COLORADO
Department of Health Care Policy & Financing

2018
Quality Strategy

Health First COLORADO™
Colorado's Medicaid Program

INDEX

Table of Contents i
Table of Acronyms ii

Section 1: Introduction 1
History of Colorado's Medicaid Managed Care Programs 1
Overview of Quality Management Structure 4
Goals and Objectives of the State's Managed Care Program 5
Development and Review of Quality Strategy 6

Section 2: Assessment 8
Quality and Appropriateness of Care 8
National Performance Measures 11
Monitoring and Compliance 13
External Quality Review 18

Section 3: State Standards (See Appendix A) 20
Access Standards 20
Structure and Operations Standards 24
Measurement and Improvement Standards 26

Section 4: Improvements and Interventions 28
Intermediate Sanctions 28
Health Information Technology 29

Section 5: Delivery System Reforms 32

Section 6: Conclusions and Opportunities 36

Appendix:
A: Access to Care Standards Crosswalk 37

TABLE OF ACRONYMS

Name	Acronym
Accountable Care Collaborative	ACC
Behavioral Health Organization	BHO
Business Intelligence and Data Management	BIDM
Centers for Medicare and Medicaid Services	CMS
Clinical Quality Measure	CQM
Colorado Community Managed Care Network	CCMCN
Colorado Department of Human Services	CDHS
Colorado Department of Public Health and Environment	CDPHE
Colorado Medicaid Management Innovation and Transformation	COMMIT
Community Mental Health Center	CMHC
Consumer Assessment of Healthcare Providers and Systems	CAHPS
Early and Periodic Screening, Diagnostic and Treatment	EPSDT
Electronic Clinical Quality Measures	eCQM
Experience of Care and Health Outcomes	ECHO
External Quality Review Organization	EQRO
External Quality Review	EQR
Emergency Department	ED
Federally Qualified Health Center	FQHC
Fee-for-Service	FFS
Health Information Exchange	HIE
Health Information Technology	HIT
Health Services Advisory Group	HSAG
Healthcare Effectiveness Data and Information Set	HEDIS
Health Care Policy and Financing	The Department
Managed Care Organization	MCO
Medicaid Management Information System	MMIS
Quality Health Improvement	QHI
Performance Improvement Project	PIP
Per Thousand Per Year	PKPY
Prepaid Ambulatory Health Plan	PAHP
Pre-paid Inpatient Health Plan	PIHP
Primary Care Case Management/Entity	PCCM/PCCMe
Primary Care Medical Provider	PCMP
Program of All-Inclusive Care for the Elderly	PACE
Regional Accountable Entity	RAE
Regional Care Collaborative Organization	RCCO
State Innovation Model	SIM

SECTION I: INTRODUCTION

Welcome to the Department of Health Care Policy & Financing's (the Department's) 2018 Quality Strategy. The Department is the single Colorado state agency responsible for administering the Medicaid program (Title XIX) and the Children's Health Insurance Program (Title XXI), known as Child Health Plan *Plus* (CHP+) in Colorado. Colorado's Medicaid program is known publicly as Health First Colorado. In addition to these programs, we administer the Colorado Indigent Care Program, the Old Age Pension State Medical Program, the Primary Care Fund, and the School Health Services Program.

Our direct customers include Coloradans who are eligible and/or enrolled in Medicaid and Child Health Plan *Plus*, and those who receive services through the other programs described above. Indirect customers (those who impact and are impacted by our work) include medical and behavioral health providers, partners such as non-profit entities and sister state agencies, the Centers for Medicare & Medicaid Services, groups that advocate for member populations, the Governor and the Legislature of the State of Colorado, service contractors, and entities that help eligible individuals apply for benefits. These entities include Colorado counties, local government agencies, and medical assistance sites.

Our Department Performance Plan details efforts to achieve our mission, vision, and goals. This plan follows guidelines from the Governor's Office of State Planning and Budgeting, and complies with Colorado's State Measurement for Accountable, Responsive, and Transparent Government Act.

Our vision is that all Coloradans have integrated health care and enjoy physical, mental and social well-being. In alignment with this vision, the Department is committed to its mission of improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

The Department's Quality Strategy provides a blueprint for advancing this commitment to improving quality health care delivered through Managed Care Organizations (MCOs), Prepaid Ambulatory Health Plan (PAHP), Pre-paid Inpatient Health Plans (PIHPs) and the Primary Care Case Management (PCCM) entities. This Quality Strategy highlights the goals, priorities, and guiding principles for continuous measurement, assessment and improvement of health care services for Health First Colorado (Colorado's Medicaid Program).

History of Colorado's Medicaid Managed Care Programs

Almost all our members are enrolled in some form of managed care which provides robust benefits to each member while demonstrating cost effectiveness. For over three decades, Health First Colorado has utilized MCO/PCCM/PIHP-BHO delivery models.

Our MCO program began in 1983 and now covers acute, primary and specialty services for Health First Colorado members. For many years, the Department offered the Primary Care Physician Program (also known as PCCM) model which was available to most non-institutionalized Medicaid beneficiaries statewide.

In 1995, the Department implemented the Medicaid Community Mental Health Services program; a mental health prepaid inpatient plan (PIHP) to manage behavioral health services for most Medicaid members under a 1915(B)(3) waiver. Health First Colorado mental health and substance use disorder services are provided through five Behavioral Health Organizations (BHOs), which are PIHPs, under a 1915(b) waiver. The services are paid for on a per-member, per-month basis for each Medicaid member in the BHO's designated geographic region. BHOs contract for services with Community Mental Health Centers and other providers, such as federally qualified health centers (FQHC), specialty clinics, private facilities, physicians and other mental health care professionals. The Department sets rates through a combination of negotiation and administrative processes using actuarial analyses. These capitated mental health and substance use disorder services are carved out of the Department's other managed care plan contracts. The contracts and organizations currently operating as BHOs will cease at the end of the contract term on June 30, 2018. The remaining Behavioral Health provider network will exist and be managed under ACC Phase II.

In 2003, the Department introduced the Program of All-Inclusive Care for the Elderly (PACE) in order to expand the range of services, including Medicare and Medicaid, available to members age 55 and older with disabilities in certain regions who meet the nursing home level of care requirement.

Denver Health Medicaid Choice was established in 2008 as a risk-based MCO for residents of the Denver metropolitan region.

In 2011, the Department introduced the latest managed care model called the ACC which is a PCCM Entity program. The ACC is the core of Colorado's Medicaid program. It promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the health care system and make smarter use of every dollar spent. It is the primary vehicle for delivering health care to over one million people and, in just six years, has shown real progress in creating a health care delivery system that improves health outcomes, better coordinates care, and reins in cost.

The ACC works on the principle that coordinated care, with needed community supports, is the best, most efficient way to deliver care, especially to members with complex health needs.

In Phase I of the ACC, Regional Care Collaborative Organizations (RCCOs), contract with primary care providers to coordinate acute, primary and specialty care; pharmacy; and select behavioral health services to our members. Within the ACC program, the Department is utilizing payment reform initiatives to improve the delivery of health services. Rocky Mountain Health Plans Prime is a comprehensive, full-risk capitation program for ACC members residing in six counties.

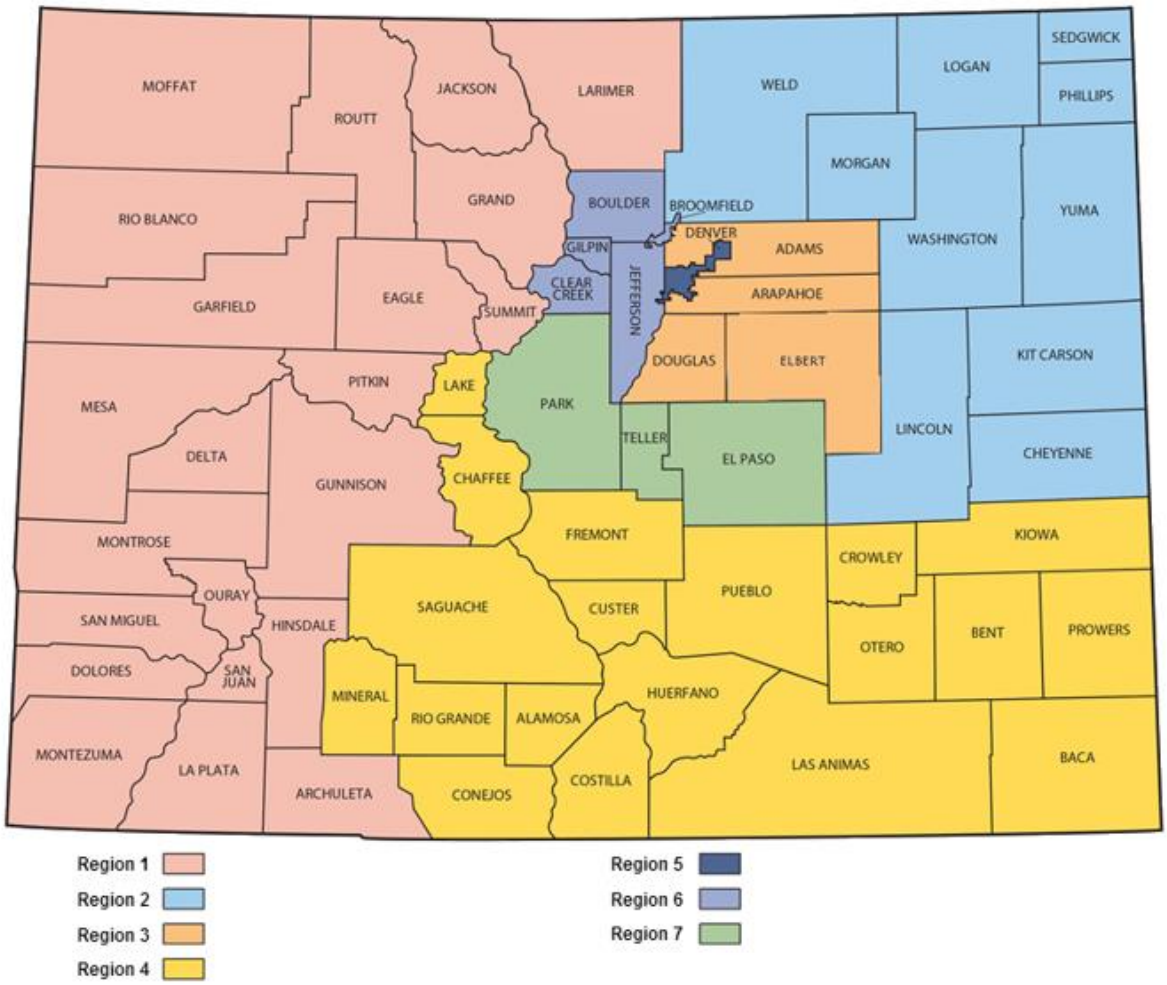
The Department is excited to launch the next phase of the ACC (Phase II), which will build upon the successes of the first seven years and advance the Department's goals to improve member health and reduce costs. Phase II will move us toward a more coordinated and integrated health care system. On July 1, 2018, one organization, a Regional Accountable Entity (RAE), in each of the seven ACC regions will be responsible for promoting physical and behavioral health,

including administering the Department's capitated behavioral health benefit. Each RAE will perform as a single administrative organization for behavioral health and physical health. To achieve these goals, the Department will:

- join physical and behavioral health under one accountable entity;
- strengthen coordination of services by advancing team-based care and health neighborhoods;
- promote member choice and engagement;
- pay providers for the increased value they deliver; and
- ensure greater accountability and transparency.

