COLORADO
Department of Health Care Policy & Financing

2024 CMS Medicaid & Children's Health Insurance Plan (CHIP) Managed Care Quality Strategy

Health First COLORADO™
Colorado's Medicaid Program

Contents

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 1.7 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 also aligns with the Department's overarching mission, the national Quality Strategy goals set forth by the Centers for Medicare & Medicaid Services (CMS), and the principles of the quadruple aim: improving population health, enhancing patient experience, reducing costs, and supporting provider well-being. 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.

The Department created the Accountable Care Collaborative (ACC) in 2011 to address the state's mission to improve health care access and outcomes for members while demonstrating sound stewardship of financial resources. As the core of Health First Colorado, the ACC 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 holding individuals and organizations that provide care accountable for the quality, outcomes and the cost of that care. The fundamental premise of the ACC 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 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 in which other health care initiatives, such as health information technology and payment reform, can thrive, as the ACC works to better serve members and create value. It is a hybrid model authorized under a 1915(b) waiver, combining the Primary Care Case Management Entity (PCCM Entity) with the Prepaid Inpatient Health Plan (PIHP) for the behavioral health benefit. In addition to the hybrid RAE entities, the ACC also includes two managed care organizations (MCOs) in regions 1 and 5. The two MCOs function as a limited managed care capitation initiative providing physical health services. The Department maintains contracts with each RAE to implement and manage all aspects of the ACC PCCM Entity-PIHP program within each of the seven regions. RAEs manage and oversee a network of primary care physical health providers and behavioral health providers while ensuring network adequacy to provide appropriate care for Health First Colorado members within their region.

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 CFR §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 and Children's Health Plan Plus (CHP+).
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.

Colorado's Separate CHIP program is called Children's Health Plan Plus (CHP+) and is a full risk managed care delivery system. CHP+ has four MCOs that provide care coordination across their service areas for children up to age 19 and pregnant people up to 260% Federal Poverty Level (FPL). The Department aims to treat all children and perinatal members as a global population without gaps in care or confusing differences between benefit coverage. The Department applies the same Quality Strategy to CHP+ and Health First Colorado programs, so that the member and provider experience is the same high quality regardless of RAE or MCO enrollment. Three of the four CHP+ MCOs are also RAEs, so the program aligns with the ACC where funding and authority allows.
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 1: Introduction and Overview

Overview

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 (the Department, or HCPF). Health First Colorado serves 1.7 million members and has an annual budget of $11.4 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 in accordance with 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.

Purpose

This purpose of this document, in accordance with **42 CFR 438.340(c)** and **457.1240(e)**, is to review and update the HCPF managed care quality strategy as needed, but no less than once every three years.

The Department works collaboratively with an engaged community of members, providers, advocacy organizations, community organizations, foundations and legislators to address their unique needs. Over the past 13 years, Health First Colorado has expanded from an FFS health plan to a hybrid FFS and managed care program covering 1.7 million children, pregnant women, parents and low-income adults. The following timeline (see Figure 2) reflects the evolution of Health First Colorado's program.

- Health First Colorado
    - Colorado's Medicaid program – A public health care program that provides access to physical and behavioral health care, hospitalization, nursing facility care, prescription drugs, dental care and other benefits.
    - 1.7 million members
- Child Health Plan *Plus* (CHP+)
    - CHP+ provides comprehensive health care benefits, including dental care, to uninsured children ages <18 and pregnant people who do not qualify for Health First Colorado and cannot afford private health insurance.
    - 47,000 members
- Colorado Indigent Care Program (CICP)
    - CICP allows Coloradans with incomes up to 250% of the Federal Poverty Level to receive discounted health care services at participating hospitals, community health centers and clinics. Only half a year's data is currently available for CICP due to the data being combined with the Hospital Discounted Care (HDC) data beginning September 1, 2022. This section of the report will contain data related to both HDC and CICP in future iterations.
    - 10,500 served

- Dental Programs
    - Health First Colorado offers dental benefits to children and adults. In fiscal year 2022-23, Health First Colorado provided dental services to 648,525 Coloradans and CHP+ provided dental care to 26,739 Coloradans.
    - 675,264 served
- Buy-In Programs
    - The Health First Colorado Buy-in programs allow members with disabilities to pay a premium for Health First Colorado if they earn too much to qualify so they don't have to choose between work and health coverage. This link is provided to learn more about Buy-in programs for adults and children.
- Long-Term Services and Supports (LTSS)
    - LTSS provides comprehensive care for members 65 and older and people with disabilities, so they can:
        - Live in a setting they choose with the supports they need
        - Participate in communities that value their contributions
        - Access services in a simple, timely and streamlined manner
        - Get the highest quality services
    - 83,187 serviced
- Accountable Care Collaborative (ACC)
    - Launched in 2011, the ACC is at the core of Health First Colorado. Regional Accountable Entities (RAEs) deliver programs to improve member health and reduce costs across the state.

This link is provided to learn more about these public health care programs for Coloradans who qualify.
Prior to 2011, members received their physical health services through an unmanaged fee-for-service approach, while members received most of their behavioral health services through capitated managed care entities. The ACC began in 2011 as a managed fee-for-service model operated under a State Plan Amendment approved by CMS. The State Plan Amendment functioned by supporting the physical health of members through the development of formal contracted networks of primary care medical homes and informal networks of specialists and ancillary providers.
Beginning in July 2018, Phase II of the ACC established the RAEs to operate both the Capitated Behavioral Health Benefit and managed fee-for-service program under single regional entities. The RAEs are authorized by CMS under a 1915(b) waiver as both a PCCM Entity and a PIHP following the applicable federal requirements in **42 CFR § 438**. As the core of Health First Colorado, RAEs are responsible for promoting an integrated, whole-person approach to members' physical and behavioral health by:

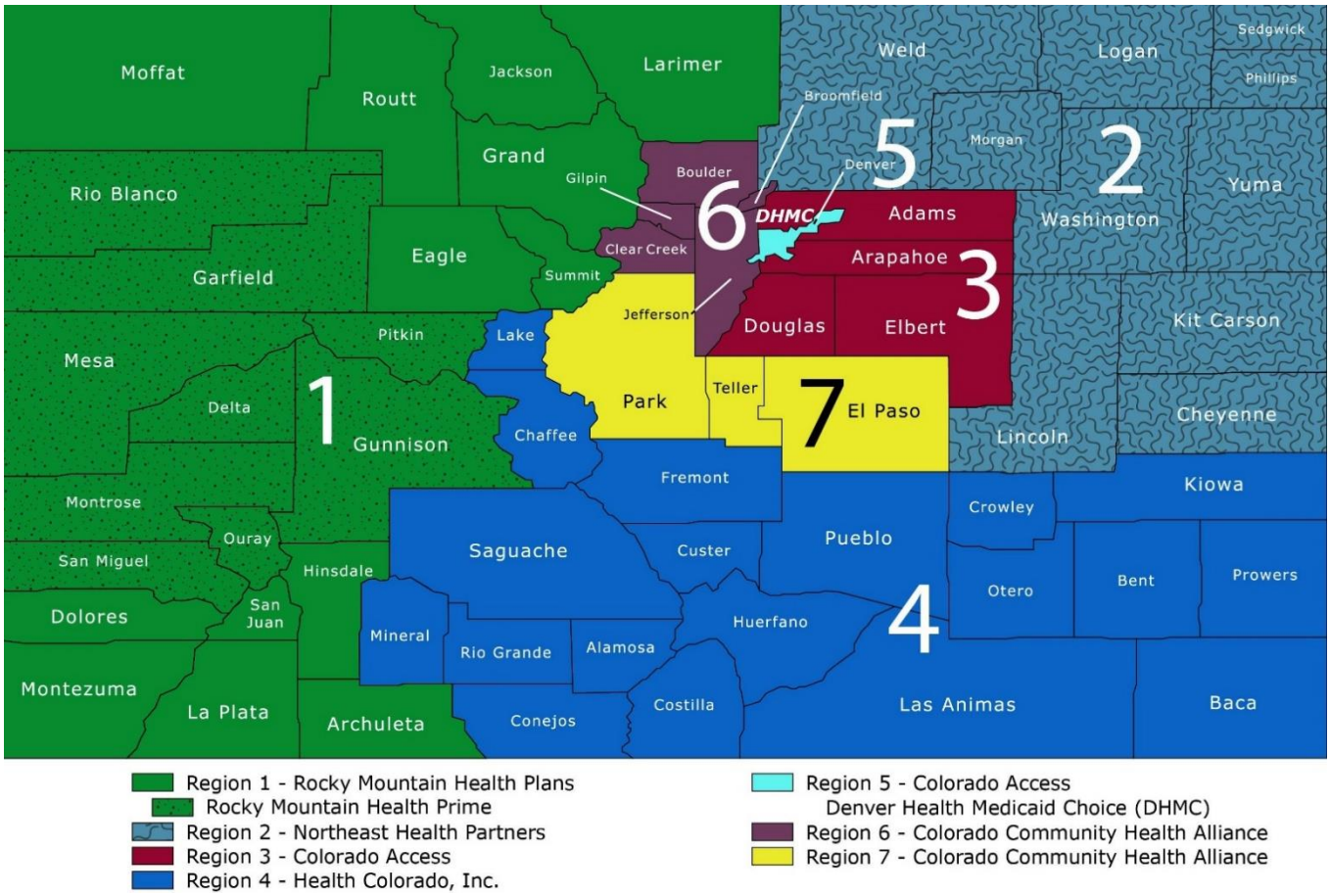
- Providing a regionally responsive approach and oversight to care, particularly for members with chronic and complex health care conditions with needs that span multiple agencies and jurisdictions. As regional organizations, RAEs are expected to understand the nuances among populations in the geographic area they cover to create cohesive provider and community support networks that deliver coordinated, whole-person care that improves health outcomes.
- Administering the Capitated Behavioral Health Benefit by maintaining a network of

providers and providing or arranging for the delivery of medically necessary mental health and substance use disorder services utilizing a full continuum of care, ranging from inpatient to residential to community-based services that adapt to a member's changing needs and provide appropriate access to care.

- Contracting with and supporting a network of Primary Care Medical Providers (PCMPs) to serve as medical homes for members, providing whole-person, coordinated, and culturally competent care.
    - Providing training and practice transformation support to providers to ensure the delivery of comprehensive, cost-effective, quality care that improves the member and provider experience.
- Providing actionable data and comprehensive support services so that providers can successfully participate in the Department's value-based payment programs.
- Managing overall administration, data and member information.
- Providing member access to care and supports by leveraging technology and establishing the infrastructure, tools and resources that enable the timely and cost-effective delivery of health care services and supports that improve member outcomes.

Although the ACC is a type of managed care, it is not a capitated comprehensive risk model for physical health care. In compliance with state law, two physical health managed care capitation plans, referred to as MCOs, also participate in the ACC. Rocky Mountain Health Plan (RMHP) PRIME (**C.R.S. 25.5-5-415**) operates as part of the Region 1 RAE contract. Denver Health Medicaid Choice (DHMC), authorized through **C.R.S 25.5-5-402**, delivers physical health care in the Denver metro region and subcontracts with the RAE in Region 5 to administer the capitated behavioral health benefit. Both are designed to maximize the integration of behavioral health and physical health services for enrolled members.

Figure 1: Map of Regional Accountable Entities



Most full-benefit Health First Colorado members are automatically enrolled in the ACC and immediately connected with a 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 connected to a PCMP 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 attributed PCMP determines the member's assignment to a RAE. Members are able to choose a different PCMP at any time through the Department's enrollment broker.

Each RAE is responsible for ensuring timely and appropriate access to medically necessary services offered by the full range of Health First Colorado 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 Health First Colorado and actively treating members. The RAEs support provider access and utilization of tools and resources to support members with complex conditions, obtain brief specialty consultations, 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 members and to ensure delivery of medically necessary mental health and substance use disorder services.

The ACC represents an innovative way to accomplish the Department's goals for Medicaid reform. It invests directly in community infrastructure to support care teams and care coordination. The fundamental premise of the ACC is that regional communities are in the best position to make changes that will cost-effectively optimize the health and quality of care for all members. The ACC also creates aligned incentives to measurably improve member health and reduce avoidable health care costs. It holds that those who actually provide care are accountable for the quality, outcomes and the cost of that care. The following examples highlight the variety of ways the ACC has been able to evolve to support providers and communities and improve members' health and well-being.

- The RAEs successfully implemented a new inpatient and residential substance use disorder benefit which covered more than 3,600 residential, withdrawal management, and intensive outpatient services from January 2021 through March 2022.
- The RAEs and HCPF worked together to expand the behavioral health provider network to include more than 11,300 active behavioral health providers.
- During the COVID-19 pandemic, RAEs were critical in supporting the expansion of telemedicine services to ensure members were still able to access needed care.
- The RAEs helped roll out the Prescriber Tool, which is used by nearly 50% of Health First Colorado prescribers.
- The RAEs were key partners in collaborating with providers and community-based organizations to increase COVID-19 vaccination rates and close health disparities measured by race.
- As part of the RAEs' work to build community supports for members, RAEs make financial investments in community organizations such as community centers, community-based recovery programs, educational programs, and local public health agencies. In fiscal year 2021-22, RAEs provided more than $24 million in grants.
- The unique structure of the ACC allowed the Department to adjust to the rapid increase in members, reflected in ACC enrollment. This represented approximately 500,000 additional ACC members from 2020 to 2023, due to federal continuous coverage enrollment rules in place during the COVID-19 public health emergency. With the end of the public health emergency in May 2023, RAEs supported members and providers, in understanding the need to renew or transition to other forms of coverage, such as employer-sponsored insurance or Medicare.

