COLORADO

Department of Health Care Policy & Financing

2020 Quality Strategy

Health First COLORADO™

Colorado's Medicaid Program

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TABLE OF ACRONYMS

Name	Acronym
Accountable Care Collaborative	ACC
ACC: Limited Managed Care Capitation Initiative	ACC:MCO
All-Payer Claims Database	APCD
Business Intelligence and Data Management	BIDM
Centers for Medicare and Medicaid Services	CMS
Child Health Plan *Plus*	CHP+
Client Over-Utilization Program	COUP
Clinical Quality Measure	CQM
Code of Federal Regulation	C.F.R.
Colorado Department of Human Services	CDHS
Colorado Department of Public Health and Environment	CDPHE
Colorado Regional Health Information Organization	CORHIO
Consumer Assessment of Healthcare Providers and Systems	CAHPS
Early Periodic Screening, Diagnostic and Treatment	EPSDT
Electronic Clinical Quality Measures	eCQM
Experience of Care and Health Outcomes	ECHO
External Quality Review/Organization	EQR/O
Federally Qualified Health Center	FQHC
Fee-for-Service	FFS
Health Information Exchange	HIE
Health Information Technology	HIT
Health Insurance Portability and Accountability Act	HIPAA
Health Services Advisory Group	HSAG
Healthcare Effectiveness Data and Information Set	HEDIS®
Health Care Policy & Financing	the Department/HCPF
Home and Community-Based Services	HCBS
Hospital Transformation Program	HTP
Long-Term Services and Supports	LTSS
Managed Care Organization	MCO
Master Person Index	MPI
Master Provider Directory	MPD
Multi-Payer Collaborative	MPC
National Core Indicators	NCI
Per Member Per Month	PMPM
Performance Improvement Project	PIP
Prepaid Ambulatory Health Plan	PAHP
Prepaid Inpatient Health Plan	PIHP
Primary Care Case Management/Entity	PCCM/PCCMe
Primary Care Medical Provider	PCMP
Prior Authorization Request	PAR

TABLE OF ACRONYMS
(Continued)

Program of All-Inclusive Care for the Elderly	PACE
Quality Assessment and Performance Improvement Program	QAPI
Regional Accountable Entity	RAE
State Innovation Model	SIM
Substance Use Disorder	SUD
Utilization Management	UM

EXECUTIVE SUMMARY

Health First Colorado (Colorado's Medicaid program) as administered by the Department of Health Care Policy & Financing (the Department, or HCPF), is pleased to present our written strategy for assessing and improving the quality of managed care services. Health First Colorado, which is funded jointly by a federal-state partnership, administers coverage to approximately 1.3 million Coloradans and serves as a national model for implementing an innovative Fee-for-Service (FFS) and managed health care system for managing costs, utilization, and quality.

For nearly a decade, Coloradans have been involved in intense efforts to create a person-centered, coordinated, community-based health care system that focuses on improving the quality of care delivered, controlling health care costs and helping the most vulnerable persons thrive. Our unique Health First Colorado program created an innovative way to accomplish the Department's goals for Medicaid reform while ensuring every Health First Colorado member has a primary care provider.

Health First Colorado differs from a capitated managed care program by investing directly in community infrastructure to support care teams and care coordination. Aligned incentives allow the Department to measurably improve member health and reduce avoidable health care costs by making the people and organizations that provide care accountable for the quality, outcomes and the cost of that care. The fundamental premise of Health First Colorado is that Regional Accountable Entities (RAEs) are in the best position to make the changes that will optimize the health and quality of care for all members. RAEs are also best positioned to identify and meet member needs and deliver efficient health care by assertively addressing unwarranted variation in practice patterns, mis-incentives from a volume-based payment system and avoidable excess costs from fragmented care, while also promoting evidence-guided, shared decision making.

The Accountable Care Collaborative (ACC) provides the framework in which other health care initiatives, such as medical homes, health information technology and payment reform help the Department to better serve members and create value. It is a hybrid model, combining the Primary Care Case Management Entity (PCCMe) with the Prepaid Inpatient Health Plan (PIHP). RAEs serve as the ACC PCCMe, PIHP and some RAEs include the ACC Managed Care Organization (MCO). The Department maintains contracts with each RAE to implement and manage all aspects of the ACC PCCMe-PIHP program within each of the seven regions. RAEs manage and oversee a network of primary care physical health providers and specialty behavioral health providers while ensuring network adequacy to provide appropriate care for Medicaid members within their region. To further support continuity of care for members receiving care through the MCOs which preceded the Department's RAE structure, and to encourage the continued engagement of the providers participating in these MCOs, the Department incorporated the MCOs into RAE Region 1 and RAE Region 5 as the ACC: Limited Managed Care Capitation Initiative (ACC: MCO). These MCOs function as a formal part of the ACC and are operated by the RAEs. RAE Region 1 and RAE Region 5 maintain the contracts with their respective MCOs.

The Department's Quality Strategy provides a blueprint for advancing our commitment to improving quality health care delivered through the RAEs and their contracted MCO. It adheres to

the Centers for Medicare and Medicaid Services' (CMS) Code of Federal Regulations (C.F.R.) 42 C.F.R. §438.340 prescribed flow of key elements as described in the Quality Strategy Toolkit for States, while highlighting the goals, priorities, and guiding principles for continuous measurement, assessment and improvement of health care services for Health First Colorado. It is not intended to describe all the activities the Department undertakes to ensure quality of care is provided to our Health First Colorado members, but rather provides a written strategy in relation to the required 42 C.F.R. §438.340 regulatory references which outline the required elements for assessing and improving the quality of managed care services offered by Health First Colorado's RAEs and their contracted MCOs.

The Department's Quality Strategy is published to our website for public comment and takes public recommendations into consideration for updating the quality strategy.

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SECTION I: INTRODUCTION

- History
- Overview of the Quality Management Structure
- Managed Care Goals, Objectives of the State's Managed Care Program

Health First Colorado (Colorado's Medicaid program) is public health insurance for Coloradans who qualify. Medicaid is funded jointly by the federal government and Colorado state government and is administered by the Department of Health Care Policy & Financing. Health First Colorado serves 1.3 million members and has an annual budget of $10.2 billion. The Department's mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources under the following Department of Health Care Policy & Financing (HCPF) administered programs. The Department's Quality Strategy provides the framework for advancing our commitment to improving quality health care, while highlighting the goals, priorities, and guiding principles for continuous measurement, assessment and improvement of health care services for Health First Colorado.

Figure 1: HCPF Administered Programs

Health First Colorado
Health First Colorado (Colorado's Medicaid Program) is a public health assistance program for Coloradans who qualify. The program provides access to primary care, hospitalization, nursing facility care, prescription drugs, and other programs to get and keep members healthy.

Buy-In Programs
The Buy-In Program for Working Adults with Disabilities with Disabilities and the Buy-In Program for Children with Disabilities allow individuals and families the opportunity to purchase Health First Colorado coverage. Members pay a monthly premium based on their income.

The Health Insurance Buy-In Program offers commercial health insurance premium assistance for Health First Colorado members who qualify.

In FY 2017-18, 8,929 Coloradans participated in Buy-In Programs.

Child Health Plan *Plus*
Child Health Plan *Plus* (CHP+) offers comprehensive health care benefits the following two populations: uninsured children, ages 18 and younger, and pregnant women who do not qualify for Health First Colorado but cannot afford private health insurance. In February 2018, Congress renewed federal funding for the program.
In FY 2017-18, the CHP+ Dental Program served nearly 51,000 children. This is a 21 percent increase over the previous year. The percentage of CHP+ children seeing a dentist, at least once during the year, rose slightly from 45 to 46 percent.

Long-Term Services and Supports
The Department offers Long-Term Services and Supports (LTSS) to qualifying Health First Colorado members. These services allow people with disabilities to live everyday lives, with family and friends, in the communities of their choosing. In FY 2017-18, 65,996 Coloradans received LTSS

The Colorado Indigent Care Program
The Colorado Indigent Care Program (CICP) allows Coloradans with incomes up to 250 percent of the Federal Poverty Level (FPL) to receive discounted health care services at participating hospitals, community health centers, and clinics.

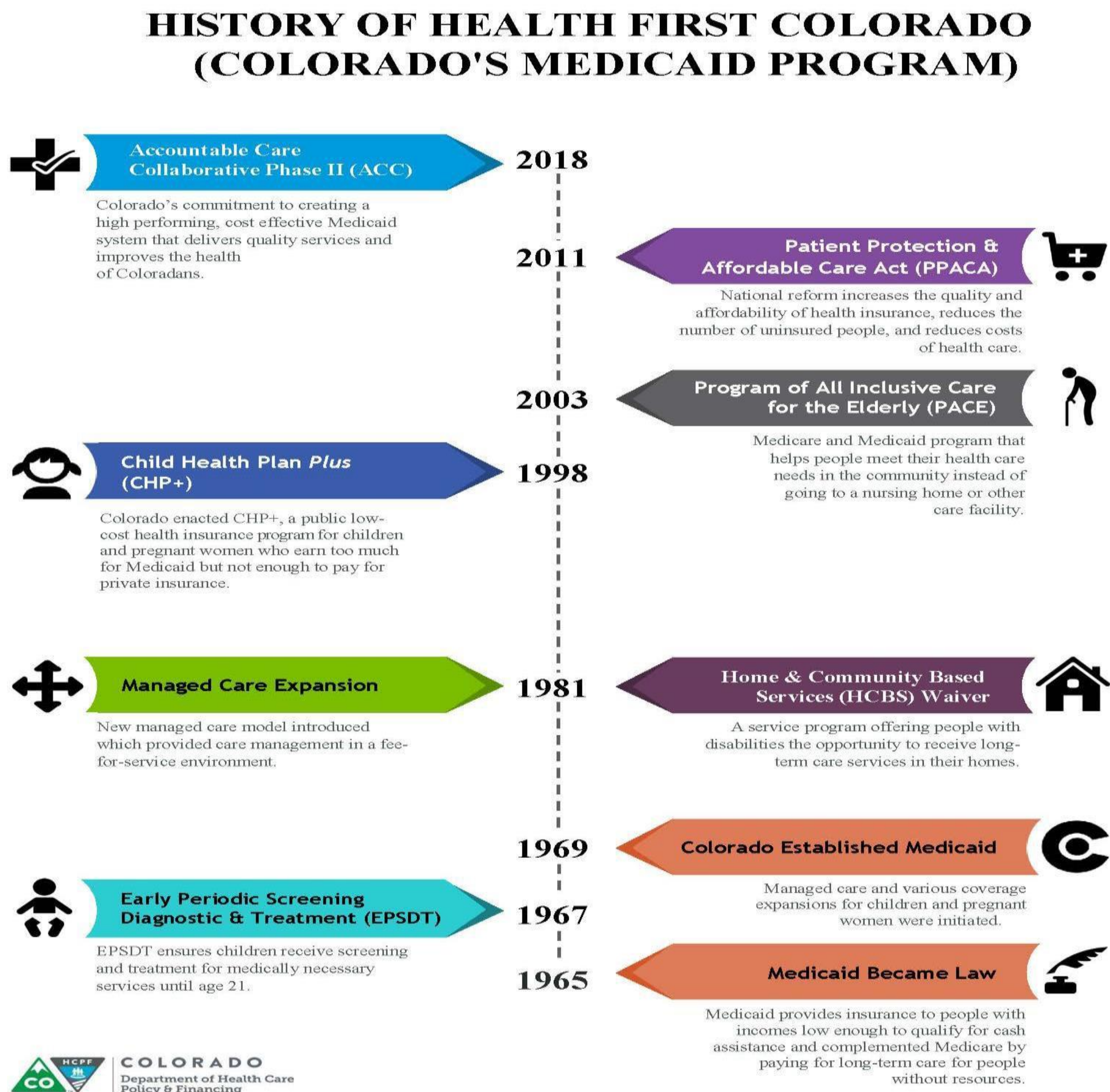
CICP is not health insurance. In FY 2017-18, CICP served approximately 50,000 Coloradans. CICP is an important safety net for Coloradans who do not qualify for Health First Colorado or CHP+.

Dental Program
Health First Colorado offers dental benefits to children and adults.

History of Colorado's Medicaid Managed Care Programs:

Research demonstrates that individuals served by Medicaid face significant barriers to better health and that individuals enrolled in Medicaid report poorer health compared to others within the state of Colorado, due to life circumstances or disability. The Department works collaboratively with a very engaged community of members, providers, advocacy organizations, community organizations, foundations and legislators to address their unique needs. Over the past decade, the Health First Colorado program has expanded from an FFS health plan to a hybrid FFS and managed care program covering 1.3 million children, pregnant women, parents and low-income adults. The following timeline (see Figure 2) reflects the evolution of Health First Colorado's program.

Figure 2: Health First Colorado Timeline



Health First Colorado's ACC operates under the 1915(b) Waiver as approved by CMS. It functions as a PCCM model following the applicable federal requirements in 42 C.F.R. § 438. Prior to 1981, Medicaid members received their physical health services through an unmanaged FFS approach.

In 2007, the State of Colorado embarked on a journey to improve Coloradans' access to cost-effective, high-quality health care services. The Blue-Ribbon Commission for Health Care Reform assessed a variety of health care reform models in Colorado and presented a comprehensive report that provided a blueprint for health care reform in Colorado. Based on this blueprint, the administration proposed a series of legislative initiatives referred to as the "Building Blocks to Health Care Reform" which passed during the 2008 legislative session. The building blocks expanded children's health care coverage, increased reimbursement for providers, improved efficiencies in private and public health insurance programs, increased transparency and accountability across the health coverage system and identified further strategies to expand access to cost-effective, high-quality health care.

Two of the reform efforts included in the Building Blocks were the Medicaid Value-Based Care Coordination Initiative (known as the ACC) and the Colorado Health Care Affordability Act which allowed the Department to generate revenue through a hospital provider fee and draw down federal matching funds. A portion of the fees were used to provide coverage to additional uninsured Coloradans and make health care more affordable by reducing uncompensated care and cost shifting. Through this legislation, at least 100,000 more Coloradans became eligible to apply for Medicaid coverage.

Enactment of the Colorado Health Care Affordability Act, coupled with the unprecedented growth in Medicaid caseload due to the economic recession, reinforced the need for the Department to re-invent and innovate every aspect of its physical, behavioral and long-term services and supports (LTSS) programs. Implementation of the Patient Protection and Affordable Care Act enabled the Department to expand the ACC to more than one million Health First Colorado members, resulting in improved health and more coordinated care. The four primary goals for the ACC included:

1. Expanding access to comprehensive primary care
2. Ensuring access to a focal point of care (i.e., Medical Home) for all members
3. Ensuring a positive member and provider experience
4. Applying an unprecedented level of statewide data and analytics functionality

Today the ACC operates on the principle that coordinated care, with needed community supports, is the best, most efficient way to deliver care to individuals. It builds on the existing PCCM model by investing directly in community infrastructure to support care teams and care coordination and created aligned incentives to measurably improve members' health and reduce avoidable health care costs. The fundamental premise of the ACC is that regional communities are in the best position to make the changes that will optimize the health and quality of care for all members. These regional communities are also best positioned to identify and meet member needs and deliver efficient health care by assertively addressing unwarranted variation in practice

patterns, mis-incentives from a volume-based payment system and avoidable excess costs from fragmented care, while also promoting evidence-guided, shared decision making.