This next iteration of the ACC, represented in the below map, will continue to promote innovation, flexibility and local ownership of public health and health care delivery.

Regional Accountable Entity Map



The RAEs will administer the ACC in compliance with the requirements for both a PCCM Entity and a PIHP. Their primary responsibility will be creating a cohesive network of primary care physical health providers and behavioral health providers who work together seamlessly and effectively to provide coordinated health care services to members. Through their expanded scope of responsibility, the RAEs will promote the population's health and functioning, coordinate care across disparate providers, interface with long-term services and supports providers, and collaborate with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex member needs that span multiple agencies and jurisdictions.

Overview of Quality Management Structure

The Department's Quality and Health Improvement Unit (QHI) operates within the Client and Clinical Care Office. QHI facilitates and manages elements that improve quality of care for Health First Colorado. QHI works in collaboration with external stakeholders, providers and other state agencies and a few of them are listed below along with their function and purpose.

The Health Impact on Lives Subcommittee meets internally and externally with stakeholders, providers and other state agencies to review, promote and implement quality and health improvement best practices for creating greater access to care, performance-based criteria to improve outcomes and achieve population health goals. Additionally, quarterly combined meetings bring together all lines of business to ensure regional and practice differences are addressed, alignment with Health First Colorado's delivery system is fostered, and payment reform efforts are achieved through greater accountability and transparency.

The Medical Quality Improvement Committee, Behavioral Quality Improvement Committee, PACE Quality Committee and Community Living Quality Improvement Committee meet routinely to review quality issues, share questions and concerns, and discuss data trends. The groups consist of different committees with representatives from MCOs, RCCOs, BHOs, PACE organizations, Department staff and various other stakeholders. These meetings provide an opportunity to communicate with the Department and one another about quality concerns, challenges and successes. It is also a time for shared learning and constructive discussions about comparative outcomes, innovations and best practices.

The Colorado State Innovation Model (SIM) is a cooperative agreement between the Centers for Medicare and Medicaid Innovation and the state of Colorado. Colorado received a $65 million SIM award to integrate primary and behavioral health care and reform health care reimbursement structure in the state. SIM's overall goal is to increase access to integrated and comprehensive behavioral and primary care services to 80 percent of Coloradans by 2019 through the SIM Triple Aim (1) better experience of care, (2) lower costs and (3) improved population health. These goals will be accomplished by focusing on four key efforts: (1) payment reform, (2) practice transformation, (3) population health and (4) Health Information Technology (HIT).

The Quality Strategy Team consists of staff from QHI working in collaboration with the Department managed care contract managers to review quality compliance reports. Quarterly reporting addresses grievances and appeals, access to care, network adequacy, stakeholder

feedback, member enrollment and disenrollment, member complaints, and other quality assurance and improvement activities. The review focuses on plan performance, including items or issues requiring follow-up by the MCO/PIHP/PCCMe. When questions arise, MCOs/PIHPs/PCCMes are asked for additional information and further action, if necessary. Issues, successes, problems or concerns identified through the review process are documented and communicated with the team and senior management.

For the RAEs the Department is implementing a key performance indicator incentive program through which the Contractor may earn a PMPM (Per Member Per Month) payment for meeting established performance goals. Similarly, the Department is implementing a Behavioral Health Incentive Program enabling the Contractor to receive incentive payments for the improvement of Behavioral Health Incentive Measures.

Goals and Objectives of the State's Managed Care Program

The 2018 Quality Strategy aligns with the National Strategy for Quality Improvement in Health Care. Additionally, the Quality Strategy fosters a delivery system that supports clinicians and provider organizations while reducing their administrative burden and helping them collaborate to improve care. The Department has implemented a person-centered approach to its operations with the goal of ensuring that all employees, providers, clients and their families experience person-centered policies, practices, and partnerships that respect and value individual preferences, strengths, and contributions. This includes development of in-person and virtual Member Experience Advisory Councils to work on person-and family-centered projects.

Guided by the Agency for Healthcare Research and Quality principles, the Quality Strategy is developed with input by stakeholders across the health care system, including federal and state agencies, local communities, provider organizations, clinicians, patients, businesses, employers, and payers.

The following aims have been used to guide the development of Colorado's QHI Strategy:

Triple Aim

- Improve the health of the population
- Enhance the patient experience of care (including quality, access, and reliability)
- Reduce, or at least control, the per capita cost of care

National Aims

- Better Care: improve overall quality by making health care more patient-centered, reliable, accessible, and safe
- Healthy People/Healthy Communities: improve the health of the U.S. population by supporting proven interventions to address behavioral, social and environmental determinants of health, in addition to delivering higher-quality care
- Affordable Care: reduce the cost of quality health care for individuals, families, employers, and government

National Priorities

- Making care safer by reducing harm caused in the delivery of care
- Ensuring that each person and family are engaged as partners in their care
- Promoting effective communication and coordination of care
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Working with communities to promote wide use of best practices to enable healthy living
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

QHI's Strategic Goals include:

- Ensure the robust management of Health First Colorado benefits
- Expand network of providers' service for Health First Colorado
- Integrate primary care and behavioral health services
- Support statewide efforts to improve population health
- Strengthen the ability of the ACC to deliver coordinated care
- Improve health outcomes, client experience and lower per capita costs
- Sustain effective internal and external relationships
- Provide exceptional service through technological and delivery system innovation
- Build and sustain a culture where we recruit and retain talented employees
- Enhance efficiency and effectiveness through process improvement
- Ensure sound stewardship of financial resources

For details, please access the 2017-18 Department Performance Plan.

Development and Review of Quality Strategy

438.202(b). The Department works with policymakers, members and key stakeholders to implement strategic, incremental and system-wide approaches to health care reform so Health First Colorado beneficiaries can access high-quality, affordable health care. The Department has many initiatives for improving access to health care, creating efficiencies, defining consumer value and promoting transparency.

Prior to implementation of the final Quality Strategy, the Department will collaborate with the following representative stakeholder groups to obtain their review and input:

- State Medical Assistance and Services Advisory Council (created under 42 CFR 431.12)
- Children's Disability Advisory Group
- Children's Services Steering Committee
- Medical Quality Improvement Committee and Behavioral Quality Improvement Committee
- Colorado Behavioral Healthcare Council
- Colorado Department of Public Health and Environment (CDPHE)

- Colorado Department of Human Services (CDHS)
- Colorado Community Health Network

438.202(d). This Quality Strategy will be revised when significant change occurs pursuant to the new regulatory reference at § 438.340(b)(11). Significant change refers to compliance with new and amended federal/state regulations, changes to Department programs, policies, and procedures, as well as quality performance review and assessment based on data analytics for improving change.

SECTION II: ASSESSMENT

Quality and Appropriateness of Care

438.204(b)(1). Quality and appropriateness of care is typically assessed by performance measures, internal assessments of contract deliverables, site audits, and periodic, focused data analysis initiated as regular reports or for identifying specific progress. The Department's quality reports are available here.

The Department also focuses on care for EPSDT eligible children and youth aged 20 and under, with an emphasis on well care, depression screenings and individuals with special health care needs. The definition of "special health care needs" in our EPSDT program refers to "those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[1] This equates to approximately a fifth of the current EPSDT population. In budget calculations, the Department defines "special health care needs" for adults 21 and older as those who qualify for Social Security benefits.

State Initiatives and the Department's Initiatives can be reviewed in the Department Performance Plan.

Colorado-Cross Agency Collaborative

The Department, CDHS, and CDPHE strive to make Colorado the healthiest state in the nation through a multitude of initiatives supporting the health and well-being of its population. In order to have the greatest impact on health outcomes in Colorado, the three state health agencies partnered and created a data alignment strategy. The purpose of this strategy is to use available data to identify and align pertinent measures impacting health outcomes of Coloradans. This initiative allows state health agencies to share a common list of metrics that help drive collaborative health improvement programs. Four Colorado Cross Agency Collaborative reports have been created with aligned metrics for the following populations: behavioral health, children, adults aged 18 to 64, and adults aged 65 and older.

