%	69.32%	68.50%	25th–49th
<b>Adolescent Well-Care Visits</b>				
<i>Adolescent Well-Care Visits</i>	48.88%	48.34%	49.87%	25th–49th
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
<i>BMI Percentile Documentation—Ages 3 to 11 Years<sup>1</sup></i>	2.81%	4.25%	7.47%^	<10th
<i>BMI Percentile Documentation—Ages 12 to 17 Years<sup>1</sup></i>	5.61%	6.97%	12.36%^	<10th
<i>BMI Percentile Documentation—Total<sup>1</sup></i>	3.85%	5.25%	9.27%^	<10th
<i>Counseling for Nutrition—Ages 3 to 11 Years</i>	1.81%	2.33%	4.39%	<10th
<i>Counseling for Nutrition—Ages 12 to 17 Years</i>	2.54%	3.98%	6.35%	<10th
<i>Counseling for Nutrition—Total</i>	2.08%	2.94%	5.11%	<10th
<i>Counseling for Physical Activity—Ages 3 to 11 Years</i>	0.09%	0.23%	1.98%	<10th
<i>Counseling for Physical Activity—Ages 12 to 17 Years</i>	1.95%	2.49%	5.13%	<10th
<i>Counseling for Physical Activity—Total</i>	0.78%	1.06%	3.14%	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
<i>Appropriate Testing for Children With Pharyngitis</i>	84.93%	88.07%	84.60%^^	50th–74th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
<i>Ages 12 to 24 Months</i>	91.23%	94.65%	90.30%^^	<10th
<i>Ages 25 Months to 6 Years</i>	86.24%	85.90%	84.52%	25th–49th
<i>Ages 7 to 11 Years</i>	91.63%	89.74%	87.98%	25th–49th
<i>Ages 12 to 19 Years</i>	92.18%	90.90%	87.78%^^	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
<i>Ages 16 to 20 Years</i>	32.72%	32.11%	32.27%	<10th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	0.24%	0.06%	0.08%	≥90th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
Initiation Phase	0.00%	0.00%	0.00%	<10th
Continuation and Maintenance Phase	0.00%	0.00%	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
Ages 1 to 5 Years	—	NA	NA	—
Ages 6 to 11 Years	—	NA	NA	—
Ages 12 to 17 Years	—	27.85%	28.33%	25th–49th
Total	—	29.59%	30.49%	25th–49th
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents<sup>*1</sup></b>				
Ages 1 to 5 Years	NA	NA	NA	—
Ages 6 to 11 Years	NA	NA	NA	—
Ages 12 to 17 Years	4.92%	8.47%	4.55%	10th–24th
Total	4.05%	6.67%	3.23%	25th–49th
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
Appropriate Treatment for Children With Upper Respiratory Infection	89.63%	92.12%	93.25%	50th–74th
<b>Medication Management for People With Asthma</b>				
Medication Compliance 50%—Ages 5 to 11 Years	51.18%	65.41%	58.41%	50th–74th
Medication Compliance 50%—Ages 12 to 18 Years	48.31%	55.77%	50.00%	25th–49th
Medication Compliance 50%—Total	50.00%	61.18%	54.68%	10th–24th
Medication Compliance 75%—Ages 5 to 11 Years	27.56%	34.59%	36.28%	75th–89th
Medication Compliance 75%—Ages 12 to 18 Years	26.97%	27.88%	23.33%	25th–49th
Medication Compliance 75%—Total	27.31%	31.65%	30.54%	25th–49th
<b>Asthma Medication Ratio</b>				
Ages 5 to 11 Years	87.50%	80.58%	83.19%	≥90th
Ages 12 to 18 Years	74.74%	72.07%	75.79%	≥90th
Total	81.70%	76.80%	79.91%	≥90th
<b>Use of Services†</b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
ED Visits*	26.48	26.36	26.90	≥90th
Outpatient Visits	224.38	221.11	218.12	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
Discharges per 1,000 Member Months (Total Inpatient)	0.96	0.99	1.03	<10th
Days per 1,000 Member Months (Total Inpatient)	3.51	3.70	3.55	<10th
Average Length of Stay (Total Inpatient)	3.64	3.74	3.43	<10th
Discharges per 1,000 Member Months (Medicine)	0.66	0.67	0.74	<10th
Days per 1,000 Member Months (Medicine)	1.91	1.91	2.19	<10th
Average Length of Stay (Medicine)	2.88	2.85	2.97	<10th
Discharges per 1,000 Member Months (Surgery)	0.26	0.28	0.25	<10th
Days per 1,000 Member Months (Surgery)	1.49	1.67	1.25	<10th
Average Length of Stay (Surgery)	5.79	6.00	4.90	<10th
Discharges per 1,000 Member Months (Maternity)	0.09	0.09	0.09	<10th
Days per 1,000 Member Months (Maternity)	0.22	0.28	0.23	<10th
Average Length of Stay (Maternity)	2.41†	3.05†	2.58†	<10th
<b>Antibiotic Utilization*</b>				
Average Scripts PMPY for Antibiotics	0.46	0.42	0.35	≥90th
Average Days Supplied per Antibiotic Script	10.94	10.88	10.87	<10th
Average Scripts PMPY for Antibiotics of Concern	0.16	0.14	0.12	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.77%	34.12%	33.71%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that NCQA recommended a break in trending; therefore, prior years' rates are not displayed. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2017.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

## DHMP Trend Table

Table B-2—DHMP Trend Table

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Pediatric Care</b>				
<b>Childhood Immunization Status<sup>1</sup></b>				
<i>DTaP</i>	75.00%	BR	69.84%	10th–24th
<i>IPV</i>	80.17%	BR	75.40%	<10th
<i>MMR</i>	84.48%	BR	78.57%	<10th
<i>HiB</i>	80.17%	BR	74.60%	<10th
<i>Hepatitis B</i>	79.31%	BR	73.81%	<10th
<i>VZV</i>	83.62%	BR	78.57%	<10th
<i>Pneumococcal Conjugate</i>	77.59%	BR	69.05%	10th–24th
<i>Hepatitis A</i>	84.48%	BR	80.16%	10th–24th
<i>Rotavirus</i>	68.97%	BR	66.67%	10th–24th
<i>Influenza</i>	56.03%	BR	53.17%	50th–74th
<i>Combination 2</i>	73.28%	BR	67.46%	10th–24th
<i>Combination 3</i>	73.28%	BR	65.87%	25th–49th
<i>Combination 4</i>	73.28%	BR	65.87%	25th–49th
<i>Combination 5</i>	67.24%	BR	57.94%	25th–49th
<i>Combination 6</i>	53.45%	BR	46.03%	50th–74th
<i>Combination 7</i>	67.24%	BR	57.94%	25th–49th
<i>Combination 8</i>	53.45%	BR	46.03%	50th–74th
<i>Combination 9</i>	50.86%	BR	41.27%	50th–74th
<i>Combination 10</i>	50.86%	BR	41.27%	75th–89th
<b>Immunizations for Adolescents</b>				
<i>Meningococcal</i>	74.26%	71.56%	84.21%^	50th–74th
<i>Tdap</i>	72.79%	85.32%	85.53%	25th–49th
<i>HPV</i>	—	56.88%	57.24%	≥90th
<i>Combination 1 (Meningococcal, Tdap)</i>	72.06%	68.81%	82.24%^	50th–74th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	49.54%	55.92%	≥90th
<b>Well-Child Visits in the First 15 Months of Life</b>				
<i>Zero Visits*</i>	6.78%	NA	15.15%	<10th
<i>Six or More Visits</i>	6.78%	NA	63.64%	25th–49th
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	59.48%	46.64%	64.74%^	10th–24th
<b>Adolescent Well-Care Visits</b>				
<i>Adolescent Well-Care Visits</i>	41.37%	37.64%	45.30%^	10th–24th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
BMI Percentile Documentation—Ages 3 to 11 Years <sup>1</sup>	5.40%	11.76%	14.27%	<10th
BMI Percentile Documentation—Ages 12 to 17 Years <sup>1</sup>	11.87%	26.76%	33.15%^	<10th
BMI Percentile Documentation—Total <sup>1</sup>	7.94%	17.71%	21.80%^	<10th
Counseling for Nutrition—Ages 3 to 11 Years	0.36%	1.45%	2.14%	<10th
Counseling for Nutrition—Ages 12 to 17 Years	3.15%	13.97%	16.67%	<10th
Counseling for Nutrition—Total	1.46%	6.41%	7.93%	<10th
Counseling for Physical Activity—Ages 3 to 11 Years	0.00%	0.39%	1.66%	<10th
Counseling for Physical Activity—Ages 12 to 17 Years	2.04%	2.94%	14.16%^	<10th
Counseling for Physical Activity—Total	0.80%	1.40%	6.65%^	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
Appropriate Testing for Children With Pharyngitis	83.87%	NA	83.33%	50th–74th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
Ages 12 to 24 Months	93.98%	69.03%	90.36%^	<10th
Ages 25 Months to 6 Years	71.52%	57.24%	73.58%^	<10th
Ages 7 to 11 Years	85.65%	81.33%	86.93%^	10th–24th
Ages 12 to 19 Years	85.48%	78.05%	82.04%	10th–24th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
Ages 16 to 20 Years	56.06%	39.74%	47.22%	25th–49th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.00%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
Ages 1 to 5 Years	—	NA	NA	—
Ages 6 to 11 Years	—	NA	NA	—
Ages 12 to 17 Years	—	NA	NA	—