The ACC provides the framework for other health care initiatives, such as medical homes, health information technology and payment reform to better serve members and create value. It is a hybrid model, adding fundamental characteristics of an ACO to the PCCM model by:

- Understanding members' health and social needs
- Managing and integrating the continuum of care across different settings, including primary care, inpatient care and post-acute care
- Supporting comprehensive performance measurement
- Prospectively planning budget and resource needs
- Developing and organizing provider networks

Designed to be iterative, the ACC allows the Department to build upon the first years of the Program and advance the Department's evolving goals to improve member health and life outcomes through:

- Joining physical and behavioral health under one accountable party
- Strengthening coordination of services by advancing team-based care and Health Neighborhoods
- Promoting member choice and engagement by providing information, resources and tools and involving members in their care planning
- Paying providers for the increased value they deliver by shifting payment within Medicaid to value-based models, including a percentage of the RAE payments distributed to providers to support the medical home and value-based care delivery and use of performance-based incentives
- Ensuring greater accountability and transparency through robust financial and public performance reporting

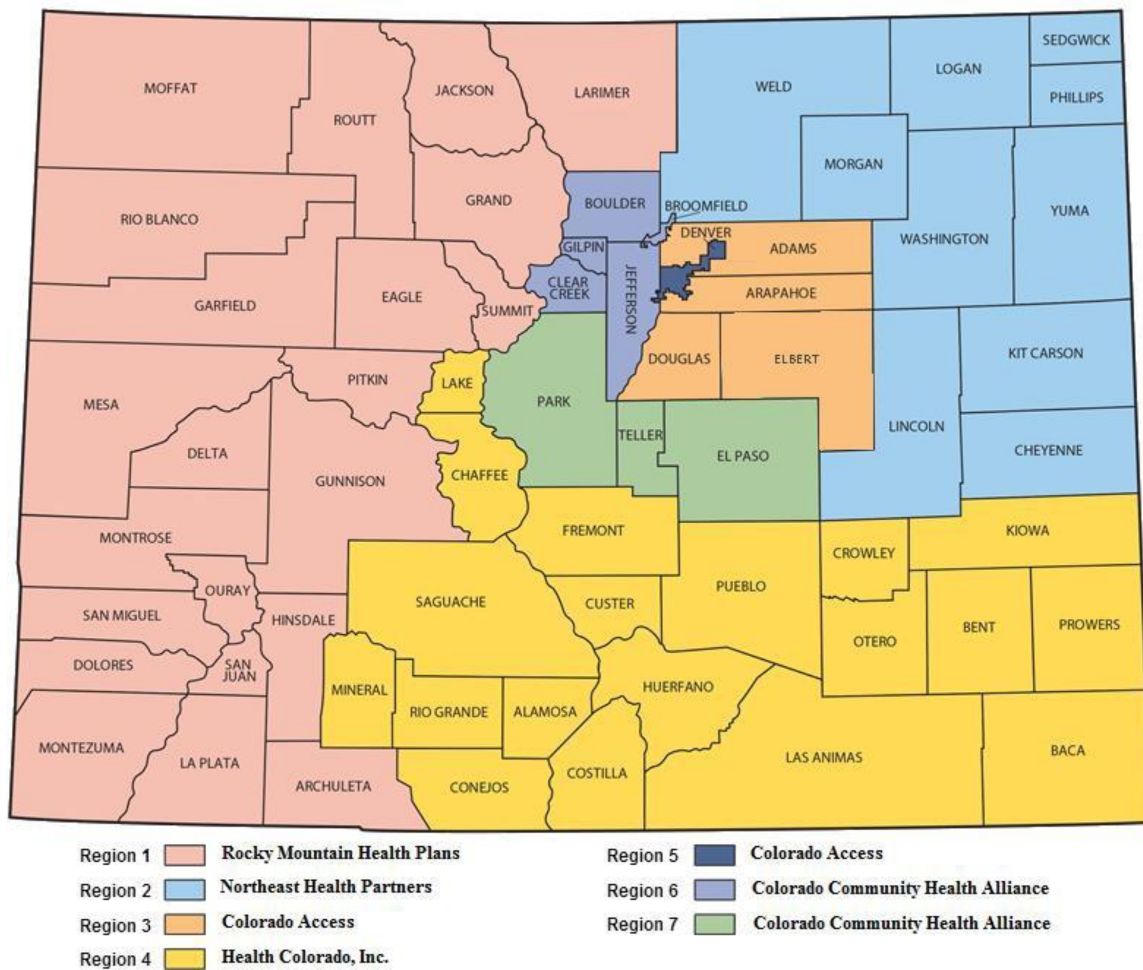
The Department holds and maintains contracts with RAEs to implement and oversee all aspects of the ACC PCCM Entity-PIHP program within each of the seven regions. RAEs manage a network of primary care physical health providers and specialty behavioral health providers to ensure access to appropriate care for Medicaid members in their region. A critical function of the RAEs is to create a cohesive network of providers that work together seamlessly and effectively to provide coordinated health care services to members, to create one point of contact and clear accountability for whole-person care.

To support continuity of care for members receiving care through the MCOs which preceded our RAE structure, and to encourage the continued engagement of the providers participating in these MCOs, the Department incorporated the MCOs into RAE Region 1 and RAE Region 5 as the ACC: MCO. These MCOs function as a formal part of the ACC and are operated by the RAEs. RAE Region 1 and RAE Region 5 maintain the contracts with their respective MCOs. The ACC: MCOs are accountable for improving health outcomes and member satisfaction, incorporating value-based payments for providers and maximizing the integration of behavioral health and physical health services within the ACC infrastructure. ACC: MCO payment reform efforts further emphasize provider value-based payments tied to quality metrics that increase care

coordination between physical and behavioral health; improve patient outcomes; and improve patient experiences.

Outside of the MCO contracts, each RAE has implemented an expanded scope of services to promote the population's health and functioning, coordinate care across disparate providers, interface with LTSS 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. RAEs are encouraged to work with other vendors; for example, creating a Memorandum of Understanding with the Medicaid Dental Administrative Services Organization to promote coordination and collaboration on shared members.

Figure 3: Map of Regional Accountable Entities



Eligible Medicaid applicants are automatically enrolled in the ACC program and immediately connected with a Primary Care Medical Provider (PCMP). A PCMP must be a medical practitioner with a focus on primary care (family medicine, internal medicine, pediatrics, geriatrics, obstetrics and gynecology). Members are assigned primarily using a claims-based attribution methodology. If the Department is unable to make an attribution via claims, and the member has not otherwise selected a PCMP, the Department attributes

the member geographically to the nearest appropriate PCMP. Each PCMP practice site contracts with only one RAE. The geographic location of the member's assigned/attributed PCMP determines the member's enrollment to a RAE. Once attributed, members are able to choose a different PCMP at any time through the Department's enrollment broker.

The ACC Program continues to strengthen Health First Colorado's PCMP network and the relationship between the RAE and PCMPs. RAEs have greater latitude to contract with practices that meet a set of basic minimum requirements that maintain the Department's commitment for enhancing the level of Medical Home standards. PCMPS are encouraged and supported in leveraging all staff to the greatest extent possible for building team-based care.

Each RAE is responsible for ensuring timely and appropriate access to medically necessary services offered by the full range of Medicaid providers in the health neighborhood, including specialty, hospital, and home-based care. The RAEs infrastructure supports coordination between network providers and the health neighborhood, including streamlining referral processes, improving communications among providers, clarifying roles and responsibilities of providers and increasing the number of specialty care providers enrolled in Medicaid and actively treating members. The RAEs support provider access and utilization of tools and resources to support members with complex conditions, obtain brief specialty consults, and make appropriate, timely and coordinated referrals for members requiring more intensive specialty care. In addition, each RAE administers the Department's capitated behavioral health benefits to promote optimized mental health and wellness for all Clients and to ensure delivery of medically necessary mental health and substance use disorder services.

Update (January 2020)

In compliance with House Bill 19-1285, the Department of Health Care Policy & Financing (Department) revised its contract arrangement for members enrolled in Denver Health Medicaid Choice. As of January 1, 2020, the Department is contracted directly with Denver Health Medical Plan for these members instead of the previous contract with Colorado Access as the Region 5 Regional Accountable Entity (RAE). This change only affects the approximately 80,000 members enrolled in Denver Health Medicaid Choice; Colorado Access continues to serve as the RAE for all other members in Region 5.

There is no change to how members access physical and behavioral health care or how providers deliver, authorize, or process reimbursement for services.

- Denver Health still administers and reimburses all covered physical health services for members enrolled in Denver Health Medicaid Choice.
- Colorado Access still administers and reimburses all covered behavioral health services for members enrolled in Denver Health Medicaid Choice.

Although when providers check Health First Colorado eligibility in the Provider Web Portal, they will see Denver Health Medical Plan listed in the Regional Accountable Entity field. **However, Denver Health is not a RAE, but a managed care capitation initiative operating as part of the**

Accountable Care Collaborative. Denver Health is contracting directly with the Department to serve Health First Colorado members in accordance with House Bill 19-1285.

OVERVIEW OF THE QUALITY MANAGEMENT STRUCTURE

In May 2018, the Colorado Legislature Enacted Senate Bill (SB) 18-266, "Controlling Medicaid Costs," requiring the Department to better support and care for individuals when they are the sickest and most vulnerable, implement programs to better control claim costs in the near term, prepare for economic volatility in years to come, and align programs with industry standards to streamline Medicaid administration for doctors and hospitals. The bill has four main components:

1. Creation of a program to review hospital admissions and improve member care coordination upon discharge
2. Funding for innovative tools that support member care pathways based on quality and cost
3. Additional safeguards to prevent inappropriate claim payments
4. Funding for a new unit in the Department that pursues cost control strategies, value-based payments, and other innovations to improve quality for Medicaid and CHP+ members, consumers, employers and taxpayers

Implementation of SB 18-266 resulted in establishment of the Cost Control and Quality Improvement (CCQI) Office which works in collaboration with the Executive Director's Office, Finance Office, Health Programs Office, Pharmacy, Office of Community Living and the Office of Policy, Communications and Administration in coordinating Department-wide quality initiatives and overseeing the development of process and outcome measurements, and implementation of quality improvement projects for the Health First Colorado Medicaid program.

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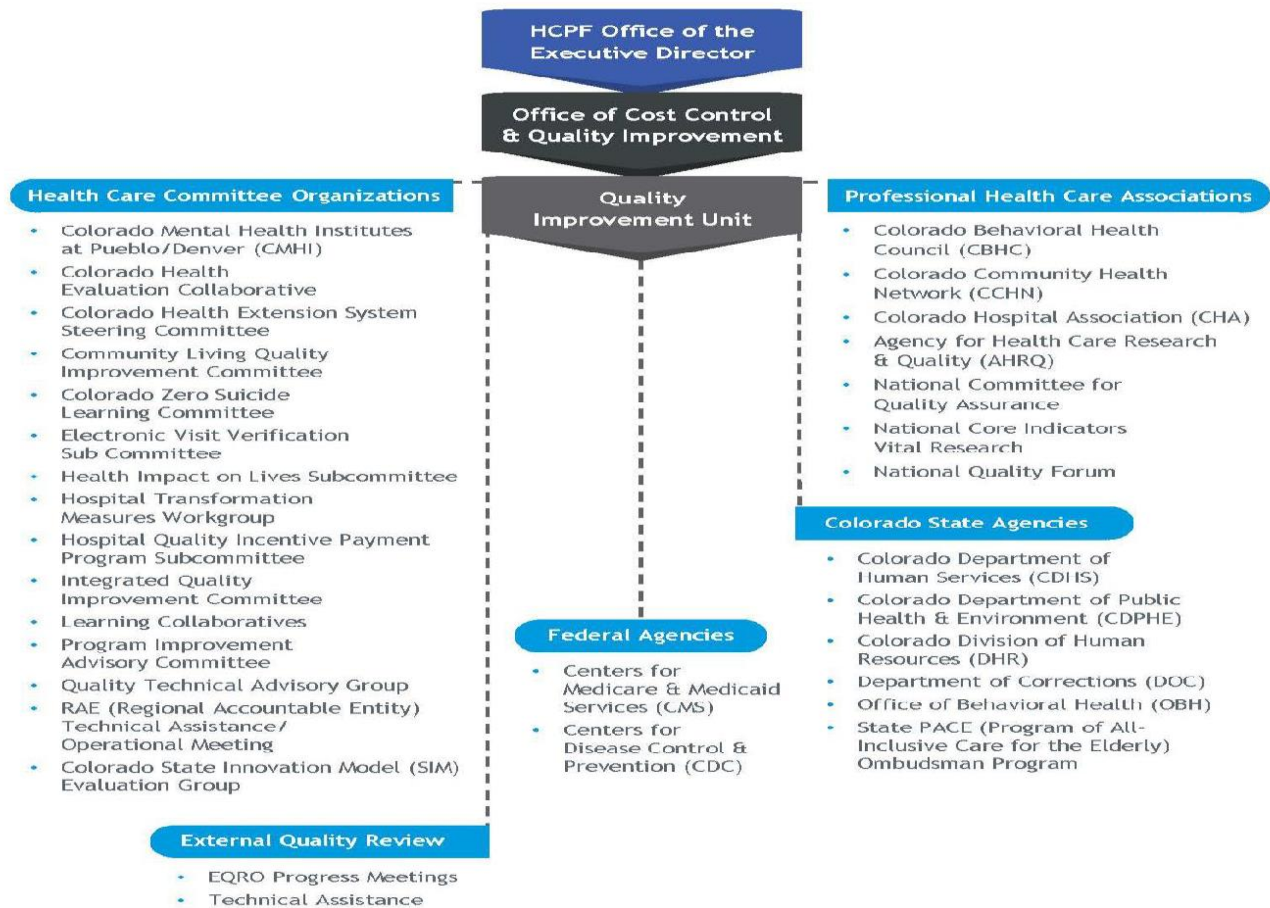
As illustrated below in Figure 4, CCQI and the Department work in collaboration with various external health care quality task forces and managed care collaboratives regarding, data quality and governance for implementing our Quality Improvement Program.

Figure 4: Quality Improvement Collaborative Teams



GOALS & OBJECTIVES OF THE STATE'S MANAGED CARE PROGRAM

The Department, in alignment with the Governor's health care priorities, continues to focus on initiatives to improve quality of care based on the following Department Strategic Quality Improvement Goals, which include the following:

- Decreasing health care cost and increasing affordability for individuals, families, employers and government
- Enhancing delivery system innovation to include:
    - Increasing and monitoring members' access to care and provider network adequacy
    - Increasing and strengthening partnerships to improve population health by supporting proven interventions to address behavioral determinants of health, in addition to delivering higher quality care
    - Protecting and improving the health of communities by preventing disease and injury, reducing health hazards, preparing for disasters, and promoting healthy lifestyles
    - Implementing Pay for Performance to providers for meeting pre-established health status efficiency and/or quality benchmarks for a panel of patients
- Improving patient safety
    - Ensure members are connected to the right care, at the right time, every time
    - Promote effective prevention and treatment of chronic disease
- Improving health outcomes, member experience and patient safety through clinical analytics, evidence-based practices and adoption

The Department's quality strategy includes a variety of performance measures which are detailed in the remaining sections. Overall quantifiable objectives are related to closing performance gaps by ten percent while identifying specific processes and policies that can become more person-centered. To calculate each goal, the Department identifies the performance gap (benchmark – performance) = gap; and determining a ten percent improvement (gap X.10 = goal).