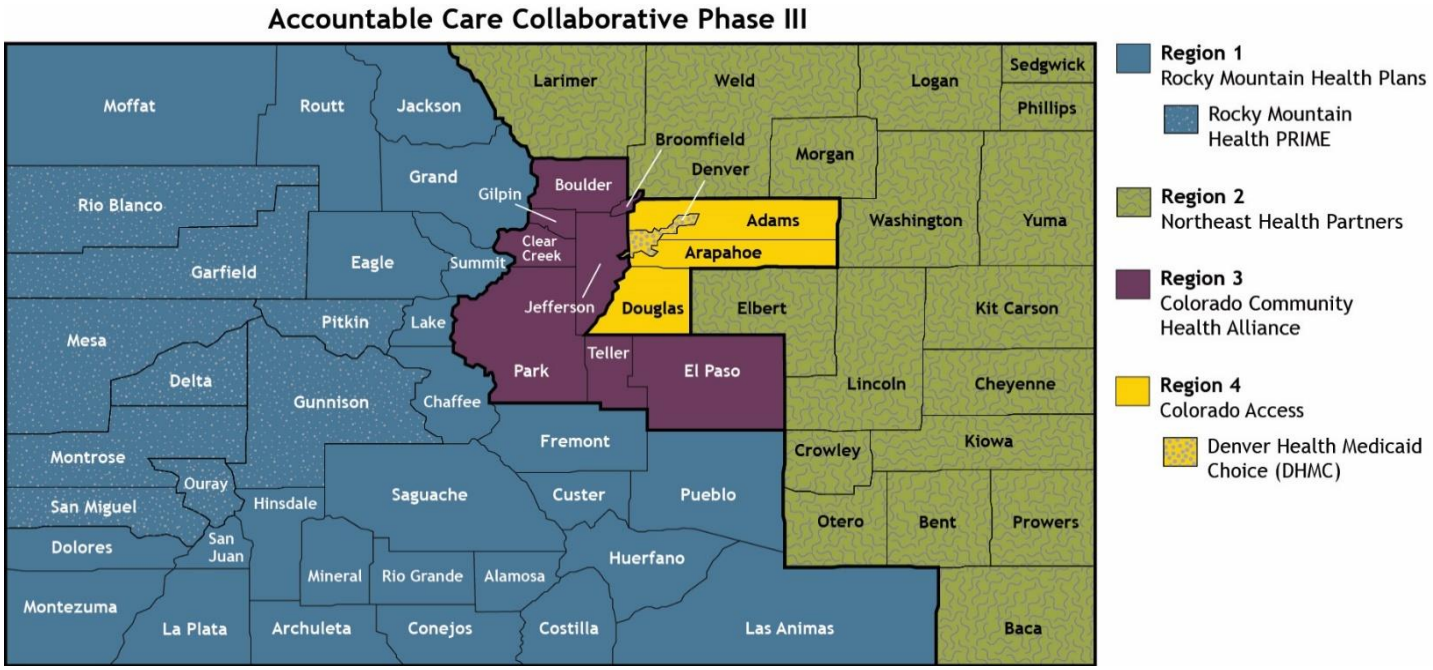
Current RAE contracts will end on June 30, 2025. HCPF is in the process of implementing the next iteration of the ACC, referred to as Phase III, which will begin on July 1, 2025. Because the ACC is Health First Colorado's delivery system, Phase III is a critical part of efforts to

improve care quality, service, equity and affordability. ACC Phase III is designed to achieve the following five goals:

- Improve quality care for members.
- Close health disparities and promote health equity for members.
- Improve care access for members.
- Improve the member and provider experience.
- Manage costs to protect member coverage, benefits and provider reimbursements.

To achieve these goals, the ACC is focused on reducing complexity and administrative burden through simplifying systems. This is intended to create more consistency and standardization by centralizing elements of the ACC that will improve the member and provider experience while generating measurable efficiencies. ACC Phase III incorporates, complements and expands on policies and programs being implemented by the Department and other state agencies, to advance health care throughout Colorado. For Phase III, the Department has reduced the number of RAE regions from seven to four. This change is part of the Department's work to simplify systems and to ensure a more consistent standard of care across the state for members.

Figure 2: ACC Phase III



Tribal Consultation Process

Colorado has a formalized Tribal Consultation process implemented in a Memorandum of Understanding with our two federally recognized Tribes, the Ute Mountain Ute Tribe and Southern Ute Indian Tribe, and the States urban Indian health organization (UIHO), Denver Indian Health and Family Services. The formalized process requires outreach to Tribal Council and health staff regarding any proposed changes to our Medicaid State Plan and systemic

and\or impactful changes that impact American Indians/Alaska Natives. Care coordination services are provided to Tribal members through the RAE that serves the Tribes' geographic region.

Section 2: Quality Oversight for Medicaid Managed Care

Goals, Objectives of the State's Managed Care Program

The Department, in alignment with the Governor's health care priorities, continues to focus on reducing health care costs while ensuring culturally responsive and equitable access to care by expanding access to comprehensive primary and behavioral health services for the Medicaid and Child Health Plan Plus (CHP+) population, based on the following mission, goals and associated performance measures.

Mission: Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

Strategic Pillars

HCPF manages projects under six pillars, to achieve Executive Leadership Team individual goals and Department goals, Governor's WIGs and the Health Cabinet WIGs. The pillars have been a cornerstone of achieving our strategic plan and are refined to best capture and ensure HCPF focuses on the most important work. Since the last issuing of this report, the Department's strategic pillars have grown. Employee Satisfaction and Equity, Diversity and Inclusion, and Care Access were added as strategic pillars.

The Department's six strategic pillars, designed to ensure customer-focused performance management, are as follows:

- **Member Health:** Improve quality of care and member health outcomes while reducing disparities in care.
- **Care Access:** Improve member access to affordable, high-quality care.
- **Operational Excellence and Customer Service:** Provide excellent service to members, providers and partners with compliant, efficient, effective person- and family-centered practices.
- **Health First Colorado Value:** Ensure the right services, at the right place and the right price.
- **Affordability Leadership:** Reduce the cost of health care in Colorado to save people money on health care.
- **Employee Satisfaction:** Invest in HCPF employees at all levels while improving equity, diversity, inclusion and accessibility

Goals

All Department goals are tied back to one of these strategic pillars. The Department is highly accountable for performance measures due to an annual performance measurement system. The Governor has annual performance goals for the Department, the Governor's Health Cabinet has annual performance goals for the Department, and the Department also has its own annual performance goals.

- All performance goals align with the Department's strategic pillars, and the performance plans are publicly available on the Governor's operations website at Performance Plans.
- Department performance is managed through Governor Office goals called Wildly important Goals (WIGs). The last six years of WIG are all available on the Governor's Dashboard.
- In addition to Governor's goals for the Department, the Department crafts goals and executes projects to reach the Department goals. The most recent year's performance strategy (FY 2025-26) has more than 95 projects to reach 45 goals.

Table 1: FY 2024 Strategic Pillars with Subset of Priorities

Member Health	Care Access	Operational & Service Excellence	Health First CO Value	Affordability Leadership
*Support health related social needs like housing and food security *Transform behavioral health and improve care for high acuity children and youth *Improve health equity in prevention, maternity care, behavioral health *Improve child/youth immunizations and prenatal care	*Keep Coloradoans covered *Expand coverage (1115, Cover All Coloradoans) *Protect member coverage, benefits, and services * Expand provider network, incl. behavioral health, specialists, rural, dental *Regularly review provider reimbursement rates to ensure access to care *Transform HCBS services for	*Improve eligibility systems, experience, county workload, automation, letter clarity *Resource counties *Stabilize LTSS ecosystem for people with disabilities *Drive service quality across all partners (calls/claims) *Innovate systems; smoothly implement system changes; bolster cyber security	*Address Medicaid costs and trends *Modernize Medicaid delivery system through ACC Phase III *Advance value-based payments to drive quality, equity, access, and affordability *Right care, right time, right place, right price *Ensure appropriate Medicaid payments balancing provider admin *Prevent avoidable ER visits and hospital care	*Manage within difficult state budget limitations *Reduce uninsured rate *Mitigate rising pharmacy cost trends *Increase hospital affordability and price transparency (tools, reports, and policies) *Drive innovation (eConsults, Prescriber Tools, SHIE, cost and quality indicators) *Lead value-based payments across payers

	people with disabilities	*Maximize and close-out ARPA funding		

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 fiscal year 2023-2024 are presented below. 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 3: Age Demographics FY 2023-24