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Total</i>	—	NA	NA	—
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</b>				
<i>Ages 1 to 5 Years</i>	NA	NA	NA	—
<i>Ages 6 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 17 Years</i>	NA	NA	NA	—
<i>Total</i>	NA	NA	NA	—
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	91.40%	100.00%	100.00%	≥90th
<b>Medication Management for People With Asthma</b>				
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Total</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Total</i>	NA	NA	NA	—
<b>Asthma Medication Ratio</b>				
<i>Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Total</i>	NA	NA	NA	—
<b>Use of Services†</b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
<i>ED Visits*</i>	18.09	18.43	21.49	≥90th
<i>Outpatient Visits</i>	117.49	123.51	135.56	<10th
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
<i>Discharges per 1,000 Member Months (Total Inpatient)</i>	0.88	0.69	0.82	<10th
<i>Days per 1,000 Member Months (Total Inpatient)</i>	2.47	2.91	2.52	<10th
<i>Average Length of Stay (Total Inpatient)</i>	2.80	4.25	3.07	<10th
<i>Discharges per 1,000 Member Months (Medicine)</i>	0.65	0.49	0.60	<10th
<i>Days per 1,000 Member Months (Medicine)</i>	1.75	1.43	1.56	<10th
<i>Average Length of Stay (Medicine)</i>	2.68	2.90	2.59	<10th
<i>Discharges per 1,000 Member Months (Surgery)</i>	0.21	0.18	0.17	<10th
<i>Days per 1,000 Member Months (Surgery)</i>	0.62	1.46	0.87	<10th
<i>Average Length of Stay (Surgery)</i>	2.92†	8.07†	5.07†	<10th
<i>Discharges per 1,000 Member Months (Maternity)</i>	0.03	0.02	0.09	<10th
<i>Days per 1,000 Member Months (Maternity)</i>	0.20	0.05	0.19	<10th
<i>Average Length of Stay (Maternity)</i>	6.00†	2.00†	2.00†	<10th



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Antibiotic Utilization*</b>				
<i>Average Scripts PMPY for Antibiotics</i>	0.13	0.09	0.14	≥90th
<i>Average Days Supplied per Antibiotic Script</i>	10.47	12.07	11.28	<10th
<i>Average Scripts PMPY for Antibiotics of Concern</i>	0.03	0.02	0.03	≥90th
<i>Percentage of Antibiotics of Concern of All Antibiotic Scripts</i>	26.07%	23.31%	24.04%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that NCQA recommended a break in trending; therefore, prior years' rates are not displayed. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2017.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

BR (Biased Rate) indicates that the reported rate was invalid; therefore, the rate is not presented.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

## FHP Trend Table

Table B-3—FHP Trend Table

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Pediatric Care</b>				
<b>Childhood Immunization Status<sup>1</sup></b>				
<i>DTaP</i>	6.12%	9.80%	7.14%	<10th
<i>IPV</i>	12.24%	15.69%	7.14%	<10th
<i>MMR</i>	57.14%	54.90%	40.48%	<10th
<i>HiB</i>	20.41%	17.65%	9.52%	<10th
<i>Hepatitis B</i>	10.20%	13.73%	7.14%	<10th
<i>VZV</i>	53.06%	52.94%	38.10%	<10th
<i>Pneumococcal Conjugate</i>	8.16%	9.80%	7.14%	<10th
<i>Hepatitis A</i>	48.98%	49.02%	52.38%	<10th
<i>Rotavirus</i>	2.04%	1.96%	4.76%	<10th
<i>Influenza</i>	14.29%	17.65%	11.90%	<10th
<i>Combination 2</i>	4.08%	7.84%	4.76%	<10th
<i>Combination 3</i>	4.08%	5.88%	4.76%	<10th
<i>Combination 4</i>	2.04%	3.92%	4.76%	<10th
<i>Combination 5</i>	0.00%	0.00%	4.76%	<10th
<i>Combination 6</i>	2.04%	3.92%	0.00%	<10th
<i>Combination 7</i>	0.00%	0.00%	4.76%	<10th
<i>Combination 8</i>	0.00%	1.96%	0.00%	<10th
<i>Combination 9</i>	0.00%	0.00%	0.00%	<10th
<i>Combination 10</i>	0.00%	0.00%	0.00%	<10th
<b>Immunizations for Adolescents</b>				
<i>Meningococcal</i>	22.22%	15.94%	31.58%^	<10th
<i>Tdap</i>	33.33%	36.23%	56.14%^	<10th
<i>HPV</i>	—	8.70%	14.04%	<10th
<i>Combination 1 (Meningococcal, Tdap)</i>	14.81%	15.94%	26.32%	<10th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	5.80%	12.28%	<10th
<b>Well-Child Visits in the First 15 Months of Life</b>				
<i>Zero Visits*</i>	NA	NA	NA	—
<i>Six or More Visits</i>	NA	NA	NA	—
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	42.18%	43.72%	55.62%^	<10th
<b>Adolescent Well-Care Visits</b>				
<i>Adolescent Well-Care Visits</i>	28.92%	25.05%	37.65%^	10th–24th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
BMI Percentile Documentation—Ages 3 to 11 Years <sup>1</sup>	1.61%	2.29%	12.15%^	<10th
BMI Percentile Documentation—Ages 12 to 17 Years <sup>1</sup>	1.40%	0.83%	6.28%^	<10th
BMI Percentile Documentation—Total <sup>1</sup>	1.53%	1.69%	9.70%^	<10th
Counseling for Nutrition—Ages 3 to 11 Years	3.87%	6.30%	4.17%	<10th
Counseling for Nutrition—Ages 12 to 17 Years	2.80%	5.37%	5.31%	<10th
Counseling for Nutrition—Total	3.44%	5.92%	4.65%	<10th
Counseling for Physical Activity—Ages 3 to 11 Years	0.65%	0.57%	0.00%	<10th
Counseling for Physical Activity—Ages 12 to 17 Years	8.88%	7.44%	14.98%^	<10th
Counseling for Physical Activity—Total	4.01%	3.38%	6.26%	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
Appropriate Testing for Children With Pharyngitis	74.07%	77.55%	81.16%	50th–74th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
Ages 12 to 24 Months	79.41%	NA	NA	—
Ages 25 Months to 6 Years	65.12%	65.33%	71.90%	<10th
Ages 7 to 11 Years	72.61%	73.58%	87.18%^	10th–24th
Ages 12 to 19 Years	76.50%	80.49%	86.43%	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
Ages 16 to 20 Years	NA	13.95%	NA	—
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.00%	0.00%	0.00%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
Initiation Phase	NA	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
Ages 1 to 5 Years	—	NA	NA	—
Ages 6 to 11 Years	—	NA	NA	—
Ages 12 to 17 Years	—	NA	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Total</i>	—	NA	NA	—
<b><i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</i></b>				
<i>Ages 1 to 5 Years</i>	NA	NA	NA	—
<i>Ages 6 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 17 Years</i>	NA	NA	NA	—
<i>Total</i>	NA	NA	NA	—
<b><i>Respiratory Conditions</i></b>				
<b><i>Appropriate Treatment for Children With Upper Respiratory Infection</i></b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	83.72%	87.72%	92.63%	50th–74th
<b><i>Medication Management for People With Asthma</i></b>				
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Total</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Total</i>	NA	NA	NA	—
<b><i>Asthma Medication Ratio</i></b>				
<i>Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Total</i>	NA	NA	NA	—
<b><i>Use of Services†</i></b>				
<b><i>Ambulatory Care (Per 1,000 Member Months)</i></b>				
<i>ED Visits*</i>	15.26	15.98	17.33	≥90th
<i>Outpatient Visits</i>	176.00	175.38	166.81	<10th
<b><i>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></i></b>				
<i>Discharges per 1,000 Member Months (Total Inpatient)</i>	0.81	0.65	0.37	<10th
<i>Days per 1,000 Member Months (Total Inpatient)</i>	2.06	1.38	0.87	<10th
<i>Average Length of Stay (Total Inpatient)</i>	2.56†	2.13†	2.33†	<10th
<i>Discharges per 1,000 Member Months (Medicine)</i>	0.54	0.45	0.21	<10th
<i>Days per 1,000 Member Months (Medicine)</i>	1.21	1.06	0.42	<10th
<i>Average Length of Stay (Medicine)</i>	2.25†	2.36†	2.00†	<10th
<i>Discharges per 1,000 Member Months (Surgery)</i>	0.27	0.16	0.17	<10th
<i>Days per 1,000 Member Months (Surgery)</i>	0.85	0.24	0.25	<10th
<i>Average Length of Stay (Surgery)</i>	3.17†	1.50†	1.50†	<10th
<i>Discharges per 1,000 Member Months (Maternity)</i>	NA	0.08	0.00	<10th
<i>Days per 1,000 Member Months (Maternity)</i>	NA	0.16	0.00	<10th
<i>Average Length of Stay (Maternity)</i>	NA	2.00†	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Antibiotic Utilization*</b>				
<i>Average Scripts PMPY for Antibiotics</i>	0.50	0.97	12.00	<10th
<i>Average Days Supplied per Antibiotic Script</i>	12.39	16.68	99.95	<10th
<i>Average Scripts PMPY for Antibiotics of Concern</i>	0.20	0.41	2.32	<10th
<i>Percentage of Antibiotics of Concern of All Antibiotic Scripts</i>	39.01%	41.62%	19.35%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that NCQA recommended a break in trending; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2017.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