<u>DEVELOPMENT AND REVIEW OF QUALITY STRATEGY</u>

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.340(b)	Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy. Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in the final.
§438.340(c)(3)(ii)	Include a timeline for assessing the effectiveness of the quality strategy (e.g. monthly, quarterly, annually). Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant changes," include the state's definition of "significant changes."

§438.340 The Department conducts an internal review of the quality strategy and makes recommended revisions based on internal priorities, identified member and provider needs and input from policymakers, members and key stakeholders.

Prior to implementing the annual Quality Strategy, the Department reviews our internal recommendations with policy makers, stakeholders and beneficiaries through the following organizations and committees:

- State Medical Assistance and Services Advisory Council (created under 42 CFR 431.12)
- Children's Disability Advisory Group
- Children's Services Steering Committee
- Integrated 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

At the end of this review process, the Department publishes a final Quality Strategy to our website for public comment. The Department takes public recommendations into consideration for updating the quality strategy.

§438.340(c)(2)(i) The Department assesses the effectiveness of the quality strategy annually and revises and modifies the strategy when significant change occurs pursuant to any new regulatory reference at **§438.340(b)(11)**. Reviews include evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. At a minimum, the Department Strategy is updated every three years or if there is a significant change due to new and amended federal/state regulations, changes to Department programs, policies, and procedures, or based on the Department's data analytics highlighting the need for change.

SECTION II: ASSESSMENT

- Quality and Appropriateness of Care
- National Performance Measures
- Monitoring and Compliance
- External Quality Review

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.330(b)(4)	Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state's definition of special health care needs.
§438.340(b)(6)	Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.
Optional Response Not Required by CMS	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care

QUALITY AND APPROPRIATENESS OF CARE

§438.330(b)(4) The scope of activities within the Quality Improvement Program provide a framework to monitor and evaluate significant aspects of care and service provided to our Health First Colorado members and the health care delivery system, including individuals with special health care needs. The Department considers special health care needs as the population who have, or are at increased risk for having, a chronic physical, developmental, behavioral, or emotional condition, that has lasted or is expected to last 12 months or longer, and who experience either service-related or functional consequences, including the need for or use of prescription medications and/or specialized therapies. Additionally, as part of the Department's focus on care for Early Periodic Screening, Diagnostic and Treatment (EPSDT), the Department uses a similar definition of "special health care needs": "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] Approximately 18.3 percent of the current Colorado EPSDT population has special health care needs. Finally, in budget calculations, the Department defines "special health care needs" for adults age 21 and older as those who qualify for Social Security benefits.

As the Department builds or updates its existing programs, we address the quality and appropriateness of care through many mechanisms including contracting with the Center for Evidence-based Policy which helps state agencies by producing reports and other tools to help

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

state policymakers make the best decisions for improving health outcomes. 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 to help our members stay healthy, get better quickly, and live effectively.

The Department's process for assessing the quality and appropriateness of care and services provided includes:

- Review of key indicators through an analysis of administrative data and comparison to performance measure benchmarks (including network adequacy review, client complaints and resolutions/ responsiveness)
- Utilization review to identify over and under utilization
- Review of quality assurance reports from managed care
- Internal assessments of contract deliverables
- External Quality Review Organization (EQRO) evaluations
- Customer satisfaction analysis
- A review of the RAEs' and the Dental ASO's own findings

In addition, the RAEs (ACC PCCM Entity/PIHP), ACC: MCO and the Dental full risk managed care for CHP+, (herein referred to as the Contractors) have processes in place to disseminate the enrollee-specific data to the members' attributed providers. Health First Colorado provides ongoing feedback and monitoring of health outcomes and utilization through weekly contractor meetings and monthly learning collaboratives to standardize processes for monitoring study design and program evaluation, including without limitation childhood immunization and lead screening studies; health education; medical record review; and the annual member experience satisfaction survey.

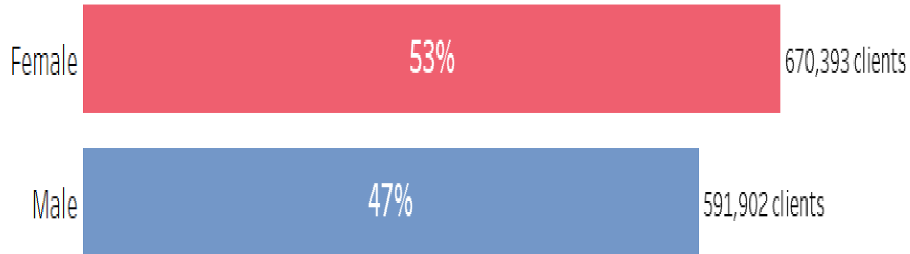
The Department's quality reports, which illustrate how we assess the quality and appropriateness of care, are available here.

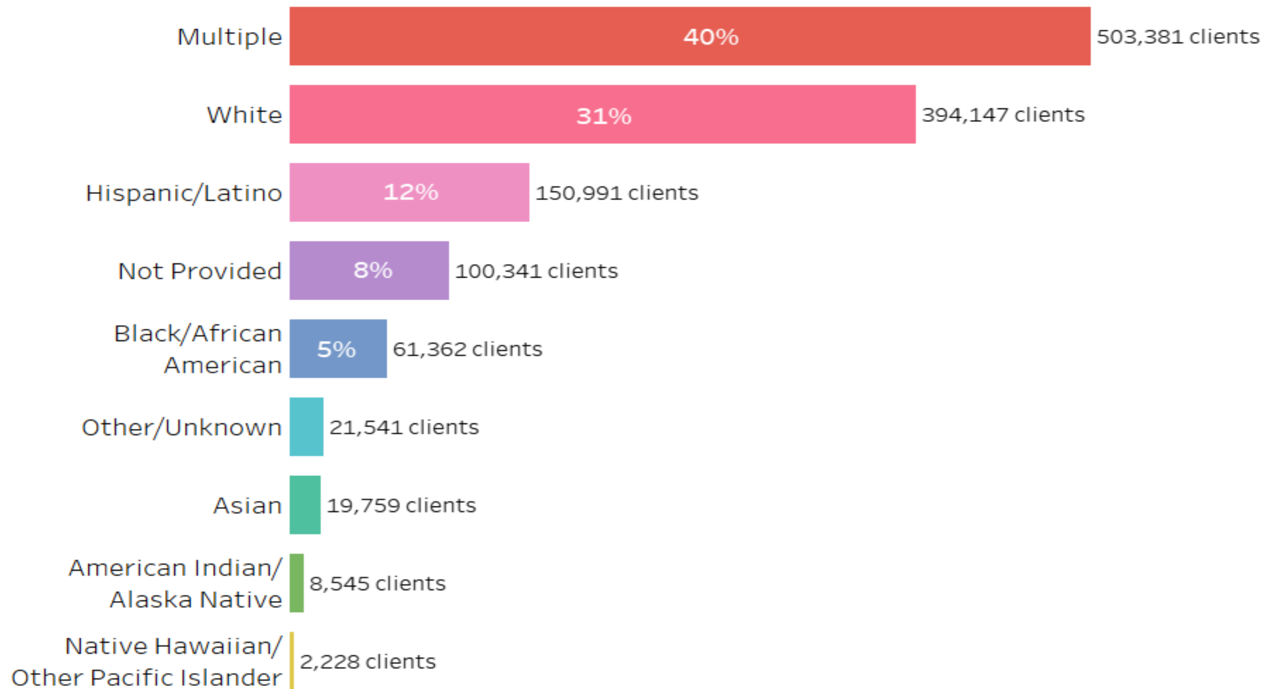
§438.340(b)(6) Member Demographics

The Department annually collects, monitors, and analyzes demographics of the Health First Colorado population during enrollment in order to understand the age, sex, racial composition, and financial status of the population we serve and how it has changed over time through the basic demographic process of birth, death and migration. Demographics for December 2018 are presented below in Figure 5. The Department provides monthly enrollee roster reports to Contractors which outline the race, ethnicity, and primary languages spoken in addition to interpretation needs for members.

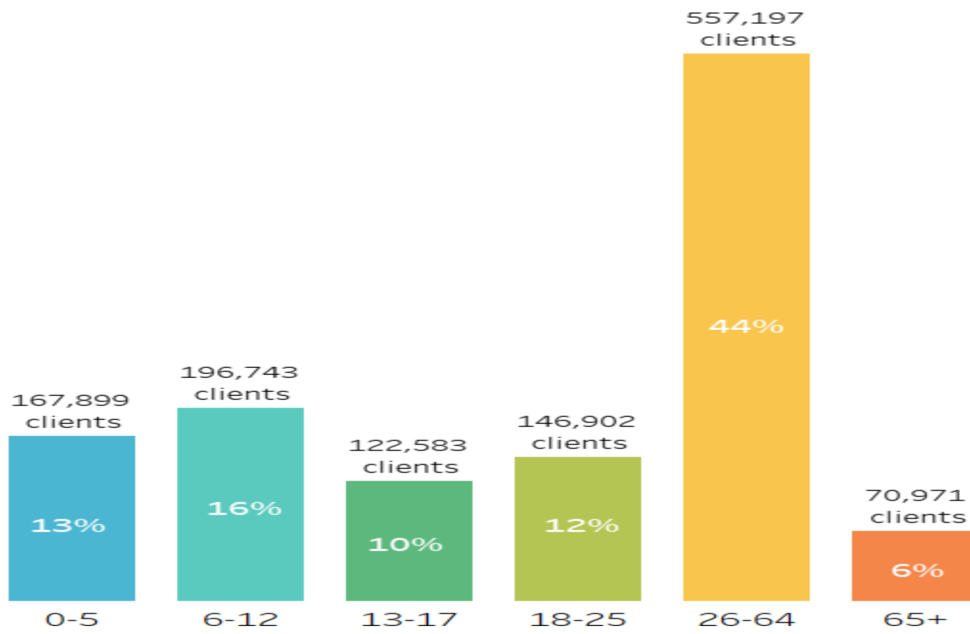
Figure 5: Health First Colorado Demographics

December 2018: 1,262,295 Members

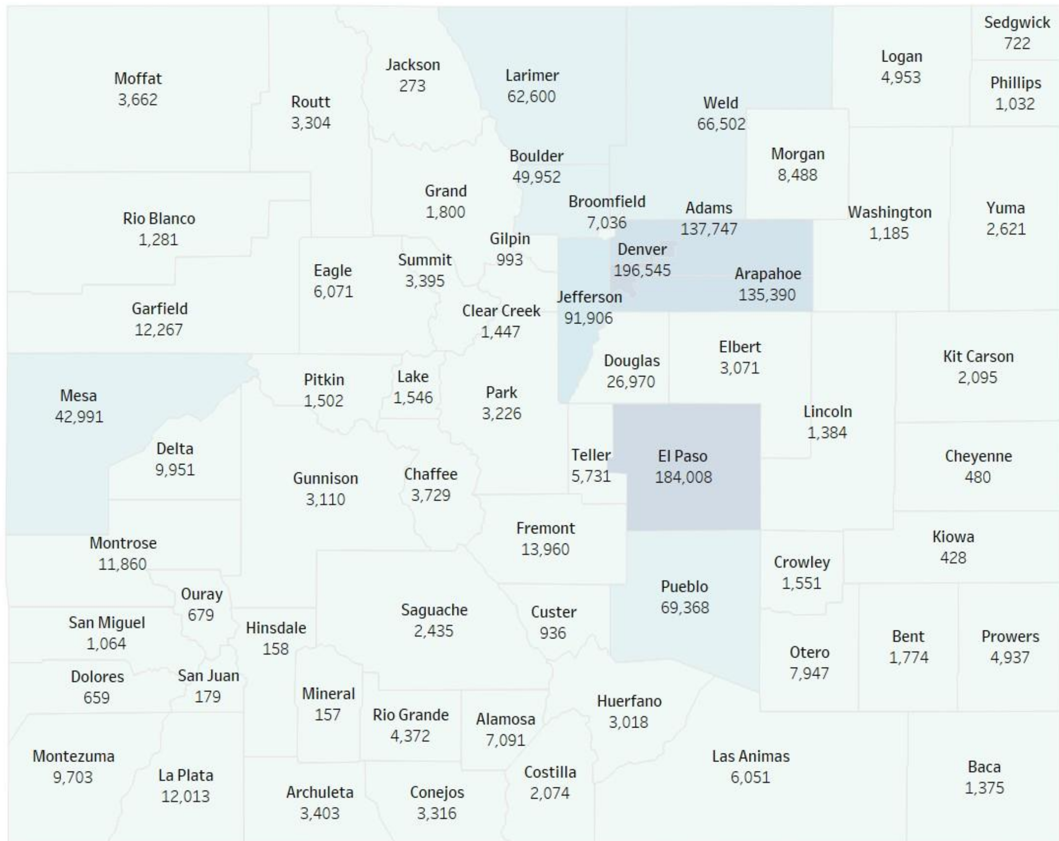




Age Distribution



County



Reducing Disparities in Health Care

Health First Colorado continues to invest in higher value primary care services with the aim of reducing health disparities through measure collection and risk stratification to create and share meaningful information. In addition, the Department expects RAEs and the MCOs to demonstrate an understanding of health disparities and to work with their respective community partners and stakeholders, such as hospitals, local public health agencies, and others, to develop interventions to address them. Interventions and initiatives are included in the population health, member engagement, and potentially avoidable cost reports.

NATIONAL PERFORMANCE MEASURES

Required CMS Regulatory References Addressed

At this time, CMS has not identified any required national performance measures. However, CMS has developed a voluntary set of core performance measures for children and adults in Medicaid and CHIP. Many of these measures have already been in widespread use as part of the HEDIS® data set and have readily available national and regional benchmarks.	
Regulatory Reference	Description
§438.330(a)(2)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders
Optional Response Not Required by CMS	Indicated whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHP+ If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting

§438.330(a)(2) The Department reviews and selects Healthcare Effectiveness Data and Information Set (HEDIS®) measures for reporting each year to evaluate performance in terms of clinical quality and customer service. Measures are identified and selected annually using input from the Contractors, the EQRO, and Department staff. The Department is currently working to implement software that will enable HEDIS® reporting for the entire Health First Colorado population.

Although CMS has not identified a list of required national performance measures, the Department has voluntarily reported a subset of the Adult and Child Core Set Measures to CMS annually. For calendar year 2019 the Department elected not to submit voluntary Adult and Child Core Set Measures due to a system conversion, which created data integrity issues. The Department continues to identify areas of opportunity for driving performance improvement and will report a select set of the CMS Adult and Child Core Measures in relation to identified national benchmarks in calendar year 2020. In addition, with CMS' initiative to streamline and promote holistic measurement of the Medicaid Adult and Child Core Measure Sets, the Department is preparing for mandatory reporting of the Child and Behavioral Health Core Sets which will take effect in 2024 as part of the Children's Health Insurance Program Reauthorization.

MONITORING AND COMPLIANCE

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.358(b)(iii)	Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards).