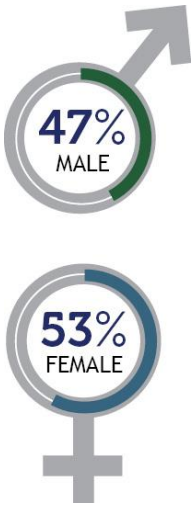


Figure 4: Age Demographics FY 2023-24

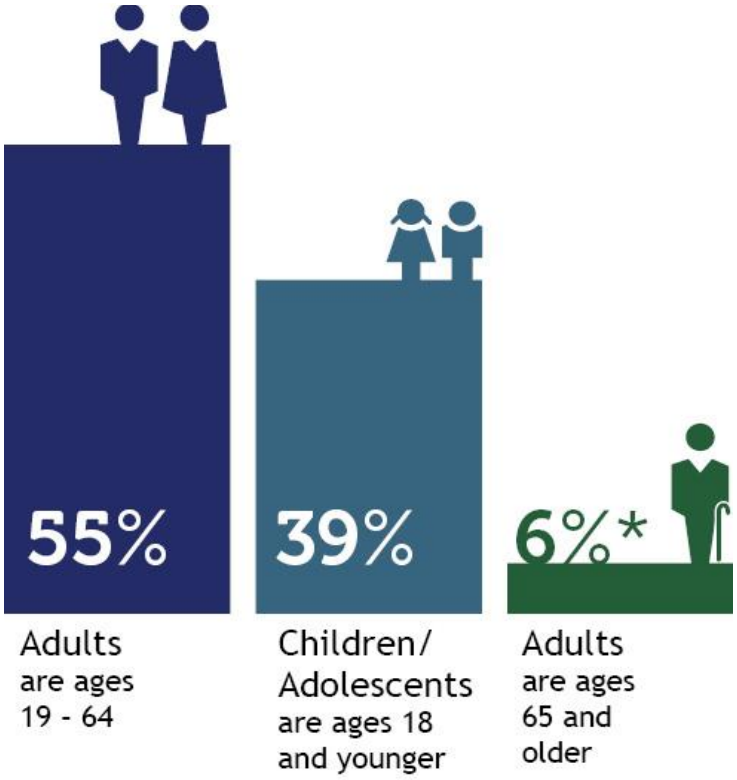


Figure 5: Race Demographics FY 2023-24

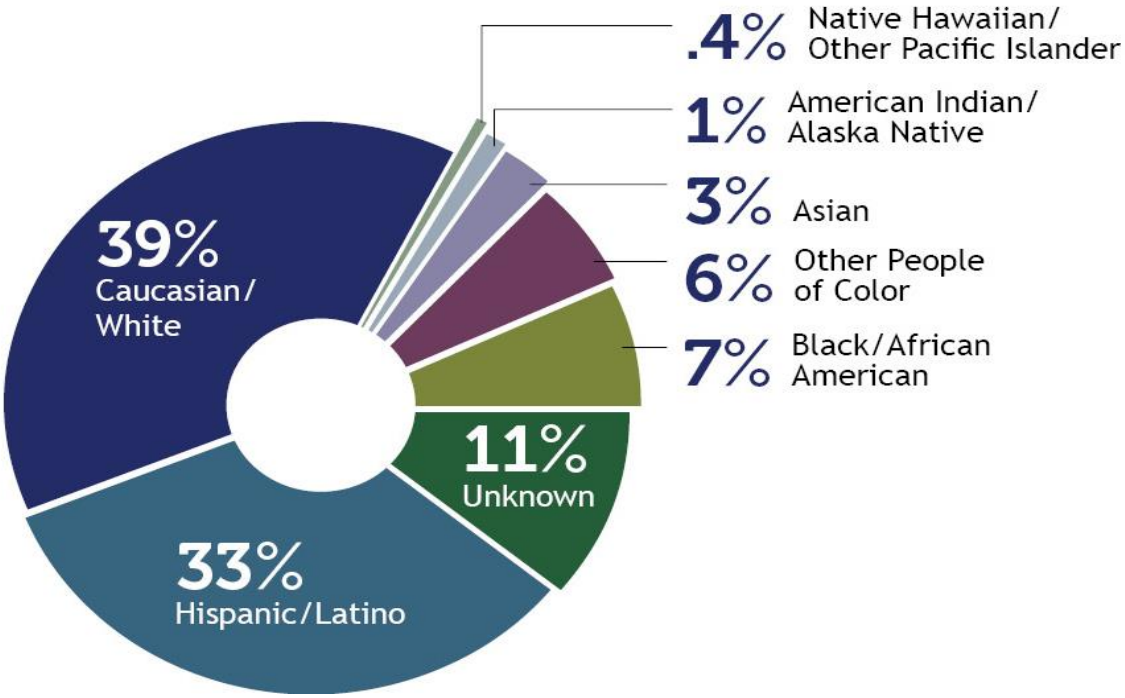
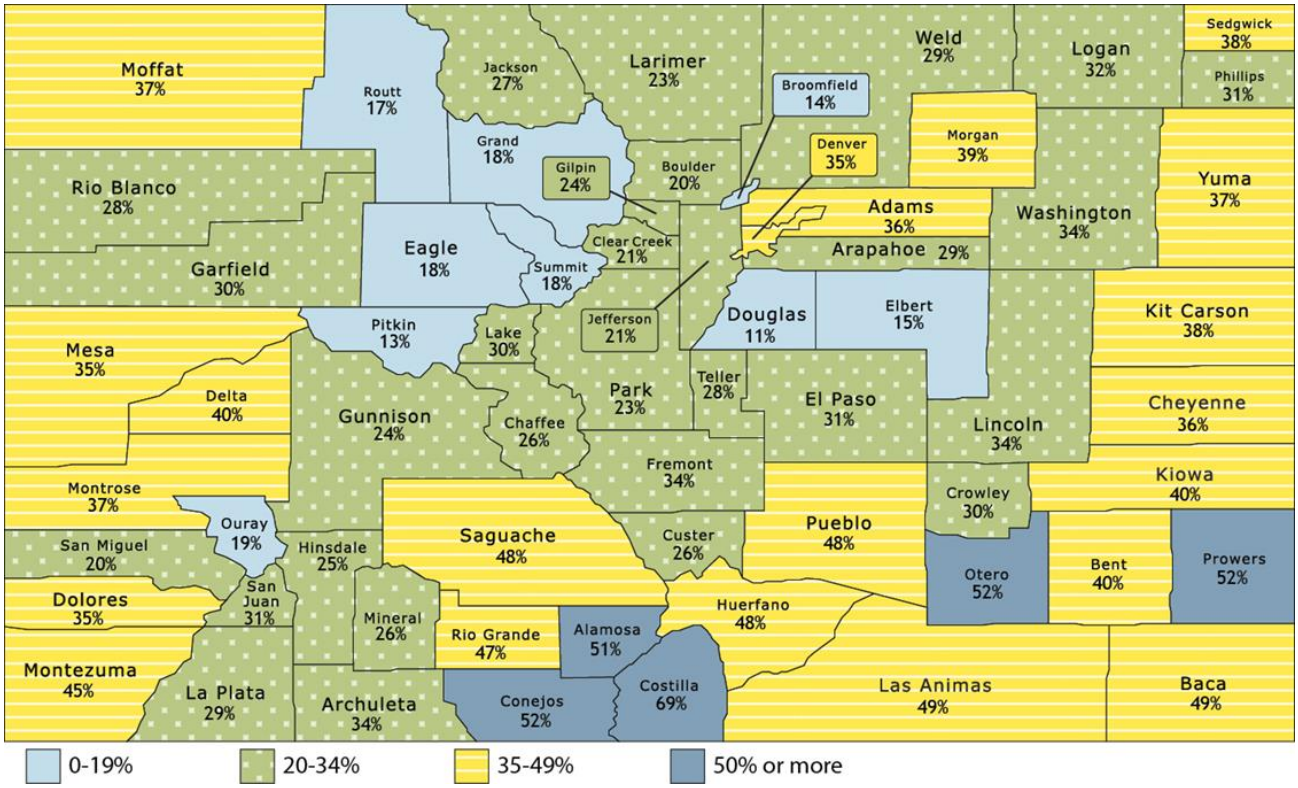


Figure 6: Percentage of Total Population Enrolled in Medicaid & CHP+, by County



Note: The source of enrollment data is Medicaid Management Information System (MMIS). Percentages represent people enrolled for one day or more during calendar year 2023. 2023 population data as forecasted by the state demographer.

Development and Review of Quality Strategy

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 members 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 members 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
- Member Experience Advisory Council
- Performance Improvement Advisory Committee
- Performance Measure and Member Engagement Sub-Committee

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. The Department is currently conducting an evaluation of the effectiveness of the quality strategy and have provided The 2021 Health Strategy Effectiveness and Evaluation report on the Department's website. The Department will post the 2024 Evaluation and Effectiveness Review when completed.

Section 3: Assessment Activities

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, who are enrolled in an MCO. 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, enrolled with an MCO. Per Colorado State regulation 10 C.C.R. 2505-10, §8.205.8, Persons with Special Health Care Needs shall mean persons having ongoing health conditions that:

1. Have a biologic, psychologic or cognitive basis;
2. That have lasted or are virtually certain to last for at least one year; and
3. Produce one or more of the following criteria:
   a. Significant limitation in areas of physical, cognitive or emotional function;
   b. Dependency on medical or assistive devices to minimize limitation of function or activities;
   c. In addition, for children:
      (i) Significant limitation in social growth or developmental function;
      (ii) Need for psychologic, educational, medical or related services over and above the usual for the child's age; or
      (iii) Special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.

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.

Mechanisms to identify persons with special health care needs for MCOs
Per the State's 1915(b) waiver, the RAEs are exempt from meeting the requirements for additional services for members with special health care needs. However, RAEs still participate in activities related to mechanisms used to identify members with special health care needs, but not explicitly for that purpose.

As part of the Members' welcome process, the Department developed a Health Needs Survey to be completed by Members. The Department's Enrollment Broker collects and stores Member survey responses and posts them in the respective MCE's FTP folder within 24 hours of receipt of the information. Information collected from the Health Needs Survey is made available to the MCE who then outreaches to Members with immediate health care and care coordination needs.

In addition, the Department conducts data pulls for extended care coordination. Individuals with a cost of more than $25,000 over 12 months are flagged and submitted to the MCEs for review for inclusion in extended care coordination. In FY 24-25, the Department conducted an onboarding survey of newly enrolled members and the MEAC provided input to update the survey questions and increase the channels available for members to complete the survey. In July 2025, the RAEs will have updated requirements for follow up based on the new survey.

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 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, member complaints and resolutions/ responsiveness)

- Utilization review to identify over and under utilization
- Review of quality assurance reports from managed care
- Review, monitoring and outcomes of grievances filed with RAEs as well as escalations
- Review of monthly managed care Ombudsman reports
- Internal assessments of contract deliverables
- External Quality Review Organization (EQRO) evaluations
- Customer satisfaction analysis

CHP Dental Benefit - DentaQuest

Rising cost in healthcare has created a need to accurately assess quality and efficiency in oral care. Establishing measures to identify and monitor innovative strategies to reduce incidents of oral disease while driving improvement on performance-based outcomes is an important Department priority. To effectively measure oral care the Department utilizes data from various administrative sources (encounters and claims), patient records, and surveys which assist the Department in making policy decisions, based on identified key performance measures. For FY 2021-24 the Department focused on the following Dental performance measure:

How many children received at least one dental care service during the reporting fiscal year.

Table 2: CMS CARTS Report (Overall Utilization; Percentage of Members Receiving Any Dental Service)

Fiscal Year	0-1 year	1-2 years	3-5 years	6-9 years	10-14 years	15-18 years	Total
FY 2021-22	6	490	3,041	6,678	8,477	5,557	24,249
FY 2022-23	72	1,174	4,563	9,756	11,661	7,020	34,246
FY 2023-24	124	3,986	8,241	12,785	14,681	9,221	49,038

Measure performance reflects an increase in all years from FY 2021 through FY 2024.

The Department's current CHP+ Contractor (DentaQuest) has active member outreach efforts in place to further drive performance improvement on this goal, including the development and distribution of electronic resources on oral health for children and families, virtual presentations (in urban, rural and frontier communities) to members and community partners on CHP+ dental benefits, the importance of oral health and how to access care during the pandemic, and coordination with dental providers across the state to ensure members receive timely and accurate information about their dental benefits.

Fiscal Year 2021 PIP Aggregate Summary Report

- Plan Name: DentaQuest
- Plan Type: PAHP
- PIP Topic: Percentage of all children enrolled under the age of 21 who received at least one dental service within the reporting year
- SMART Aim Statement: By June 30, 2022, use key driver diagram interventions to increase the percentage of members who received any dental service among members age 3-5 who reside in Weld County from 45.47% to 49.30%
    - Mod 1: Completed
    - Mod 2: Completed
    - Mod 3: In Progress
    - Mod 4: Not Yet Initiated

- Confidence Level: TBD in FY 2023

Fiscal Year 2022-2023 PIP Activities

Table 3: SMART Aim Results (Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year)

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Statistically Significant Improvement Achieved?
The percentage of members who received any dental service among members ages 3-5 who reside in Weld County	45.47%	49.30%	59.86%	Yes

Table 4: Intervention Testing Results (Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service within the Reporting Year)

Intervention Description	Type of Improvement (demonstrated by Intervention Evaluation Results)	Final Intervention Status
Free online provider training on preventing early childhood dental care, with continuing education credits offered to dentist in Weld County	No improvement	Abandoned
Outreach with incentives offered to members and their caregivers to seek dental services by offering appointment scheduling assistance and a backpack with age-appropriate oral health materials for completing the visit.	Significant clinical improvement	Adapted

Based on the validation findings, HSAG assigned the Percentage of All Children Enrolled Under the Age of 21 Who Received at Least One Dental Service Within the Reporting Year PIP a level of High Confidence.

Medicaid Measures
Percentage of Members who had at least one dental visit and one PCP visit in the reporting year.
The correlation between oral health and systemic health have been well established. Oral health impacts chronic health conditions such as diabetes and cardiovascular disease. In an effort to promote continuity of care, DentaQuest is tasked with increasing the percentage of child and adult members who have at least one dental visit and one primary care visit (PCP) in the reporting year.

- Tier 1 goal is to increase by 2% from baseline.
- Tier 2 goal is an increase of 5% from baseline.
- Tier 3 goal is an increase of 8% from baseline.

- Baseline percentage for each fiscal year is the final calculated percentage for the fiscal year prior.

Table 5: Dental and PCP Visit Results

Performance Measure	FY 2020-21	FY 2021-22	FY 2022-23
Members with one dental visit and one PCP visit	21.73%	24.82%	25.54%

The baseline for FY 2020-21 was 24%. The impact of COVID-19 during this year crippled the ability of most dental offices to provide care. This resulted in a decrease in the number of members who saw both their PCP and dental provider during this fiscal year.

In FY 2022, DentaQuest used targeted interventions to increase the number of members who had a PCP and dental visit. Outreach to families with more than one child in the household who were due for a dental exam resulted in positive results. Members who lived in areas with plenty of access were also encouraged to see their dental providers. This type of outreach resulted in an increase of 3.09% meeting the Tier 1 goal.

DentaQuest continued to work on the PCP and dental visit goal for FY 2022-23. The year over year increase continued and the final percentage of members who had both a PCP and dental visit was 25.54%. This was a 0.72% increase which did not meet the tier 1 goal.
There remain opportunities for improvement with this goal and DentaQuest will continue working on increasing the number of members who have had a dental and PCP visit.

The Department's current CHP+ Contractor has active member outreach efforts in place to further drive performance improvement on this goal, including the development and distribution of electronic resources on oral health for children and families, virtual presentations (in urban, rural and frontier communities) to members and community partners on CHP+ dental benefits, the importance of oral health and how to access care during the pandemic, and coordination with dental providers across the state to ensure members receive timely and accurate information about their dental benefits.

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.

Transitions of Care Policy

When a member leaves an MCE or FFS, the MCE or State, must:

- Identify the member(s) and notify the receiving MCE about the incoming member(s).
- Coordinate care and share care coordination information upon request.
- Make referrals to appropriate network and out-of-network providers if necessary.
- Assist in transferring appropriate clinical information between the old and new providers within 7 business days pursuant to federal and state laws.

The Department's quality reports, which illustrate how we assess the quality and appropriateness of care, can be found in the 2024 Evaluation and Effectiveness Review.

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.

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.

Colorado's Health Care Policy and Financing's (HCPF) person-centered work has always prioritized awareness and recognition of the impacts of social determinants of health on outcomes for the culturally diverse communities our programs serve. Department workgroups have prioritized data collection to address racial health disparities related to maternal and infant health and diabetes care. The Department is developing an internal plan to address health disparities. Addressing health care disparities first requires the ability to accurately measure where a health disparity exists.

In 2023, the Department focused on the following performance measures which were selected from the Adult and Child Centers for Medicare and Medicaid Services Core set. These measures were categorized into 3 focus areas. In December 2023, the Regional Accountable Entities (RAEs), Managed Care Organizations (MCOs) and Child Health Plan Plus (CHP+) programs submitted their first Health Equity Plans identifying two disparity populations in each performance measure and their strategic initiatives to achieve their goals of closing the gap. The RAEs' health equity plans are available here.

RAEs and MCOs

- Focus Area – Maternity and Perinatal Health
  - Prenatal and Postpartum Care
- Focus Area - Behavioral Health
  - Follow-up after Emergency Department Visit for Mental Illness
  - Follow-up after Emergency Department Visit for Substance Use
  - Follow-up after Hospitalization for Mental Illness
  - Depression Screening and Follow-up Plan
- Focus Area – Prevention/Population Health and Strategy
  - Childhood Immunization Status
  - Immunizations for Adolescents
  - Hemoglobin A1c Control for Patients with Diabetes
  - Well-child visits in the first 30 months of life
  - Oral Evaluation, Dental Services
  - Child and Adolescent Well-care Visits

CHP+

- Focus Area – Maternity and Perinatal Health
  - Prenatal and Postpartum Care
- Focus Area - Behavioral Health
  - Follow-up after Hospitalization for Mental Illness
  - Depression Screening and Follow-up Plan
- Focus Area – Prevention/Population Health and Strategy
  - Childhood Immunization Status
  - Immunizations for Adolescents
  - Well-child visits in the first 30 months of life
  - Oral Evaluation, Dental Services
  - Child and Adolescent Well-care Visits

In 2024, the Department included additional core measures in which the Managed Care Entities have submitted their Health Equity plans identifying two disparity populations in each new performance measure and their strategic initiatives to achieve their goals of closing the gap.