## Kaiser Trend Table

Table B-4—Kaiser Trend Table

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Pediatric Care</b>				
<b>Childhood Immunization Status<sup>1</sup></b>				
DTaP	82.23%	73.90%	71.13%	10th–24th
IPV	88.43%	84.75%	87.03%	25th–49th
MMR	88.02%	83.05%	81.17%	<10th
HiB	89.67%	85.42%	87.87%	25th–49th
Hepatitis B	88.84%	83.39%	88.70%	25th–49th
VZV	87.19%	81.69%	81.59%	<10th
Pneumococcal Conjugate	85.12%	78.64%	77.82%	25th–49th
Hepatitis A	87.60%	81.36%	81.17%	10th–24th
Rotavirus	78.10%	68.14%	76.57%^	75th–89th
Influenza	53.72%	47.80%	48.95%	50th–74th
Combination 2	79.34%	70.85%	69.46%	10th–24th
Combination 3	78.93%	70.17%	67.36%	25th–49th
Combination 4	78.93%	69.15%	66.95%	25th–49th
Combination 5	72.31%	62.03%	62.76%	50th–74th
Combination 6	50.41%	43.73%	41.84%	50th–74th
Combination 7	72.31%	61.02%	62.34%	50th–74th
Combination 8	50.41%	43.39%	41.84%	50th–74th
Combination 9	47.11%	39.32%	40.59%	50th–74th
Combination 10	47.11%	38.98%	40.59%	50th–74th
<b>Immunizations for Adolescents</b>				
Meningococcal	88.14%	84.96%	84.49%	50th–74th
Tdap	89.41%	87.02%	89.77%	50th–74th
HPV	—	56.05%	58.42%	≥90th
Combination 1 (Meningococcal, Tdap)	86.02%	82.30%	82.84%	50th–74th
Combination 2 (Meningococcal, Tdap, HPV)	—	53.98%	56.44%	≥90th
<b>Well-Child Visits in the First 15 Months of Life</b>				
Zero Visits*	2.53%	2.91%	2.02%	25th–49th
Six or More Visits	67.09%	66.02%	73.74%	75th–89th
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.99%	59.35%	65.44%^	10th–24th
<b>Adolescent Well-Care Visits</b>				
Adolescent Well-Care Visits	59.26%	41.18%	45.24%^	10th–24th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
BMI Percentile Documentation—Ages 3 to 11 Years <sup>1</sup>	94.43%	97.40%	98.82%	≥90th
BMI Percentile Documentation—Ages 12 to 17 Years <sup>1</sup>	93.60%	97.12%	98.18%	≥90th
BMI Percentile Documentation—Total <sup>1</sup>	94.10%	97.29%	98.57%	≥90th
Counseling for Nutrition—Ages 3 to 11 Years	97.00%	96.10%	96.57%	≥90th
Counseling for Nutrition—Ages 12 to 17 Years	97.44%	94.78%	95.59%	≥90th
Counseling for Nutrition—Total	97.18%	95.57%	96.18%	≥90th
Counseling for Physical Activity—Ages 3 to 11 Years	97.00%	96.10%	96.57%	≥90th
Counseling for Physical Activity—Ages 12 to 17 Years	97.44%	94.78%	95.59%	≥90th
Counseling for Physical Activity—Total	97.18%	95.57%	96.18%	≥90th
<b>Appropriate Testing for Children With Pharyngitis</b>				
Appropriate Testing for Children With Pharyngitis	96.58%	96.37%	94.20%	≥90th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
Ages 12 to 24 Months	87.43%	87.44%	97.22%^	75th–89th
Ages 25 Months to 6 Years	79.56%	75.76%	83.25%^	10th–24th
Ages 7 to 11 Years	87.93%	86.56%	86.81%	10th–24th
Ages 12 to 19 Years	87.81%	88.45%	88.26%	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
Ages 16 to 20 Years	48.46%	41.43%	45.51%	10th–24th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.27%	0.17%	0.00%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
Effective Acute Phase Treatment	NA	NA	NA	—
Effective Continuation Phase Treatment	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
Initiation Phase	NA	NA	45.16%	50th–74th
Continuation and Maintenance Phase	NA	NA	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
Ages 1 to 5 Years	—	NA	NA	—
Ages 6 to 11 Years	—	NA	NA	—
Ages 12 to 17 Years	—	NA	NA	—



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Total</i>	—	NA	NA	—
<b><i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</i></b>				
<i>Ages 1 to 5 Years</i>	NA	NA	NA	—
<i>Ages 6 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 17 Years</i>	NA	NA	NA	—
<i>Total</i>	NA	NA	NA	—
<b><i>Respiratory Conditions</i></b>				
<b><i>Appropriate Treatment for Children With Upper Respiratory Infection</i></b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	98.91%	99.01%	96.94%	≥90th
<b><i>Medication Management for People With Asthma</i></b>				
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	NA	46.67%	NA	—
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Total</i>	32.26%	46.34%	NA	—
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	NA	23.33%	NA	—
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Total</i>	12.90%	21.95%	NA	—
<b><i>Asthma Medication Ratio</i></b>				
<i>Ages 5 to 11 Years</i>	NA	93.33%	NA	—
<i>Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Total</i>	80.65%	90.48%	NA	—
<b><i>Use of Services†</i></b>				
<b><i>Ambulatory Care (Per 1,000 Member Months)</i></b>				
<i>ED Visits*</i>	2.98	11.54	18.86	≥90th
<i>Outpatient Visits</i>	179.23	151.08	133.57	<10th
<b><i>Inpatient Utilization—General Hospital/Acute Care<sup>‡</sup></i></b>				
<i>Discharges per 1,000 Member Months (Total Inpatient)</i>	0.64	0.62	0.49	<10th
<i>Days per 1,000 Member Months (Total Inpatient)</i>	2.13	2.17	1.81	<10th
<i>Average Length of Stay (Total Inpatient)</i>	3.35	3.51	3.67	10th–24th
<i>Discharges per 1,000 Member Months (Medicine)</i>	0.49	0.46	0.40	<10th
<i>Days per 1,000 Member Months (Medicine)</i>	1.48	1.52	0.93	<10th
<i>Average Length of Stay (Medicine)</i>	3.04	3.34	2.29	<10th
<i>Discharges per 1,000 Member Months (Surgery)</i>	0.15	0.12	0.08	<10th
<i>Days per 1,000 Member Months (Surgery)</i>	0.65	0.53	0.86	<10th
<i>Average Length of Stay (Surgery)</i>	4.36†	4.24†	10.50†	<10th
<i>Discharges per 1,000 Member Months (Maternity)</i>	0.00	0.07	0.01	<10th
<i>Days per 1,000 Member Months (Maternity)</i>	0.00	0.22	0.04	<10th
<i>Average Length of Stay (Maternity)</i>	NA	3.20†	3.00†	<10th



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Antibiotic Utilization*</b>				
<i>Average Scripts PMPY for Antibiotics</i>	0.28	0.26	0.19	≥90th
<i>Average Days Supplied per Antibiotic Script</i>	12.32	12.15	12.47	<10th
<i>Average Scripts PMPY for Antibiotics of Concern</i>	0.08	0.05	0.05	≥90th
<i>Percentage of Antibiotics of Concern of All Antibiotic Scripts</i>	28.27%	19.57%	24.21%	≥90th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that NCQA recommended a break in trending; therefore, prior years' rates are not displayed. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2017.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