§438.358(b)(iii) Health First Colorado's comprehensive quality improvement program strives to incorporate all Departmental operational areas to monitor and ensure compliance with all state and federal regulatory requirements. Utilizing various sources of data, the Department annually reviews structure, operations, processes and care outcomes to ensure members have the highest quality medical care. Health First Colorado's specific performance goals and quality monitoring measures are detailed below in Figure 6 for each program.

Figure 6: Performance Goals and Quality Monitoring Measures
(For more detailed information regarding measures for each program, please select the relevant link below)

Program	Entity being assessed	Members	Description
Key Performance Indicators (KPIs)	Regional Accountable Entities	All	KPIs are calculated for contracted RAEs in the Accountable Care Collaborative. KPIs were identified based on needs identified throughout the state
Behavioral Health Incentive Program	Regional Accountable Entities	All	Performance measures are developed each year through a collaborative effort between PIHPs and Department staff. All measures are calculated by the Department using paid claims/encounters data. The state's contracted EQRO does a Performance Measure Validation Audit on these measures annually.
Behavioral Health Standard Performance Measures	Regional Accountable Entities	All	As a result of the transition from Regional Care Collaborative Organizations to RAEs, standard measures are still under review and will be completed in (FY) 2019–2020
Primary Care Alternative Payment Model	Primary Care Providers	Adults and Children in Primary Care	The Primary Care Alternative Payment model makes differential fee-for-service payments based on the provider's performance in selected Clinical Quality Measures. Providers receive greater flexibility in care provided, reward performance, and maintain transparency and accountability in payments made. Providers can earn higher reimbursement when designated as meeting specific criteria or performing on quality metrics. Measures were developed and/or selected to align with on NCQA's HEDIS®, CMS Core Measures, NCQA's PCMH Program, and SIM, CPC+ and QPP Programs.

Hospital Quality Incentive Program	Hospitals	Members seen in hospitals	A part of the Hospital Provider Fee program that provides incentive payments to hospitals for improving health care and patient outcomes.
HealthCare Effectiveness Data & Information Set (HEDIS)	Primary Care Providers, MCOs	All	Performance measures designed by the National Committee for Quality Assurance (NCQA) utilized for identifying and eliminating gaps in care, and to monitor compliance with incentive programs.
Medical Loss Ratio	MCOs	All	The Department implemented two payment reform initiatives under Section 25.5-5-415 C.R.S. that demonstrated innovative ways of paying for improved client outcomes while reducing costs within the ACC. The report described payment methodologies and quality measures, provided performance data, and how program design impacts members and providers. Rocky Mountain Health Plans Prime, a comprehensive, full-risk capitation program and Access Kaiser Permanente, a limited benefit, full-risk capitation program participated in the pilots.
CMS Adult & Child Core Sets	Primary Care Providers, Behavioral Health Providers, Hospitals	All	The Department reports annually on the CMS Adult and Child Core Measures for which data are available.

Additional monitoring and compliance measures for specific programs are listed below.

Program of All-Inclusive Care for the Elderly (PACE)

- Number of falls per 1000 member months
- Number of level II events per 1000 member months
- Flu
  - Percent of participants immunized for flu
  - Percent of participants not immunized for flu due to contraindication
  - Percent of participants not immunized for flu due to refusal
  - Total percent of participants engaged in flu vaccination
- Pneumonia
  - Percent of participants immunized for pneumonia
  - Percent of participants not immunized for pneumonia due to contraindication
  - Percent of participants not immunized for pneumonia due to refusal
  - Total percent of participants engaged in pneumonia vaccination
- Percent of voluntary disenrollment rate
- Days attended PACE center per 1000 member months
- Emergency room visits per 1000 member months
- Acute hospital admissions per 1000 member months
- Acute hospital days per 1000 member months
- Psychiatric hospital admissions per 1000 member months

- Psychiatric hospital days per 1000 member months
- Number of skilled home-care visits per 1000 member months
- Number of CNA visits per 1000 member months
- Average number of prescriptions filled per member per month
- Percent of acute hospital readmissions within 30 days
- Percent of participants with advanced directives
- Average participant risk factor score
- Percent prevalence of cognitive impairment among participants
- Behavioral Screening
  - Percent of participants without a Depression or Bipolar diagnosis who were screened for Depression
  - Number of those screened who tested positive
  - Of those screened and tested positive, percent with a documented follow-up plan within 30 days
- Percent of participants living at home/community
- Percent of participants not living in the community
- Death as percent of total served

Member Experience Surveys

Members' perceptions of the quality of care and the services they receive offer the Department valuable information and data on which to build improvement efforts, identify areas of opportunity and to track quality improvement progress over time.

The Department employs the following surveys:

- The Consumer Assessment of Health Providers and Systems (CAHPS) survey for health plans is used to obtain information related to Health First Colorado Client experience with health care. The EQRO administers the Health Plan 5.0 CAHPS Survey on behalf of the Department for the Health First Colorado programs. The goal of the CAHPS Health Plan Surveys is to provide performance feedback that is actionable and aid in improving overall member satisfaction. The EQRO summarizes the results of the survey in the annual EQR technical report.

- The Experience of Care and Health Outcomes (ECHO) survey for Behavioral Health plans is used to obtain information related to Health First Colorado members' experiences with behavioral health care. Member satisfaction with services and providers is measured for all Health First Colorado 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.

- National Core Indicators (NCI) – Aging and Disabilities Survey is a collaborative effort between the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute. The purpose of this program is to gather a standard set of performance and outcome measures to track performance over

time and compare results across states and establish national benchmarks. Performance measures and domains analyzed by Health First Colorado include:

- Number and percent of waiver participants and/or family members who indicate on the NCI survey that they know who to contact if they want to make changes to their service plan
- Number and percent of (waiver specific) waiver participants and/or family members responding to the NCI survey who indicate they received services and supports outlined in their service plan
- Number and percent of waiver participants and/or family members responding to the NCI survey who indicate they had a choice of service providers
- Proportion of people who are as active in the community as they would like to be
- Proportion of people who can always/almost always see or talk to friends and family when they want to
- Proportion of people who feel sad or depressed at least sometimes or often
- Proportion of people who have a paying job in the community, either full-time or part-time
- Proportion of people who feel that their paid support staff treat them with respect
- Proportion of people whose services meet all their needs and goals
- Proportion of people who can choose/change what kind AND how often they get all services

Compliance Site Reviews assess compliance, and application with state and federal regulations, as well as contract provisions and are conducted by the Department's EQRO and attended by Department Quality Improvement (QI) and Health Programs Office staff. Site reviews consist of several activities: submission and review of documents, up to a four-day visit depending upon site, interviews with key personnel, grievance and appeals review, identification of areas needing correction and follow-up to assure the necessary corrective actions are completed. The EQRO also ensures readiness reviews are conducted in a timely manner to assess the ability and capacity of the health plan to perform satisfactorily in all the applicable areas outlined in CFR §438.66(d)(4).

The EPSDT Participation Report (form CMS-416) provides basic information on participation in the Medicaid child health program and utilization of services for children ages 20 and younger. The information is used to assess the effectiveness of the EPSDT benefit 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. The 416 is broken out by child welfare, RAE and county to further trend high risk and allow for in depth contract management.

Performance Improvement Projects (PIPs) by each Contractor. Each Contractor 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, plans will choose two PIP topics (except for the CHP+ plans, which will choose one topic) one on behavioral health and one on physical health. The topic may be specified by the Department. The PIPs 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 the 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 administers the Rapid Cycle PIP Approach 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 Contractors through a process of using rapid cycle improvement methods to test small changes
- A series of five modules with a framework that represents a modified version of the Institute for Healthcare Improvement's (IHI's) Model for Improvement
- Aligns with CMS PIP Protocols
- Consists of an Eighteen-month PIP cycle
- Technical assistance throughout the process with frequent contact and feedback from the EQRO
- PIP topics have a narrowed focus. For example, HEDIS® measure at a low-performing, high volume provider

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

Focus Studies are conducted as appropriate and as funding is available. The goal of Focus Studies represents a wide range of clinical and non-clinical research activities that are fundamental to the Department for measuring and improving an aspect of care or service affecting a significant number of members. The EQRO may evaluate and validate focus studies as required by the Department.

Annual Quality Summary. Quality improvement plans are submitted by Contractors to the Department yearly. The plans summarize actual performance, 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.

Contractors must submit regular reports and deliverables to the Department for routine monitoring and oversight to ensure compliance with contract requirements and to evaluate performance. Department staff analyze the data, examine trends over time and compare the performance of Contractors to each other when applicable. To ensure a regular flow of information, the Department provides Contractors with a list of required reports (or deliverables), along with frequency requirements.

EXTERNAL QUALITY REVIEW (EQR)

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.340(b)(4)	Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract.
Optional Response Not Required by CMS	Identify, what, if any, optional EQR activities the state has contracted with its External Quality Review Organization to perform. The five optional activities include: 1) Validation of encounter data reported by an MCO or PIHP, 2) Administration or validation of consumer or provider surveys of quality of care, 3) Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an ERQO, 4) Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO, and 5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time
§438.360(b)	If applicable, identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 C.F.R. §438.340.
§438.360(c)	If applicable, for MCOs or PIHPs serving only dual eligible, identify the mandatory activities for which the state has exercised the non-duplication option under §438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §§ 438.358(b)(1) and (b)(2).

§438.340(b)(4)) In accordance with federal regulation 42 C.F.R. Part 438, Subpart E, the Department maintains a written quality strategy for assessing and improving the quality of health care and services furnished through Contractors. To assist the state with assessing and improving the services provided by the Contractors, the Department executed a contract July 1, 2018 with Health Services Advisory Group Inc. (HSAG) for EQR activities until the end of FY 2022-23. Mandatory activities HSAG is currently performing for the Department include:

- Compliance Site Review Audits
- Performance Measure Validation
- Performance Improvement Projects, and
- Network Adequacy Validations.

In addition, HSAG performs the following optional EQR activities:

- Encounter Data Validation
- Consumer or Provider Survey Administration

- Information Systems Reviews
- Quality of Care Reviews
- State Managed Care Audits
- Technical Assistance calls

State regulation 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. In addition, the Department adheres to regulatory requirements §438.360(b)(4) and §438.360 (c)(4) which provide the Department with options to avoid duplicated services that may be performed by the EQRO. 42 C.F.R **§438.360** states "to avoid duplication the State may use information from a Medicare or private accreditation review of an MCO, PIHP, or Prepaid Ambulatory Health Plan (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 Department does not currently allow managed care health plans to deem EQR activities.

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SECTION III: STATE STANDARDS

- Access Standards
  - Availability of Services
  - Assurance of Adequate Capacity and Services
  - Coordination and Continuity of Care
  - Coverage and Authorization of Services
- Structure and Operations Standards
  - Provider Selection
  - Enrollee Information
  - Confidentiality
  - Enrollment and Disenrollment
  - Grievance Systems
  - Subcontractual Relationships and Delegation
- Measurement and Improvement Standards
  - Practice Guidelines
  - Quality Assessment and Performance Improvement Program
  - Health Information Systems

ACCESS STANDARDS

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.206(b)(1)	Maintains and monitors a network of appropriate providers
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional
§438.206(b)(4)	Adequately and timely coverage of services not available in network
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment
§438.206(b)(6)	Credential all providers as required by §438.214
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services
§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
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week
§438.206(c)(1)	Mechanisms/monitoring to ensure compliance by providers
§438.206(c)(2)	Culturally competent services to all enrollees

§438.206(b)(1) 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's Contractors monitor all state access to care standards, rules, regulations, member ratios and distance standards, in order to maintain a service delivery system that includes

mechanisms for ensuring access to high-quality, general and specialized care, from a comprehensive and integrated provider network. Contractors are required to administer and maintain a sufficient network of providers including contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, cultural identities, limited English proficiency, and members with physical or mental disabilities.

§438.206(c)(1) EQRO activities for monitoring provider compliance are required for the Contractors and other applicable entities with comprehensive risk contracts. The Department's EQRO works to validate Availability of Services, as appropriate and as defined by CMS Network Access Standards, in accordance with requirements set forth in §438.358(2)(b)(iv). In addition, the Department's EQRO is developing a crosswalk of provider types to ensure consistency across the RAEs and MCOs for categorizing provider types. Categorization will further assist the Department in providing a data dictionary, statewide provider network composition analyses, and recommendations for ongoing Contractor network adequacy reporting to assess capacity, geographic distribution, access, and availability of specific provider types and service types as determined by the Department. FFS is monitored through the Access Monitoring Review Plan, which establishes a process for the ongoing analysis and monitoring of Medicaid member access to medical assistance, as is required under section 1902(a)(30)(A) of the Social Security Act. The Access Monitoring Review Plan must consider:

- The extent to which member needs are fully met
- The availability of care through enrolled providers to members in each geographic area, by provider type and site of service
- Changes in member utilization of covered services in each geographic area
- The characteristics of the member population (including considerations for care, service and payment variations for pediatric and adult populations and for individuals with disabilities)
- Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service

In addition, the following service categories provided under a fee-for-service (FFS) arrangement are analyzed in this Plan:

- Primary Care Services
- Physician Specialist Services
- Behavioral Health Services (FFS)
- Obstetric Services (including pre-and post-natal services, labor and delivery)
- Home Health Services

Availability of Services

§438.206(b)(6) A primary focus of the Department is to ensure members have adequate access to care and receive services from credentialed providers as required by **§438.214**. Contractors shall have documented procedures for credentialing and re- credentialing Network Providers, that are publicly available to providers upon request. The documented procedures shall include the Contractor's timeframes for the credentialing and re-credentialing processes.

Covered services are available and accessible to members as defined within the contract link provided in Appendix A. In accordance with 42 C.F.R **§438.206(c)(2),** the Contractor shall provide and facilitate the delivery of services in a culturally competent manner to all members including those with limited English proficiency, and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. **§438.206(b)(4), §438.206(c)(1)(i)** The Contractor is required to comply with "medically necessary," and maintain and monitor a network of providers in accordance with state standards to ensure timely and adequate access to all services covered under the contract for meeting health care needs of Health First Colorado members. Contractors must provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities regardless of eligibility category. **§438.206(b)(2)** Female members have a choice of women's health specialist or have direct access to a women's health care provider within the network for women's routine and preventive health care services. **§438.206(b)(3)** Members may request and receive a second opinion from a qualified health care professional through a network of affiliated providers or through covered services outside of the network if the Contractor is unable to provide services to a particular member within its network. The Contractor shall provide the covered services out-of-network at no cost to the member in accordance with the access to care standards outlined with the contract. **§438.206(b)(5)** The Contractor shall coordinate payment with out-of-network providers and ensure the cost to the member is no greater than it would be if the services were furnished in-network. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification. **§438.206(c)(1)(ii)** Services must be sufficient to support minimum hours of provider operation to include service coverage form 8:00 a.m.– 5:00 p.m., Mountain Time, Monday through Friday. **§438.206(c)(1)(iii)** Services must be available 24 hours per day, 7 days a week, when medically necessary. Medical Necessity shall be defined as described in IO CCR 2505-10 §8.076.1.8.