RAEs and MCOs

- Focus Area – Prevention/Population Health and Strategy
  - Developmental Screening in the First Three Years of Life
  - Controlling High Blood Pressure
  - Colorectal Cancer Screening
  - Cervical Cancer Screening
  - Chlamydia Screening in Women

CHP+

- Focus Area – Prevention/Population Health and Strategy
  - Developmental Screening in the First Three Years of Life
  - Chlamydia Screening in Women

HCPF is addressing health care disparities by refining data collection and systems on member and provider demographics, particularly race and ethnicity. This approach allows the Department and researchers to better disentangle factors that are associated with health care disparities. Further, collecting and analyzing patterns of health care by patient race, ethnicity, and other demographic data can help the Department to monitor the quality of care provided by its provider network. Such monitoring ensures accountability to enrolled members, improve member choice, and allow for evaluation of intervention programs. Focusing on data equity enables the Department to condition value-based payments to providers on evidence that they are improving health outcomes where disparities currently exist and enable new quality measurement that better allows the Department and providers to improve health disparities. Specifically, the Department has begun to:

- Address gaps in Medicaid application and claims data collection and analysis.
- Collect and analyze racial and ethnic disparities data from provider electronic health records systems (EHR), which includes information on clinical data and social determinants of health, such as food insecurity and housing.
- Identify and incorporate Medicaid health disparities data into key dashboards and/or develop a health equity-focused data dashboard.
- Enhance internal data analytics and health equity capacity to guide equity-focused, data-informed and evidence-based programmatic interventions to improve health outcomes for marginalized and underserved communities.
- Develop and implement health equity lens or framework to evaluate the Department's policies, systems, programs and services.

The Department has already initiated conversations with both of Colorado's Health Information Exchange (HIE) organizations – Colorado Regional Health Information Organization (Contexture and Quality Health Network (QHN) on the western slope – and they are providing the Department with options to merge their demographic data with our Medicaid data. The Department is beginning similar conversations with the state's All Payers Claims Database (APCD) and the Department of Public Health and Environment. By leveraging all available data sources that can expand the Department's demographic markers, the accuracy of measuring where health disparities exist, and the potential solutions increase.

The Department is uniquely positioned to incentivize Medicaid providers to capture demographic and clinical information from their patients and to build the interface to collect the data. The Department invests in HIE infrastructure that allows Medicaid providers and hospitals to securely connect their individual EHR systems with other systems through the health information exchange network.

Using enhanced federal funding, the Department has overseen the connection of over 400 clinics and 90 hospitals' electronic health records (EHRs) to Colorado's Health Information

Exchange (HIE) and other health data organizations which cover over 6,300 providers and more than 6.5 million patients (including out-of-state visitors). The Department seeks to maintain these funds to continue connecting providers to the health information exchange and maintain this flow of information. Further, the Department can leverage enhanced federal funding to establish regular data feeds with these external databases to integrate demographic data into the Department's existing data warehouse. Once the data feeds and processes for merging data have been established, the same process can be duplicated so demographic data in the state's APCD can be expanded. That larger data set can be leveraged to address health care disparities statewide, beyond Medicaid.

Advancing Health Equity at the Department

The Department's approach to addressing health disparities is anchored in the tenet of ensuring high quality care and services for the people Medicaid serves. Our role as the Medicaid payer in Colorado's health care ecosystem affords the Department the lever to maximize health care investments in underserved and underrepresented communities by working collaboratively with partners to identify and remove obstacles to access and utilization among historically marginalized populations.

In accordance with the Governor Polis' **Executive Order D2020-175**, the Department has developed a 5 year Equity, Diversity, Inclusion and Accessibility Plan that explicitly addresses nine EDI topic areas. Topic areas pertaining to health equity are highlighted below.

Long-Term Plan and Reporting. In an effort to create and continuously update a long-term plan to identify and address barriers as well as metrics to evaluate progress, Department activities will focus on:

- Convening an internal, employee-led workgroup dedicated to advancing health equity among Colorado Medicaid members.
- Developing a health equity lens or framework to guide decision-making across the Department.

Community Engagement. This topic area calls upon agencies to involve community partners in decision-making from the beginning to end of projects, as well as measuring equity, diversity and inclusion efforts on state boards and commissions appointed by the Governor's Office. In our focus on health equity, the Department intends to engage with Medicaid stakeholders and partners by:

- Cultivating meaningful and respectful dialogue on equity and diversity issues with Medicaid members, providers, advocacy groups and other stakeholders
- Engaging member and provider advisory groups in the work of health equity
- Allowing space for regional or geographic differences in defining diversity and equitable health outcomes for diverse Colorado communities
- Intentionally seek feedback from stakeholders about the emerging Department health equity lens or framework

Policy, System, Program, and Services Review. To abide by the expectation that agencies shall review, acknowledge, and dismantle any inequities within agency policies, systems, programs, and services, and continually update and report agency progress, the Department's health equity work will be guided by a focus on data analytics for the Medicaid population to include:

- Identify disparities data among marginalized, underrepresented and underserved communities across the state.
- *Examples:* racial and ethnic disparities in Medicaid enrollment, primary care utilization, emergency department admissions, specific diagnostic and treatment codes.
- data challenges from Medicaid claims data, as well as electronic health records systems (e.g., gaps in self-reported data).
- Data analytics will focus on ability, race and ethnicity, gender, language, national origin, sexual orientation, and other protected classes.
- Highlight a focus on intersectionality, for example, specific health disparities linked to race and gender; ability and gender; language and race.
- Acknowledge different conceptualizations of diversity by region and/or geography.
- Identify and incorporate Medicaid health disparities data into key dashboards and/or develop a health equity-focused data dashboard.

The Department defines disability as the inability to do any substantial gainful activity (or, in the case of a child, having marked and severe functional limitations) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of l2 months or more. This definition can be found in the Department's Rules and Regulations at 10 CCR 2505-10, Section 8.100.1

In addition to adhering to this definition of disability, the Department determines a member's eligibility for optional Medicaid programs, such as 1915(c) Home and Community Based Waivers, through additional criteria. Individuals may qualify for Medicaid based on a disability if they meet one of the following eligibility groups:

- Supplemental Security Income (SSI) eligible, per criteria set by the Social Security Administration (SSA);
- Eligible under 42 CFR § 435.217
    - This allows those who would qualify for Medicaid if institutionalized and in the absence of home and community-based services would otherwise require level of care furnished in a hospital, nursing facility, or and ICF/IID or
    - the group would require the level of care furnished in a nursing facility and are 65 years or older;
- Optional State Supplement Recipients;

- Working individuals with disabilities who buy into Medicaid as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act; and

- Working individuals with disabilities who buy into Medicaid as provided in section 1902(a)(10)(A)(ii)(XV) of the Act;

Additionally, eligibility for Home and Community-Based Services (HCBS) waivers is limited to individuals who meet one of the target groups specified in **42 CFR § 441.301(b)(6)**:

- Aged or Disabled (or both),

- Individuals with Intellectual or Developmental Disabilities (I/DD), or both,

- Individuals with Serious Mental Illness (SMI).

Disability determinations are further governed by state regulations outlined in **10 CCR 2505-10, Section 8.100.5**.

Disability Determination Process

As detailed in the Department's Medicaid Disability Application processindividuals who do not have a current SSA disability determination are assessed through a state-administered disability determination process. Key steps include:

- Completion of the Disability Determination Application;

- Review of medical and functional information to determine if the individual meets the federal definition of disability;

- Coordination with Disability Determination Services (DDS) to evaluate eligibility for Medicaid benefits based on disability criteria.

The state uses this process to support eligibility determinations for both standard Medicaid and HCBS waiver services. These data sources are used collectively to track and stratify Medicaid populations by disability status to support equity monitoring and quality improvement.

Alignment with the Colorado Department of Public Health and Environment's Health Equity Efforts

The Department's efforts to address health disparities and advance equity, diversity, inclusion and accessibility are aligned with equity-focused guidelines and principles championed by the Colorado Equity Alliance, a cross-agency group founded by staff of the Colorado Department of Public Health and Environment's Office of Health Equity. The alliance, comprised of representatives from both state agencies and community organizations, aims to operationalize equity and make sure it is woven into the fabric of state governance. The Department is represented in the core committee of the Colorado Equity Alliance. The Department of Public Health and Environment's Health Disparities Program is focused on

preventing targeted conditions (e.g., cancer, cardiovascular/pulmonary disease) through upstream investments in social determinants such as housing.

In 2021, the Department joined the Governor's Office and CDPHE to sponsor and pass **Senate Bill 21-181**. This bill focused on advancing health equity across all state departments. In accordance with this landmark legislation, HCPF launched the first-of-its-kind Health Equity Plan after gathering feedback from over 3,500 stakeholders (members, RAE/CHP+, providers and advocates) across 20 town hall meetings. This plan focuses on closing disparities that exist among four focus areas: vaccinations, maternity and perinatal health, behavioral health and prevention and chronic care management. HCPF has evolved our plan with the roll out of ACC Phase 3 and will refresh and share progress in the 2024 Health Equity Report which will be published in March 2025.

National Performance Measures

Required CMS Regulatory References Addressed

Currently, The Department is working on the mandatory reporting requirements of the CMS Child and Behavioral Health Core Measures, as well as reporting on as many adult core measures as available.	
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 the CMS Core Sets that are published each year for data availability and to ensure they can be reported. Measures are selected based on required measures initially, and then on other CMS Core Measures and Plans are notified each year what they will be expected to report on the following year. The Department is currently reporting these measures using HEDIS Certified Reporting tool, Care Analyzer, for reporting on FFS populations and Managed Care Plans are reported through EQRO Reporting.

Quality improvement goals and quality expectations are often specified and/or assessed in the form of quality measures. The Department's goal is to align with CMS Core Sets in programs to enable comparison between Colorado's performance to national benchmarks. The measures serve to evaluate how the contracting entity is performing against HCPF expectations and standards. Quality measures are attuned to the program and population for which services are being contracted for and delivered. They gauge care delivery, member experience with care, and the outcomes of care. On occasion, they also assess infrastructure supportive of good care delivery.

HCPF establishes multiple performance measure sets for the purpose of evaluating the quality performance of the Health First Colorado and CHP+ programs. Performance measures include:

- Primary Care Access and Preventative Care
    - Cervical Cancer Screening
    - Chlamydia Screening in Women Ages 21 to 24
    - Colorectal Cancer Screening
    - Screening for Depression and Follow-Up Plan: Age 18 and Older
    - Breast Cancer Screening
- Care and Acute Chronic Conditions
    - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
    - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

    - Plan All-Cause Readmissions
    - Asthma Medication Ratio: Ages 19 to 64
- Behavioral Health Care
    - Initiation and Engagement of Substance Use Disorder Treatment
    - Antidepressant Medication Management
    - Screening for Depression and Follow-Up Plan
    - Follow-Up After Hospitalization for Mental Illness
    - Follow-Up After Emergency Department Visit for Substance Use
    - Follow-Up After Emergency Department Visit for Mental Illness

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 Table 6 for each program.

Table 6: Performance Measures and Methodology

Entity being assessed	Members	Description	Performance Target Methodology
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	10% Gap Closure between performance and Department Goal
Behavioral Health Incentive Program			

Regional Accountable Entities	All	Performance measures are reviewed 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 measures access to services, including safety net services which have been revised through safety net reforms, including the use of directed payments to support access to defined services including crisis services at all times including nights, weekends and holidays statewide. The state's contracted EQRO does a Performance Measure Validation Audit on these measures annually.	10% Gap Closure between performance and Department Goal
Primary Care Alternative Payment Model			
Primary Care Medical Providers (PCMPs)	Adults & 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. PCMPs who serve at least 500 attributed ACC enrollees are automatically enrolled in APM Providers have greater flexibility in providing care, performance is rewarded, and accountability and transparency are highlighted in this payment structure. 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, and NCQA's PCMH Certification Programs.	PCMPs will receive an adjusted FFS rate based on how many points they earned under the APM 1 program. Points are earned by 'closing the gap' between baseline performance and a goal set by the Department. If a PCMP earns 200 points or more, then the providers can keep and possibly earn an even more enhanced FFS rate. Primary Care APM Master Measures List with Goals.
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.	The Department continues to review and identify opportunities for driving performance HEDIS based outcomes and is currently building HEDIS measurement goals that align with the CMS Core measure sets.
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 member outcomes while reducing costs within the ACC. The report described payment methodologies	A 10% gap closure between performance and the defined department goal on the established four clinical

		and quality measures, provided performance data, and program design impacts on members and providers. Our MCOs are Rocky Mountain Health Plans Prime, a comprehensive, full-risk capitation program and Denver Health Medicaid Choice, a risk based managed care capitation initiative.	quality metrics for each MCO.
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. Data for reporting comes from the Department's external quality review organization (HSAG), and from internal claims data that is run through a HEDIS Certified Reporting tool for most measures. Reports are then broken out by different demographic reporting fields for entry to QMR System.	The Department is currently working to enhance data collection for CMS Adult and Child Core measures to improve performance. The last 2 reporting years (MY2021 and MY2022) the Department has voluntarily reported on all data that has been available. For MY2023 reporting on the Child Core Set and the Behavioral Health related measures in the Adult Core measure set, are mandatory. The Department is also voluntarily reporting on all available demographic data for the fee-for-service population.
Maternity Bundle			

Obstetric care providers	Pregnant Persons and Newborns	The Maternity Bundled Payment program covers all prenatal care, care related to labor and delivery, and postpartum care for Health First Colorado pregnant and postpartum parents. Bundled payments involve providing a single, comprehensive payment that covers all the services within an episode of care. Under a bundled payment model, participating providers are only responsible for outcomes of the episode. These providers hold limited risk for staying within the designated budget threshold and are eligible for shared savings when the threshold is not exceeded.	Each provider participating in the Maternity Bundle Program has their own performance target goals for the following measures: • Postpartum Depression Screenings • Postpartum Contraceptive Care • Unexpected Complications in Term Newborns • Severe Maternal Morbidity • Low Birthweight The first 4 measures are tied to payment while the 5th measure is for monitoring and tracking. Measures 1-4 are split evenly for 25% of the incentive payments.