## RMHP Trend Table

Table B-5—RMHP Trend Table

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Pediatric Care</b>				
<b>Childhood Immunization Status<sup>1</sup></b>				
<i>DTaP</i>	67.72%	72.80%	68.14%	10th–24th
<i>IPV</i>	76.38%	83.20%	84.07%	10th–24th
<i>MMR</i>	79.13%	85.60%	77.88%^^	<10th
<i>HiB</i>	78.35%	82.40%	76.99%	<10th
<i>Hepatitis B</i>	74.80%	81.60%	79.65%	<10th
<i>VZV</i>	79.53%	84.40%	80.97%	<10th
<i>Pneumococcal Conjugate</i>	68.50%	75.60%	74.34%	25th–49th
<i>Hepatitis A</i>	75.20%	81.20%	76.55%	<10th
<i>Rotavirus</i>	67.32%	69.60%	75.66%	75th–89th
<i>Influenza</i>	53.54%	50.80%	54.42%	50th–74th
<i>Combination 2</i>	58.27%	64.80%	57.08%	<10th
<i>Combination 3</i>	55.91%	62.40%	57.08%	<10th
<i>Combination 4</i>	54.33%	60.40%	54.42%	<10th
<i>Combination 5</i>	51.57%	54.40%	54.87%	10th–24th
<i>Combination 6</i>	43.31%	41.20%	41.15%	50th–74th
<i>Combination 7</i>	50.39%	53.20%	52.21%	10th–24th
<i>Combination 8</i>	42.13%	41.20%	39.38%	25th–49th
<i>Combination 9</i>	40.16%	36.40%	39.82%	50th–74th
<i>Combination 10</i>	39.37%	36.40%	38.05%	50th–74th
<b>Immunizations for Adolescents</b>				
<i>Meningococcal</i>	51.17%	62.88%	60.67%	<10th
<i>Tdap</i>	77.73%	82.94%	84.67%	25th–49th
<i>HPV</i>	—	17.06%	22.33%	<10th
<i>Combination 1 (Meningococcal, Tdap)</i>	49.61%	60.87%	57.67%	<10th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	13.71%	18.33%	<10th
<b>Well-Child Visits in the First 15 Months of Life</b>				
<i>Zero Visits*</i>	3.00%	5.00%	0.00%^	≥90th
<i>Six or More Visits</i>	23.00%	29.00%	15.79%^^	<10th
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	63.66%	68.75%	67.68%	25th–49th
<b>Adolescent Well-Care Visits</b>				
<i>Adolescent Well-Care Visits</i>	43.69%	47.07%	49.19%	25th–49th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
<i>BMI Percentile Documentation—Ages 3 to 11 Years<sup>1</sup></i>	3.30%	2.81%	3.38%	<10th
<i>BMI Percentile Documentation—Ages 12 to 17 Years<sup>1</sup></i>	6.64%	7.18%	7.35%	<10th
<i>BMI Percentile Documentation—Total<sup>1</sup></i>	4.44%	4.38%	4.83%	<10th
<i>Counseling for Nutrition—Ages 3 to 11 Years</i>	19.87%	22.32%	23.76%	<10th
<i>Counseling for Nutrition—Ages 12 to 17 Years</i>	17.43%	20.11%	21.67%	<10th
<i>Counseling for Nutrition—Total</i>	19.04%	21.52%	23.00%	<10th
<i>Counseling for Physical Activity—Ages 3 to 11 Years</i>	0.31%	2.04%	4.96%	<10th
<i>Counseling for Physical Activity—Ages 12 to 17 Years</i>	3.19%	6.12%	6.43%	<10th
<i>Counseling for Physical Activity—Total</i>	1.29%	3.51%	5.50%	<10th
<b>Appropriate Testing for Children With Pharyngitis</b>				
<i>Appropriate Testing for Children With Pharyngitis</i>	78.26%	80.27%	77.64%	25th–49th
<b>Access to Care</b>				
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
<i>Ages 12 to 24 Months</i>	91.26%	93.48%	94.68%	25th–49th
<i>Ages 25 Months to 6 Years</i>	82.13%	83.49%	82.81%	10th–24th
<i>Ages 7 to 11 Years</i>	86.72%	86.90%	88.00%	25th–49th
<i>Ages 12 to 19 Years</i>	87.34%	86.82%	87.04%	25th–49th
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
<i>Ages 16 to 20 Years</i>	23.31%	31.93%	33.57%	<10th
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
<i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i>	0.00%	0.00%	0.00%	≥90th
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
<i>Effective Acute Phase Treatment</i>	NA	NA	NA	—
<i>Effective Continuation Phase Treatment</i>	NA	NA	NA	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
<i>Initiation Phase</i>	NA	47.06%	53.33%	75th–89th
<i>Continuation and Maintenance Phase</i>	NA	NA	NA	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
<i>Ages 1 to 5 Years</i>	—	NA	NA	—
<i>Ages 6 to 11 Years</i>	—	NA	NA	—
<i>Ages 12 to 17 Years</i>	—	NA	NA	—

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<i>Total</i>	—	NA	NA	—
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents*</b>				
<i>Ages 1 to 5 Years</i>	NA	NA	NA	—
<i>Ages 6 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 17 Years</i>	NA	NA	NA	—
<i>Total</i>	NA	NA	NA	—
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
<i>Appropriate Treatment for Children With Upper Respiratory Infection</i>	95.41%	95.80%	93.68%	50th–74th
<b>Medication Management for People With Asthma</b>				
<i>Medication Compliance 50%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 50%—Total</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Medication Compliance 75%—Total</i>	NA	NA	NA	—
<b>Asthma Medication Ratio</b>				
<i>Ages 5 to 11 Years</i>	NA	NA	NA	—
<i>Ages 12 to 18 Years</i>	NA	NA	NA	—
<i>Total</i>	NA	NA	75.00%	≥90th
<b>Use of Services†</b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
<i>ED Visits*</i>	18.26	18.26	18.38	≥90th
<i>Outpatient Visits</i>	212.07	218.41	211.60	<10th
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
<i>Discharges per 1,000 Member Months (Total Inpatient)</i>	0.73	0.89	0.75	<10th
<i>Days per 1,000 Member Months (Total Inpatient)</i>	2.21	3.64	3.26	<10th
<i>Average Length of Stay (Total Inpatient)</i>	3.01	4.11	4.37	50th–74th
<i>Discharges per 1,000 Member Months (Medicine)</i>	0.45	0.59	0.49	<10th
<i>Days per 1,000 Member Months (Medicine)</i>	1.16	1.93	1.61	<10th
<i>Average Length of Stay (Medicine)</i>	2.57	3.29	3.27	<10th
<i>Discharges per 1,000 Member Months (Surgery)</i>	0.27	0.28	0.21	<10th
<i>Days per 1,000 Member Months (Surgery)</i>	1.01	1.67	1.54	<10th
<i>Average Length of Stay (Surgery)</i>	3.71	5.91	7.46†	<10th
<i>Discharges per 1,000 Member Months (Maternity)</i>	0.02	0.03	0.10	<10th
<i>Days per 1,000 Member Months (Maternity)</i>	0.08	0.09	0.23	<10th
<i>Average Length of Stay (Maternity)</i>	4.00†	2.50†	2.33†	<10th

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Percentile Ranking
<b>Antibiotic Utilization*</b>				
<i>Average Scripts PMPY for Antibiotics</i>	0.40	0.40	0.39	≥90th
<i>Average Days Supplied per Antibiotic Script</i>	10.49	10.18	10.20	<10th
<i>Average Scripts PMPY for Antibiotics of Concern</i>	0.15	0.14	0.14	≥90th
<i>Percentage of Antibiotics of Concern of All Antibiotic Scripts</i>	38.64%	35.07%	35.98%	75th–89th

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that NCQA recommended a break in trending; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2017.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

## Colorado CHP+ Weighted Averages Trend Table

Given that the MCOs varied in membership size, the statewide average rate for each measure was weighted by each MCO's eligible population for the measure. For the MCOs with rates reported as *Small Denominator (NA)*, the numerators, denominators, and eligible populations were included in the calculations of the statewide rate. MCO rates reported as *Biased Rate (BR)* or *Not Reported (NR)* were excluded from the statewide rate calculation. Of note, the Colorado CHP+ weighted averages are based on the CHP+ MCOs and the SMCN.

**Table B-6—Colorado CHP+ Weighted Average Trend Table**

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Plan Rate Range
<b>Pediatric Care</b>				
<b>Childhood Immunization Status<sup>1</sup></b>				
<i>DTaP</i>	71.93%	69.02%	71.44%	7.14%–75.83%
<i>IPV</i>	80.89%	80.23%	82.98%	7.14%–87.03%
<i>MMR</i>	83.57%	82.05%	82.31%	40.48%–86.44%
<i>HiB</i>	81.31%	80.75%	82.38%	9.52%–87.87%
<i>Hepatitis B</i>	79.34%	78.81%	81.97%^	7.14%–88.70%
<i>VZV</i>	81.31%	79.84%	81.57%	38.10%–84.32%
<i>Pneumococcal Conjugate</i>	74.05%	72.20%	74.68%	7.14%–78.07%
<i>Hepatitis A</i>	77.86%	77.12%	79.27%	52.38%–81.17%
<i>Rotavirus</i>	69.11%	66.56%	73.33%^	4.76%–76.57%
<i>Influenza</i>	49.22%	48.54%	53.75%^	11.90%–57.08%
<i>Combination 2</i>	65.30%	62.54%	66.78%^	4.76%–71.58%
<i>Combination 3</i>	63.61%	61.05%	65.16%^	4.76%–69.58%
<i>Combination 4</i>	61.14%	59.17%	63.13%^	4.76%–66.95%
<i>Combination 5</i>	57.33%	53.79%	59.76%^	4.76%–63.21%
<i>Combination 6</i>	41.61%	40.51%	45.31%^	0.00%–49.53%
<i>Combination 7</i>	55.57%	52.43%	58.20%^	4.76%–62.34%
<i>Combination 8</i>	40.34%	39.53%	44.29%^	0.00%–48.23%
<i>Combination 9</i>	38.50%	36.49%	42.27%^	0.00%–45.64%
<i>Combination 10</i>	37.59%	35.77%	41.39%^	0.00%–44.58%
<b>Immunizations for Adolescents</b>				
<i>Meningococcal</i>	69.48%	71.03%	75.41%^	31.58%–84.49%
<i>Tdap</i>	81.55%	82.47%	86.32%^	56.14%–89.77%
<i>HPV</i>	—	37.05%	41.42%^	14.04%–58.42%
<i>Combination 1 (Meningococcal, Tdap)</i>	67.55%	68.89%	73.33%^	26.32%–82.84%
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	33.79%	39.02%^	12.28%–56.44%

Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Plan Rate Range
<b>Well-Child Visits in the First 15 Months of Life</b>				
Zero Visits*	3.04%	2.63%	5.06%	0.00%–15.15%
Six or More Visits	48.01%	51.41%	48.28%	15.79%–73.74%
<b>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</b>				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.60%	64.97%	67.34%	55.62%–68.50%
<b>Adolescent Well-Care Visits</b>				
Adolescent Well-Care Visits	48.26%	45.09%	48.23%^	37.65%–49.87%
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</b>				
BMI Percentile Documentation—Ages 3 to 11 Years	15.25%	18.03%	20.52%	3.38%–98.82%
BMI Percentile Documentation—Ages 12 to 17 Years	19.08%	23.01%	26.36%^	6.28%–98.18%
BMI Percentile Documentation—Total	16.67%	19.89%	22.71%	4.83%–98.57%
Counseling for Nutrition—Ages 3 to 11 Years	17.68%	19.06%	20.41%	2.14%–96.57%
Counseling for Nutrition—Ages 12 to 17 Years	18.92%	21.89%	23.21%	5.31%–95.59%
Counseling for Nutrition—Total	18.14%	20.12%	21.46%	4.65%–96.18%
Counseling for Physical Activity—Ages 3 to 11 Years	13.05%	14.47%	15.93%	0.00%–96.57%
Counseling for Physical Activity—Ages 12 to 17 Years	16.44%	18.23%	20.34%	5.13%–95.59%
Counseling for Physical Activity—Total	14.31%	15.87%	17.58%	3.14%–96.18%
<b>Appropriate Testing for Children With Pharyngitis</b>				
Appropriate Testing for Children With Pharyngitis	84.35%	87.36%	84.99%	77.64%–94.20%
<b>Access to Care</b>				
<b>Prenatal and Postpartum Care</b>				
Timeliness of Prenatal Care	57.08%	58.29%	55.13%	—
Postpartum Care	42.50%	43.42%	45.01%	—
<b>Children and Adolescents' Access to Primary Care Practitioners</b>				
Ages 12 to 24 Months	90.02%	90.65%	92.33%	90.30%–97.22%
Ages 25 Months to 6 Years	82.88%	80.91%	82.93%	71.90%–84.52%
Ages 7 to 11 Years	88.99%	87.49%	87.66%	86.81%–88.00%
Ages 12 to 19 Years	89.39%	88.09%	87.14%	82.04%–88.26%
<b>Preventive Screening</b>				
<b>Chlamydia Screening in Women</b>				
Ages 16 to 20 Years	35.31%	33.66%	36.52%	32.27%–47.22%
<b>Non-Recommended Cervical Cancer Screening in Adolescent Females*</b>				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17%	0.07%	0.04%	0.00%–0.08%



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Plan Rate Range
<b>Mental/Behavioral Health</b>				
<b>Antidepressant Medication Management</b>				
Effective Acute Phase Treatment	NA	48.65%	55.00%	—
Effective Continuation Phase Treatment	NA	40.54%	37.50%	—
<b>Follow-Up Care for Children Prescribed ADHD Medication</b>				
Initiation Phase	13.02%	21.84%	15.21%	—
Continuation and Maintenance Phase	20.00%	21.57%	20.00%	—
<b>Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>				
Ages 1 to 5 Years	—	NA	NA	—
Ages 6 to 11 Years	—	NA	NA	—
Ages 12 to 17 Years	—	41.51%	38.89%	—
Total	—	39.85%	38.98%	—
<b>Use of Multiple Concurrent Antipsychotics in Children and Adolescents<sup>*1</sup></b>				
Ages 1 to 5 Years	NA	NA	NA	—
Ages 6 to 11 Years	NA	NA	NA	—
Ages 12 to 17 Years	4.05%	7.14%	5.41%	—
Total	3.37%	5.62%	4.04%	—
<b>Respiratory Conditions</b>				
<b>Appropriate Treatment for Children With Upper Respiratory Infection</b>				
Appropriate Treatment for Children With Upper Respiratory Infection	91.24%	93.84%	94.09%	92.63%–100.00%
<b>Medication Management for People With Asthma</b>				
Medication Compliance 50%—Ages 5 to 11 Years	49.43%	61.29%	59.75%	—
Medication Compliance 50%—Ages 12 to 18 Years	45.74%	51.75%	51.64%	—
Medication Compliance 50%—Total	47.85%	57.14%	56.38%	—
Medication Compliance 75%—Ages 5 to 11 Years	25.86%	32.26%	33.96%	—
Medication Compliance 75%—Ages 12 to 18 Years	20.93%	24.48%	27.05%	—
Medication Compliance 75%—Total	23.76%	28.88%	31.21%	—
<b>Asthma Medication Ratio</b>				
Ages 5 to 11 Years	85.80%	82.90%	82.63%	—
Ages 12 to 18 Years	73.72%	74.03%	71.32%	—
Total	80.25%	78.96%	77.63%	75.00%–79.91%
<b>Use of Services<sup>†</sup></b>				
<b>Ambulatory Care (Per 1,000 Member Months)</b>				
ED Visits*	20.84	21.80	23.83	17.33–26.90
Outpatient Visits	205.26	199.00	195.91	133.57–218.12



Performance Measures	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate	Plan Rate Range
<b>Inpatient Utilization—General Hospital/Acute Care<sup>1</sup></b>				
Discharges per 1,000 Member Months (Total Inpatient)	0.87	0.88	0.88	0.37–1.03
Days per 1,000 Member Months (Total Inpatient)	2.97	3.31	3.09	0.87–3.55
Average Length of Stay (Total Inpatient)	3.42	3.77	3.51	2.33–4.37
Discharges per 1,000 Member Months (Medicine)	0.60	0.60	0.63	0.21–0.74
Days per 1,000 Member Months (Medicine)	1.69	1.78	1.82	0.42–2.19
Average Length of Stay (Medicine)	2.82	2.96	2.89	2.00–3.27
Discharges per 1,000 Member Months (Surgery)	0.24	0.24	0.21	0.08–0.25
Days per 1,000 Member Months (Surgery)	1.20	1.43	1.17	0.25–1.54
Average Length of Stay (Surgery)	4.97	5.90	5.50	1.50–7.46
Discharges per 1,000 Member Months (Maternity)	0.06	0.07	0.07	0.00–0.10
Days per 1,000 Member Months (Maternity)	0.16	0.21	0.18	0.00–0.23
Average Length of Stay (Maternity)	2.68†	2.97	2.49	2.00–3.00
<b>Antibiotic Utilization*</b>				
Average Scripts PMPY for Antibiotics	0.40	0.38	0.33	0.14–12.00
Average Days Supplied per Antibiotic Script	11.06	11.36	16.86	10.20–99.95
Average Scripts PMPY for Antibiotics of Concern	0.13	0.12	0.11	0.03–2.32
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.99%	33.02%	31.91%	19.35%–35.98%

\* For this indicator, a lower rate indicates better performance.

<sup>1</sup> Due to changes in the technical specifications for this measure, NCQA recommends trending between 2019 and prior years be considered with caution.

— Indicates that NCQA recommended a break in trending; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed. This symbol may also indicate that the MCOs were not required to report this measure for HEDIS 2017.

NA (Small Denominator) indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files; differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance. This symbol may also indicate that fewer than 30 discharges were reported for this measure indicator. Exercise caution when evaluating this rate.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^) indicate a statistically significant decline in performance from the previous year.

## Appendix C. Information System Findings

### Information System Findings

NCQA's Information System (IS) standards are the guidelines used by NCQA-certified HEDIS compliance auditors to assess the MCOs' HEDIS reporting capabilities.<sup>C-1</sup> HSAG evaluated each MCO on six IS standards. To assess the MCOs' adherence to standards, HSAG reviewed several documents for the CHP+ MCOs, which included the Final Audit Reports (FARs) (generated by an NCQA-licensed audit organization [LO]), IDSS files, and audit review tables. The findings indicated that all but one MCO was compliant with all of NCQA's IS standards. For the MCOs that were compliant, no issues were identified that resulted in material bias to the HEDIS measure results reported for the CHP+ population. These MCOs accurately reported all Department-required HEDIS performance measures.

One MCO was fully compliant with four IS standards and partially compliant with two standards. However, all the measures presented in this report for this plan were assigned an audit designation of *Reportable* by its contracted HEDIS auditor.

As in last year, all the MCOs except Kaiser contracted with a software vendor to produce the reported HEDIS measure rates. The vendors submitted programming code developed for each HEDIS measure to NCQA for the measure certification process. Through certification, NCQA tested that the software produced valid results and that calculations met NCQA standards. Kaiser's certified HEDIS auditor selected a core set of measures for source code review. The selected source codes were reviewed and approved for measure reporting.

Each Colorado CHP+ MCO contracted with a licensed HEDIS audit organization to perform the NCQA HEDIS Compliance Audit. The SMCN program did not undergo an NCQA HEDIS Compliance Audit. The following table presents NCQA's IS standards and summarizes the audit findings related to each IS standard for the CHP+ MCOs only.

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<sup>C-1</sup> National Committee for Quality Assurance. HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5. Washington D.C.