The Department continues to foster 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 to eligible members for transportation to covered Health First Colorado services when 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 provides members with real-time evidence-based medical advice regarding the right level of care most appropriate for their acute care needs.
- Telemedicine and eConsult services allow 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

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution

The Department consistently implements strategies and improvements to expand provider networks serving the Health First Colorado geographical population. **§438.207(a), §438.207(b)(1)** The Contractor must demonstrate through assurances and documentations that they have the capacity to provide service delivery for all covered services with an appropriate range of preventive services, primary care, behavioral health, dental, and specialty services for meeting the needs of the Health First Colorado population. **§438.207(b)(2)** Contractors are 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.

Coordination and Continuity of Care

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP
§438.208(b)(3)	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
§438.208(b)(4)	Protect enrollee privacy when coordinating care
§438.208(c)(1)	State mechanisms to identify persons with special health care needs
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals
§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
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs

§438.208(b)(1) Each RAE and MCO manage a network of PCMPs who serve as the Medical Home for members by providing whole-person, coordinated, and culturally competent care to ensure members have an ongoing source of primary care to meet their health needs.

§438.208(b)(2), §438.208(b)(4), §438.208(c)(1), §438.208(c)(2), §438.208(c)(3). RAEs and MCOs are required to ensure they have mechanisms and a process for identifying special health care needs and for coordinating timely care in accordance with applicable state standards which protect and respect the member's privacy and confidentiality.

§438.208(b)(3) Care Coordination may range from deliberate provider interventions to coordinate with other aspects of the health system to interventions over an extended period of time by an individual designated to coordinate a member's health and social needs.
§438.208(c)(4) Contractors are required to collaborate with LTSS providers and care coordinators/case managers, No Wrong Door Entities, Area Agencies on Aging, and Aging and Disability Resources for Colorado to develop holistic approaches to assisting LTSS Clients achieve their health and wellness goals. In addition, Contractors work to improve coordination of LTSS with members' physical and behavioral health needs through a variety of methods, such as developing policies and/or means of sharing member information especially if a member transitions between Contractors.

Contractors also incorporate lessons learned from the Cross-System Crisis Response Pilot Program established by House Bill 15-1368 to improve the delivery and coordination of behavioral health services for individuals with intellectual and developmental disabilities. The goal of the Cross-System Crisis Response Pilot Program is to provide crisis intervention, stabilization, and follow-up services to individuals who have both an Intellectual or Developmental Disability and a mental health or behavioral health condition and who also require services not available through an existing Home and Community-Based Services (HCBS) waiver or covered under the Colorado behavioral health care system.

Coverage and Authorization of Services

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service
§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
§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
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition
§438.210(a)(3)(iii)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity
§438.210(a)(4)	Specify what constitutes "medically necessary services"
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services
§438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional
§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
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)
§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

Coverage and authorization of services under Health First Colorado is of paramount importance to both our RAEs and MCOs (Rocky Mountain Health Plans Prime and Denver Health Medicaid Choice) and are an integral part of service to our members. The RAEs and MCOs have the common objective of providing coverage of services and authorization of those services in a way that does not impede timely access to services. RAEs and MCOs have a contractual obligation to provide the Department a documented Utilization Management Program and Procedures which meet the requirements of §438.210.

§438.210(a)(1) Utilization Management procedures set forth a process to identify, define, and specify the amount, duration, and scope of each service. **§438.210(a)(2)** Covered health services are furnished in an amount, duration, and scope that is no less than those furnished to beneficiaries under FFS Medicaid. **§438.210(a)(3)(iii)** Each RAE and MCO may place appropriate limits on a service, such as medical necessity, and providers and members can obtain utilization management decision-making criteria upon request. The Contractors provide education and ongoing guidance to members and providers about its utilization management program and protocols.

§438.210(a)(3)(i) Members receive services in an amount, duration, and scope, as medically necessary as defined in accordance with 10 CCR 2505-10 § 8.076.1.8 for achieving appropriate and quality care. **§438.210(a)(4)** Medical necessity means a Medical Assistance program good or service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. It may also include a course of treatment that includes mere observation or no treatment at all. The good or service must be:

- Provided in accordance with generally accepted standards of medical practice in the United States;
- Clinically appropriate in terms of type, frequency, extent, site, and duration;
- Not primarily for the economic benefit of the provider or for the convenience of the member, caretaker, or provider; and

Performed in a cost effective and most appropriate setting required by the member's condition **§438.210(c)** The Contractor pursuant to their UM Program and Procedures shall notify the requesting provider and give the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Contractor has strict timeframes around this process.

§438.210(b)(1), **§438.210(b)(2)** Contractors must follow written procedures for processing requests for initial and continuing authorizations of covered services with mechanisms in place to ensure consistent application of review criteria. **§438.210(a)(3)(ii)** In addition, the Contractor shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely

because of the type of illness, diagnosis or condition of the member or place limits on service (outside of medical necessity) for utilization control. §438.210(b)(3) Decisions to deny or reduce services must be made by a health care professional with clinical expertise in treating the member's condition or disease, with notification to the requesting provider and written notice to the member. §438.210(d) Contractors provide a description of coverage and authorization of services along with a Provider Dispute Resolution process which details strict timeframes that must be maintained throughout the authorization decision-making process.

§438.210(e) Compensation to RAEs and MCO activities are not structured to provide incentives for denying, limiting, or discontinuing medically necessary services. The Department continues to work with its Contractors to further improve the coverage and authorization of services process through a data-driven, evidence-based approach. 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:

Provider Selection

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.214(a)	Written policies and procedures for selection and retention of providers
§438.214(b)(1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow
§438.214(b)(2)	Documented process for credentialing and recredentialing that each MCO/PIHP must follow
§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
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from federal health care programs

Contractors must perform all services and other required duties deemed by the Department in accordance with, and subject to, applicable Administrative Rules and Department polices including rules and regulations which may be issued or disseminated from time to time.

Provider relations are critical to the Department's strategy of expanding the Colorado Medicaid provider network and retaining providers that serve Health First Colorado. Recognizing a need for dedicated resources for provider recruitment, retention and relations, the Department established a Provider Relations Unit which operates in compliance with federal rules implemented in 2011 under the ACA. The unit works to grow the Medicaid provider network so that it is adequate and comprehensive, with sufficient physical, behavioral, dental, and LTSS providers. The Department's resource page for Provider Enrollment/Revalidation is located at: https://www.colorado.gov/hcpf/provider-enrollment.

The Provider Relations Unit works to review and approve Contractor networks to provide Health First Colorado members with a reasonable choice of a culturally diverse network of

providers. Additional responsibilities of the Provider Relations Unit include outreach, recruitment/retention, enrollment support, revalidation, and communications. Provider Relations or Network Development staff help providers with recruitment and revalidation. **§438.214(d)** These teams do extensive outreach to revalidate network providers while ensuring MCOs/PIHPs do not employ or contract with providers excluded from Federal health care plans under either section 1128 or section 1128A of the Social Security Act. 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.

§438.214(b)(1) Prior to being credentialed into a managed care (MCE) entity provider network, all Health First Colorado and CHP+ providers must enroll in the Colorado interChange. The Department operates in compliance with federal rules implemented in 2011 under the Affordable Care Act (ACA). All interested providers must submit an application with all required documentation into the Provider Portal, which is reviewed and evaluated for accuracy and completeness by our fiscal agent, DXC Technology. If the application requires corrections, an email notice outlining the needed changes is sent back to the provider. If the application is correct and complete, it is forwarded to a Quality Assurance specialist for a second review. Some provider types require a site survey, which is performed by DXC Technology staff, and some require an additional level of screening by Department policy staff. When these, and any other screening processes are complete and correct, the provider's application is approved, and an enrollment profile is created in the system. The Department's main landing page for Provider Enrollment/Revalidation is here: https://www.colorado.gov/hcpf/provider-enrollment. Upon completion of enrollment for each individual and/or service location, providers may work with the Department's contracted managed care entity on applicable provider network requirements.

The Department's FFS provider network does not use any selection criteria beyond those established in our enrollment requirements; any willing provider who meets these requirements may be enrolled. Provider retention is highly dependent on the perceived ease or burden of administrative participation and provider reimbursement rates.

§438.214(c) Maintaining a provider network strategy is essential to ensure the Department's Contractors do not discriminate against providers serving high-risk populations or specializing in conditions that require costly treatment. The strategy facilitates consistently recruiting and retaining qualified, diverse and culturally responsive providers, who represent racial and ethnic communities, the deaf and hard of hearing community, the disability community and other culturally diverse communities for the members we serve. **§438.214(a), §438.214(b)(2)**Written provider credentialing and recredentialing policies and procedures are consistent with 42 C.F. R §438.12, which ensure they contract with a culturally-diverse network of providers of both genders and prioritize recruitment of bilingual or multi-lingual providers. Contractors shall ensure their networks provide Health First Colorado members with a reasonable choice of providers and that they do not discriminate against any provider who is acting within the scope of his or her license or certification under applicable state law. In addition, if Contractors decline to include individual or groups of providers in their provider network, they must provide the Department upon request with written notice of the reason in accordance with their policies and procedures. Contractors are encouraged to work with individual practitioners and clinics to

increase participation and expand capacity by distribution of revalidation materials to their providers.

Enrollee Information

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.218	Incorporate the requirements of §438.10

§438.218 In accordance with requirement §438.10, the Department requires all 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 sixth-grade reading level. The information is also translated into other non-English languages prevalent in the service area and may be available in alternative formats. Oral interpretation services are also made available to members. Contractors continue to collaborate with the Department regarding the member handbook and notify members on an annual basis of their ability to receive a handbook.

In addition, Contractors shall develop electronic and written materials for distribution to newly enrolled and existing members, with input from the Department, in accordance with 42 C.F.R. §438.10 that must include, at a minimum, all of the following:

- Contractor's single toll-free, customer service phone number
- Contractor's Email address
- Contractor's website address
- State Relay information
- The basic features of the Contractors managed care functions
- The service area covered by the Contractor
- Medicaid Benefits
- Any restriction on the member's freedom of choice network providers
- A directory of network providers

Confidentiality

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.224	Individually identifiable health information is disclosed in accordance with federal privacy requirements

§438.224 The Department ensures the privacy of each member in accordance with federal privacy requirements (Health Insurance Portability and Accountability Act). Each Contractor expressly addresses confidentiality and agrees that 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. Contractors shall also preserve the confidentiality; integrity and accessibility of state data with administrative, technical and physical measures that conform to generally recognized industry standards and best practices.

Enrollment and Disenrollment

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.226	Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in §438.56

§438.226 In accordance with §438.56 the Department ensures enrollment and disenrollment services are compliant with federal and state regulations. The Health First Colorado Enrollment Broker 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. Contractors receive enrollment information from the Department, including Health Insurance Portability and Accountability Act (HIPAA) compliant 834, 820, and roster files, to ensure accurate enrollment and attribution within the ACC. Due to mandatory enrollment, Contractors do not oversee any disenrollment processes for the ACC but rather collectively work to find more appropriate providers or Contractors to assist the member.

Grievance Systems

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.228(a)	Grievance system meets the requirements of Part 438, subpart F
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner

§438.228(a) Procedures and timeframes in which a member can initiate a grievance have been established in accordance with Part 438, subpart F. Contractors shall ensure information about the grievance process, including how to file a grievance is available to all members and is given to all network providers and subcontractors. Members have 20 calendar days from the date of an incident to file a grievance with any matter other than an Action. Contractors are required to provide the members written notice, within two days, for the decision to extend the timeframes and inform the member's acknowledgement of 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. In addition, if the Department is contacted by a member, family members or caregivers of a member, advocates, the Ombudsman for Medicaid Managed Care, or other individual/entities with a grievance regarding concerns about the care or lack of care a member is receiving, the Contractor shall address all issues as soon as possible after the Department has informed the Contractor of the concerns. The Contractor shall keep the Department informed about progress on resolving concerns in real time and shall advise the department of final resolution.
§438.228(b) Contractors also submit a quarterly grievance and appeals report to the Department for review which includes the following information about member grievances and appeals:

- The general description of the reason for the grievance or appeal

- The date received
- The date of each review or, if applicable review meeting
- Resolution at each level of the appeal or grievance, if applicable
- Name of the covered member for whom the appeal or grievance was filed

Sub Contractual Relationships and Delegation

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.230(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities
§438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform
§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
§438.230(b)(3)	Monitoring of subcontractor performance on an ongoing basis
§438.230(b)(4)	Corrective action for identified deficiencies or areas for improvement

Through the ACC, state contracts ensure ultimate responsibility for adhering to and fully complying with all terms and conditions of the contract, and subcontractors must also meet those requirements. **§438.230(a)**, **§438.230(b)(2)** Delegation activities, obligations, and/or related reporting responsibilities are specified in the ACC contracts or written agreement. **§438.230(b)(1)** Delegated Contractors evaluate and review sub-contractor care requirements. The Department specifies that no more than 40 percent of a contract may be subcontracted. In each instance, a subcontractor and their arrangement must be approved with the Department. The Department reserves the right to require a Contractor to amend any agreement as reasonably necessary to conform to the Department's policies, procedures, and obligations. **§438.230(b)(3)** Furthermore, the Department also requires consistent reporting and, thus, demonstrated oversight of a subcontractor by a Contractor for work products including care coordination and financial accounting. **§438.230(b)(4)** Should the Department identify a subcontracting relationship with a Contractor that does not adhere to these standards, the Department may reject or issue a corrective action plan for the subcontractor.

MEASUREMENT AND IMPROVEMENT STANDARDS:

Practice Guidelines

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§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.
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees

§438.236(b) RAEs and MCOs are required to develop practice guidelines in accordance with Departmental policies and prevailing professional community standards based on valid and reliable clinical evidence or a consensus of health care professionals in a field. The guidelines consider the needs of the member and are adopted in consultation with participating network providers. §438.236(c) The Contractor reviews and updates the guidelines at least annually and disseminates the practice guidelines to all affected providers and, upon request, to members, the Department and the public at no cost. Decisions regarding utilization management, member education, covered services and other areas are consistent with established guidelines.

Quality Assessment and Performance Improvement Program

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.330(a)(i)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program
§438.330(b)(2) **§438.330(c)(2)(i)**	Each MCO and PIHP must conduct PIPs and measure and report to the state its performance List out PIPs in the quality strategy
§438.330(c)(2)(i) **§438.330**	Each MCO and PIHP must measure and report performance measurement data as specified by the state List out performance measures in the quality strategy
§438.330(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services
§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
§438.330(c)(2)	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.

The Department is focused on objectives related to improving health, ensuring members receive quality care, implementing evidence-based policies, and financing services efficiently. In accordance with §438.330(a)(3) the Department requires each Contractor to develop, submit and implement an ongoing Quality Assessment and Performance Improvement Program (QAPI) that complies with 42 C.F.R. §438.310-370 to the Department and/or its designee, that assesses the quality of care and adjusts processes and operations to improve the quality of care provided to members. Each QAPI shall align with the Department's Quality Strategy and include population health objectives as well as clinical measures of quality care. Quality improvement activities shall, at a minimum, consist of the following:

- Performance Improvement Projects (PIPs)
- Collection and submission of performance measurement data, including member experience of care

- **§438.330(b)(3)** Mechanisms to detect both underutilization and overutilization of services
- **§438.330(b)(4)** Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs
- Measurement and intervention to achieve a measurable effect on health outcomes and member satisfaction
- Measurement of performance using objective valid and reliable quality indicators
- Implementation of system interventions to achieve improvement in quality
- Empirical evaluation of the effectiveness of the interventions
- Quality of care concerns
- Advisory committees and learning collaboratives

Contractors shall make reasonable changes to the QAPI at the Department's direction.