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

Programs of All-Inclusive Care for the Elderly (PACE)
The Department continues to review each PACE organization's compliance with the requirements of 42 CFR Part 460, including the organization's capacity to provide comprehensive medical and social services to elderly individuals who enroll in the PACE program. While services are furnished across all settings, a primary PACE program objective is to enable participants to live in the community rather than a skilled nursing facility. As part of the review process the Department implemented two (2) uniform surveys to identify areas of opportunity to improve the delivery of services, participant care and overall member satisfaction and experience. For fiscal year 2019-2020, the top three (3) satisfaction concerns identified are:

- Communication
- Care Coordination (including lack of follow-up on test results)
- Specialist (not seen as soon as needed)

The Department Continues to work with PACE organizations to further drive improvement in initiating various performance improvement projects across the following performance measures:

- Number of falls per 1000 member months
- Plan All-Cause Readmissions
- PACE Participants Satisfaction Survey Report
- Falls: Screening
- Falls: Risk assessment
- Falls: Plan of Care
- Transitions of Care: Notification of Inpatient Admission
- Transitions of Care: Receipt of Discharge Information
- Transitions of Care: Patient Engagement after Inpatient Discharge
- Transitions of Care: Medication Reconciliation
- Percentage of Participants Not in Nursing Homes
- Percentage of voluntary disenrollment
- Depression: Screening for Depression
- Depression: Follow up plan
- Days attended PACE center per 1000 member months.
- Psychiatric hospital Admissions per 1000 member months (excludes LTAC).
- Number of skilled home-care visits per 1000 member months.
- Number of non-skilled home-care visits per 1000 member months.
- Average number of prescriptions filled per member per month (not OTC).
- Participant risk factor score.
- Percent prevalence of cognitive impairment among participants.

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 member experience with health care. The EQRO administers the Health Plan 5.1H 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.

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 collected is used to assess the effectiveness of both benefit policies and service delivery systems in meeting participation goals. Data categories are assessed both in terms of the number of children (by age group and basis of Medicaid eligibility) and the expected frequency who are provided child health screening services, referred for corrective treatment, lead testing, 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 Colorado's screening periodicity schedule, which is Bright Futures. The completed report demonstrates our attainment of its participation and screening goals. From the completed reports, trend patterns and projections are developed on a national basis, and for our individual vendors, from which decisions and recommendations can be made to ensure that eligible children are given the best possible health care. In Colorado, 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 work on two PIP topics, one clinical and one non-clinical. The topics may be specified by the Department. The PIPs identify and measure a clinical and 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 to align plan projects and attain more impact as it relates to quality improvement activities and overall population health. The Department administers the traditional Outcome-Focused PIP Approach. The following elements are included in this approach:

- Aligns with CMS PIP Protocols
- Consists of a three-year PIP cycle
- Technical assistance throughout the process with frequent contact and feedback from the EQRO
- PIP topics may have a narrow or plan wide focus

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 Report and Plan Updates
Quality improvement Reports and Plans are submitted by Contractors to the Department annually. 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.

One of the primary objectives of the Accountable Care Collaborative is to ensure greater accountability and transparency. One way the Department looks to increase the transparency of the ACC is to share data on clinical and utilization measures used to monitor the program and its vendors. In addition, the Department shares data on social determinants of health metrics to highlight the roles RAEs play in supporting overall population health. These measures are important for tracking utilization of services and access to care.

The public reporting dashboard is designed to help the RAEs identify the health needs of their members on a population level and provide stakeholders with a means to hold the RAEs accountable for performance and quality improvement.

Annual public reporting of performance measures can be accessed at: https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-public-reporting.

External Quality Review Organization (EQRO)

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 six 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, 6) Assist with Quality Rating of Medicaid and CHIP Managed Care.
§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 Validation and ISCA Validation (Protocol 4)

In addition, HSAG performs the following optional EQR activities:

- Encounter Data Validation (add this language “Protocol 5”)
- Consumer or Provider Survey Administration (add this language “Protocol 6”)
- Information Systems Reviews (delete this bullet)
- Quality of Care Reviews (delete this language and add “Conducting Focus Studies Protocol 9)”
- State Managed Care Audits (delete this bullet)
- Technical Assistance calls (delete this bullet)

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.

The Department in collaboration with its' EQRO conducts EQRO Quality Strategy review meetings which are designed to review and take into consideration EQRO recommendations for influencing quality processes, progress reports, compliance site audits, and technical reports. The Department also meets with the EQRO to review and discuss planning for new quality initiatives, improvements to current quality activities and Department quality performance.

Most recently the EQRO recommended the Department have the RAEs' PIP close-out reports include intervention testing summaries, challenges encountered, successes achieved, and lessons learned. The Department followed up on the EQRO's recommendation and received close out information for the managed care entity PIPs.

The Department met with its EQRO in various meetings to further discuss ways to continue quality audits in light of COVID-19. It was determined that virtual audits allowed for more participation and would not compromise the audit process and the Department agreed and conducted virtual audits.

In collaboration with the EQRO, The Department follows up with the MCEs to ensure that new processes have been put in place based on HSAG's recommendations. The follow up is collected for each MCE. Below are some examples based on the EQRO recommendations from FY 2022-2023.

It was recommended for some of the MCEs to focus on enhancing engagement with members through campaigns and outreach activities aimed at emphasizing the importance of timely prenatal and postpartum care. Additionally, MCEs were encouraged to explore programs or vendors that could offer appointment and transportation scheduling, pregnancy education, and monitoring services. Some of the changes the MCEs have implemented included developing "Performance Measure Tips Sheets" to streamline provider coding processes the result in improvement of HEDIS performance measures. One MCE implemented the "Healthy Mom Healthy Baby" program, which focuses on improving maternal and child health outcomes. This program offers a combination of care management and digital interventions which includes contact with a care manager during each trimester and after birth.

Another recommendation the EQRO provided the Department included implementing internal processes for ongoing 411/412 encounter data monitoring and providing training to ensure that behavioral health service coding is accurate. In response to those recommendations, some of the MCEs have distributed regular behavioral health provider bulletins to share updates on billing and coding practices. Some noted that claims with repeated errors were reprocessed and denied, which resulted in project partners to review medical records and correct claims before resubmission for reimbursement.

The Department's complete accreditation for all managed care plans is located on the state's website at: Managed Care Accreditation

Network adequacy and availability of services

Availability of services
Continuation of compliance to **42 C.F.R. §438.358(b)(1)(iv)** the Department, through its EQRO contract, implemented a stringent process to monitor the MCEs provider networks to ensure adequate access to care. Each managed care entity (MCE) must maintain a network of healthcare providers and facilities that offers access to covered physical and/or behavioral healthcare services to meet the enrolled members' needs, appropriate to the geographic area. Since FY 2018–19, HSAG has collaborated with the Department to develop and implement an annual NAV study1 that supports the Department's oversight of the MCEs' networks.
As of September 2021, CMS had not released the EQR NAV protocol. However, the State of Colorado Department of Health Care Policy and Financing (Department) requested that Health Services Advisory Group, Inc. (HSAG) conduct NAV activities for the Health First Colorado and Child Health Plan Plus (CHP+) practitioner/practice/entity networks for all managed care entities (MCEs) during fiscal year (FY) 2021–2022 under the EQR contract. The activities aligned with current federal regulations and aided the Department to meet the NAV requirements once the EQR protocol was released, in 2024.

The FY 2021–2022 NAV included the following activities that enhanced the quarterly NAV process established during FY 2020–2021:

- Development of NAV Study Materials
- Quarterly Network Adequacy (NA) Data Processing and Validation, Including Maintenance of Quarterly Reporting Materials
- Implementation of Dashboards for Enhanced Data File Review Results
- Exploration of Alternate Time/Distance Requirements
- Network Exception Template Development*

*Network Exception Template Development: Based on preliminary input from the Department during July 2021, HSAG collaborated with the Department to identify and define an exception

request process, as well as developed a standard template that MCEs would use when requesting exceptions to network requirements. This standard was not implemented, however it is included in the new contract period to begin July 1, 2025.

The managed care plans are required to provide quantitative assessments of contracted networks on a quarterly basis of whether state established metric standards were met. These standards remained consistent, measuring both member access within time and distance and provider to member ratios, throughout their current five-year contract, to end on June 30, 2025. Additionally, MCEs provided quantitative companion reports that included detailed efforts of expanding network access, and concurrent strategies to assist members in gaining access to needed services where provider shortages were identified. MCEs were also required to provide to the state in an annual report their Strategic Network Management plan, to detail network challenges, strategies to mitigate access to care deficiencies. As provider types and covered benefits expanded through the states 1115 waiver, new metric standards were included in the MCE contracts and applied to the Network Adequacy reporting requirements, consisting of residential SUD services. The Department's NAV process is outlined in the Colorado FY 2023-24 NAV Report, which is posted to our website, which details requirements for the states Managed Care plans and outlines EQRO involvement.

Table 7: Managed Care Entities

MCE	MCE Abbreviation for Data Submissions	MCE Abbreviation for Reporting
Five CHP+ Managed Care Organizations (MCOs)		
Colorado Access CHP+ Managed Care Organization	COA_CHP	COA CHP+
Denver Health Medical Plan CHP+	DHMP_CHP	DHMP CHP+
Friday Health Plans	Friday	FHP
Kaiser Permanente	Kaiser	Kaiser
Rocky Mountain Health Plans CHP+	RMHP_CHP	RMHP CHP+
Two Limited Managed Care Capitated Initiative Plans (Medicaid MCOs)		
Denver Health Medicaid Choice MCO	MDH	DHMP
Rocky Mountain Health Plans—Prime	MRM	RMHP Prime
One Prepaid Ambulatory Health Plan (PAHP)		
DentaQuest	DDQ	DentaQuest
Seven Regional Accountable Entities (RAEs), including each RAE's physical health and behavioral health networks		
RAE 1: Rocky Mountain Health Plans	RAE1	RMHP
RAE 2: Northeast Health Partners, LLC	RAE2	NHP
RAE 3: Colorado Access	RAE3	COA Region 3
RAE 4: Health Colorado, Inc.	RAE4	HCI
RAE 5: Colorado Access	RAE5	COA Region 5
RAE 6: Colorado Community Health Alliance	RAE6	CCHA Region 6

RAE 7: Colorado Community Health Alliance	RAE7	CCHA Region 7

CHP+ MCO Contract Requirements

Table 8: CHP+ MCO Time/Distance Standards and Practioner/Practice/Entity to Member Ratios

Network Category Description	Required Within Standard	Urban-Time/Distance Standard	Rural-Time/Distance Standard	Frontier-Time/Distance Standard	Ratio
Physical Health - Primary Care					
Pediatric Primary Care Practitioner (MD, DO, NP, CNS)[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Pediatric Primary Care Practitioner (PA)[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA
Adult Primary Care Practitioner (MD, DO, NP, CNS)[2]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Adult Primary Care Practitioner (PA)[2]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA
Family Practitioner (MD, DO, NP, CNS)	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Family Practitioner (PA)	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA
Gynecology, OB/GYN (MD, DO, NP, CNS)[3]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Gynecology, OB/GYN (PA)[3]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	NA
Physical Health - Specialist					
Pediatric Cardiology[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Endocrinology[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Gastroenterology[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Surgery[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Neurology[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Ophthalmology[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Orthopedics[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800

Pediatric Otolaryngology/ ENT[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Pulmonary Medicine[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
Pediatric Urology[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	100 minutes or 100 miles	1:1,800
General Cardiology[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Endocrinology[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Gastroenterology[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Surgery[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Neurology[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Ophthalmology[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Orthopedics[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Otolaryngology/ ENT[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Pulmonary Medicine[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Urology[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Physical Health - Entities					
Pharmacies	1 Facility	10 minutes or 10 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
Acute Care Hospitals	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
Behavioral Health - Specialists					
Pediatric Behavioral Health[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Pediatric Psychiatrists and other Psychiatric Prescribers[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Pediatric SUD Treatment[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Behavioral Health[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Psychiatrists and other Psychiatric Prescribers[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General SUD Treatment[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800

Behavioral Health - Entities					
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA

Table 9: Medicaid MCO Time/Distance Standards and Practitioner/Practice/Entity to Member Ratios