Table C-1—Summary of Compliance With IS Standards

NCQA's IS Standards	HSAG's Findings Based on HEDIS 2019 FAR Review
<p><b>IS 1.0—Medical Service Data—Sound Coding Methods and Data Capture, Transfer, and Entry</b></p> <ul style="list-style-type: none"> <li>Industry standard codes are required and captured.</li> <li>Primary and secondary diagnosis codes are identified.</li> <li>Nonstandard codes (if used) are mapped to industry standard codes.</li> <li>Standard submission forms are used.</li> <li>Timely and accurate data entry processes and sufficient edit checks are used.</li> <li>Data completeness is continually assessed, and all contracted vendors involved in medical claims processing are monitored.</li> </ul>	<p>All MCOs were fully compliant with IS Standard 1.0 for medical services data capture and processing. No issues or concerns were noted for this standard relevant to the selected Colorado CHP+ measures.</p> <p>The MCOs only accepted industry standard codes on industry standard forms.</p> <p>All data elements required for HEDIS reporting were adequately captured.</p>
<p><b>IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry</b></p> <ul style="list-style-type: none"> <li>All HEDIS-relevant information for data entry or electronic transmissions of enrollment data is accurate and complete.</li> <li>Manual entry of enrollment data is timely and accurate, and sufficient edit checks are in place.</li> <li>The MCOs continually assess data completeness and take steps to improve performance.</li> <li>The MCOs effectively monitor the quality and accuracy of electronic submissions.</li> <li>The MCOs have effective control processes for the transmission of enrollment data.</li> </ul>	<p>All MCOs were fully compliant with IS Standard 2.0 for enrollment data capture and processing. No issues or concerns were noted for this standard relevant to the selected Colorado CHP+ measures.</p> <p>The MCOs had policies and procedures in place for submitted electronic data. Data elements required for reporting were captured. Adequate validation processes were in place, ensuring data accuracy.</p>
<p><b>IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry</b></p> <ul style="list-style-type: none"> <li>Provider specialties are fully documented and mapped to HEDIS provider specialties.</li> <li>Effective procedures for submitting HEDIS-relevant information are in place.</li> <li>Electronic transmissions of practitioner data are checked to ensure accuracy.</li> <li>Processes and edit checks ensure accurate and timely entry of data into the transaction files.</li> <li>Data completeness is assessed, and steps are taken to improve performance.</li> <li>Vendors are regularly monitored against expected performance standards.</li> </ul>	<p>All MCOs were fully compliant with IS Standard 3.0 for practitioner data capture and processing. No issues or concerns were noted for this standard relevant to the selected Colorado CHP+ measures.</p> <p>The MCOs appropriately captured and documented practitioner data. Data validation processes were in place to verify practitioner data.</p> <p>In addition, for accuracy and completeness, all plans reviewed all provider data received from delegated entities.</p>

NCQA's IS Standards	HSAG's Findings Based on HEDIS 2019 FAR Review
<p><b>IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight</b></p> <ul style="list-style-type: none"> <li>Forms or tools used for medical record review capture all fields relevant to HEDIS reporting.</li> <li>Checking procedures are in place to ensure data integrity for electronic transmission of information.</li> <li>Retrieval and abstraction of data from medical records are accurately performed.</li> <li>Data entry processes, including edit checks, are timely and accurate.</li> <li>Data completeness is assessed, including steps to improve performance.</li> <li>Vendor performance is monitored against expected performance standards.</li> </ul>	<p>All MCOs were fully compliant with IS Standard 4.0 for medical record review processes. No issues or concerns were noted for this standard relevant to the selected Colorado CHP+ measures. However, HSAG did not review this step since the State requires administrative rates only.</p> <p>The data collection tools used by the MCOs were able to capture all data fields necessary for HEDIS reporting. Sufficient validation processes were in place to ensure data accuracy. <b>However</b>, HSAG did not review this step since the State requires administrative rates only.</p>
<p><b>IS 5.0—Supplemental Data—Capture, Transfer, and Entry</b></p> <ul style="list-style-type: none"> <li>Nonstandard coding schemes are fully documented and mapped to industry standard codes.</li> <li>Effective procedures for submitting HEDIS-relevant information are in place.</li> <li>Electronic transmissions of supplemental data are checked to ensure accuracy.</li> <li>Data entry processes, including edit checks, are timely and accurate.</li> <li>Data completeness is assessed, including steps to improve performance.</li> <li>Vendor performance is monitored against expected performance standards.</li> <li>Data approved for electronic clinical data system (ECDS) reporting met reporting requirements.</li> </ul>	<p>All MCOs were fully compliant with IS Standard 5.0 for supplemental data capture and processing. No issues or concerns were noted for this standard relevant to the selected Colorado CHP+ measures. Two MCOs reported using only standard supplemental databases for reporting. The other three MCOs reported using both standard and nonstandard supplemental databases for reporting.</p> <p>The HEDIS repository contained all data fields required for HEDIS reporting. In addition, staff members were interviewed to confirm the appropriate quality processes for the data source and to determine if primary source verification (PSV) was needed on all supplemental data that were in nonstandard form.</p>

NCQA's IS Standards	HSAG's Findings Based on HEDIS 2019 FAR Review
<p><b>IS 6.0 Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity</b></p> <ul style="list-style-type: none"> <li>• Nonstandard coding schemes are fully documented and mapped to industry standard codes. Organization-to-vendor mapping is fully documented.</li> <li>• Data transfers to HEDIS repository from transaction files are accurate and file consolidations, extracts, and derivations are accurate.</li> <li>• Repository structure and formatting is suitable for measures and enable required programming efforts.</li> <li>• Report production is managed effectively and operators perform appropriately.</li> <li>• Vendor performance is monitored against expected performance standards.</li> </ul>	<p>All MCOs were compliant with IS Standard 6.0 for data preproduction processing.</p> <p>File consolidation and data extractions were performed by the MCOs' staff members. Data were verified for accuracy at each data merge point.</p>
<p><b>IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support HEDIS Reporting Integrity</b></p> <ul style="list-style-type: none"> <li>• Data transfers to the HEDIS repository from transaction files are accurate.</li> <li>• Report production is managed effectively and operators perform appropriately.</li> <li>• HEDIS reporting software is managed properly.</li> <li>• The organization regularly monitors vendor performance against expected performance standards.</li> </ul>	<p>All the MCOs were fully compliant with IS Standard 7.0 for data integration. No issues or concerns were noted for this standard relevant to the selected Colorado CHP+ measures.</p> <p>The MCOs used an NCQA-certified measure vendor for data production and rate calculation.</p>

## Appendix D. FHP Administrative and Hybrid Rates

Appendix D shows FHP's rates for HEDIS 2019 for measures with a hybrid option, along with the percentile ranking for each HEDIS 2019 hybrid rate.

**Table D-1—HEDIS 2019 Administrative and Hybrid Performance Measure Results for FHP**

Performance Measures	Administrative Rate	Hybrid Rate	Percentile Ranking
<b><i>Pediatric Care</i></b>			
<b><i>Childhood Immunization Status</i></b>			
<i>Combination 2</i>	4.76%	47.62%	<10th
<i>Combination 3</i>	4.76%	47.62%	<10th
<i>Combination 4</i>	4.76%	45.24%	<10th
<i>Combination 5</i>	4.76%	38.10%	<10th
<i>Combination 6</i>	0.00%	28.57%	10th–24th
<i>Combination 7</i>	4.76%	38.10%	<10th
<i>Combination 8</i>	0.00%	28.57%	10th–24th
<i>Combination 9</i>	0.00%	23.81%	<10th
<i>Combination 10</i>	0.00%	23.81%	10th–24th
<b><i>Immunizations for Adolescents</i></b>			
<i>Combination 1 (Meningococcal, Tdap)</i>	26.32%	38.60%	<10th
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	12.28%	17.54%	<10th
<b><i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i></b>			
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	55.62%	58.58%	<10th
<b><i>Adolescent Well-Care Visits</i></b>			
<i>Adolescent Well-Care Visits</i>	37.65%	48.53%	25th–49th
<b><i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i></b>			
<i>BMI Percentile Documentation—Total</i>	9.70%	33.74%	<10th
<i>Counseling for Nutrition—Total</i>	4.65%	40.20%	<10th
<i>Counseling for Physical Activity—Total</i>	6.26%	37.98%	<10th



## **COLORADO**

Department of Health Care  
Policy & Financing

### **Public Notice**

#### **Title XXI Section 1115 Demonstration Extension Application for Colorado Adult Prenatal Coverage In CHP+ (NO. 21-W-00014/8)**

Public Comment Period Begins: July 10, 2020 at 8:00 a.m. MDT  
Public Comment Period Ends: August 10, 2020 at 5:00 p.m. MDT

Public notice is hereby given that the State of Colorado Department of Health Care Policy & Financing is seeking public comments on a title XXI Section 1115 Demonstration Extension Application ("Demonstration") to support the improvement of health outcomes for low-income mothers and their babies by providing necessary prenatal, delivery, and postpartum care to eligible Medicaid clients who identified as pregnant.

#### **Proposed Demonstration Extension Summary**

Medicaid and CHIP Section 1115 waivers allow states to test new approaches to administering Medicaid and CHIP programs beyond what is required by federal statute. The Colorado Department of Health Care Policy & Financing ("Department") is submitting the Demonstration to request an extension to the program from August 1, 2020, through July 31, 2025. Specifically, the State is requesting an extension of the federal authority for Colorado to continue to receive title XXI funds for uninsured pregnant women with income from 142% of the Federal Poverty Level (FPL) to 195% of the FPL. The state is not requesting any program changes during the requested renewal period.