Collaboratives

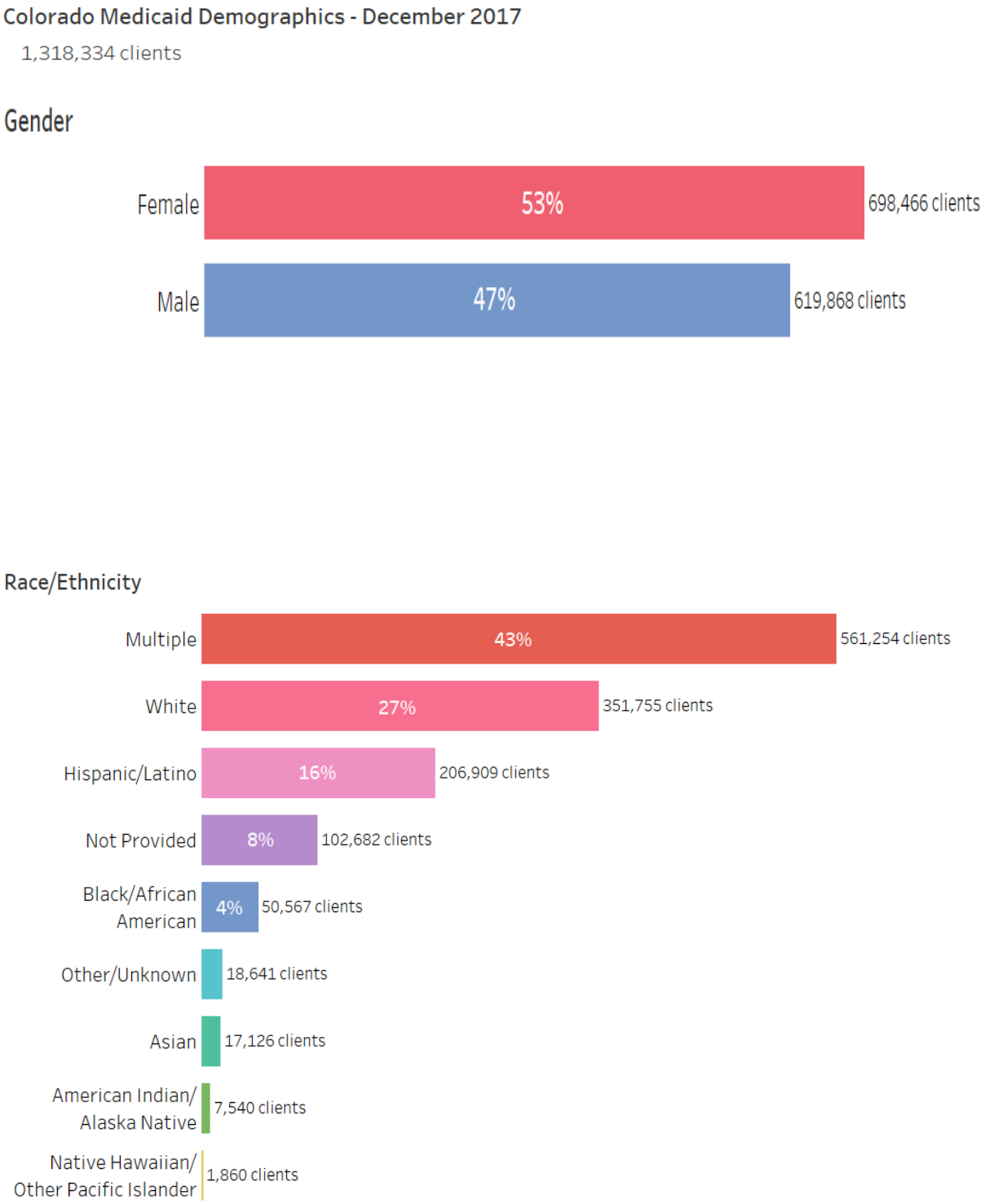
QHI staff participate in collaboratives and groups addressing issues of health equity, including: behavioral and physical health quality committees, Colorado Opportunity Project, Colorado State Innovation Model (SIM), Community Living Quality Improvement Committee, and the ACC Program Improvement Advisory Committee.

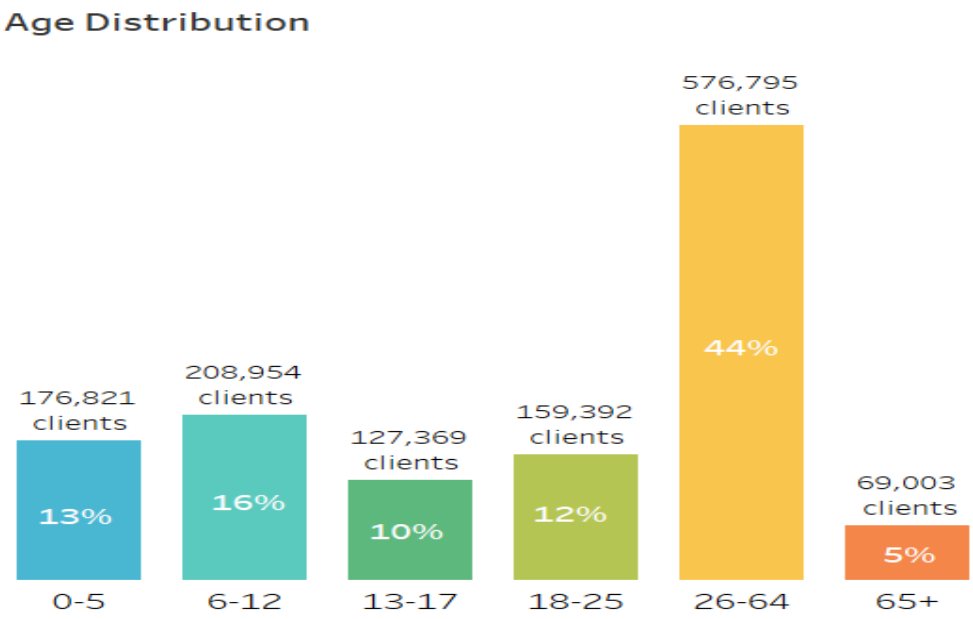
438.204(b)(2). Client Demographics

Demographics of the Medicaid population in Colorado are collected during enrollment. Demographics are monitored and analyzed annually by the Department. Demographics for December 2017 are presented below. Colorado places the onus on MCOs/PIHPs/PCCMes to

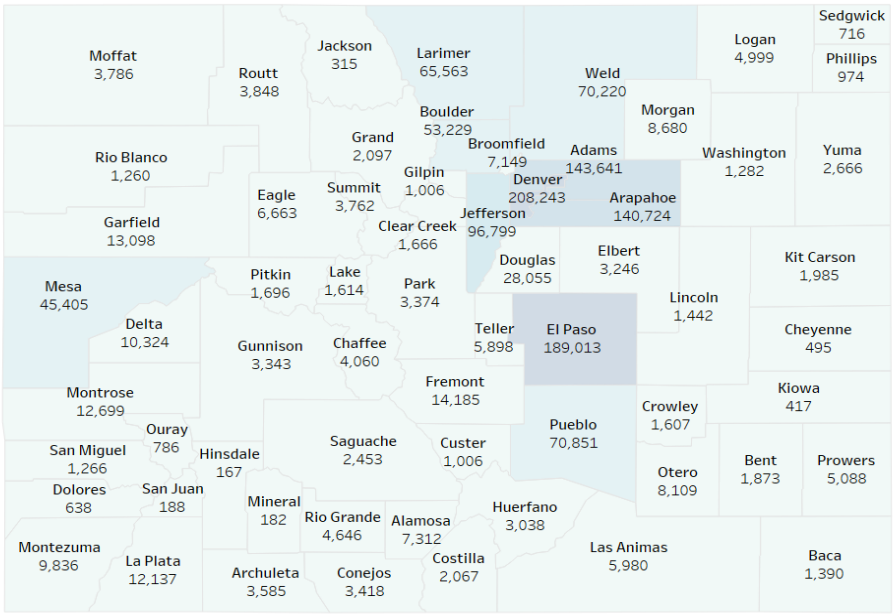
[1] Archives of Pediatric and Adolescent Medicine, 150:10 17, 2005.

assess the race, ethnicity, and primary languages spoken translation and interpretation needs for their enrollees and to address those needs accordingly.





County



<u>Clinical Guidelines</u>

The Department supports the use of physical and behavioral health clinical guidelines through Agency for Healthcare Research and Quality, the Cochrane Collaboration, PubMED, and other evidenced-based sources. The Department also supports patient centered medical home models,

trauma informed care, recovery and resilience, and the Substance Abuse and Mental Health Services Administration model for behavioral and physical health integration.

National Performance Measures

438.204(c). Although CMS has not identified a list of required national performance measures, the Department continues to report the voluntary adult and child core set measures to CMS on an annual basis.

Adult and Child Core Measures

The Department reports annually on the CMS Adult and Child Core Measures, as well as all measures for which data are available. The Department reported on the following 2017 Adult and Child Core Measures in 2018:

Adult Core Set

- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: HBA1c poor control (>9%)
- Adult Body Mass Index assessment
- Antidepressant Medication Management
- Breast Cancer Screening
- Cervical Cancer Screening
- Consumer Assessment of Healthcare Providers and Systems® (CAHPS)
- Screening for Clinical Depression and Follow-up Plan
- Chlamydia Screening in Women
- Follow-up After Hospitalization for Mental Illness or Alcohol and Other Drug Dependence
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Annual Monitoring for Patients on Persistent Medications
- Use of Opioids at High Dosage in Persons without Cancer
- Plan All-Cause Readmission
- Timeliness of Postpartum Care
- PQI 01: Admissions for diabetes, short-term complications
- PQI 05: Admissions for chronic obstructive pulmonary disease
- PQI 08: Admissions for congestive heart failure
- PQI 15: Admissions for adult asthma

Child Core Set

- Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
- Ambulatory Care – Emergency Department (ED) Visits
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Adolescent Well-Care Visit
- Consumer Assessment of Healthcare Providers and Systems® (CAHPS)
- Children and Adolescents' Access to Primary Care Practitioners
- Chlamydia Screening

- Childhood Immunization Status
- Pediatric Central Line Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit
- Developmental Screening in the First Three Years of Life
- Frequency of Ongoing Prenatal Care
- Follow-Up After Hospitalization for Mental Illness
- Immunizations for Adolescents
- Live Births Weighing Less Than 2,500 Grams
- Medication Management for People with Asthma
- PC-02: Cesarean Section
- Percentage of Eligible Clients Who Received Preventive Dental Services
- Timeliness of Prenatal Care
- Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents

Maternal and Infant Health Grant

As part of the Maternal and Infant Health grant, the Department has implemented an evidence-based program aimed to improve the health outcomes of adolescents. The Adolescent Champion model transforms health care settings by improving high-quality services for adolescent members, enhancing the health center culture and climate, impacting patient outcomes without increasing costs, and strengthening innovative interdisciplinary collaboration and practice. The program assesses the health center environment, policies and practices, trains providers and staff in core areas of adolescent-centered care, collects data and conducts quality improvement initiatives to enhance adolescent health outcomes and patient satisfaction. As part of the grant, four contraceptive care measures will be reported on an annual basis:

Contraceptive Care Measure

Among women ages 15-44 at risk of unintended pregnancy (defined as those that have ever had sex, are not pregnant or seeking pregnancy, and are fecund), the percentage that is provided:

- A most effective or moderately effective method of contraception
- A long-acting reversible method of contraception (LARC)

SIM and Comprehensive Primary Care *Plus*

The SIM Office worked with Centers for Medicare and Medicaid Innovation to align SIM and Comprehensive Primary Care *Plus* operationally so practices can benefit from participation in both programs without duplication of efforts or funds. SIM and the Centers for Medicare and Medicaid Services (CMS) agree that the goals and objectives of the two initiatives create natural synergies and provide practices with an opportunity to redesign processes and offer comprehensive primary care that integrates physical and behavioral health. Our vision of alignment is one in which practice requirements in certain areas – including learning collaborative

offerings, multi-stakeholder symposiums, and quality measure alignment and reporting – are coordinated to reduce provider burden while preserving SIM's focus on the integration of physical and behavioral health.