Network Category Description	Required Within Standard	Urban-Time/Distance Standard	Rural-Time/Distance Standard	Frontier-Time/Distance Standard	Ratio
Physical Health - Primary Care					
Pediatric Primary Care Practitioner (MD, DO, NP, CNS)[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Pediatric Primary Care Practitioner (PA)[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Adult Primary Care Practitioner (MD, DO, NP, CNS)[2]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Adult Primary Care Practitioner (PA)[2]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Family Practitioner (MD, DO, NP, CNS)	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Family Practitioner (PA)	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Gynecology, OB/GYN (MD, DO, NP, CNS)[3]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Gynecology, OB/GYN (PA)[3]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Physical Health - Specialists					
Pediatric Cardiology[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Endocrinology[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Gastroenterology[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Surgery[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Neurology[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Ophthalmology[1]	1 Practitioner	30 minutes	60 minutes	100 minutes	1:1,800

		or 30 miles	or 60 miles	or 100 miles	
Pediatric Orthopedics[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Otolaryngology/ ENT[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Pulmonary Medicine[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Pediatric Urology[1]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Cardiology[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Endocrinology[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Gastroenterology[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Surgery[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Neurology[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Ophthalmology[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Orthopedics[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Otolaryngology/ ENT[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Pulmonary Medicine[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
General Urology[2]	1 Practitioner	30 minutes or 30 miles	60 minutes or 60 miles	100 minutes or 100 miles	1:1,800
Physical Health - Entities					
Pharmacies	1 Facility	10 minutes or 10 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
Acute Care Hospitals	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
Behavioral Health - Specialists[4]					
Pediatric Behavioral Health[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Pediatric Psychiatrists and other Psychiatric Prescribers[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Pediatric SUD Treatment Practitioner[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Behavioral Health[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Psychiatrists and other Psychiatric	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800

Prescribers[2]					
General SUD Treatment Practitioner[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Behavioral Health - Entities[4]					
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
SUD Treatment Facilities-ASAM 3.1	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.3	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.5	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.7	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.2 WM (Withdrawal Management)	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.7 WM	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA

Table 10: PIHP (RAE) Time/Distance Standards and Practitioner/Practice/Entity to Member Ratios

Network Category Description	Required Within Standard	Urban-Time/Distance Standard	Rural-Time/Distance Standard	Frontier-Time/Distance Standard	Ratio
Physical Health - Primary Care					
Pediatric Primary Care Practitioner (MD, DO, NP, CNS)[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Pediatric Primary Care Practitioner (PA)[1]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Adult Primary Care Practitioner (MD, DO, NP, CNS)[2]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Adult Primary Care Practitioner (PA)[2]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Family Practitioner (MD, DO, NP, CNS)	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Family Practitioner	2 Practitioners	30 minutes	45 minutes	60 minutes	1:1,200

(PA)		or 30 miles	or 45 miles	or 60 miles	
Gynecology, OB/GYN (MD, DO, NP, CNS)[3]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,800
Gynecology, OB/GYN (PA)[3]	2 Practitioners	30 minutes or 30 miles	45 minutes or 45 miles	60 minutes or 60 miles	1:1,200
Behavioral Health - Specialists[4]					
Pediatric Behavioral Health[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Pediatric Psychiatrists and other Psychiatric Prescribers[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Pediatric SUD Treatment Practitioner[1]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Behavioral Health[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General Psychiatrists and other Psychiatric Prescribers[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
General SUD Treatment Practitioner[2]	2 Practitioners	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	1:1,800
Behavioral Health - Entities					
Psychiatric Hospitals or Psychiatric Units in Acute Care Hospitals	1 Facility	20 minutes or 20 miles	30 minutes or 30 miles	60 minutes or 60 miles	NA
SUD Treatment Facilities-ASAM 3.1	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.3	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.5	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.7	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.2 WM	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA
SUD Treatment Facilities-ASAM 3.7 WM	1 Facility	30 minutes or 30 miles	60 minutes or 60 miles	90 minutes or 90 miles	NA

Results are aggregated and included in the EQRO annual NAV reports to include the CMS added Protocol 4, ISCA Validation of Network Adequacy Results. EQRO findings and recommendations are included in the CO FY 2023-2204 Network Adequacy Validation report June 2024.

The Department continued to expand monitoring and oversight of the MCE networks to include the health plans' provider directory. HSAG recommended the Department consider conducting an independent network directory review to verify the health plans' publicly available network data accurately represent the network data supplied to members and used for the quantitative time and distance metric standard analyses.

Based on feedback from stakeholders and members, the Department had concerns regarding the adequacy of the behavioral health network. The PDV validated managed care entities' online provider directories to ensure members have appropriate access to provider information. The goal of the fiscal year 2023-2024 PDV was to determine if the information on the MCEs' online provider directories matched the provider data submitted to the EQRO for network adequacy metric standard validation. The assessment included all managed care plan directories, PIHP, PAHP, MCO and CHP programs. Provider Directory Validation (PDV) in SFY 2022-23. Based on feedback from stakeholders and members, the Department had concerns regarding the adequacy of the behavioral health network. The PDV validated managed care entities' online provider directories to ensure members have appropriate access to provider information. The goal of the fiscal year 2022-2023 PDV was to determine if the information on the MCEs' online provider directories matched the provider data submitted to the EQRO for network adequacy metric standard validation. The assessment included all managed care plan directories, PIHP, PAHP, MCO and CHP programs.

Section 4: State Standards

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

The Department RAEs are required to implement and maintain a strategy to ensure member access which complies with federal and contracted network access and adequacy requirements as outlined in Table 4 Time and Distance Standards. RAE's provides specific details Primary Care Medical Providers and specialty behavioral health provider networks through the following required network adequacy reports:

- Network Adequacy Quarterly Reports —Includes a narrative report with detailed information about the ability of the RAE's Primary Care Medical Provider network and Specialty behavioral health network to serve their members. MCEs perform an assessment of their contracted network to ensure metric standards are met in an excel file report. These assessments are validated on a quarterly basis by the Department's EQRO.
- Practice Support Plan—Description of the RAEs' strategies to provide a range of resources and services to support network providers in improving the delivery of care and advancing practice capabilities.
- Administrative Payment Report—Provides information regarding the different payment arrangements the RAEs have in place with network providers and Health Neighborhood participants, as well as a description of how the RAE is implementing value-based payment strategies with its providers.
- Quality Improvement Plan—The RAE's annual strategy to implement a comprehensive quality assessment and performance improvement program in compliance with federal regulations and in alignment with the Department's quality strategy.

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 from 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 members 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 (CSCR) 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 CSCR Pilot sought to identify and address gaps in behavioral health services for individuals with intellectual and developmental disabilities (I/DD). By partnering with a contractor to provide crisis intervention, stabilization, and follow-up supports, the pilot gained firsthand experience with the needs of this population. Simultaneously, actuarial studies were conducted to analyze service utilization and identify barriers to care. This combined approach

of direct service provision and data analysis allowed the CSCR Pilot to develop informed recommendations for bridging gaps and improving behavioral health services for individuals with I/DD, which were included in final CSCR Pilot Legislative Report, submitted in 2019.

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 members 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. 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 members 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 policies 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 apply 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 changes needed 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 CFR §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 Spanish and available upon request in other 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. The handbook is available at HealthFirstColorado.com, CO.gov/PEAK and in the Health First Colorado mobile app. It is available in print and other formats upon request. Upon enrollment, and once a year, thereafter, members receive a letter from the Enrollment Broker, explaining the availability of the member 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 (HIPAA). 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
§438.402(a)	The grievance and appeal system
§438.402(b)	Level of appeals
§438.402(c)	Filing requirements (authority to file)

§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. 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

Subcontractual 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.

Listed below are the RAEs clinical practice guidelines that are being used to guide efforts to improve the quality of care for members and facilitate implementation of evidence-based clinical recommendations into practice. Shown for each RAE are their practice guidelines and sources. The lists are not exhaustive.

Rocky Mountain Health Plan RAE 1

RMHP Guidelines were developed based on evidence-based clinical guidelines from nationally recognized sources and best practices.

- Adult Preventive Care
- Asthma
- Cardiovascular Disease
- Diabetes
- Dementia
- Hypertension
- Major Depression
- Perinatal Care
- Special Healthcare Needs-Children
- Special Healthcare Needs-Adult
- Atrial Fibrillation
- Cervical Cancer Screening
- Chest Pain

- Cholesterol Management
- Chronic Coronary Disease
- Chronic Obstructive Lung Disease (COPD)
- Heart Failure
- Hemophilia
- Human Immuno-deficiency Virus (HIV)
- Kidney Disease
- Perinatal Care
- Persons with Disabilities
- Preventive Pediatric Health Care Screening
- Sepsis
- Sickle Cell Disease
- Violence and Abus

Northeast Health Partners RAE 2

The source for all NHP practice guidelines is InterQual unless specifically noted otherwise.

Adult Community Based Treatment

- Adult and Geriatric Psychiatry
- Adult Residential Treatment
- Adult-Residential Crisis Program
- Adult Day Treatment Program
- Adult Observation
- Adult Inpatient

Child Community Based Treatment

- Child and Adolescent Psychiatry
- Child Subacute Care
- Child Residential Treatment Center
- Child Outpatient Services
- Child Intensive Outpatient Program
- Child Partial Hospital Program
- Child Observation
- Child Residential Crisis Program

Substance Use

- Lab Testing for SUD and Alcohol (Beacon Health Options)
- SUD Medication Management (Beacon Health Options)
- SUD Outpatient Counseling (Beacon Health Options)

Colorado Access RAEs 3 and 5

- Preventive Care
- Pediatric Health Maintenance (American Academy of Pediatrics)
- Pediatric Immunizations (Centers for Disease Control and Prevention)
- Maternity Care (American Academy of Family Physicians)
- Perinatal and Prenatal Care for Women and Infants
- Postpartum Care for Women and Infants (American College of Obstetricians and Gynecologists)

- Physical Health
- Down Syndrome (Global Down Syndrome Foundation)
- Obesity Prevention – Child (American Academy of Family Physicians)
- Behavioral Health and Substance Use
- Attention Deficit Hyperactivity Disorder (American Academy of Pediatrics)
- Bipolar Disorder – Child/Secondary Source
- Generalized Anxiety Disorder – Child

Health Colorado RAE 4

The source for all Health Colorado practice guidelines is InterQual unless specifically noted otherwise.

Adult Community Based Treatment

- Adult and Geriatric Psychiatry
- Adult Outpatient Services
- Adult Residential Treatment
- Adult-Residential Crisis Program
- Adult Day Treatment Program

Child Community Based Treatment

- Child and Adolescent Psychiatry
- Child Subacute Care
- Child Residential Treatment Center
- Child Outpatient Services
- Child Intensive Outpatient Program
- Child Partial Hospital Program
- Child Observation

Substance Use

- Lab Testing for SUD and Alcohol (Beacon Health Options)
- SUD Medication Management (Beacon Health Options)
- SUD Outpatient Counseling (Beacon Health Options)
- SUD Social Detoxification Services (Beacon Health Options)

Colorado Community Health Alliance (CCHA) RAEs 6 and 7

CCHA's Preventive Health Clinical Practices Guidelines Matrix is very expansive and includes these categories: Adult Health, Infectious Disease, Pediatric/Adolescent Health, Substance Use and Women's Health.

Denver Health Medical Plan (DHMP)

Guidelines:

- Adult depression
- Asthma
- Diabetes for adults
- Hypertension
- Antenatal/Postpartum care
- Pediatric Preventive Care
- Pediatric early intervention
- Behavioral Health

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 2024-2025 include:

- Child & adolescent well-care visits
- Follow up after Emergency room visits for Substance Use- Ages 13 and up
- Increase rate of enrollees accessing preventive dental services
- Follow up after hospitalization for Mental Illness
- Diabetes A1c poor control

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 are required to report and focus on Medicaid and CHIP Child and Adult Core Set Measures. The Department holds providers accountable in incentive programs to a sub-set of these measures, as well as some state specific measures which can be found on our public stakeholder webpage. Much of the Department's focus includes improving data quality and increasing the appropriate data sources to accurately report on these measures administratively. The Department reviews performance on all quality measures on a quarterly basis. The thresholds for each measure are reviewed annually prior to the start of the new performance period. Contractors are held accountable for closing their performance gap between their performance and the Department Stretch Goal by 10% Annually. Baseline performance and Targets are clearly outlined in the Program Specification Documents.