§438.330(b)(2), To ensure continuous quality improvement, the Department requires the Contractor to conduct regular examination (annually at a minimum) of the scope and content of the QAPI to ensure it covers all types of services, including behavioral health services, in all settings. Each Contractor shall have a minimum of two PIPs chosen in collaboration with the Department: one that addresses physical health and may include behavioral health integration into physical health, and one that addresses behavioral health and may include physical health integration into behavioral health. **§438.330(c)(2),** PIPs are conducted on topics selected by the Department or by CMS when the Department is directed by CMS to focus on a topic which is designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. **§438.330(c) §438.330(d)** PIP measures for State FY 2018-2019 include:

- Well Child Visits
- Improving Adolescent Well Care
- Increasing Number of Depression Screenings
- Substance Use Disorder Treatment
- Percentage of Children <21 who received at least one Dental Service during the reporting year

Contractors shall ensure the PIPs include the following:

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

§438.330(c)(2) Contractors are required to submit and publicly post a written Annual Quality Report to the Department and/or designee, detailing the progress, utilization, and effectiveness of each component of its QAPI. Included within the Report are the following:

- A description of the measurement techniques the Contractor used to improve its performance
- A description of the techniques to assess the quality and appropriateness of care furnished to members with special health care needs

- A description of the qualitative and quantitative impact the techniques had on quality and overutilization of services
- The status and results of each PIP project conducted during the year
- Opportunities for improvement
- Planning and initiation of activities for increasing or sustaining improvement

Contractors also participate in an annual PIP learning collaborative hosted by the Department that includes sharing of data, outcomes, and interventions.

The EQRO technical report (**https://www.colorado.gov/pacific/hcpf/annual-technical-reports**) also addresses the effectiveness of the Contractor QAPI program.

Health Information Systems

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§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
§438.242(b)(1)	Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees
§438.242(b)(2)	§438.242(b)(2) Each MCO and PIHP must ensure data received is accurate and complete

§438.242(a) The Department utilizes the Business Intelligence and Data Management (BIDM) system, a data warehouse that collects, consolidates, and organizes data from multiple sources, and fully integrates Medicaid eligibility and claims data for reporting, analytics and decision support. RAEs and MCOs are contractually obligated to have in place a health information system that collects, analyzes, integrates and reports data. In keeping with 42 C.F.R., the RAEs and MCOs systems must provide information on utilization, grievances and appeals and disenrollment's.

RAEs and MCOs incorporate risk adjusted utilization expectations into their analytic procedures as members with more complex conditions and needs are expected to use more resources. There is an established interface that enables the RAEs and MCOs to use the Colorado interChange to retrieve eligibility, enrollment and attribution information for members. RAEs and MCOs must have expertise to educate and inform network providers about the data reports and systems available to them and make available technical assistance and training on how to use state-supported Health Information Technology (HIT) systems.

In addition, the RAEs and MCOs establish the infrastructure to support outbound raw claims data extracts to the PCMPs, including both behavioral health claims from the RAE's and MCO's internal system and physical health claims data from the Department. The RAEs and MCOs facilitate clinical information sharing by supporting Network Providers in connecting electronic health records with the regional health information exchange (HIE) for exchanging clinical alerts and clinical quality measures data and identifies and addresses gaps in information sharing or

data quality. The RAEs and MCOs have processes to collect and track information regarding grievances and appeals and all subcontractors and providers comply with record maintenance requirements as applicable and pursuant to 42 C.F.R 438.416.

§438.242(b)(1) All RAEs and MCOs possess and maintain a HIPAA-compliant health information system that collects data on members, providers and services furnished. Enrollment reports are used to identify and confirm membership and provide a definitive basis for payment adjustment and reconciliation. The Care Coordination Tool support communication and coordination among members of the Provider Network and Health Neighborhood. The Care Coordination Tool has the capacity to capture information that can aid in the creation and monitoring of a care plan for the member, such as clinical history, medications, social supports, community resources and member goals. At a minimum the Care Coordination Tool captures the following information on each member: name, Medicaid ID, age, gender identity, race/ethnicity, name of entity or entities providing Care Coordination, member's choice of lead care coordinator, Care Coordination notes, activities, member need and stratification level.

RAEs and MCOs collect information to establish, maintain and monitor a Provider Network, consisting of physicians, specialists, behavioral health providers and all provider types that is sufficient to provide adequate access to all covered services under the contract, taking into consideration:

- Anticipated number of enrollees
- Expected utilization of services
- Number and types of providers required to furnish the covered services
- Number of network providers who are not accepting new patients
- Geographic location of providers and members, (distance, travel time, transportation means)
- Physical access for enrollees with disabilities
- Special population and specialty care resources
- Social determinants

§438.242(b)(2) RAEs and MCOs submit monthly data certifications for encounter data ensuring that data is accurate, complete and truthful, and that all paid encounters are for covered services provided to or for enrolled members. The certification is signed by the appropriate Chief Executive or Chief Financial Officer.

The Department may use any appropriate, efficient or necessary method for verifying information received from the Contractor including fact checking, auditing, site visits and requesting additional information. If the Department determines that there are errors or omissions in any reported information, the Contractor will produce an updated report that corrects all errors and includes all omitted data or information to the Department.

SECTION IV: IMPROVEMENT AND INTERVENTIONS

- **Intermediate Sanctions**
- **Health Information Technology**

Required CMS Regulatory References Addressed

Regulatory Reference	Description
Optional Response not required by CMS	Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to: • Cross-state agency collaborative; • Pay-for-performance or value-based purchasing initiatives; • Accreditation requirements; • Grants; • Disease management programs; • Changes in benefits for enrollees; • Provider network expansion, etc.

The Department recognizes the importance of improving physical and mental health of all Coloradoans and is committed to developing comprehensive approaches for continuous quality improvement for improving health care outcomes. To this end, the Department has and continues to create numerous processes, programs and collaborative efforts to improve the quality of care delivered to our members. A few are detailed below:

Population Health Management

As a foundational step for identifying members at various levels of risks, the Department is implementing clinical risk stratification to further identify the right level of care and services for the Health First Colorado population. Risk stratification is a foundational step where the Department is utilizing data on our member population to target interventions for better health outcomes at lower costs with a better care experience. In addition, it provides the Department and Contractors the opportunity to:

- Align available resources
- Predict risks
- Identify member-specific care plans
- Understand population health trends

Risk Stratification allows the Department to help our members achieve the best health and quality of life possible by preventing chronic disease, stabilizing current chronic conditions, and preventing acceleration to higher-risk categories and higher associated costs.

Cross-State Agency Collaborative

The Cross-State Agency Collaborative is composed of the CDHS, CDPHE, and HCPF. These three state health agencies work collaboratively toward making Colorado the healthiest state in the nation through initiatives that support the health and well-being of its population. To have the

greatest impact on health outcomes in Colorado, these agencies created a data alignment strategy to identify and align pertinent measures that impact the health outcomes of Coloradans. Through available data at each state health agency, this allows the sharing of a common list of metrics to inform collaborative health improvement programs. The three state health agencies collectively report, track and trend the aligned metrics, thereby sharing a common area of focus to strategically leverage resources in areas of need. Reports issued by the partnership are available for review: Measuring Health in Adults 65 and Older, Measuring Health in Adults Aged 18-64 and Measuring Child Health.

Challenges of Opioid Misuse

Another collaborative program involving state agencies addresses the challenges of opioid misuse. Opioid use is a serious problem in Colorado and across the nation. Among other sources, the Department is utilizing data analytics assistance provided through the CMS Innovative Accelerator Program grant to gain a better understanding of how the opioid crisis is impacting Colorado Medicaid members. The grant supports efforts to streamline data sharing with our substance use disorder care management partner, the Office of Behavioral Health at CDHS. The goal for both agencies is to establish a holistic picture of opioid use disorder care in the state to support development of policies and programs that meet our goals of controlling costs and better coordinating member services.

Lift the Label

In tandem with the challenges of opioid misuse, the Department is supporting the Lift the Label campaign, rolled out in May 2018 by CDHS. The Lift the Label campaign is designed to address those who are already addicted to opioids through a campaign designed to remove the stigma associated with addiction, encouraging individuals to seek help if they need it.

Reduction of Opioids Prescribed

The Department has intervened on behalf of Health First Colorado members and sought to reduce opioid amounts prescribed in an effort to prevent addiction. The Department continued to adjust prescribing policies during FY 2018–19 and has reduced the number of opioid pills prescribed by 30 percent over the past three years. The Department's goal for all adjustments is to reduce the number of opioid pills available to members while ensuring appropriate access for pain management. Recently, short-acting opioids were added to our Preferred Drug List and the impact of this addition will be measured during FY 2018–19 to determine need for further adjustments. The Department will consider a further decrease to the Morphine Milligram Equivalent limit, and work toward reducing the maximum supply of opioids for dental procedures.

Hospital Review Program

In recognition that hospitals are responsible for about 30 percent of Health First Colorado spending and 10 percent of the state's budget, the Hospital Review Program provides inpatient utilization review through pre-admission certification and continued stay review using evidence-based guidelines. Targeted for implementation in 2019, the program will notify Contractors of member diagnosis and treatment plans and highlight opportunities for discharge planning care coordination and case management of patients who are at risk for readmission. The program will also allow Contractors to invite patients who are "more coachable" due to a chronic disease

exacerbation into population health and disease management programs. Last, it includes a complex claim, pre-payment review to ensure proper DRG coding and claim adjudication/payment.

Colorado Choice Transitions

In keeping with the goal to provide member choice, the Department has participated in a federally-funded demonstration program called Colorado Choice Transitions (CCT). CCT is designed to help transition Colorado Medicaid members out of long-term care facilities such as nursing homes into home and community-based settings. Members who have transitioned into the community using the CCT program report having a higher quality of life, better health outcomes, and a reduction in the total cost of their care. With federal funding for the demonstration ending in 2019, the Colorado Legislature passed House Bill 18-1326, directing the Department to implement successful services to support additional transitions to community-based settings.

Provider Cost and Quality Tools

The Department rolled out a suite of powerful cost and quality assessment capabilities to the seven RAEs, hospitals and PCMHs. The Department's new Prometheus tool enables the identification of potentially avoidable costs on member care, individual physicians, PCMHs, specialists and hospitals. This tool enables providers to improve their referral patterns towards more cost effective, higher quality physicians and hospitals, enables hospitals to identify and self-correct inefficient, lower quality care delivery or affiliated providers, allows RAEs to target members for care management and enables the Department to direct members seeking provider locator services to higher performing providers.

Improving Provider Experience

The Department's provider services call center vendor has implemented improvements focused on benefitting providers in need of assistance. These include new training modules, quality monitoring, and additional staff to ensure provider calls are answered efficiently and effectively for improving member experience in services received. Setting this standard represents an ambitious goal due to implementation of significant changes to the ACC and our enhanced focus on claims cost controls. Additional stronger call center metrics include how long calls are on hold, and how many are resolved the first time a provider calls.

PEAK*Health* app

The free PEAK*Health* app was created to simplify and improve member experience accessing and updating account information. It leverages members' preferred means of accessing online information – through their mobile phone. During FY 2018–19, we will be working with the Regional Transportation District (RTD) to provide public transit special discount cards for certain populations through the mobile app.

Dashboards/Report Cards

The Department also continues to create reporting and monitoring strategies for all its Contractor-specific measures by developing external-facing interactive dashboards. The purpose of these dashboards is to create accountability and transparency and drive performance improvement within the Health First Colorado Program. Data presented will

include some nationally recognized and validated measures from various sources, including HEDIS® and CAHPS. The Department also plans to report on state-specific measures, such as Key Performance Indicators and Behavioral Health measures. Three-year trends and Department goals will be presented to allow Contractor assessment and comparison.

Cost Control Roadmap

The Department is leading a collaborative process to devise a three to five plus year Cost Control Roadmap for the State of Colorado to frame policy and drive actions that reduce health care prices to the benefit of employers, consumers, and other payers, and identify drivers of health care costs/prices as well as options to significantly and favorably impact those drivers to the benefit of consumers, employers, and other payers. The Roadmap will be comprehensive and will cover major areas impacting health care utilization, costs, and outcomes including:

- Provider practice patterns and changing norms
- Clients such as seniors, individuals in rural areas, and children
- Opportunity areas for innovation with a special focus on employing local businesses to solve challenges to the benefit of our state's economy
- Benefit areas such as hospital, primary care and pharmacy
- Value-based payments and other alternate payment methodologies; and
- Lifestyle and population health influencers such as tobacco use, addiction, and excess weight

The Cost Control Roadmap will be framed by expert health care thought leaders and refined by stakeholders such as medical care providers, business chambers, consumer advocates and union leaders, and legislators. Based on the Roadmap's inclusive approach, the Department has set a goal that by the close of FY 2018–19, the number of thought leaders, industry influencers, and stakeholders who are aware of, engaged to develop, or support the execution of the Roadmap will exceed 1,000 individuals. In the years to come, the goals associated with the Roadmap will evolve from engagement to implementation of initiatives through cost/price impact.

INTERMEDIATE SANCTIONS

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.340(b)(7)	For MCO's detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, Subpart 1
Optional Response not required by CMS	Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems

§438.340(b)(7) The Department maintains and may implement intermediate sanctions as described in 42 C.F. R. Part 438 Subpart I if the Department's RAEs and MCOs:

- Fail substantially to provide medically necessary services the Contractor is required to provide, under law or under its contact

- Impose on members premiums or charges that are in excess of the premiums or charges permitted under the Health First Colorado program
- Act to discriminate among members on the basis of their health status or need for health care services
- Misrepresent or falsify information that the contract furnishes to CMS or to the Department
- Misrepresent or falsify information that it furnishes to a member, potential member, or health care providers
- Fail to comply with the requirements for physician incentive plans, as set forth in 42 C.F. R. 422.208 and 422.210
- Distribute directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information
- Violate any of the other applicable requirements

Before imposing any of the intermediate sanctions, the Department must give the affected entity timely written notice that explains the basis and nature of the sanction, and any other due process protections that the Department elects to provide. Prior to terminating any contracts, the Department provides a pre-termination hearing, a written notice of the Departments intent to terminate, the reason for the termination, and the time and place of the hearing. After the hearing, the Department must provide the RAEs and MCOs written notice of the decision affirming or reversing the proposed termination of the Contract and, for an affirming decision, the effective date of termination, and for an affirming decision, give members of the Contract notice of the termination and information on their options for receiving Health First Colorado services following the date of termination.

The Department may also impose temporary management if the RAEs and MCOs 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 RAEs and MCOs timely written notice that explains the basis and nature of the sanction pursuant to 42 C.F.R 438.710.

HEALTH INFORMATION TECHNOLOGY

Required CMS Regulatory References Addressed

Regulatory Reference	Description
§438.364(a)(4)	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.