Practices that participate in SIM, including those that also participate in Comprehensive Primary Care Plus, receive the following supports:

- Practice transformation support
- Access to a data aggregation tool
- Use of new electronic clinical quality measure extraction service
- Access to regional health connectors, who identify valuable, relevant community-based resources
- Opportunity to earn achievement-based payments
- Access to apply to small grants to fund behavioral health integration
- Business support education

Monitoring and Compliance

438.204(b)(3). QHI uses many sources and types of data to look at the structure, process and outcome of care and services provided to Health First Colorado clients. These areas are outlined below.

Accountable Care Collaborative Performance Measures. Below are incentive and other measures being monitored by the Department:

Key Performance Indicators 2017-2018:

- ER Visits - Per thousand, per year (PKPY)
- Postpartum Care
- Well-Child Checks (3-9)

ACC Key Performance Indicators 2018-2019:

- Behavioral Health Engagement
- Dental Visits
- Well Visits (All Ages)
- Prenatal Engagement
- Emergency Department Visits (PKPY)
- Health Neighborhoods (to be defined)
- Potentially avoidable costs (to be defined)

Other performance measures:

- Well-Child Checks (0-21)
- 30-day Readmits PKPY
- High Cost Imaging PKPY
- Chlamydia Screening in Women
- 30-day Post Discharge Follow Up
- Depression Screening
- Adult Clients with Diabetes and Annual HBA1c

Dashboards. The Department continues to create a reporting strategy for all its health-plan specific measures to develop external-facing interactive dashboards. The purpose of these dashboards is to create accountability, transparency and drive performance improvement within our Medicaid program. Data presented will come from validated measures from various sources, including Healthcare Effectiveness Data and Information Set (HEDIS) and CAHPS. Three-year trends will be provided as available, as well as Department goals, to allow for health plan assessment and comparison.

HEDIS® Performance Measures. The Department selects HEDIS measures for reporting each year. Reporting organizations include all contracted MCOs, PIHPs, and Health First's fee-for-service (FFS) program. Measures are selected annually using input from the MCOs, PIHPs and Department staff. Below are the 2018 HEDIS measures proposed to be reported by the Department:

- Adult Body Mass Index Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
- Childhood Immunization Status Combos 2-10
- Immunizations for Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening
- Non-Recommended Cervical Cancer Screening in Adolescent Females
- Chlamydia Screening in Women
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Spirometry Testing in Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
- Medication Management for People with Asthma
- Asthma Medication Ratio
- Statin Therapy for Patients with Cardiovascular Conditions
- Persistence of Beta-Blocker Treatment After Heart Attack
- Statin Therapy for Patients with Diabetes
- Comprehensive Diabetes Care
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Use of Imaging Studies for Low Back Pain
- Anti-depressant Medication Management
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Adults' Access to Preventive/Ambulatory Health Services
- Children and Adolescents' Access to Primary Care Practitioners
- Annual Dental Visit
- Prenatal and Postpartum Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

- Adolescent Well-Care
- Frequency of Selected Procedures
- Ambulatory Care - Outpatient and/or ED
- Inpatient Utilization – General Hospital/ Acute Care
- Antibiotic Utilization
- Annual Monitoring for Patients on Persistent Medications

The CAHPS survey for health plans is used to obtain information related to Medicaid and CHP+ clients' experiences with health care. Client satisfaction with services and providers is measured for all Medicaid and CHP+ MCOs, PIHPs, and FFS program. The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and aids in improving overall member satisfaction.

The Experience of Care and Health Outcomes (ECHO) survey for Behavioral Health plans is used to obtain information related to Medicaid clients' experiences with behavioral health care. Client satisfaction with services and providers is measured for all Medicaid Community Mental Health Centers. The goal of the ECHO survey is to provide performance feedback that is actionable and will aid in improving overall member care and satisfaction.

The Department is developing a series of report cards to compare cost and quality of care among different types of service providers, such Federally Qualified Health Centers, hospitals, and primary care providers. This new initiative will help identify areas for improvement and provide valuable feedback for providers. The report cards will be shared with providers, their representative agencies and eventually made public. The report cards will be updated quarterly.

The first report card of this series focuses on FQHCs. FQHCs are evaluated and compared on the following performance measures:

- Diabetes HbA1c Tests
- Colorectal Cancer Screenings
- Total Cost of Care
- Overhead Cost Ratio
- ER Visits per 1000 Clients
- LARC Insertions
- Hospital All Cause 30-day Readmissions
- New Chronic Opioid Users
- Depression Screenings
- Child Well Visits
- Asthma Treatment

These measures come from various sources such as HEDIS and CMS core sets, and often align with measures used in other Department initiatives, such as payment reform. Performance measures are risk-adjusted where appropriate and FQHCs are ranked by their performance in comparison to the state average. This allows for easy comparison between FQHCs and highlights key areas in need of improvement. The Department met with the Colorado Community Health Network (CCHN) throughout the development of this report card to gather feedback and suggestions. The Department anticipates publishing this report card in Spring 2018.

A similar report card that focuses on hospitals is in the early stages of development. Proposed measures include:

- ER Recidivism within 72 hours
- 30-Day All Cause Readmissions
- Caesarean Section Rate
- 30-Day Follow-up Care Following Inpatient Discharge
- Clostridium Difficile Infection
- Falls with Injury
- Patient Experience
- Infant Mortality Rate
- NICU Length of Stay

In the future, the Department plans to create additional report cards, such as a Primary Care Provider report card and a Long-Term Services and Supports report card.

The EPSDT report (form CMS-416) provides basic information on participation in the Medicaid child health program and utilization of services for children under 20 years of age. The information is used to assess the effectiveness of the EPSDT program in terms of the number of children (by age group and basis of Medicaid eligibility) who are provided child health screening services, referred for corrective treatment, and receive dental services. For the purposes of reporting on this form, child health screening services are defined as initial or periodic screens required to be provided according to a state's screening periodicity schedule. The completed report demonstrates the state's attainment of its participation and screening goals. Participant and screening goals are two different standards against which EPSDT participation is measured on form CMS-416. From the completed reports, trend patterns and projections are developed on a national basis, and for individual states or geographic areas, from which decisions and recommendations can be made to ensure that eligible children are given the best possible health care.

Performance Improvement Projects (PIPs) are undertaken by each MCO, PCCM Entity and PIHP. Each plan previously selected at least one PIP and chose study topics based on data that identifies an opportunity for improvement. For the upcoming state fiscal year, the plans will choose two PIP topics (with the exception of the CHP+ plans, which will choose one topic). They will choose a behavioral health and physical health topic. The topic may be specified by the Department. The PIP is used to identify and measure a clinical or non-clinical targeted area, implement interventions for improvement and analyze results. PIP benefits include improving performance measure rates, keeping plans focused on improving performance, and improving member satisfaction. PIPs are evaluated and validated by an External Quality Review Organization (EQRO). The EQRO supports the Department in consulting with health plans regarding PIPs in an effort to align plan projects and attain more impact as it relates to quality improvement activities and overall population health. The Department has decided to participate in a different approach for the upcoming year. The Rapid Cycle PIP Approach will be used in place of the traditional Outcome-Focused PIP Approach. The following elements are included in this approach:

- Greater emphasis on improving outcomes using quality improvement science.
- Approach guides MCOs through a process of using rapid cycle improvement methods to test small changes.
- Health Services Advisory Group (HSAG) developed a series of five modules.
- Framework represents a modified version of the Institute for Healthcare Improvement's (IHI's) Model for Improvement.
- Aligns with CMS PIP Protocols.
- PIPs last 18 months.
- HSAG provides technical assistance throughout the process with frequent contact and feedback.
- PIP topics have a narrowed focus. For example, HEDIS measure at a low-performing, high volume provider.

The EQRO also coordinates with the Department to host a summit at the end of every two-year PIP cycle to promote quality strategies, share information, and host a keynote speaker relevant to the plan PIPs. PIPs are validated by the EQRO using the methodology outlined in the CMS protocol and regulations found in CFR 438.240.

Focused studies are conducted as appropriate and as funding is available. The goal of focused studies is to measure and improve an aspect of care or service affecting a significant number of plan members. The EQRO may evaluate and validate focus studies as required by the Department.

Compliance Site Reviews assess MCO, PCCM Entity, and PIHP compliance with state and federal regulations, as well as contract provisions and are conducted by our EQRO and attended by Department QHI and Health Programs Office staff. Site reviews consist of several activities: submission and review of documents, a one- to two-day visit of the MCO/PIHP/PCCMe administrative offices, interviews with key MCO/PIHP/PCCMe personnel, identification of areas needing correction and follow-up to assure the necessary corrective actions are completed.

Annual Quality Summary. Quality improvement plans are submitted by the MCOs/PIHPs/ PCCMes to the Department each year. The plans identify current and anticipated quality assessments and performance improvement activities and integrate findings and opportunities for improvement identified by performance measure data, member satisfaction surveys, PIPs and other monitoring and quality activities. These plans are for the Department's approval. The MCOs/PIHPs/PCCMes also submit annual quality improvement reports included within the annual report summarizing actual performance, improvement opportunities and accomplishments from the previous year.

Behavioral Health performance measures are selected each year using input from the PIHPs and Department staff. Measures are calculated by the PIHP in collaboration with the Department, and the data is audited by our EQRO. A list of standard measures calculated and audited in state fiscal year (SFY) 2017–2018 are below:

- Depression Screening and Follow-Up
- Child Welfare Screening for Foster Care

- Suicide risk assessment
- Follow-up for positive suicide risk assessment
- Hospital Readmissions: 7, 30, 90 and 180 days
- Percent of members prescribed redundant or duplicated atypical antipsychotic medication
- Adherence to antipsychotics for individuals with schizophrenia
- ECHO survey
- Inpatient utilization
- Penetration rates
- Diabetes screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication
- ED utilization for a mental health condition
- ED utilization for alcohol and other drug dependence
- Follow-up appointments within 7 and 30 days after hospital discharge for a mental health condition
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Mental Health Engagement

EQRO

42 CFR 438.340 states "each State contracting with an MCO, PIHP, or PAHP as defined in § 438.2 or with a PCCM entity as described in § 438.310(c)(2) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP or PCCM entity. To assist the state with assessing and improving the services provided by the contracted health plans the state of Colorado has contracted with Health Services Advisory Group Inc (HSAG). HSAG has more than 30 years of experience performing external quality review (EQR) activities. While officially designated as an EQRO for 13 states, HSAG provides EQR-like services in 15 states. HSAG began performing EQR activities in 1983. In 2017 HSAG was again selected as the state of Colorado's EQRO and will be contracted for EQR activities until the end of FY 2022-23. Mandatory services that HSAG is currently doing and planning for the state include Compliance Site Review audits, Performance Measure Validations, Performance Improvement Project validations (PIPs), and Network Adequacy Validations. Optional EQR activities HSAG is currently performing for the state of Colorado include validation of encounter data, and administration of consumer satisfaction surveys.