Measure Name	Program	State Performance	State Stretch Target
Depression Screening and Follow-Up Plan	KPI	18.6396%	89.79%
Oral Evaluation, Dental Services	KPI	51.5209%	80%
Well-child Visits in the first 30 months of life	KPI •	59.3667% 63.48%	68% 78%
Child and Adolescent Well-care Visits	KPI	40.8519%	63%
Prenatal and Postpartum Care (Prenatal)	KPI	61.4692%	92%
Prenatal and Postpartum Care (Postpartum)	KPI	49.6025%	84%
Emergency Department Visits PKPY	KPI	Regional	Regional
Extended Care Coordination	Performance Pool	Regional	Regional
Premature Birth Rate	Performance Pool	Regional	5.5%
Behavioral Health Engagement for Members Releasing from State Prisons	Performance Pool	31.64%	34.28%
Asthma Medication Ratio	Performance Pool	Regional	74.21%
Antidepressant Medication Management - Acute	Performance Pool	Regional	71.26%
Antidepressant Medication Management - Continuous	Performance Pool	Regional	56.24%
Contraceptive Care for Postpartum Women	Performance Pool	Regional	53.9%
Initiation and Engagement of Substance Use Disorder Treatment (Engagement)	BHIP	15%	24%
Follow-Up After Hospitalization for Mental Illness	BHIP	31%	53%

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	BHIP	24%	38%
Follow-Up After a Positive Depression Screening	BHIP •	55.45%	92.22%
Behavioral Health Screening or Assessment for Children in the Foster Care System	BHIP •	17.44%	40.24%

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

Interventions Table

Plan Name	Plan Type	PIP Topic	Intervention(s)
Colorado Access	CHP+	Well-Child Visits for Members 10-14 Years of Age	(1) Conduct targeted telephonic outreach to members ages 10–14 who are due or overdue for their annual well visit (2) Provider and staff member training to ensure well visit services are itemized in the billing process, particularly if these services are added on to other types of appointments
Denver Health Medical Plan	CHP+	Improving Adolescent Well-Care Access for Denver Health CHP+ Members 15 - 18 Years of Age	Education and communication to members about the importance of AWC visits and free transportation to appointment options
Friday Health Plan	CHP+	Well Child Visits in the 6th through 14th Years of Life	Working with the narrowed focus provider to identify members due for well visits and conducting member outreach phone calls to provide education and schedule well visit appointments
Kaiser Permanente	CHP+	Improving CHP+ Adolescent Well Visit Adherence for Members 15 - 18 Years of Age	Outreach calls prior to adolescent well care (AWC) visit due
Rocky Mountain Health Plans	CHP+	Improving Well-Child Visit (WCV) Completion Rates for Colorado Child Health Plan Plus (CHP+) Members Ages 15-18	Registry-based outreach campaign to identify members due for well visits, send and track text message WCV reminders, and track scheduled and completed well visits
Denver Health Medicaid Choice	MCO	Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15 - 18 Years of Age	Education and communication to members about the importance of AWC visits and free transportation to appointment options
Rocky Mountain Health Plans-Prime	MCO	Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older	Use of a CRAFT approach to engage family support at initial and subsequent SUD treatment visits to help increase commitment level for engaging in SUD treatment
DentaQuest	PAHP	Percentage of Children Under Age 21 Who Received At Least One Dental Service During the Reporting Year	Not available
Colorado Access-Region 3	RAE	Well-Child Visits for Members 10-14 Years of Age	(1) Conduct targeted telephonic outreach to members ages 10–14 who are due or overdue for their annual well visit (2) Provider and staff training to ensure well visit services are itemized in the billing process, particularly if these services are added on to other types of appointments

Colorado Access-Region 3	RAE	Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10 - 14 Years of Age	Educate providers on qualifying follow-up services and proper billing codes to enhance billing practices and more effectively capture work that is already being done
Colorado Access-Region 5	RAE	Well-Child Visits for Members 10-14 Years of Age	Chart audits to identify providers who missed opportunities to bill for well visit services and targeted training for these providers on when and how to bill for well visit services
Colorado Access-Region 5	RAE	Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10 - 14 Years of Age	Educate providers on qualifying follow-up services and proper billing codes to enhance billing practices and more effectively capture work that is already being done
Colorado Community Health Alliance-Region 6	RAE	Well-Care Visits for Children Ages 15-18 Years	Extended hours, summer walk-in clinic every other Saturday
Colorado Community Health Alliance-Region 6	RAE	Supporting Member's Engagement in Mental Health Services Following a Positive Depression Screening	Brightly color the PHQ-9 screening document
Colorado Community Health Alliance-Region 7	RAE	Well-Care Visits for Children Ages 15-18 Years	Update established member recall workflows including processes to catch missed tickler reminders
Colorado Community Health Alliance-Region 7	RAE	Supporting Member's Engagement in Mental Health Services Following a Positive Depression Screening	Referral and tracking mechanism for a follow-up visit
Health Colorado, Inc.-Region 4	RAE	Increasing Well Checks for Adult Members 21 - 64 Years of Age	Care coordinators will reach out to members to address the importance of a well check and assist them in scheduling a well check appointment
Health Colorado, Inc.-Region 4	RAE	Increasing Mental Healthcare Services After a Positive Depression Screening	Telephone outreach to members who have not scheduled their follow-up appointment within 7 days after their positive depression screen
Northeast Health Partners-Region 2	RAE	Increasing Well Checks for Adult Members 21 - 64 Years of Age	Outreach to inform members about well checks
Northeast Health Partners-Region 2	RAE	Increasing Mental Healthcare Services After a Positive Depression Screening	Provider contact and education to facilitate the need to submit a claim for completed depression screening with correct billing codes
Rocky Mountain Health Plans-Region 1	RAE	Improving Well-Child Visit (WCV) Completion Rates for Regional Area Entity (RAE) Members Ages 15-18	Registry-based outreach campaign to identify members due for well visits, send and track text message WCV reminders, and track scheduled and completed well visits
Rocky Mountain Health Plans-Region 1	RAE	Increase the Number of Depression Screenings Completed for RAE Members Ages 11 and Older	Member outreach campaign using the Relatient system, to identify RAE members due for a wellness visit, track scheduled and completed wellness visits, and track completed depression screenings for targeted members. The intervention will also include workflow review with providers to reinforce offering depression screenings during wellness visits and proper coding of completed depression screenings.

The EQRO technical report (**https://hcpf.colorado.gov/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 Enterprise Data Warehouse (EDW), formerly known as 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. Scheduled interfaces from the EDW provide the RAEs and MCOs with member, provider, claims and other types of data to support RAE and MCO operations. 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 5: Improvement and Interventions

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:

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 Behavioral Health Administration. 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.

As part of the Substance Use Disorder (SUD) 1115 Demonstration Waiver an Interim Evaluation conducted by the independent evaluator, TriWest, identified some recommendations for areas of improvement for Colorado. A recommendation from the Interim Evaluation found that the growth in medication assisted treatment (MAT) providers has not translated into more MAT services. It is advised that Colorado work with providers to improve the MAT penetration rates for members with SUD including improving follow-up after withdrawal management where MAT is inducted.

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.

Perinatal Substance Use Disorder

The Department has undertaken a number of initiatives to address perinatal substance use disorder. As referenced in the previous Colorado Quality Strategy Report, the Department applied for and was awarded a $4.6 million cooperative agreement, the Maternal Opioid Misuse (MOM) Model, from the Center for Medicare and Medicaid Innovation. This model was created to better support pregnant and postpartum Medicaid members with opioid use disorders (OUDs).

Given the unique needs and existing efforts in communities across Colorado, the Department's approach for the MOM model (ending December 2024) supported local providers while building statewide capacity to serve pregnant and parenting people with OUD and their infants. This $4.6 million model provided two components of support for integrating care:

- Regionally specific sub-grants for integrating SUD treatment into primary and obstetric care sites that are appropriate to their community, and
- Technical assistance to sub-grantees through a learning collaborative model.

Significant successes during the MOM Model include building perinatal SUD workflows and peer navigator implementation strategies for two different care settings (a rural federally qualified health center with local hospital and OB/GYN connections, and a major metropolitan safety net hospital system), and strengthened collaboration with other State agencies, including the further development and refinement of Plans of Safe Care with the Colorado Department of Human Services.

The Health Equity Atlas is a MOM Model deliverable that aims to capture the resources that are available to pregnant and postpartum members with a substance use disorder (SUD) while also outlining the burden of SUD across Colorado. To better capture the experience of being pregnant and postpartum with an SUD, we travelled to communities across the state to meet with providers, peers, care coordinators, and others engaged in this work. The Health Policy Office will continue to develop and publicize the Health Equity Atlas after the MOM Model period ends.

Structurally, we've strengthened the relationship between the Health Policy Office and the Behavioral Health Initiatives and Coverage Office to develop and facilitate the Perinatal SUD Regional Accountable Entity workgroup, which is comprised of care coordinators from each of the RAEs and addresses issues, questions, and concerns regarding perinatal SUD, with an emphasis on care coordination. The two offices have also collaborated with the Behavioral Health Administration to strengthen the Special Connections program, which provides gender-responsive treatment for pregnant and postpartum people with substance use disorders to increase positive outcomes for the birthing person, infant, and their families. Special Connections providers offer pregnancy risk assessments, care coordination services, group counseling sessions, individual counseling sessions, health education groups, and residential substance use disorder treatment in a women-only setting.

Inpatient Hospital Transitions (IHT) Formerly referred to as the Inpatient Hospital Review Program)

Background of IHT, Health First Colorado is required by statute to have an inpatient hospital review program (Colorado Revised Statutes, 25.5-4-402). In 2023 HRF pivoted from Inpatient Hospital Review Program 1.0 which included a standard utilization management model to Inpatient Hospital Review Program 2.0 which incorporated both classic utilization management and transition of care information. In 2024, IHRP 2.0 was transitioned to Inpatient Hospital Transitions (IHT).
Inpatient Hospital Transitions is not associated with authorization for inpatient stay. IHT is focused on complex inpatient hospital transitions from the acute care to outpatient level of care. It is a mechanism for hospitals to share focused member-specific care coordination information with the RAEs to ensure successful discharge planning from the inpatient setting to the outpatient setting. Hospitals will follow the current process of submitting the request for RAE assistance in care coordination and transition of care as part of the newly designed "IHT Questionnaire" housed in Acentra's PAR Platform (Atrezzo). Inpatient included in IHT: - all hospitalized non-Neonatal Intensive Care Unit (NICU) patients, in which the hospital determines to have a complex discharge plan, rather than a subset of select diagnosis.

- All inpatients (non-NICU) at hospital day 30 and every 30 days thereafter.
- NICU members only:
    - Hospitals need only submit one time on every NICU admission
    - NICU Level I: Well Newborn Nursery and NICU Level II: Special Care Nursery are exempt.
    - 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.

Money Follows the Person

In keeping with the goal to provide member choice, the Department has participated in a federal demonstration program called Money Follows the Person (MFP). The program is designed to help transition Colorado Medicaid members out of qualified long-term care facilities such as nursing homes into home and community-based settings. Members transitioning to the community from a qualified setting have access to additional support through the demonstration and supplemental services available under MFP. The goal is to cultivate higher quality of life, better health outcomes, and a reduction in the total cost of their care. Colorado completed an initial demonstration of MFP called Colorado Choice Transitions (CCT) in 2019. Based on the success of the demonstration, the Colorado Legislature passed House Bill 18-1326, directing the Department to implement permanent transition services and supports. Following House Bill 18-1326 the Department implemented five key services in Colorado's Medicaid benefits—transition coordination, peer mentorship, life skills training, home delivered meals, and transition setup. In 2023 CMS approved the Department's plans for a second MFP demonstration that will allow Colorado to offer transition services and supports previously unavailable under Medicaid.

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.

Health First Colorado Mobile app
The free Health First Colorado mobile app offers self-service tools that previously required a member to call a call center. Implementing self-service tools simplify and improve member experience and help members manage their health.

Features to help them stay covered include to-do lists, updating their information, completing renewals, uploading documents like pay stubs, viewing important letters, reporting a pregnancy, add a newborn or remove household members who have left the household, and view previously submitted forms and their processing status. Members with buy-in premiums can pay their premiums and setup autopay within the app.

Features to help them manage their care include: digital member ID cards that display their current coverage status, , phone numbers for their PCP, RAE, and dental plan, Nurse Advice Line, Colorado Crisis Line and smoking Quitline, interactive provider directory, a searchable member handbook and a connection to their RAE's mobile app. Additional app features include quick sign-in, push notifications and managing communication preferences. Members can also report feedback directly in the app to help better resolve their issues with care and any mobile app experience.

Upcoming mobile app features will shorten the current member onboarding process. Members will be able to select or change their PCP and complete a health needs survey which initiates a RAE follow-up to coordinate care.

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.

Internal Quality Councils
The Quality Council includes Department staff and managers from various offices responsible for different aspects of quality programs. The Quality Council evaluates and provides recommendations to the Executive Quality Council on new quality program details, as well as any significant alterations to program components or measures. Additionally, the Quality Council focuses on reviewing data and offers recommendations for performance management discussions with contractors and providers as necessary.
The Executive Quality Council includes executive-level staff across offices, including directors

and office directors. The Executive Quality Council plays a pivotal role in shaping high-level quality strategy goals and initiatives within the organization. This forum primarily convenes to assess essential areas such as measure selection, target setting, compliance, and member experience results, aiming to foster continuous improvement and align quality efforts with the department's mission.