Optional Response Not Required by CMS	Describe any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals

§438.364(a)(4) HIT is an essential part of the Health First Colorado quality measurement process which is designed to support the Department's ongoing operation and review of the Department's Quality Strategy. The Department, in collaboration with the Colorado Regional Health Information Organization (CORHIO) is developing a Master Person Index (MPI) through the CORHIO Verato software solution to ensure accuracy and availability of a member's health information to inform the best care possible. Utilizing a suite of data records and services, the Department can link and synchronize the member's data, a provider and the Contractor's data into a single trusted authoritative data source of member information.

An MPI with a standard data set for demographic data and algorithms for linking assigned identifiers (Health Plan IDs, Member ID numbers, etc.) will improve care coordination, ensure better patient safety with more accurate matching of patient records across multiple entities, and increase the accuracy of quality measurement and provider payments. CORHIO's database already includes over 5 million lives. By July 2019, the Department and CORHIO will test the Verato solution to see if it meets the Department's needs.

In addition, the Department is exploring whether it can leverage the Master Provider Directory (MPD) that CDPHE is developing as an enterprise state service. Together, MPI and MPD will allow the Department to achieve a unified view of Health First Colorado provider and member data across the HIE networks, improving the quality of data, patient to provider attribution, care coordination, and reducing costs.

The Department, in collaboration with State Innovation Model (SIM), is implementing the automated entry of electronic Clinical Quality Measures (eCQM) to improve the HIE data collection foundation for supporting the transition to automated Meaningful Use (MU) 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 is leveraging 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 ACC.

SIM, through a sole-source procurement, selected the CORHIO and its partners Quality Health Network and the Colorado Community Managed Care Network (collectively, Health Data Colorado, also known as HDCo) 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 HDCo, 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 eCQM reporting will support Transitions of Care, Continuity of Care Documents, and the capability to run analytics on the eCQMs 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 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.

The Department is 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 Colorado Health First providers and critical access hospitals to connect to the Colorado HIE Network.

The All-Payer Claims Database (APCD) is a data collection system of health care claims paid by non-Employee Retirement Income Security Act covered payers across the state. The APCD can provide a more complete picture of a member'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.

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SECTION V: DELIVERY SYSTEM REFORMS

Regulatory Reference	Description
Optional Response Not Required by CMS	Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.
Optional Response Not Required by CMS	List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.
Optional Response Not Required by CMS	List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.
Optional Response Not Required by CMS	Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.

As referenced throughout the strategy the Department continues to assess, monitor and drive performance improvement initiatives for the population we serve, through key performance measures and performance improvement projects as identified in Sections, II, III, and IV. Contractors are required to develop and implement a comprehensive assessment for those members identified by the state as requiring long-term support services or having special health care needs. Comprehensive assessments shall identify any special conditions that necessitate a special treatment and care coordination plan or regular care monitoring, pursuant to 42 C.F.R 438.208(c)(2).

The Department also continues to advance delivery system reforms in the Health First Colorado program through the coordination of multiple state and national initiatives that aim to change structures and incentives to encourage quality and efficiency of care, reward care coordination through sharing of information and improve member engagement. Key initiatives include the following:

PAYMENT REFORMS

Alternative Payment Models

The Department continues to transform payment design across the entire delivery system with the goal of rewarding improved quality of care while containing costs. The Department is currently pursuing the four-primary care alternative payment methodologies reflected in Figure 6: two for Federally Qualified Health Centers (FQHCs), and two for other qualifying primary care providers. All four models modify reimbursement based on provider performance; two of the four incorporate additional risk for utilization.

All eligible providers are accountable for meeting Department-defined targets on a set of measures identified by the Department. Available measures include structural (practice characteristics such as having integrated physical and behavioral health), claims-based measures (predominantly HEDIS® measures), and eCQMs. The measures were vetted extensively and strategically align with SIM, Medicare Access and the CHIP Reauthorization Act, and Comprehensive Primary Care Plus. Providers select measures appropriate for their practice, earn points based on their performance, and

receive an aggregate score that translates to a quality modifier that is applied to the providers' reimbursement the subsequent state fiscal year. Financial accountability for performance began January 1, 2019 for all eligible providers.

The models are designed to be glidepaths with increased accountability for performance and opportunity for taking on utilization risk over time. For example, the Department plans to phase out the majority of structural measures over time, pushing practices to be accountable for claims-based measures, eCQMs, and ultimately total cost of care as the models mature. Additionally, the amount of financial risk increases annually to a maximum of 10 percent of reimbursement at risk for performance.

Models that incorporate risk for utilization are still under development. The Department is very interested in exploring multi-payer models to maximize the financial incentives and the impact on the delivery system.

Figure 7: Medicaid Primary Care Alternative Payment Methodologies

	FQHCs	**Other Qualifying Primary Care Practices**
At Risk for Performance	Quality adjusted FFS encounter rates **Implementation date:** 1/1/19 **Risk level:** 4% in first year, growing by 1.5% each year with a minimum reimbursement at PPS and maximum risk level of 10%; potential upside risk depending on available budget. **Federal authority:** already approved via State Plan **Key partners and technical support:** Colorado Community Health Network, Colorado Community Management Care Network **Status of model:** on track to implement	Quality adjusted FFS rates **Implementation date:** 1/1/19 **Risk level:** 4% in first year growing by 1.5% each year to a maximum of 10%; potential upside risk depending on available budget. **Federal authority:** State Plan - not yet approved **Key partners and technical support:** engaged provider network, MPC, SIM **Status of model:** on track to implement
At Risk for Performance and Utilization	Quality adjusted Per Member Per Month (PMPM) reimbursement model **Implementation date:** 1/1/19 (pending federal approval) **Risk level:** 100% at risk for utilization above or below PMPM based on historical utilization. 4% at risk in first year based on performance growing by 1.5% each year while maintaining PPS equivalent floor. **Federal authority:** CMS says 1115 waiver, we say State Plan. Resolution pending. **Key partners and technical support:** NASHP, Colorado Community Health Network, Colorado Community Managed Care Network, Salud, Clinica **Status of model:** delayed due to federal authority issue	Quality adjusted PMPM - potentially multipayer option **Implementation date:** 7/1/19 at the earliest (pending approval of waiver) **Risk level:** Variable **Federal authority:** 1115 waiver **Key partners and technical support:** CMMI, SIM, MPC **Status of model:** exploratory phase

Specialty Care

The Department is actively exploring implementation of bundled payments for episodes of care.

Federally Qualified Health Centers (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 designed to increase provider flexibility in delivering care while holding providers accountable for member 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.

Hospitals

The Department is developing a Hospital Transformation Program (HTP) to allow the state to continue delivery system reform and value-based purchasing for hospitals. From the Department's perspective, hospital reimbursement is bifurcated into two primary funding mechanisms:

1. Hospitals are reimbursed directly through claims-based reimbursement for services rendered.
2. Hospitals are additionally reimbursed through supplemental payments funded by the Hospital Provider Fee. The Department is engaged in payment reform on both fronts.

HTP will change the supplemental payments from a predominantly guaranteed payment to one that is earned by achieving strategic delivery system transformations or performance on key performance measures to drive meaningful delivery system reform in partnership with hospitals, other payers, and a wide array of other stakeholders across the state.

In addition to reforming the supplemental payment program, the Department will implement service payment reforms in which hospitals are accountable for performance on a suite of measures, and their FFS reimbursement will be modified accordingly. The Department plans to introduce financial accountability for performance on measures starting January 1, 2020. Similar to the primary care models, financial accountability for performance and the performance standards themselves will increase over time.

Goals of HTP are:

- 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

The Department is further exploring leveraging analytics to identify "centers of excellence" and modifying reimbursement to incentivize hospitals to steer utilization to those most capable of providing high quality, efficient care. In addition, the Department is actively engaged in the development of global budgets for rural community hospitals. Fixed budgets encourage financial accountability while providing flexibility for providers to organize the delivery system as efficiently as possible.

DELIVERY SYSTEM REFORMS

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 members from nursing or other Long-Term Care facilities to the community using HCBS. 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 HCBS 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.

Substance Use Disorder (SUD) Waiver

During the 2018-2019 legislative session, House Bill 19-1287 was passed to allow the Department to implement the SUD inpatient and residential treatment benefits, including withdrawal management. Adding this benefit would complete the continuum of SUD services available to Health First Colorado members. The Department's objective is to make these services available for individuals who meet medical necessity requirements, as determined by a nationally-recognized set of evidence-based criteria without shifting care from outpatient settings when they are more appropriate.

The Department has studied the CMS Guidance on Section 1115 Institutions for Mental Disease SUD Payment Waivers and is working to design a waiver that advances the goals and milestones outlined by CMS. Working in collaboration with CMS, the Department will design a benefit which will:

- Develop level of care requirements and criteria for SUD inpatient and residential treatment
- Involve providers to assess readiness and fidelity to American Society of Addiction Medicine Standards
- Develop a robust monitoring and evaluation protocol
- Conduct network adequacy analysis and develop provider support mechanisms to ensure the expansion of services is accessible to members
- Develop an approach that maintains existing community-based services and integrates physical and behavioral health services as appropriate

When implemented, the residential and inpatient SUD benefit will be managed by the RAEs and MCOs and the costs will be built into capitation rates. The RAEs and MCOs are best situated to coordinate care for members across the continuum of SUD treatment, and the Department can continue to incentivize behavioral and physical health indicators that relate to SUD treatment and outcomes (e.g. reduction in ER visits, behavioral health engagement, follow-up after hospitalizations).

In conjunction with seeking the waiver approval, the Department will work collaboratively with CMS to develop a robust monitoring and evaluation plan. Goals that will be evaluated relate to improved treatment outcomes, increased retention in treatment, reduced utilization of ED and inpatient hospital care and reduction in overdose deaths.

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SECTION VI: CONCLUSIONS AND OPPORTUNITIES

- **Successes and Best or Promising Practices**
- **Opportunities and/or Recommendations**
- **Grants Received**

Regulatory Reference	Description
Optional Response Not Required by CMS	Identify any successes that the state considers to be best or promising practices.
Optional Response Not Required by CMS	Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.
Optional Response Not Required by CMS	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.
Optional Response Not Required by CMS	Include recommendations that the state has for ongoing Medicaid and CHP+ quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable

Success and Best or Promising Practices

The Colorado State Innovation Model (SIM) has been a catalyst for change across the state with its work across four pillars by increasing access to integrated physical and behavioral health care services in coordinated community systems with value-based payment structures. The Colorado plan accounted for all aspects of patient health — from investments in local public health to efforts to reduce mental health stigma to practice coaching and health information technology that helps providers collect, use and report patient data in actionable ways. The approach included a built-in sustainability plan with funding to Colorado health departments and data collection that provides a business case for continuation of this work.

SIM proves that integrated care is a key component to succeeding with value-based payments because whole-person care leads to improved outcomes and the reduction or avoidance of unnecessary health care costs. One of the hallmarks of the SIM investment in Colorado has been stakeholder engagement. The Colorado team has empowered its stakeholders to lead these efforts, and data proves that this plan works.

Continuing implementation of reform initiatives that span the health care delivery system and with an emphasis on strategic alignment and accountability, the Department continues to focus on an outcome-driven health care program that aligns with the core commitments for improving the health and quality of care delivered; helping the most vulnerable persons thrive; and reducing per capita health care costs within the Medicaid delivery system. This ongoing strategy allows the

Department to further build upon evidence-based measurable strategies for improving population health outcomes while creating alignment of quality and health improvement initiatives. To track progress towards these outcomes, the Department ensures accountability is enabled and supported through various performance metrics.

Cost Control and Quality Improvement

The Cost Control and Quality Improvement Office will continue to lead the strategic development of a targeted, consistent, and comprehensive cost control approach across all programs, including the ACC. Initiatives for FY 2018–19 focus on: pharmacy; home health, hospital costs; identifying and reducing "potentially avoidable costs"; better informing Contractors of high cost, impactable members for increased care coordination and management; instituting analytics that help stratify the population in order to improve care coordination; and reducing fraud, waste and abuse including new medical claim system technology to prevent overpayments. As part of this work, the Department and its Contractors will work together to find opportunities for cost containment and institute cost control best-practices.

EPSDT

Under a Center for Health Care Strategies Technical Assistance opportunity, the Department will explore how to better utilize benefits included under EPSDT in systems where young children and families interact, such as child care, child welfare, child abuse prevention programs, home visiting, Women Infants and Children, and health systems, and how to better support Colorado Shines Brighter, to the benefit of having all Colorado children kindergarten-ready. The Office of Early Childhood is an ideal partner in that many two generation prevention programs are administrated in the Office, and support and expansion of kindergarten is a priority for the new administration of the Governor.

Target populations will be children age eight and younger with risk factors making them more likely to have poor outcomes in health, mental health, and the ability to succeed in school. Risk factors include poor parental mental health, low family income, teen parents, history of child welfare involvement, and low parental academic achievement. The Department will examine using a psychosocial screener to identify children with high risk factors and will prioritize based on family characteristics such as poverty and education level.

Maternal Opioid Misuse (MOM) Model

Building upon the Department's success to deliver improved health outcomes and reduce costs, the Department is planning to submit application for expanding care options through the Center for Medicare and Medicaid Innovation MOM Grant opportunity. The model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder through state-driven transformation of the delivery system surrounding this vulnerable population. By supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery, the MOM model has the potential to improve quality of care and reduce costs for mothers and infants. With the agreement of stakeholders, the Department plans to include alcohol and methamphetamine use in our model, as these are crucial substance use issues in Colorado and may be served by some of the same treatment modalities and structures.

The Department will develop and implement coverage and payment strategies; work with the Center for Medicaid and Medicaid Innovation and Children's Health Insurance Program Services to implement necessary authorities, including state plan amendments and/or program waivers; ensure provision of usable claims and encounter data to operate and evaluate the model; and coordinate with care-delivery partners to support information-sharing.

The Department's goals for the MOM Model include:

- Improve quality of care and reduce expenditures for pregnant and postpartum women with opioid use disorder/SUD as well as their infants
- Increase access to treatment, service delivery capacity, and infrastructure based on state-specific needs
- Create sustainable coverage and payment strategies that support ongoing coordination and integration of care

Health Care Analytics

As health care technology and care treatments continue to evolve, the Department views data as a critical tool for bringing about much needed value-based health care to balance cost-effective care with high quality care. As the amount of available data increases, the Department continues to drive value-based care, thereby decreasing the prescription of unnecessary or costly treatments, and thus ensuring treatment plans follow best practices. Based on this, the Department continues to focus and invest in data collection systems that enable the Department and our Contractors to make decisions that benefit the member while reducing overall cost of care.

As raw data, in and of itself, cannot provide insight and direction for continuous improvement, the Department will maintain focus on analytics processes, such as data visualization and visual narrative storytelling, to foster the transformation of data into information and understanding. These processes will include efforts such as the further development of dashboards to monitor and adjust quality initiatives to gain efficiencies and lead to effective outcomes, along with advanced visualization and analytics methods to discover new insights to improve treatments, care coordination, and reduce costs, and reveal relationships across a diverse set of data elements (such as medical, behavioral, and social determinants of health) to promote innovations in programs.

Substance Use Disorder Treatment Services

The Department has begun work to implement House Bill 18-1136 that adds residential and inpatient SUD services to Medicaid's covered benefits to ensure the full continuum of care is available for people needing treatment. The first stakeholder meeting occurred in October 2018 and the Department is participating in several technical assistance opportunities to design the benefit. The Department has initiated discussions with federal partners regarding the appropriate federal authorization needed for the new benefit.