The Department plans to submit the Demonstration to CMS at the end of July 2020. The waiver, if approved, will authorize an extension of the federal authority for Colorado to continue to receive title XXI funds for pregnant women with income from with income from 142% of the FPL to 195% of the FPL.

#### **Program Background**

- In September 2002, the State of Colorado received approval from the Centers for Medicare and Medicaid Services (CMMS) for a five-year demonstration period through September 2006 for its "Adult Prenatal Coverage in CHP+" program. This program permitted the state to use Title XXI funds to expand coverage to uninsured pregnant women with family incomes between 133% and 185% of the federal poverty level (FPL).
- In January 2006, Center for Medicaid Services (CMS) approved an amendment to the demonstration, allowing Colorado to expand eligibility for uninsured pregnant women under the demonstration, from 185% to 200% of the FPL.
- On September 29, 2006, CMS approved Colorado's request to renew the demonstration for a three-year period through September 30, 2009.
- CMS then approved Colorado's extension request, which extended the program through June 2012. On July 30, 2012, Colorado received approval to expand coverage for uninsured pregnant women from 200% to 250% of the FPL.
- In July 2015, the Colorado's application for extension of Colorado's title XXI section 1115 demonstration project No. 21-W-00014/8 was approved by CMS. This extension effectively continued the project at the 2012 FPL levels that raised the upper limit to 250% FPL and applied a five-year demonstration period.



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

To comply with the spirit of CHIPRA, Colorado submitted a Medicaid State Plan Amendment and received approval for transitioning pregnant women from 133% to 185% of the FPL, to the Medicaid State Plan and to provide full Medicaid benefits to these women. The State has continued to receive Title XXI funds for uninsured pregnant women from 133% to 185% of the FPL. In addition, the State submitted and received approval for a corresponding CHIP State Plan Amendment to transition pregnant women between 185% and 250% of the FPL to the CHIP State plan. As required under Special Terms and Conditions (STCs) #17, the State transitioned coverage of pregnant women from this demonstration to the Medicaid State Plan and the CHIP State Plan, effective January 1, 2013.<sup>1</sup>

### Waiver Objectives and Goals

The demonstration population includes pregnant Medicaid expansion clients who would have been covered under CHP+ if not for the expansion (142%-195% FPL). The state targeted this population to achieve three key objectives:

1. Decrease the uninsured rate for pregnant women;
2. Increase prenatal and postpartum care for pregnant women enrolled in the Demonstration;
3. Increase the number of healthy babies born to pregnant women enrolled in the Demonstration

### Eligibility

The eligibility criteria included as part of this demonstration from the program's current standards will not change. The demonstration will be open to uninsured pregnant women age 19 and over, with family income above 141% through 195% of the FPL. The demonstration will not have enrollment limits.

### Services

The Department will continue to provide health benefits coverage to those eligible for the demonstration using the State's fee-for-service and managed care delivery systems. Demonstration enrollees receive all services pursuant to the approved CHIP State plan and Medicaid State plan. The benefit coverage approved in the State Medicaid State Plan and CHIP State Plan are provided in accordance with CMS classification of this demonstration as MEC.

### Cost Sharing

Cost sharing is not applied to this population for any type of service.

### Delivery System

Under the service delivery systems authorized under section 1915(a), section 1915(b), and section 1932(a) of the Social Security Act, the State provides services through this demonstration in combination of fee-for-service and managed care delivery systems. Upon full implementation of the

<sup>1</sup> The federal poverty levels listed in the Historical Summary of the Demonstration Project section prior to January 2014 are pre-MAGI-converted levels.





proposed extension, the Department will continue to provide health benefits coverage to those determined eligible for the demonstration using the State's fee-for-service and managed care delivery systems.

#### Demonstration Hypotheses and Measures

The state is committed to ensuring that there is a robust monitoring and evaluation process in place for this demonstration. It is anticipated that this waiver demonstration will:

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

During the present demonstration period, August 1, 2015 through July 31, 2020, the following objectives, hypotheses, and methodology were used to determine if Colorado is achieving the demonstration's goals. The table below presents an overview of possible evaluation objectives, hypothesis, and methodology for measurement, which are subject to change and will be further defined as the program is implemented. The example measures are not final and do not represent an exhaustive list of measures that could be used to test each hypothesis.

Table 1. Evaluation Objectives, Hypotheses and Methodology

Hypothesis	Methodology
<b>OBJECTIVE 1:</b> Increase the percentage of pregnant women in the demonstration who received prenatal and postpartum care	
<p>Pregnant women enrolled in the CHP+ demonstration will have a statistically significant increase in prenatal care visits.</p> <p>Pregnant women enrolled in the CHP+ demonstration will have a statistically significant increase in postpartum care visits.</p>	<p>Use of claims data, birth certificate data, and HEDIS data to measure prenatal and postpartum care for the women in the demonstration program, as well as, for the pregnant women in CHP+ and Medicaid.</p>
<b>OBJECTIVE 2:</b> Increase the number of healthy babies born to pregnant women enrolled in the Demonstration	
<p>The proportion of babies born to women enrolled in CHP+ and admitted to the NICU will decrease over the five years of the demonstration.<sup>2</sup></p> <p>The proportion of babies born to women enrolled in the demonstration that weigh</p>	<p>Use of claims data, birth certificate data, HEDIS data and PRAMS data to track the birth weights of newborns and length of stay and time spent in the ICU for babies born to mothers in the demonstration program, as</p>

<sup>2</sup> The original evaluation proposal included this hypothesis, but a corresponding measure was not included in the approved demonstration evaluation design, dated April 26, 2017. Details on this change are included in the Interim Evaluation Report.



under 2,500 grams will decrease by 10 percent over the five-year demonstration.	well as, for the newborns born to mothers in Medicaid as a whole.
<b>OBJECTIVE 3:</b> Decrease the uninsured rate for pregnant women	
This objective is included here for completion but was not part of the approved demonstration evaluation design, dated April 26, 2017.	As described in the interim evaluation report, the absence of an appropriate dataset prevented the state from further analysis during the demonstration period.

### Proposed Federal Demonstration Authorities

Colorado is requesting the same waiver and expenditure authority as approved in the current demonstration to authorize title XXI expenditures for health benefits coverage to uninsured pregnant women age 19 and over, with family income above 141% through 195% of the FPL. Specifically, Colorado requests, under the authority of section 1115(a)(2) of the Social Security Act (the Act), that expenditures made by Colorado identified below, which are not otherwise included as expenditures under section 1903 of the Act, shall, for the period of this demonstration extension, be regarded as expenditures under the state's title XXI plan:

1. Section 2112(b)(2) Minimum Income Standard for Pregnant Women in CHIP
  - a. To permit Colorado to have income levels for eligibility for the specified demonstration population that are lower than applicable Medicaid levels, to the extent necessary to provide title XXI coverage for the Medicaid benefit package for pregnant women.
2. Section 2105(c)(6)(B) CHIP Secondary Payer to Medicaid
  - a. To permit Colorado to make payment under title XXI primary to payment under Medicaid for this demonstration population, to the extent necessary to provide title XXI coverage for the Medicaid benefit package to pregnant women with incomes above 141 percent of the FPL through 195 percent of the FPL.

### Estimated Impact of the Demonstration

Historical and projected enrollment trends for Colorado's Combination CHIP program, which is represented as the Separate CHIP population (SCHIP), Medicaid expansion CHIP population (MCHIP), and the Prenatal Demonstration CHIP population, are presented in the following tables. The figures presented in tables 2 through 5 provide an assessment of how the proposed demonstration is expected to impact CHIP program enrollment for the extension period Colorado is requesting. These figures are total annual, unduplicated, person counts.

### **Estimated Projections of Annual Enrollment**

Table 2. Historical and Projected Enrollment Figures by Category

	Total Combination CHIP Enrollment by Year	SCHIP Plan Enrollment by Year	MCHIP Plan Enrollment by Year	Total 1115 Demonstration Enrollment by Year (142%- 195% FPL)



FFY 2015	107,800	52,346	53,747	1,707
FFY 2016	117,471	54,549	61,103	1,819
FFY 2017	137,145	69,603	65,503	2,039
FFY 2018	147,012	81,893	62,854	2,265
FFY 2019	141,221	80,967	57,995	2,259
FFY 2020	135,265	76,032	57,088	2,145
FFY 2021	137,874	77,519	58,121	2,234
FFY 2022	140,290	79,121	58,856	2,313
FFY 2023	140,290	79,121	58,856	2,313
FFY 2024	140,290	79,121	58,856	2,313
FFY 2025	140,290	79,121	58,856	2,313

Due to the State's 2013 transition of the pregnant women from this demonstration to the Medicaid State Plan and the subsequent MAGI conversion, were the demonstration extension not implemented, individuals receiving benefits through the demonstration and with income between 142% and 195% FPL would be expected to enroll in benefits through Medicaid.

Table 4. Annual counts of individuals expected to be enrolled in the demonstration, assuming that the proposed demonstration is implemented.

	Annual counts of individuals expected to be enrolled in the demonstration by year
FFY 2021	2,234
FFY 2022	2,313
FFY 2023	2,313
FFY 2024	2,313
FFY 2025	2,313

Table 5. Annual counts of individuals that would be expected to enroll in CHIP, if the proposed demonstration is not implemented, based on historical program trends and expectations as described in the state's analysis.<sup>3</sup>

	Annual counts of individuals that would be expected to enroll in CHIP, if the proposed demonstration is not implemented.
FFY 2021	135,640
FFY 2022	137,977

<sup>3</sup> The annual counts in Table 5 are calculated by removing the projected annual demonstration population figure from the corresponding annual total combination CHIP enrollment figure(s). These individuals would be expected to enroll in benefits under the Medicaid state plan.