The state of Colorado has a number of requirements to help facilitate monitoring of EQR activities. State regulation at 10 CCR 2505-10, Section 8.079.3.A requires managed care entities and all providers to comply with the Department's efforts to monitor performance to determine compliance with state and federal requirements, contracts or Provider agreements, Medicaid service provision and billing procedures, and/or Medicaid Bulletins and Provider Manuals.

Other federal requirements provide states with options to avoid duplicated services that may be performed by the EQRO. 42 CFR 438.360 states "to avoid duplication the State may use information from a Medicare or private accreditation review of an MCO, PIHP, or PAHP to provide information for the annual EQR (described in § 438.350) instead of conducting one or more of the EQR activities described in § 438.358(b)(1)(i) through (iii) (relating to the validation

of performance improvement projects, validation of performance measures, and compliance review).” The state of Colorado does not currently allow managed care health plans to deem EQR activities.

SECTION III: STATE STANDARDS

Access Standards

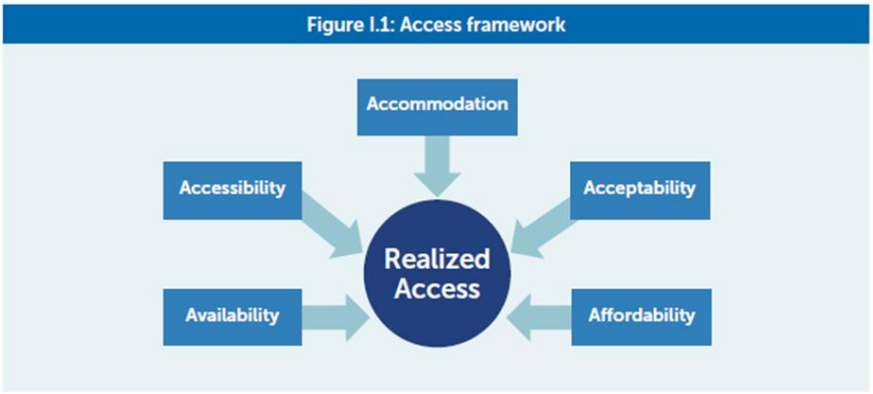
The Department is committed to improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. The Department uses a combination of strategies to achieve this goal. The Department delivers Medicaid services through a combination of FFS and MCOs where access to care standards, rules, and regulations apply. EQRO activities are only required for MCOs, PIHPs, PAHPs, and other applicable entities with comprehensive risk contracts. The Department sets standards for network adequacy and meets these standards through our MCO/PIHP/PCCMe contracts. FFS is monitored through the Access Monitoring Review Plan.

Access Measurement and Monitoring Plan

CMS has required states through the final rule Access to Care regulations (42 CFR §§ 447.203-.205) to track access to care at the state level in hopes that it will ultimately help CMS identify priority areas for access improvement, as well as policies and practices that contribute high levels of access.[2]

Title 42 CFR Part 438, subpart D. In accordance with CMS's final rule on "Methods for Assuring Access to Covered Medicaid Services," (as required under section 1902(a)(30)(A) of the Social Security Act, in accordance with 42 CFR 447.203), the Department authored its first Access Monitoring Review Plan on October, 2016 and will continue to monitor access through methodologies discussed further.

The 2016 final rule contains multiple provisions designed to ensure enrollees' access to care through FFS and MCOs. CMS provides a toolkit to assist states to set provider network adequacy and standards within a broader access landscape. This tool-kit recommends using the "5 A's of Access" framework, developed by Penchansky and Thomas (1981).[3]



This framework is similar to one proposed to CMS to enable it to monitor Medicaid enrollees' access to care across and within states for key services and populations covered by the program, regardless of the delivery system (that is, FFS, managed care, or waivers). The two frameworks are largely consistent.

[2] https://www.medicaid.gov/medicaid/access-to-care/downloads/review-plans/monitoring-plan.pdf
[3] https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf

The Department is using this framework to measure access in these three domains:

· Provider availability and accessibility (potential access)
· Beneficiary utilization (realized access)
· Beneficiary perceptions and experiences

Measuring access to care in Medicaid is a complex endeavor and the Department has combined several data sets to complete the evaluation. The Plan includes analysis of administrative claims utilization data, health access survey data, and rate comparison data. One of the most informative claims data access measures is the service penetration rate; this is a percentage calculated by dividing the number of utilizers by the number of total eligible members. It reveals the trend of utilization of a service, which is useful for monitoring how access to those services changes over time. By combining these three sets of data the Department can analyze, to the best of our available resources, if individuals covered by Health First Colorado have access to health care that is comparable to that of the state's general population.

The Department sets standards for network adequacy and meets these standards through our MCO/PIHP/PCCMe contracts. MCOs/PIHPs/PCCMe prepare quarterly and yearly reports to assure these regulations are being implemented. Through our claims database, these reports are monitored to ensure accuracy. Below is a list of regulations we monitor through this process:

- *Maintains and monitors a network of appropriate providers [§438.206(b)(1)].*
- *Mechanisms/monitoring to ensure compliance by providers [438.206(c)(1)].*
- *Female enrollees have direct access to a women's health specialist [438.206(b)(2)].*
- *Culturally competent services to all enrollees [438.206(c)(2)].*
- *Provide a second opinion from a qualified health care professional [438.206(b)(3)].*
- *Adequately and timely coverage of services not available in network [438.206(b)(4)].*
- *Out-of-network providers coordinate with the MCO with respect to payment [438.206(b)(5)].*
- *Credential all providers as required by §438.214 [438.206(b)(6)].*
- *Providers meet state standards for timely access to care and services [438.206(c)(1)(i)].*
- *Services included in the contract are available 24 hours a day, 7 days a week [438.206(c)(1)(iii)].*
- *Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid-fee-for-service.*

The FFS program's network adequacy is measured through our Access Monitoring Review Plan process. The PCCMes submit a plan and reports.

The Department is also working with our sister agency, CDPHE, to provide external-facing, interactive dashboards. These dashboards will be used to create accountability, transparency and quality improvement within our Medicaid program. Data presented will come from validated measures from various sources, including National Committee for Quality Assurance, HEDIS and CAHPS. Three-year trends will be provided, as well as national benchmarks, to allow for health plan assessment and comparison.

The Department has a goal to reduce disparities in access to and utilization of primary and specialty health care, preventive services, and reducing disparities in care for diverse populations through:

- Improving the use of data for monitoring and continuous improvement in population health by aligning population health programs and metrics for tracking prevention and treatment;

- Improving access to coordinated services so that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing;

- Testing and development of Innovation Center models that strengthen links between public health, clinical care, and community supports for health and wellness and aligned incentives;

- Creating access to information about public and private insurance options for persons seeking and receiving health care services; and

- Requiring MCOs/PIHPs/PCCMes to focus on promoting effective member engagement strategies.

The Department's access to care standards are at least as stringent as those listed in the CMS Toolkit Crosswalk. To demonstrate compliance with the CMS Quality Strategy Toolkit for States, the Department created a crosswalk that lists each of the required and recommended elements of state quality strategies and the corresponding section of the Department's Quality Strategy and/or MCO/PIHP/PCCMe plans that address the required or recommended elements.

Availability of Services. A primary focus of the Department is to ensure members have adequate access to care and receive services from appropriate providers. The Department fosters adequate access to care through several programs and projects. One such program is non-emergent medical transportation; the Department provides this mandatory state plan benefit that is offered to eligible members in order to receive transportation to covered Health First Colorado services when the members have no other means of transportation. The Department and Public Utilities Commission also implemented a new Public Utilities Commission permit to make it easier for Non-emergent Medical Transportation providers to obtain a permit to provide services while also not changing requirements for existing Non-emergent Medical Transportation providers.

Other access to care elements include the Health First Colorado Nurse Advice Line, which provides free 24-hour access to medical information and advice. The nurse advice line triages members and advises them on how urgently their health concerns should be addressed and which level of care is most appropriate for them to access.

Another access to care element at Health First Colorado is the rheumatology-pilot program, eConsult, allowing providers access to new telemedicine technologies that connect specialty care providers and members. Primary care providers can submit clinical questions and relevant personal health information to a specialist for guidance on how to treat a member or to determine if the specialist can see the member.

Assurances of Adequate Capacity and Services. The Department initiated strategies and improvements to expand provider networks serving the Medicaid population. When provider payment rates are reduced or restructured, network adequacy is monitored to ensure access is not diminished.

The RAEs are required to develop and maintain a network of physical and mental health providers that meets the needs of the members. This includes qualities like reasonable distance from the Member, access to the provider outside of normal business hours, and developing a panel that's scalable to adapt to the Medicaid population. The RAE is required to provide a Network Adequacy Report annually which details these and other facets of the network as well as a quarterly Network Report that details the changes in makeup of the network over a quarter.

BHOs have historically been integrating TeleHealth in the regions, particularly to affect access for behavioral health access. This is especially present in one region which is primarily rural and frontier where access can be the most challenging.

The Department plays an active role in helping to establish this network by doing things such as the recruitment of Rural Health Centers to become contracted providers in the ACC Program. As of June 2017, 63 of the total Rural Health Centers in the state are PCMPs.

In 2015, Colorado Revised Statute 25.5-4-401.5 established the Medicaid Provider Rate Review Advisory Committee (MPPRAC) and required the Department to create a Rate Review Process and determine a schedule that ensures an analysis and reporting of each Medicaid provider rate at least every five years. The process includes an analysis of the access, service, quality, and utilization of each service subject to rate review. The analysis compares the rates paid to Medicaid providers with Medicare provider rates, usual and customary rates paid by private pay parties, and other benchmarks, and uses qualitative tools to assess whether payments are sufficient to allow for provider retention and member access and to support appropriate reimbursement of high value services. The findings of this analysis are published annually. The Department authors a second recommendation report to review the analysis report and develop strategies for responding to the findings, including any non-fiscal approaches or rebalancing of rates. The recommendation report includes the Department's recommendations regarding the sufficiency of provider rates and includes the data relied upon in making those recommendations.