Telemedicine

As access to care remains an issue for many Health First Colorado members, more initiatives are focusing on expansion of telemedicine as a solution. Telemedicine has the potential to increase access to care and reduce costs by expanding access to providers, decreasing wait times, and improving convenience. Telemedicine is not a unique service, but a means of providing selected

services approved by Health First Colorado through live interactive audio and video telecommunications equipment. Telemedicine allows providers to provide services that are already covered by Health First Colorado.

Despite the evidence behind telemedicine, utilization among Health First Colorado beneficiaries remains low. Low utilization could be due to a range of factors including technology costs, insufficient broadband, lack of provider buy-in, billing challenges, and adaptability to current clinic workflow. To reduce the barriers of telemedicine adoption, the Department is working to increase telemedicine education among providers and members while supporting health systems with implementation. Specifically, the Department has identified telemedicine funding for health systems, started quarterly stakeholder engagement workgroups, and is working on updates to the telemedicine billing manual.

The Department of Health Care Policy & Financing continues to refine its managed care approach and contracting strategy with the ultimate goal of improving quality of care for Health First Colorado members. With additional focus on data, reporting, dashboards, value-based care, Contractor oversight and an improved Quality Improvement Committee structure, the Department is confident that we are meeting and exceeding CMS's goals and objectives for state quality strategies.

Recommendations

Quality Improvement Committee

The Department looks forward to implementing a Quality Improvement Committee structure to further define, prioritize, oversee and monitor performance improvement activities. Proposed duties of the Quality Improvement Committee include:

- Support the overall vision and mission of the Department
- Monitor and review the Department's overall performance against the Department Quality Improvement defined goals and objectives
- Review Quality of Care Concerns
- Identify and recommend quality improvement initiatives to the Leadership Team
- Develop work plans for the implementation of quality improvement initiatives that are assigned to the Quality Improvement Committee
- Work with appropriate sections/units within the Department to implement quality improvement initiatives as assigned
- Participate in the development of dashboards/report cards and other measurement tools to monitor quality within the Department
- Coordinate activities with other internal and external committees/stakeholders
- Monitor member satisfaction
- Communicate outcomes and action plans to the Leadership Team and other stakeholders as appropriate for driving quality improvement performance

APPENDIX A: ACCESS TO CARE STANDARDS CROSSWALK

CONTRACTS: PCCM/PIHP/MCO (page 1-152 refers to PCCM/PIHP) (pages 153 to 302 refers to MCO); CHP+		
Regulatory Reference	**SECTION I: INTRODUCTION**	
Development and Review of Quality Strategy		**QS Page Reference**
§438.340(b)	Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.	**12**
§438.340(c)(1)	Include a description of how the state made (or plans to make) the quality strategy available for public comment.	**12**
§438.340(c)(2)(i)	Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	**12**
§438.340(c)(3)(ii)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant changes," include the state's definition of "significant changes."	**12**
Regulatory Reference	**SECTION II: ASSESSMENT**	**QS Page Reference**
Quality and Appropriateness of Care		
§438.340(b)(4)	Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs. This must include the state's definition of special health care needs.	**13**
§438.340(b)(6)	Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.	**13**
National Performance Measures		
§438.330(a)(2)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.	**17**
Monitoring and Compliance		
§438.358(b)(iii)	Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include, but are not limited to: •Member or provider surveys; •HEDIS® results; •Report Cards or profiles; •Required MCO/PIHP reporting of performance measures; •Required MCO/PIHP reporting on performance improvement projects; •Grievance/ Appeal logs, etc.	**18**
External Quality Review		
§438.340(b)(4)	Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time.	**23**
§438.360(b)	If applicable, identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are	**23**

	duplicative to those in 42 C.F.R. §438.340.		
§438.360(c)	If applicable, for MCOs or PIHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication option under §438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §§ 438.358(b)(1) and (b)(2).		**23**
Regulatory Reference	**SECTION III: STATE STANDARDS**	**Entity**	**Citation**
Access Standards			
§438.206	**Availability of Services (Access Measurement & Monitoring Plan)**	**CO Quality Strategy, page 26**	
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	PCCMe/PIHP	9.5.1.1.
		MCO	9.4.1.1.
		CHP+	10.2.1.1.
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist	PCCMe/PIHP	9.2.7.
		MCO	9.2.8.3.2.
		CHP+	10.2.1.14.
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	PCCMe/PIHP	9.4.17.
		MCO	9.3.13.
		CHP+	10.2.1.15.
§438.206(b)(4)	Adequately and timely coverage of services not available in network	PCCMe/PIHP	10.2.2.1.
		MCO	14.6.11.
		CHP+	10.2.2.1.
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	PCCMe/PIHP	14.6.11.1.
		MCO	
		CHP+	10.2.2.3.
§438.206(b)(6)	Credential all providers as required by §438.214	PCCMe/PIHP	9.3.4.3.
		MCO	9.2.3.
		CHP+	14.2.1.3.
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	PCCMe/PIHP	9.4.13.
		MCO	9.3.1.
		CHP+	11.1.2.
§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	PCCMe/PIHP	9.4.2-9.4.4.
		MCO	9.3.3.
		CHP+	7.1.
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week	PCCMe/PIHP	9.2.1.10. 9.2.2.
		MCO	9.2.8.1.10. 9.2.8.2.
		CHP+	8.7.
§438.206(c)(1)	Mechanisms monitoring to ensure compliance by providers	PCCMe/PIHP	9.1.12.
		MCO	9.1.14.
		CHP+	10.2.4.1.
§438.206(c)(2)	Culturally competent services to all enrollees	PCCMe/PIHP	7.2.1.
		MCO	7.2.1.
		CHP+	8.9.2. 10.5.3.2.5.
§438.207	**Assurances of Adequate Capacity and Services**	**CO Quality Strategy, page 28**	
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	PCCMe/PIHP	9.1.4.
		MCO	9.4.1.8.-9.

		CHP+	10.3.2.3.
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	PCCMe/PIHP	7.1.1.4. 10.2.1.
		MCO	10.2.1.
		CHP+	15.3.2.1.
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	PCCMe/PIHP	9.1.4. 9.1.4.1.-5.
		MCO	9.1.5. 9.1.5.3.-5.
		CHP+	10.3.2.4.
§438.208	**Coordination and Continuity of Care**	**CO Quality Strategy, page 28**	
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	PCCMe/PIHP	11.3.9. 14.6.3.
		MCO	14.4.3. 14.6.3.
		CHP+	8.9.1.-2.
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MC/PIHP	PCCMe/PIHP	11.3.5. 11.3.9.
		MCO	11.3.5. 11.3.9.
		CHP+	10.5.3.3.1.-2.
§438.208(b)(3)	Share with other MCOs, PIHPs, & PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	PCCMe/PIHP	11.3.6. 121.11.6. 16.2.1.4.
		MCO	10.2.2. 11.3.6. 11.3.7.7. 12.11.6.
		CHP+	10.6.1.
§438.208(b)(4)	Protect enrollee privacy when coordinating care	PCCMe/PIHP	7.3.7.2.1. 11.3.7.11.
		MCO	7.3.7.1. 11.3.7.11.
		CHP+	10.5.1.1.
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	PCCMe/PIHP	16.2.1.4. 16.3.7.3.
		MCO	16.2.1.4. 16.3.7.3.
		CHP+	10.5.3.1.1.
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	PCCMe/PIHP	14.6.6. 16.2.1.4.
		MCO	9.1.12. 14.6.6.
		CHP+	10.6.3.
§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	PCCMe/PIHP	9.2.1.12. 14.7.1.2.
		MCO	9.2.8.1.12. 14.5.1.2.
		CHP+	1.1.9.

§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	PCCMe/PIHP	10.2.4.13. 14.6.3.
		MCO	9.1.12. 16.2.1.4.2.
		CHP+	10.5.3.2.5.
§438.210	**Coverage and Authorization of Services**	**CO Quality Strategy, page 29**	
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	PCCMe/PIHP	7.3.8.1.3.
		MCO	7.3.8.1.3.
		CHP+	14.1.3.10.- 14.1.3.13.1.
438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than those furnished to beneficiaries under fee-for-service Medicaid	PCCMe/PIHP	14.6.1. 14.11.9.
		MCO	14.4.1.
		CHP+	8.3.
§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	PCCMe/PIHP	14.6.2
		MCO	14.1.1.1.
		CHP+	8.3.
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	PCCMe/PIHP	14.6.4.
		MCO	14.1.1.3.
		CHP+	8.11.
§438.210(a)(3)(iii)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	PCCMe/PIHP	14.6.5.1.
		MCO	14.4.5.1.
		CHP+	8.13.2.
§438.210(a)(4)	Specify what constitutes "medically necessary services"	PCCMe/PIHP	2.1.62.*
		MCO	2.1.69.*
		CHP+	8.13.2.
		*10 CCR 2205-10, §8.076.1.8	
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	PCCMe/PIHP	7.3.8.1.4.
		MCO	7.3.8.1.4.
		CHP+	11.1.5.
§438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	PCCMe/PIHP	14.8.5.
		MCO	14.6.5.
		CHP+	11.1.6.
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	PCCMe/PIHP	14.6.6.
		MCO	14.4.6.
		CHP+	11.1.3.
§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	PCCMe/PIHP	8.7.13.6.
		MCO	8.7.13.6.
		CHP+	11.1.8.
§438.210(d)	Provide for the authorization decisions and notices as set forth in section §438.210(d)	PCCMe/PIHP	8.4.1.1.
		MCO	8.4.1.1.
		CHP+	11.1.10.
§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	PCCMe/PIHP	14.8.6.
		MCO	14.6.6.
		CHP+	11.1.1.
Structure and Operations Standards			
§438.214	**Provider Selection**	**CO Quality Strategy, page 31**	
§438.214(a)	Written policies and procedures for selection and retention of	PCCMe/PIHP	9.1.6.

	providers	MCO	9.1.7.
		CHP+	14.2.1.1.
§438.214(b) (1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	PCCMe/PIHP	9.3.4.2.1.
		MCO	9.2.4.
		CHP+	14.2.1.2.-3.
§438.214(b) (2)	Documented process for credentialing and recredentialing that each MCO/PIHP must follow	PCCMe/PIHP	9.3.4.1.
		MCO	9.2.1.
		CHP+	14.2.1.3.
§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	PCCMe/PIHP	9.1.6.1
		MCO	9.1.7.1
		CHP+	14.2.1.1.2.1.
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	PCCMe/PIHP	9.1.15.
		MCO	17.5.4.1.
		CHP+	14.2.1.7.
§438.218	**Enrollee Information**	**CO Quality Strategy, page 33**	
§438.218	Incorporate the requirements of section §438.10	PCCMe/PIHP	7.2.2.
		MCO	7.2.7.5.
		CHP+	14.1.7.4.
§438.224	**Confidentiality**	**CO Quality Strategy, page 33**	
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	PCCMe/PIHP	15.1.1.5.
		MCO	15.1.1.6.
		CHP+	14.1.6.2.
§438.226	**Enrollment and Disenrollment**	**CO Quality Strategy, page 34**	
§438.226	Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in §438.56	PCCMe/PIHP	6.
		MCO	6.
		CHP+	6.3. 6.4.
§438.228	**Grievance Systems**	**CO Quality Strategy, page 34**	
§438.228(a)	Grievance system meets the requirements of Part 438, subpart F	PCCMe/PIHP	8.1.
		MCO	8.1.
		CHP+	7.9.1.
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	PCCMe/PIHP	8.7.13.6.
		MCO	8.7.13.6.
		CHP+	
§438.230	**Subcontractual Relationships and Delegation**	**CO Quality Strategy, page 35**	
§438.230(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	PCCMe/PIHP	4.2.12.6.
		MCO	4.2.12.6.
		CHP+	5.5.3.3.
§438.230(b) (1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	PCCMe/PIHP	3.10.3.
		MCO	3.10.3.
		CHP+	
§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	PCCMe/PIHP	3.14.
		MCO	3.14.
		CHP+	

§438.230(b)(3)	Monitoring of subcontractor performance on an ongoing basis	PCCMe/PIHP	3.14.
		MCO	3.14.
		CHP+	
§438.230(b)(4)	Corrective action for identified deficiencies or areas for improvement	PCCMe/PIHP	16.5.7.2. 17.4.9.
		MCO	16.5.8.2. 17.4.9.
		CHP+	8.14. 14.2.5.4.
Measurement and Improvement Standards			
§ 438.236	**Practice Guidelines**	**CO Quality Strategy, page 35**	
§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.	PCCMe/PIHP	14.8.2.6. 14.8.8.1. 14.8.8.2. 14.8.8.3.
		MCO	14.6.2.6. 14.6.7.1. 14.6.7.2. 14.6.7.3. 14.6.8.
		CHP+	12.2.1.
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees	PCCMe/PIHP	14.8.8.
		MCO	7.3.4.
		CHP+	12.2.1.3.
§438.330	**Quality Assessment & Performance Improvement Program**	**CO Quality Strategy, page 36**	
§438.330(a)(1)	Each MCO/PIHP must have an ongoing quality assessment and performance improvement program	PCCMe/PIHP	16.1.1.
		MCO	16.1.1.
		CHP+	12.4.7.1.
§438.330(b)(2) & §438.330(c)(2)(1)	Each MCO and PIHP must conduct PIPs and measure and report to the state its performance List out PIPs in the quality strategy	PCCMe/PIHP	16.4.1.-2.
		MCO	16.4.1.-2.
		CHP+	12.3.
§438.330(c)(2) §438.330	Each MCO and PIHP must measure and report performance measurement data as specified by the state List out performance measures in the quality strategy	PCCMe/PIHP	16.2.1.2.
		MCO	16.2.1.2.
		CHP+	12.3.4.
§438.330(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	PCCMe/PIHP	16.2.1.3. 16.6.
		MCO	16.2.1.3. 16.6.
		CHP+	12.4.4.1.
§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	PCCMe/PIHP	16.2.1.4.
		MCO	16.2.1.4.
		CHP+	8.9.1.
§438.330(c)(2)	Annual review by the state of each quality assessment and performance improvement program If the state requires that an MCO/PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program,	PCCMe/PIHP	16.3.2.
		MCO	16.2.5.
		CHP+	15.7.2.1.

	indicate this in the quality strategy.		
§438.242	**Health Information Systems**	**CO Quality Strategy, page 38**	
§438.242(a)	Each MCO/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	PCCMe/PIHP	15.1., 15.2.
		MCO	15.1., 15.2.
		CHP+	11.1.16.
§438.242(b)(1)	Each MCO/PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	PCCMe/PIHP	15.1.
		MCO	15.1.
		CHP+	12.4.10.2.
§438.242(b)(2)	Each MCO/PIHP must ensure data received is accurate and complete	PCCMe/PIHP	15.2.2.3.5.1. 16.11.1.2.
		MCO	15.2.4.1.
		CHP+	18.2.5.
Regulatory Reference	**SECTION IV: IMPROVEMENTS AND INTERVENTIONS**		**QS Page Reference 40**
	Intermediate Sanctions		
§438.340(b)(7)	For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42C.F.R. Part 438, subpart I.		43
	Health Information Technology		
438.364(a)(4)	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.		44