FFY 2023	137,977
FFY 2024	137,977
FFY 2025	137,977

Table 6. Annual counts of individuals expected to be enrolled in CHIP, assuming that the proposed components of the demonstration are implemented, for each year of the proposed demonstration period, and by each category of beneficiary whose Medicaid or CHIP enrollment is likely to be impacted by the demonstration.

	Total Combination CHIP Enrollment by Year	SCHIP Plan Enrollment by Year	MCHIP Plan Enrollment by Year	Total 1115 Demonstration Enrollment by Year (142%-195% FPL)
FFY 2021	137,874	77,519	58,121	2,234
FFY 2022	140,290	79,121	58,856	2,313
FFY 2023	140,290	79,121	58,856	2,313
FFY 2024	140,290	79,121	58,856	2,313
FFY 2025	140,290	79,121	58,856	2,313

### Historical Expenditures and Projected Annual Expenditures

The table below provides historical demonstration expenditures and projected costs over the requested extension period.

Table 7. Summary Historical and Projected Demonstration Expenditures

Demonstration Population Annual Expenditures and Projected Annual Costs for Requested Extension Period	
Federal Fiscal Year (Demonstration Period)	Expenditure
FFY 2016 (Current Demonstration Period - Year 1)	\$ 18,135,045
FFY 2017 (Current Demonstration Period - Year 2)	\$ 14,820,787
FFY 2018 (Current Demonstration Period - Year 3)	\$ 18,689,341
FFY 2019 (Current Demonstration Period - Year 4)	\$ 23,151,976
FFY 2020 (Current Demonstration Period - Year 5)	\$ 22,279,510
FFY 2021 (Requested Demonstration Extension Period - Year 1)	\$ 23,153,954



FFY 2022 (Requested Demonstration Extension Period - Year 2)	\$ 24,075,335
FFY 2023 (Requested Demonstration Extension Period - Year 3)	\$ 25,055,201
FFY 2024 (Requested Demonstration Extension Period - Year 4)	\$ 26,074,948
FFY 2024 (Requested Demonstration Extension Period - Year 5)	\$ 27,136,198

### Opportunity for Public Comment

The proposed section 1115 demonstration extension application and interim evaluation report are available for public review and comment at:

<https://www.colorado.gov/pacific/sites/default/files/CHPPlusPrenatal1115DemonstrationApplication.pdf>

<https://www.colorado.gov/pacific/sites/default/files/CHPPlusPrenatal1115InterimEvaluation.pdf>

To request a copy of the waiver, please contact the Department by:

- Sending an email request to [hcpf\\_PrenatalDemonstration@state.co.us](mailto:hcpf_PrenatalDemonstration@state.co.us)
- Send a request by fax to 303-866-2573, Attn: 1115 CHP+ Prenatal Waiver Application, or
- Obtaining a paper copy in person is not possible at the Department's office due to the need to follow proper social distancing and safety precautions for the COVID-19 public health emergency.
- You may request to receive a paper copy by post by submitting a request to the email or telephone number below.
  - [hcpf\\_PrenatalDemonstration@state.co.us](mailto:hcpf_PrenatalDemonstration@state.co.us)
  - 303-866-3284

During the public comment period, comments may be sent to [hcpf\\_PrenatalDemonstration@state.co.us](mailto:hcpf_PrenatalDemonstration@state.co.us). Public comments may also be submitted by post to:

Colorado Department of Health Care Policy and Financing  
1570 Grant Street  
Denver, Colorado 80203  
ATTN: Public Comment – 1115 CHP+ Prenatal Waiver Application

Additional information will be posted on the Department's Child Health Plan *Plus* Prenatal Waiver webpage, at <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus-prenatal-waiver>.

### Public Hearings

The Department invites the public to attend public hearings by teleconference/webinar to learn more about Colorado's waiver application and provide comments.

	<b>Public Hearing #1</b>	<b>Public Hearing #2</b>
Date	Wednesday July 15, 2020	Thursday July 16, 2020
Time	11:00 am — 1:00 pm	11:00 am — 1:00 pm



Venue	Virtual Remote Meeting	Virtual Remote Meeting
Teleconference	Conference Line: 1-877-820-7831 Participant Code: 499-449 #	Conference Line: 1-877-820-7831 Participant Code: 499-449 #
Webinar	<a href="https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/">https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/</a>	<a href="https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/">https://cohcpf.adobeconnect.com/chpplusprenatal1115waiver/</a>

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Department's 504/ADA Coordinator at [hcpf504ada@state.co.us](mailto:hcpf504ada@state.co.us) or Jeffrey Jaskunas at [jeffrey.jaskunas@state.co.us](mailto:jeffrey.jaskunas@state.co.us) at least one week before the public notice period to make arrangements.

#### CMS/Medicaid Demonstration Website

Relevant webpages and additional information regarding the Medicaid demonstration can be viewed on the CMS/Medicaid website, at: <https://www.medicaid.gov/medicaid/section-1115-demo/index.html>

**This notice is submitted pursuant to Title 42 Code of Federal Regulations, Part 431.408, Subpart G, which outlines public notice processes and transparency requirements for Section 1115 Demonstrations.**



TRIBAL CONSULTATION - PROGRAMMATIC ACTION LOG					KEY									
COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING					Red Text	New additions or updates to the Log								
					Black Text	Item was on previous Log; Project is ongoing; there may be future updates								
					Grey Text	Item was on previous Log; Item is basically completed								
Log #	Log Date	Major Program (Medicaid, CHP+, etc)	Action Type (SPA, waiver, other)	Category (Eligibility, benefits, rates, etc)	Programmatic Action Title	Brief Description	Important Dates and Timelines	Clearly Foreseeable Tribal Implications	Actionable or Non-Actionable Item - Why	Feedback? Other Implications?	Was Further Consultation Requested?	By Whom	Date Further Consultation Was Requested	Follow-Up, Updates, Resolution
340	2/1/2020	Medicaid	1115 Demonstration Waiver	CHP+ Rates Enhanced Match	Extension of Colorado's 1115 Demonstration Project Regarding Prenatal Women	The Department of Health Care Policy and Financing (Department) intends to submit an application for an extension of Colorado's title XXI section 1115 demonstration project concerning prenatal women. The application will request an extension of the federal authority for Colorado to continue to receive title XXI funds for pregnant women with income above 142 percent of the federal poverty level (FPL) through 195 percent of the FPL. During the application process, the Department will also fulfill all transparency, noticing and reporting requirements as they relate to this demonstration project.	Estimated Effective Date: July 1, 2020 Estimated Submission Date: May 1, 2020	The Department does not foresee any negative tribal implications as a result of this Waiver Amendment.	Any comments or questions are welcome.					

TRIBAL CONSULTATION - PROGRAMMATIC ACTION LOG						KEY									
COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						Red Text									
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368	7/9/2020	Medicaid	1115 Demonstration Waiver	CHP+ Rates Enhanced Match	Extension of Colorado's 1115 Demonstration Project Regarding Prenatal Women	<p>The Department of Health Care Policy and Financing (Department) intends to submit an application for an extension of Colorado's title XXI section 1115 demonstration project concerning prenatal women. The application will request an extension of the federal authority for Colorado to continue to receive title XXI funds for pregnant women with income above 142 percent of the federal poverty level (FPL) through 195 percent of the FPL. During the application process, the Department will also fulfill all transparency, noticing and reporting requirements as they relate to this demonstration project.</p> <p>The Department invites the public to comment on the requested waiver extension application and supporting documents. The Department intends to submit the amendments to the Center for Medicare and Medicaid Services (CMS) on July 31, 2020 and will ask for an effective date that continues the current demonstration without lapse.</p> <p>The Department will make the waiver application available for public comments from July 10, 2020 to August 10, 2020. During the public comment period, comments may be submitted by email to <a href="mailto:hcpf_PrenatalDemonstration@state.co.us">hcpf_PrenatalDemonstration@state.co.us</a> and will be accepted from February 6, 2020 to March 6, 2020.</p> <p>For more detailed information on the demonstration, including copies of the full demonstration renewal application, interim evaluation report, and the comprehensive public notice document, please go to the Department's website at <a href="https://www.colorado.gov/pacific/hcpf/child-health-plan-plus-prenatal-waiver">https://www.colorado.gov/pacific/hcpf/child-health-plan-plus-prenatal-waiver</a>.</p> <p>To request a paper or electronic copy of any materials, including the full draft demonstration renewal application and/or provide public comment please call: 303-866-3284, fax: 303-866-2786 ATTN: Public Comment – 1115 CHP+ Prenatal Waiver Application, or email: <a href="mailto:hcpf_PrenatalDemonstration@state.co.us">hcpf_PrenatalDemonstration@state.co.us</a>.</p>	<p><b>Estimated Effective Date:</b> August 1, 2020</p> <p><b>Estimated Submission Date:</b> July 31, 2020</p>	The Department does not foresee any negative tribal implications as a result of this Waiver Amendment.	Any comments or questions are welcome.						