The Medicaid Provider Rate Review Advisory Committee can recommend changes to the rate review schedule, review and provide input on the analysis report, and conduct public meetings to allow stakeholders the opportunity to participate in the process. Data review sessions allow committee members and stakeholders the opportunity to learn about, and discuss, how the Department categorizes services, the methodologies used for pulling utilization data, the potential sources for pulling quality data, and the methods used for analyzing and presenting access data.

Access issues are identified through the analysis conducted and within Medicaid Provider Rate Review Advisory Committee meetings, by engaging with the provider, stakeholder, and beneficiary community.

Recurring provider rate reviews analyzing utilization, access and quality, and rate comparison by service are also performed. Our goal through the Primary Care Medical Provider (PCMP) Outreach and Enrollment Program is to increase the number of providers available as PCMPs. Rural PCMPs are targeted through outreach at Rural Health Center events. The Department will be supporting SIM's goal of recruiting 400 primary care practices and helping them transition to care delivery models that integrate physical and behavioral health care.

Coordination and Continuity of Care. The Department is committed to delivering a member-focused Medicaid program that improves health outcomes and member experience while delivering services in a cost-effective manner. This goal leverages proven reforms to health care delivery models, such as care coordination, payment incentives, and advances in HIT to improve member health and well-being.

Within the ACC program, the contracted entities regularly participate in Department initiated program initiatives that seek to better reach target populations and develop better methods to deliver services. The RAEs also develop and implement initiatives that are ideally suited for their region's population but may also be replicated for other parts of the state.

Coverage and Authorization of Services. The Colorado Prior Authorization Request Program for utilization management is an effective way to ensure robust management of Health First Colorado benefits. These guidelines help clients receive the right services and supports at the right time and for the correct duration. This program also improves quality of care and saves taxpayer money by reducing unnecessary and duplicative services. In FY 2017-18, the Department continues to work with eQHealth Solutions (the Department's UM vendor) to further improve the PAR process through a data-driven, evidence-based approach. eQHealth Solutions identified numerous initiatives to decrease inappropriate utilization of benefits. The Department expects to see inappropriate benefit utilization and cost reductions as collaboration, process efficiencies, program alignment, and policy enforcement efforts increase.

Structure and Operations Standards

438.214. The Department's contract with the MCOs/PIHPs/PCCMes requires them to comply with all applicable federal and state laws, rules and regulations, including but not limited to, all Structure and Operations standards, as required by 42 C.F.R. Part 438, subpart D. The Department's work ensures rigorous compliance internally with our processes, and externally by holding our business partners accountable. This enables the Department to minimize waste of resources resulting from fraud, waste and abuse.

Provider Selection. Provider relations are critical to the Department's strategy of expanding the network as well as retaining providers serving Health First Colorado. Recognizing a need for dedicated resources for provider recruitment, retention and relations, the Department established a Provider Relations Unit. The unit works to grow the Medicaid provider network so that it is adequate and comprehensive, with sufficient physical, behavioral, dental, and long-term services and supports.

Ongoing responsibilities include outreach, recruitment/retention, enrollment support, revalidation, launch of the interChange and communications. Provider Relations or Network Development staff help providers with recruitment and revalidation. These teams do extensive outreach to get as many of their contracted and network providers revalidated. The Department distributes monthly revalidation status of all providers and they then cross-reference this list with their network list and do targeted outreach to specific providers.

The ACC works with individual practitioners and clinics to encourage participation and expand capacity. All entities share the common goal of supporting positive provider experiences, provider engagement and provider satisfaction while meeting with providers to evaluate provider network needs.

The Department's strategy focuses on purchasing value; effective services resulting in better health outcomes for the lowest practicable cost. Incentive programs reward providers for improving member health and limiting unnecessary use of services.

Enrollee information. The Department requires contractors to establish and maintain written policies and procedures regarding the rights and responsibilities of members which is accessible through the Health First Colorado Member Handbook. The information in the handbook is provided at a 6th grade reading level, is translated into other non-English languages prevalent in the service area and may be in alternative formats. Oral interpretation services are also made available to members.

Confidentiality. The Department ensures the privacy of each member in accordance with the federal privacy requirements (Health Insurance Portability and Accountability Act), and each MCO/PIHP/PCCMe plan expressly addresses confidentiality; they and their sub-contractors must maintain written policies and procedures for compliance with all applicable federal, state and contractual privacy, confidentiality and information security requirements.

Enrollment and disenrollment. The Department ensures enrollment and disenrollment services are compliant with federal and state regulations. The Health First Colorado Member Contact Center improves quality and efficiency of customer service for enrolling members by integrating technology in its processes and using data to increase efficiency and measured performance.

Grievance system. Procedures and timeframes in which a member can initiate a grievance have been established. The member has 20 calendar days from the date of an incident to file a grievance with any matter other than an Action. The contractor has two days to acknowledge the grievance. Grievances are not handled by persons in any previous level of review or decision-making. The grievance can be oral or written. Each grievance is handled in an expeditious manner not to exceed 15 working days from receipt by the contractor. The member is informed of the disposition of the grievance in writing, including the results of the disposition/resolution process and the date it was completed. If the member is dissatisfied with the disposition the matter can be brought before the Department for review and resolution.

Sub-contractual relationships and delegation. State contracts must ensure, through the ACC, ultimate responsibility for adhering to and fully complying with all terms and conditions of the contract, and subcontractors must also meet those requirements. Delegation activities, obligations, and/or related reporting responsibilities are specified in the contract or written agreement.

Measurement and Improvement Standards

438.236(b). The Department's contract with the RAEs, require them to comply with all applicable federal and state laws, rules and regulations including but not limited to all Measurement and Improvement standards, as required by 42 C.F.R. Part 438, subpart D.

Practice Guidelines. Contractors are required to develop practice guidelines including, but not limited to, perinatal, prenatal and postpartum care for women, conditions related to persons with a disability or special health care needs, chronic care management, and preventative services. The contractor ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field. The guidelines consider the needs of the member and are adopted in consultation with participating providers. The contractor reviews and updates the guidelines at least annually and disseminates the practice guidelines to all affected providers and, upon request, to members, clients, the Department and the public at no cost. Decisions regarding utilization management, member education, covered services and other areas are consistent with the guidelines.

Several provisions in the Medicaid and CHIP managed care final rule require states to ensure access to services for enrollees with specific characteristics and health needs. For example, §438.68(c)(1) for Medicaid and §457.1218 for CHIP require that states consider such factors as physical access, reasonable accommodations, culturally competent communications, and accessible equipment when developing their provider network adequacy standards. States also must ensure that services are delivered in "a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity" [§438.206 (c)(2) for Medicaid and §457.1230(a) for CHIP]. Consequently, it is important to consider health disparities and the effects of disability on access to care.

Health disparities. Federal law (42 U.S.C. 3101) identifies a number of data elements, collected at the smallest geographical level statistically possible, that are important to informing trends on health disparities. The data elements include race, ethnicity, sex, primary language, and disability status, as well as information on locations where individuals with disabilities obtain primary, acute, and long-term care; the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities; and the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities.[4]

These new provisions have been written into Managed Care Contracts and our FFS data collections align with these standards as well.

[4] https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf, pg. 26

Quality Assessment and Performance Improvement Program. The Department is focused on objectives related to improving health, ensuring members receive quality care, implementing evidence-based policies, and financing services efficiently. In an effort to make performance and goals meaningful, the Department uses multiple measures to define success.

Health Information Systems. Colorado Medicaid Management Innovation and Transformation (COMMIT) is the Department's four-year project to design, develop, test and implement systems to replace the 20-year-old Medicaid Management Information System (MMIS) and other information technology components. COMMIT includes three distinct systems: Colorado interChange, Pharmacy Benefits Management System, and Business Intelligence and Data Management (BIDM) system. The Colorado interChange improves our ability to process and pay medical claims, BIDM enhances our analytic and business intelligence capabilities, and Pharmacy Benefits Management System enables point-of-sale pharmacy claims processing, drug utilization review, and other functions.

The HIT and data analytics emerging from COMMIT advances our ability to improve member health outcomes and reduce health care costs. As an initiative aligned with the State Health Information Exchange (HIE) strategic plan, and integrated with broader statewide enterprise architecture development, COMMIT contributes to expansion of health information technologies throughout the state.

SECTION IV: IMPROVEMENT AND INTERVENTIONS

As the primary strategic innovation for the Department, the ACC program avoided medical costs for the state as shown in the calculation below:

FY 2015-16			FY 2016-17				
Medical Costs	Member Months	Average Medical Cost Per Member Per Month	Medical Costs	Member Months	Average Medical Cost Per Member Per Month	Difference in Average Medical Cost per Member Per Month	Total Medical Costs Avoided in FY 2016-17
$2,654,511,380	10,799,922	$245.79	$2,641,432,057	10,855,762	$243.32	$2.47	$26,804,230

See ACC Legislative Report.

Plan Do Study Act Cycle activities in QHI are based on the "Plan, Do, Study, Act" cycle, which sets a continuous quality improvement framework for quality activities in the Department. Corrective action plans play an important role in this process and are the documented efforts of an ongoing Plan Do Study Act process, which comes out of the Compliance Site Reviews.

Policy changes are considered when cost savings can be documented and changes can be shown to improve health care quality and health outcomes.

Intermediate Sanctions

438.340. In accordance with 42 CFR 438.700, the Department may implement sanctions for MCO/PIHP/PCCMe non-compliance with state and/or federal statutory guidelines and contractual provisions. The Department maintains sanctions policies that detail the requirements cited in 42 CFR 438, Subpart I for the MCOs/PIHPs/PCCMe/. The policies cite the types of sanctions and monetary penalties or other types of sanctions, should a MCO/PIHP/PCCMe not adhere to the provisions of the contractual requirements and/or state and federal regulations. The Department may implement sanctions for:

- failure to provide medically necessary services to members
- imposing excessive premiums or charges on members
- discriminating acts on members because of health status/need for health care services
- misrepresenting or falsifying information to CMS or to the Department
- misrepresenting or falsifying information to a member, potential member, or health care provider
- failure to comply with physician incentive plans, as set forth in 42 CFR 422.208 and 42.210
- improper distribution directly or indirectly of marketing materials that have not been approved by the state
- violating any of the other applicable requirements of sections 1903(m), 1932, or 1905(t) of the Act and any implementing regulations

The Department may choose to impose intermediate sanctions involving civil monetary penalties:

- to a limit of twenty-five thousand dollars ($25,000.00) for each determination of failure to adhere to contract requirements
- to a limit of one hundred thousand dollars ($100,000.00) for each determination of a failure to adhere to contract requirements
- to a limit of fifteen thousand dollars ($15,000.00) for each member the Department determines was not enrolled because of a discriminatory practice, up to a limit of one hundred thousand dollars ($100,000.00)
- to a limit of twenty-five thousand dollars ($25,000.00), or double the amount of excess charges, whichever is greater

The Department may also impose temporary management if the Contractor repeatedly fails to meet substantive requirements in Section 1903(m) or Section 1932 of the Social Security Act. Temporary management will continue until it is determined the Contractor can ensure the sanctioned behavior will not recur.

As a result of the imposition of temporary management, members would be granted the right to terminate enrollment and would be notified of their right to terminate enrollment in writing. All new enrollments are subject to suspension and sanctions for each failure to adhere to contract requirements until the necessary services or corrections in performance are satisfactorily completed as determined by the Department. Suspension of payment for new enrollments will also go into effect. Before imposing any intermediate sanctions, the Department shall give the MCO timely written notice that explains the basis and nature of the sanction pursuant to 42 CFR 438.710.

Health Information Technology (HIT)

438.204(f). HIT is an essential part of the quality measurement process. Later this year, the Department plans to issue a Request for Proposal to launch a procurement for a Master Person Index. And the Department is currently exploring whether it can leverage the Master Provider Directory that the CDPHE is developing. Together, a Master Person Index and a Master Provider Directory will allow Colorado to achieve a unified view of Medicaid provider and member data across the Health Information Exchange (HIE) networks, improving the quality of data, patient to provider attribution, care coordination, and reducing costs. The MPI and MPD will create a suite of data records and services allowing the Department to link and synchronize a Health First Colorado member, provider, and organization data to HIE sources. This effort will result in a single, trusted, authoritative data source.

The Department, in collaboration with the SIM, is also researching the automated entry of electronic clinical quality measures (eCQM) to improve the HIE data collection foundation for supporting the transition to automated Meaningful Use and Alternative Payment Model CQM reporting for Health First Colorado providers as the Department moves away from fee-for-service to value-based payment models. The Department plans to leverage HIE infrastructure to support CQM reporting to CMS and to implement CQM analytics for Health First Colorado providers and other care coordination organizations participating in the Medicaid ACC. SIM, through a sole-

source procurement, selected the Colorado Regional Health Information Organization and its partners Quality Health Network and the Colorado Community Managed Care Network (collectively, the Clinical Quality Measure Network) to design, develop, and implement an automated eCQM reporting solution. The Department is working closely with SIM to ensure that the solution is scalable to meet the Department's needs. The Department's approach includes updating infrastructure to effectively collect existing CQM data, additional data elements, and support MU, SIM, APM and other program reporting directly from the clinical health record from Health First Colorado providers. The data will be aggregated, normalized, and validated by Clinical Quality Measure Network, and ultimately shared as appropriate with the Health First Colorado enterprise data management solution (MMIS-BIDM). This improvement of data will be used to support advanced risk stratification analysis, enhance care coordination infrastructure and activities, and measure provider performance and outcomes within Health First Colorado programs. Updated CQM reporting will support Transitions of Care, Continuity of Care Documents, and the capability to run analytics on the CQMs submitted by eligible professionals and eligible hospitals, with enhanced reporting and data validation services.

The SIM Office currently collects eCQMs from participating practice sites on a quarterly basis. Practice sites submit aggregate numerators and denominators via a practice interface called the Shared Learning Practice Improvement Tool. SIM practice sites report on an adult or pediatric measure set, and phase in the required CQMs over time. Each SIM practice site receives support from a Practice Facilitator to work on QI activities, performance goals, etc. and a Clinical HIT Advisor to support eCQM reporting and data quality. Part of SIM's long-term HIT strategy focuses on electronic health records data extraction, for the purpose of eCQM reporting for programs like SIM. After year 1 of SIM implementation, the SIM office responded to practice and Clinical HIT Advisor feedback to simplify the CQM reporting requirements. The reduced, more focused set of measures reduces the reporting burden for practices and aligns with existing initiatives.

The Department is also expanding the provider base that is sending data to and receiving data from the HIE through our Provider Onboarding Program. Through this program, the Department pays for interfaces to eligible Medicaid providers and critical access hospitals to connect to the Colorado HIE Network.

The All-Payer Claims Database is a data collection system of health care claims paid by non-Employee Retirement Income Security Act covered payers across the state. The All-Payer Claims Database can provide a more complete picture of a person's experience with the health care system and include claims paid by private and public payers, including insurance carriers, health plans' third-party administrators, pharmacy benefit managers, Medicare, and Medicaid.

BIDM System Overview

In November 2014, the Department selected Truven Health Analytics as the contractor to design, develop and implement the new BIDM system which replaced the legacy decision support system and the legacy Statewide Data and Analytics Contractor. The Department desired a system that hosts data from the new Colorado interChange (formerly known as the MMIS), from other Colorado state agencies and from other sources within Colorado and nationally. BIDM is

intended to be the premier Medicaid analytics solution, allowing the Department and its stakeholders unprecedented capabilities to better manage Medicaid programs. The BIDM solution brings:

- Dedicated staffing – The BIDM contract incorporates a full-time Analytics Manager and 18 dedicated staff for analytics, operations, and system projections. In addition, Truven will provide web portal training and dedicated help desk support

- Accessibility to stakeholders, especially providers – The provider community has access to BIDM reporting via the Data Analytics Portal

- Integration of new data – BIDM will directly interface with existing and future Medicaid data systems (Colorado Business Management System, interChange, and Pharmacy Benefits Management System) while building capacity to exchange health information with numerous other data sources inside and outside of the state domain (e.g. HL7 clinical data)

- Innovative program integrity – Comprehensive statistical profiling of health care delivery and utilization patterns by providers allows users to set, monitor, and report on performance benchmarks that demonstrate progress in the detection of fraud and abuse that may result in recoveries and cost avoidance

SECTION V: DELIVERY SYSTEM REFORMS

The Department is advancing delivery system reforms in the Health First Colorado program through the coordination of multiple state and national reform initiatives. The Department's reforms range from big-picture ideas to narrowly targeted changes. They address varied parts of the complicated health care delivery system, but they share a common theme: a commitment to financial stewardship of taxpayer dollars by ensuring payments are accurate and calibrated to incentivize the right care at the right time. Key initiatives, including payment reforms that support delivery system reform, are described below.

The Accountable Care Collaborative (ACC). The ACC is the core of Colorado's Medicaid program. It promotes improved health for members by delivering care in an increasingly seamless way, making it easier for members and providers to navigate the health care system and make smarter use of every dollar spent. It is the primary vehicle for delivering health care to over one million people.

The objectives of the ACC (Phase I) are to: ensure access to a medical home for all members; coordinate medical and non-medical care and services; improve member and provider experiences in the Colorado Medicaid program; and, provide the necessary data to support these goals, analyze progress, and move the program forward.

To accomplish these objectives, the Department has contracted with seven RCCOs, each accountable for the program in a different part of the state. The RAEs manage a network of primary care medical home providers to help meet the medical and nonmedical needs of their members. The RCCOs are also responsible for providing care coordination to members, supporting providers, and being accountable by reporting on progress towards programmatic goals.

As part of the financing structure in the program, the Department implemented incentive payments that reward cost containment, provision of comprehensive primary care, and more.

In the next phase of the ACC (Phase II), the Department will move toward a more integrated health care system that will join physical and behavioral health under one accountable entity, called a Regional Accountable Entity (RAE). Each RAE will carry out the functions required of a PCCM Entity and PIHP to administer physical health services (which will continue to be paid FFS), and the capitated behavioral health benefit.

RAEs will develop networks of primary care physical health providers and behavioral health providers that work together seamlessly and effectively to provide coordinated health care services to members. More information on the next phase of the ACC can be found here: https://www.colorado.gov/hcpf/accphase2

Behavioral Health Quality Improvement Strategy. The Department, in collaboration with the CDHS's Office of Behavioral Health, is implementing a coordinated behavioral health improvement strategy. Medicaid Behavioral Health services are predominantly rendered under a full risk managed care system. Contracts for the managed care program have been updated to

include pay-for-performance incentives in addition to the full risk capitation rates. Simultaneously, the CDHS is implementing provider level contract changes to align with the Medicaid managed care contract reforms. The complementary incentive structures build on work with the provider community that initially was intended to support the state's efforts to pursue the Certified Community Behavioral Health Center Demonstration; even though the state was not selected for participation in the demonstration, this work ultimately evolved into a state-wide behavioral health quality improvement strategy.

The initial quality metrics for the Medicaid behavioral health incentive performance measures are listed below:

Incentive Performance Measures

- Mental Health Engagement (all members excluding foster care)
- Mental Health Engagement (ONLY foster care)
- Engagement of Substance Use Disorder Treatment
- Follow-up appointment within 7 days after a hospital discharge for a mental health condition
- Follow-up appointment within 30 days after a hospital discharge for a mental health condition
- Emergency Department Utilization for Mental Health Conditions
- Emergency Department Utilization for Substance Use Conditions

Incentive Process Measures

- Suicide Risk Assessment
- Documented Care Coordination Agreements
- Dual Diagnosis Denials

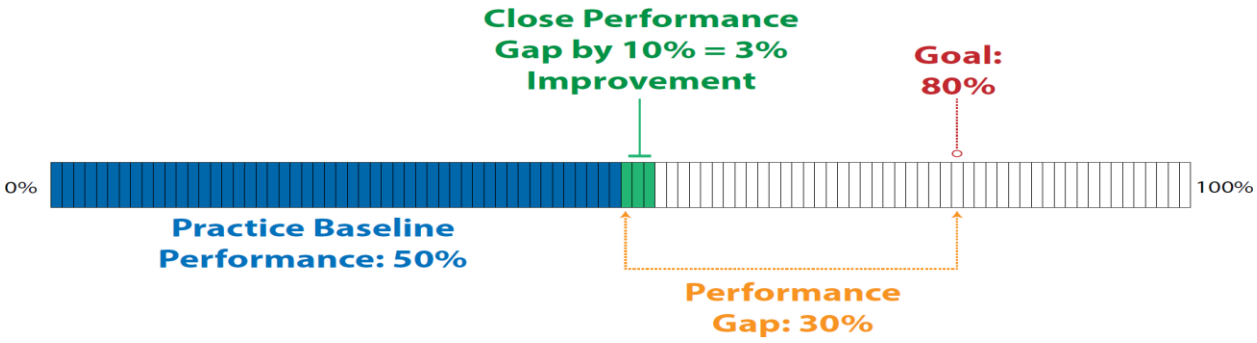
For ACC Phase II, the incentive performance measures will be updated to better reflect the new delivery system.

The Colorado SIM award focuses on improving access to integrated physical and behavioral health services in primary care settings with support from public and private payers, including the Department. The award also includes a focus on public health initiatives. SIM, a federally funded, governor's office initiative, published "The Colorado Framework," which outlines its goal to spur innovation and improve the health of Coloradans by:

- Improving access to integrated physical and behavioral health services in coordinated community systems
- Applying value-based payment structures
- Expanding information technology efforts, including telehealth

Primary Care Payment Reforms. As part of the Department's efforts to shift providers from volume to value, the Department, along with stakeholders, are developing a payment model to make differential fee-for-service payments based on provider's performance. This payment model aims to give providers greater flexibility in care provided, reward performance, and maintain transparency and accountability in payments made. Under the proposed model, providers can earn higher reimbursement when designated as meeting specific criteria or

performing on quality metrics. Progress within this framework not only encourages higher organizational performance but also helps the ACC achieve its respective programmatic goals. The goal is to lead, manage and facilitate performance improvement by closing performance gaps by 10 percent while identifying specific processes and policies that can become more person-centered. To calculate this goal you would do the (benchmark – performance) = gap; and (gap X .10 = goal).



In developing the proposed framework, the Department strives to create a single Health First Colorado primary care payment model that aligns with other state and national initiatives such as the Comprehensive Primary Care Initiative, Comprehensive Primary Care Plus, Enhanced Primary Care Medical Provider incentive program, Medicare Access and CHIP Reauthorization Act of 2015, and SIM, as well as with National Committee for Quality Assurance standards for Patient-Centered Medical Homes.

Stakeholders were engaged in the design of every aspect of the alternative payment methodologies.

FQHC Reforms. Similar to, and aligned with, the primary care payment reforms described above, the Department is engaged in payment reforms with FQHCs to improve access to high quality care by offering alternative payment methodologies that are designed to increase provider flexibility in delivering care while holding providers accountable for client outcomes.

One of the alternative payment methodologies the Department is developing will put a portion of the FQHC encounter rate at-risk based on performance, to give providers greater flexibility, reward performance while maintaining transparency and accountability, and create alignment across the delivery system. Under the proposed model, providers can earn higher reimbursement when designated as meeting specific criteria or performing on quality metrics. Progress within this framework not only encourages higher organization performance but also helps the ACC achieve its respective programmatic goals.

The second alternative payment methodology the Department is developing is a pilot program that will change the reimbursement structure to incentivize value and population-specific needs over volume.

Hospital Transformation Program. The Department is developing the Hospital Transformation Program, which will allow the state to continue delivery system reform and value-based purchasing for hospitals. The Department seeks to promote the Quadruple Aim's goals of better patient experience, improved health outcomes, provider satisfaction, and reduced cost via the Colorado HTP, which is designed to advance care redesign and integration with community-based providers, lower Medicaid costs through reductions in avoidable care, and preparation among the state's hospitals for future value-based payment environments.

Goals of HTP:

- Improve patient outcomes through care redesign and integration of care across settings
- Improve the patient experience in the delivery system by ensuring appropriate care in appropriate settings
- Lower Health First Colorado costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery
- Accelerate hospitals' organizational, operational, and systems readiness for value-based payment
- Increase collaboration between hospitals and other providers, particularly ACC participants, in data sharing, analytics and evidenced-based care coordination and transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health and disparities reduction efforts

Colorado Choice Transitions. This program is part of the federal Money Follows the Person Rebalancing Demonstration. The primary goal of this eight-year grant program is to facilitate the transition of Medicaid clients from nursing or other Long-Term Care facilities to the community using Home and Community Based Services. Services are intended to promote independence, improve the transition process and support individuals in the community. Participants of the Colorado Choice Transitions program have access to qualified waiver services as well as demonstration services. They are enrolled in the program for up to 365 days, after which they enroll into a Home and Community Based Services waiver, given they remain Medicaid eligible.

Community First Choice. Colorado's Community First Choice, also known as 1915(k), allows states to offer Medicaid attendant care services on a state-wide basis to eligible participants. Participants in Community First Choice would have the option to direct their attendant care services or to receive services through an agency. Attendant care services are those that assist in activities of daily living such as eating, dressing and bathing; instrumental activities of daily living such as shopping and keeping doctor appointments; and health-related tasks such as medication monitoring.

SECTION VI: CONCLUSIONS AND OPPORTUNITIES

Through implementation of reform initiatives that span the health care delivery system, with an emphasis on strategic alignment and accountability, the Department aims to reduce costs within the Medicaid delivery system while improving quality of care with access to integrated physical and behavioral health services. This strategy allows the Department the opportunity to focus attention on evidence-based measurable strategies for improving population health outcomes while creating alignment of quality and health improvement initiatives with the ACC, Behavioral Health Quality Improvement Strategy, SIM, Primary Care Reforms, FQHC reforms, and Community First Choice. In addition, it is aimed to reward providers for quality of care instead of quantity of services performed through value-based purchasing models across public and provider payers. Continued opportunities for Health First Colorado include care model enhancements, safety, financing and accountability, data analytics, workforce development, governance and operations, policy and advocacy, all of which encourage engagement and collaboration from a range of stakeholders including members, providers and policymakers.

APPENDIX A: Access to Care Standards Crosswalk

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.206	Availability of Services (Access Measurement and Monitoring Plan)	CO Quality Strategy pg 20
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	Contract §§ 2.5.1.1.2, 2.5.1.1.2
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist	Contract § 2.5.1.1.5
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	Contract § 2.5.1.1.6
§438.206(b)(4)	Adequately and timely coverage of services not available in network	Contract § 2.5.1.2.1
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	Contract § 2.5.1.2.2
§438.206(b)(6)	Credential all providers as required by §438.214	Contract §§ 3.2.1.2, 3.2.1.3
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	Contract § 2.5.1.3.1
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service	Contract § 2.5.1.4.1
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week	Contract §§ 2.5.1.4.1, 2.5.1.4.1.2
§438.206(c)(1)(v)	Mechanisms/monitoring to ensure compliance by providers	Contract§ 2.5.1.4.1
§438.206(c)(2)	Culturally competent services to all enrollees	Contract §§ 2.5.4.3.1.4, 2.5.6.3
§ 438.207	Assurances of Adequate Capacity and Services	CO Quality Strategy pg 23
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	Contract § 2.5.2.4
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	Contract § 2.5.2.4.1.
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	Contract § 2.5.2.4.2
§ 438.208	Coordination and Continuity of Care	CO Quality Strategy pg 24
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	Contract § 2.5.4
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP	Contract § 2.5.4.1

§438.208(b)(4)	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	Contract § 2.5.5.2
§438.208(b)(6)	Protect enrollee privacy when coordinating care	Contract § 2.5.4.1
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	Contract § 2.5.5.3
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	Contract§§ 2.5.5.3, 2.5.5.4
§438.208(c)(3)	If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards	Contract § 2.5.5
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	Contract § 2.5.5.4
§438.210	Coverage and Authorization of Services	CO Quality Strategy pg 24
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	Contract § 2.4, Exhibit D
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	Contract § 2.4.1.2
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	Contract § 2.4.1.1
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	Contract § 2.4.1.3
§438.210(a)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	Contract § 2.4.2.1
§438.210(a)(5)	Specify what constitutes “medically necessary services”	Contract § 2.4, Exhibit D
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	Contract § 2.2.3
§438.210(b)(2)(i)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	Contract § 2.6.1.2
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	Contract § 2.6.1.5

§438.210(c)	Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	Contract § 2.6.1.2
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	Contract §§ 2.6.1.1, 2.6.1.2
§438.210(e)	Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	Contract §§ 2.6.1.1, 3.2.4.1
§438.214	Provider Selection	CO Quality Strategy pg 24
§438.214(a)	Written policies and procedures for selection and retention of providers	Contract§ 3.2.1.1
§438.214(b)(1)	Uniform credentialing and re-credentialing policy that each MCO/PIHP must follow	Contract§ 3.2.1.2
§438.214(b)(2)	Documented process for credentialing and re-credentialing that each MCO/PIHP must follow	Contract § 3.2.1.3
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	Contract § 3.2.1.6
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from federal health care programs	Contract§ 3.2.5.13.1
§438.10	Enrollee Information	CO Quality Strategy pg 25
§438.10	Incorporate the requirements of §438.10	Contract Exhibit F: Member Handbook
§438.224	Confidentiality	CO Quality Strategy pg 25
§438.224	Individually identifiable health information is disclosed in accordance with federal privacy requirements	Contract § 3.1.1.6.1
§438.56	Enrollment and Disenrollment	CO Quality Strategy pg 25
§438.56	Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitation in §438.56	Contract § 2.3.2-2.3.5.10.2
§438.228	Grievance Systems	CO Quality Strategy pg 25
§438.228(a)	Grievance system meets the requirements of Part 438, subpart F	Contract § 3.1.1.5
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	Contract § 3.1, Exhibit J
§438.230	Subcontractual Relationships and Delegation	CO Quality Strategy pg 26

§438.230(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	Contract § 2.2.1
§438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	Contract § 2.2.1
§438.230(b)(2)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate	Contract § 2.2.2
§438.230(c)(3)(1)	Monitoring of subcontractor performance on an ongoing basis	Contract § 2.2.3
§438.230(c)(1)(iii)	Corrective action for identified deficiencies or areas for improvement	Contract § 2.2.4
§438.236	Practice Guidelines	CO Quality Strategy pg 26
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	Contract §§ 2.7.2.1.2-2.7.2.1.4
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees	Contract §§ 2.7.2.13
§438.330	Quality Assessment and Performance	CO Quality Strategy pg 26
§438.330(a)(1)	Each MCO and PIHP must have an ongoing quality assessment and performance	Contract §§ 2.7.2.2.1-2.7.2.2.4
§438.330(a)	Each MCO and PIHP must conduct PIPs and measure and report to the state its performance	Contract § 2.7.2.2.3
§438.330(a)(3)	Each MCO and PIHP must measure and report performance measurement data as specified by the state	Contract § 2.7.2.3
§438.330(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	Contract § 2.7.2.5.1

§438.330(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs	Contract §§ 2.5.5.3, 2.5.5.4
§438.330(e)	Annual review by the state of each quality assessment and performance improvement program If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy	Contract §§ 2.7.2.8.1
§438.242	Health Information Systems	CO Quality Strategy pg 27
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility	Contract§ 2.7.21.1
§438.242(b)(2)	Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	Contract § 2.7.2.11.2
§438.240(b)(3)	Each MCO and PIHP must ensure data received is accurate and complete	Contract § 4.4.1