Cost Control/Value & Affordability Leadership

The Department is dedicated to controlling costs and improving affordability for all Coloradans. Cost Control, Value and Affordability Leadership are Department strategic pillars, described above in the Strategic Pillars section, and Department leadership is actively working in collaboration with the Governor's Health Cabinet on goals and key strategies to achieve Health Care Affordability for Coloradans. In addition to the Department's ACC, described extensively above, the state and Department has made several accomplishments towards Medicaid value and affordability goals:

- Medicaid Cost Control and Value Based Care
    - Payment methodologies that move away from fee-for-service payment and toward alternative payment models that tie financial rewards to performance measures that achieve shared goals, like improving patient health, closing disparities and/or improving health care affordability. Colorado intends to have 50% of Medicaid payments tied to a value-based arrangement by 2025.
        - Primary care providers currently have opportunities to participate and receive quality-based payments through the Accountable Care Collaborative and through the Department's Alternative Payment Models (APMs) for Primary Care: APM 1, APM 2, and the upcoming Payment Alternatives for Colorado Kids (PACK).
        - The Maternity Bundled Payment program concluded its third year of operation in October 2023 with nine obstetrical practices enrolled, representing approximately 30% of Health First Colorado births in the state. Savings resulted from greater use of delivery facilities with a lower base rate, changes in delivery mix to more vaginal deliveries and migration to lower cost genetic testing.
    - The Hospital Transformation Program ties fee-funded hospital payments to implement quality interventions and quality performance metrics. The program is currently in its fourth year and all general hospitals within the state participate.
    - The Prescriber Tool Alternative Payment Model launched on Oct. 1, 2023 and incentivizes Preferred Drug List compliance through use of the Prescriber Tool. The Prescriber Tool is a versatile platform accessible to prescribers through most electronic health record (EHR) systems. 55% of prescribers are using this tool.
    - Five value-based pharmaceutical contracts which tie payments to patient outcomes. The most recent pharmaceutical value-based contract is for Dupixent® and contract will measure the health outcomes of specific Medicaid patients starting or continuing on Dupixent. Clinical outcomes will be monitored by partners at the University of Colorado Skaggs School of Pharmacy. If the clinical outcomes do not meet preselected targets, the pharmaceutical company

agrees to reimburse part of the upfront cost.
    - The Canadian Prescription Drug Importation Program which will reduce prescription drug costs.
    - The eConsult platform connects primary care providers with specialists to bridge gaps in specialty access care, particularly in rural communities. This platform is win-win for cost savings and access to care by efficiently connecting members to specialty care through their primary care provider and without the geographic barriers and long wait times associated with additional in-person specialist appointments.
- Affordability Leadership and Statewide Partnership
    - The Governor created the Office of Saving People Money on Health Care and the Behavioral Health Administration.
    - Colorado has increased hospital transparency through financial and price transparency programs.
    - Establishing a Section 1332 State Innovation Waiver reinsurance program.

The Department continues to explore opportunities to add value to the Medicaid program and improve affordability for all Coloradans:

- In addition to the existing value-based payment programs are several in development including, the Colorado Providers of Distinction, the Essential and Comprehensive Safety Net Behavioral Health Provider Alternative Payment Model, and ACC pay-for performance programs. The Department is also working to evolve the current maternity bundled payment program into a new alternative payment model for maternal care to center health equity in both the program design and design process.
- A workgroup has been convened to create a State Directed Payment Program (DPP) to increase reimbursement for hospitals services provided through Medicaid managed care to submit to the federal Centers for Medicare and Medicaid Services (CMS) for implementation to begin no later than July 1, 2025. The program's goals are to increase hospital reimbursement, support Medicare & CHP+ expansion populations and improve quality of care provided to our members.

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) Health IT 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 Contexture, the Health Information Exchange (HIE) in Colorado has developed a Master Person Index (MPI) through Contexture's 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. Contexture's database already includes over 6 million lives.
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 covering 74% of insured individuals with medical coverage 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.

Section 6: 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 Reform

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 currently has primary care alternative payment methodologies (APMs) for Federally Qualified Health Centers (FQHCs) and for other non-FQHC Primary Care Medical Providers (PCMPs) The APM programs for FQHCs and for non-FQHC PCMPs vary slightly but are based on provider performance on a set of clinical quality measures.

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), administrative measures (claims-based measures) and eCQMs. The measures used are a part of the CMS Adult and Child Core Set. FQHCs and other PCMPs select measures appropriate for their practice,

earn points based on their performance, and receive reimbursement based on their performance and the performance of other participants in the subsequent fiscal year. Financial accountability for performance began January 1, 2021 for all eligible providers.

Figure 7: Medicaid Primary Care Alternative Payment Methodologies

At Risk for Performance	
FQHCs	Non-FQHC PCMPs
Alternative Payment Model 1 for FQHCs -Quality adjusted FFS encounter rates Implementation date: 01/01/2019 Risk level: 4% Federal Authority: State Plan Amendment Approved Key partners and technical support: Colorado Community Health Network, Colorado Community Management Care Network Status of model: Implemented	APM 1 - Adjusted FFS rates based on quality performance. Implementation date: 01/01/2019 Risk level: 4% of FFS rate is at risk. Potential to earn above or below 4% based on quality measure performance. Budget neutral program so increase to FFS rate is based upon the number of PCMPs who fell below the quality performance score of 200 points. Federal authority: State Plan Amendment Approved Key partners and technical support: engaged PCMPs, RAE coaches, HIEs. Status of model: Implemented
Alternative Payment Model 2 for FQHCs - Per Member Per Month (PMPM) reimbursement model, and shared savings for Chronic Conditions. Performance on APM 1 quality measures. Implementation date: 7/1/2022 Risk level: Required to reconcile back to PPS (federal floor). Must be budget neutral to cost-based encounter rate (FFS). Federal authority: State Plan Amendment Approved Key partners and technical support: Colorado Community Health Network, Colorado Community Managed Care Network, Salud, Clinica, Mountain Family Status of model: Implemented	Alternative Payment Model 2 – performance on clinical quality measures, PMPM payment option, and shared savings for Chronic Conditions. Implementation date: 1/1/2022 Risk level: Variable, rates set budget neutral to fee-for-service Federal authority: State Plan Amendment approved Key partners and technical support: PCMPs, RAE coaches, KPMG, HIEs Status of model: Implemented

At Risk for Performance and Utilization	
FQHCs	Non-FQHC PCMPs
Alternative Payment Model 1 for FQHCs -Quality adjusted FFS encounter rates Implementation date: 01/01/2019 Risk level: 4% Federal Authority: State Plan Amendment - Approved Key partners and technical support: Colorado Community Health Network, Colorado Community Management Care Network Status of model: Implemented	APM 1 - Adjusted FFS rates based on quality performance. Implementation date: 01/01/2019 Risk level: 4% of FFS rate is at risk. Potential to earn above or below 4% based on quality measure performance. Budget neutral program so increase to FFS rate is based upon the number of PCMPs who fell below the quality performance score of 200 points. Federal authority: State Plan Amendment Approved Key partners and technical support: engaged PCMPs, RAE coaches, HIEs. Status of model: Implemented
Alternative Payment Model 2 for FQHCs - Per Member Per Month (PMPM) reimbursement model, and shared savings for Chronic Conditions. Performance on APM 1 quality measures. Implementation date: 7/1/2022 Risk level: Required to reconcile back to PPS (federal floor). Must be budget neutral to cost-based encounter rate (FFS). Federal authority: State Plan Amendment Approved Key partners and technical support: Colorado Community Health Network, Colorado Community Managed Care Network, Salud, Clinica, Mountain Family Status of model: Implemented	Alternative Payment Model 2 – performance on clinical quality measures, PMPM payment option, and shared savings for Chronic Conditions. Implementation date: 1/1/2022 Risk level: Variable, rates set budget neutral to fee-for-service Federal authority: State Plan Amendment approved Key partners and technical support: PCMPs, RAE coaches, KPMG, HIEs Status of model: Implemented

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 developed 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 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 developed is a program that changed the reimbursement structure to incentivize value and population-specific needs over volume.

Hospitals
The Department has implemented 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:

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

HTP changes the supplemental payments from a predominantly guaranteed payment to one that is earned by participating in the program and will carry downside and upside risk associated with achieving strategic delivery system transformations and performance on key performance measures to drive meaningful delivery system reform in partnership with hospitals, and a wide array of other stakeholders across the state.

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 Hospital Quality Incentive Payment (HQIP) program is an additional supplemental payment that hospitals can receive based on their performance on measures in three measure groups:

- Maternal Health and Perinatal Care
- Patient Safety
- Patient Experience

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 has introduced 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.

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

House Bill 22-1289 called "Cover All Coloradans" helps children and pregnant people get health coverage, no matter what their immigration status is. Effective Jan. 1, 2025, these newly eligible populations will get the same support and services provided to Health First Colorado and Child Health Plan Plus (CHP+) members. New Cover All Coloradan members will have the same services and delivery system as current Health First Colorado and CHP+ members. RAEs and MCOs will be held to the same contract deliverables and quality standards for this population, ensuring equity in access to care and service delivery.

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 (CFC), also known as 1915(k), allows states to offer Medicaid long-term care services on a state-wide basis to eligible participants. CFC expands access to long-term care for members who meet an intuitional level of care, but not 1915(c) waiver-specific targeting criteria. Participants utilizing CFC services will have the option to direct their attendant care services or to receive services through an agency. The Department received CMS approval to add CFC to the State Plan in December 2024. Members will begin to access services through CFC beginning July 1, 2025.

Substance Use Disorder (SUD) 1115 Demonstration 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, through an 1115 demonstration waiver effective January 2020-December 2025 completed the continuum of SUD services available to Health First Colorado members. The Department's objective in seeking this demonstration waiver was to make these services available for individuals who meet medical necessity requirements, as determined by American Society of Addiction Medicine (ASAM) criteria without shifting care from outpatient settings when they are more appropriate.

The residential and inpatient SUD benefit is managed by the RAEs and MCOs and the costs are 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).

Goals of the 1115 SUD waiver include:

- Increased rates of identification, initiation, and engagement in treatment
- Increased adherence to and retention in treatment
- Reductions in overdose deaths, particularly those due to opioids
- Reduced utilization of emergency departments and inpatient hospitals settings
- Fewer readmissions to the same of higher level of care where the readmission is preventable or medically inappropriate
- Improved access to care for physical health conditions among beneficiaries

Section 7: Conclusions and Opportunities

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 members.
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) 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

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 2024–25 focus on: pharmacy; hospital costs; 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.

Colorado Child Health

Under a Center for Health Care Strategies Technical Assistance opportunity, the Department will explore how to better utilize benefits included 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.

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.

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 members 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.

eConsults

On February 1st, 2024, HCPF launched its eConsult platform (ColoradoMedicaideConsult.com), facilitating asynchronous communication between Primary Care Medical Providers (PCMPs) and Specialty Providers. Safety Net Connect (SNC) serves as the selected vendor for operating HCPF's eConsult platform.

One of the primary goals of the Colorado Medicaid eConsult initiative is to bridge gaps in specialty care access, particularly in rural and frontier communities. By minimizing geographical barriers, the platform helps manage Members with chronic health conditions and reduces the long wait times traditionally associated with in-person specialist appointments.

The platform also addresses social determinants of health-related barriers, ensuring equitable access to care for all Members. With 21 adult specialty fields and 16 pediatric specialty fields available, Colorado Medicaid eConsult expands the range of electronic medical expertise accessible to Members across the state.

Available specialties for clinical guidance include:

Adult Specialties Available (21): Addiction Medicine, Allergy/Immunology, Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology/Medical Oncology, Hepatology, Infectious Disease, Nephrology, Neurology, OB/GYN, Ophthalmology, Orthopedics, Otolaryngology (ENT), Pain Medicine, Physical Med/Rehab, Psychiatry, Pulmonology/Sleep Medicine, Rheumatology, Urology

Pediatric Specialties Available (16): Allergy/Immunology, Cardiology, Dermatology, Developmental Pediatrics, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Orthopedics, Otolaryngology (ENT), Psychiatry, Pulmonology, Rheumatology, Urology

Colorado Medicaid eConsult has received a total of 428 eConsults since February 1, 2024. Only 34 of the 428 have led to a referral for a face-to-face appointment with a specialist. This highlights how Colorado Medicaid eConsult is improving access to specialty care for our members, while also reducing barriers and saving costs.

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 members 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 duplicative to those in 42 C.F.R. §438.340	**23**

§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+	7.2.1
§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	PCCMe/PIHP	9.2.1.12. 14.7.1.2.
		MCO	9.2.8.1.12. 14.5.1.2.

	specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards	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 members 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 members in a timely manner	PCCMe/PIHP	8.7.13.6.
		MCO	8.7.13.6.
		CHP+	
§438.230	**Sub-contractual 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 members; 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 members	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	PCCMe/PIHP	16.3.2.
		MCO	16.2.5.

	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,	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 member 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

Appendix B: Public Comments Received

Colorado received two comments during the public comment period that took place from January 30, 2025 – March 1, 2025. The following is a summary of the comments and questions received and the state's responses.

Comment/Question	State Response
(Internal email "Re: Persons with "Special Health Care Needs" Feb 6, 9:35am) Sending to everyone in this group because I believe it captures some aspect of your work or you might have background to contribute. In the process of working on the 1915b, I've been looking into stuff around requirements around "persons with special health care needs." The federal regs let the state determine who qualifies as a "person with special health care needs." While looking into this, it brought up a list of possible issues to address: Do we need to update state regulation, as it doesn't appear to align with what is going into the next Quality Strategy? Definition in state reg and definition from quality strategy are below. By way of definition in the quality strategy, do we remove PIHP exceptions to SHCN requirements in the waiver? There is an option to "except" PIHPs from the additional requirements of 42 CFR 438.208 related to persons with SHCNs.But the logic used in the waiver to except PIHPs relies on them being limited to BH services. "The ACC PIHP is limited to behavioral health services. Based on the Department's definition of Persons with Special Health Care Needs, the Department does not require the PIHP to meet the primary care requirements nor implement any additional mechanism for identifying, assessing and developing a treatment plan for Persons with Special Health Care Needs." But since the new definition from the QS mentions "population who have or are at increased risk of having... behavioral... condition....", I don't know that this exception applies anymore. Tied to the edit in question to the 1915b, should we need to update the RAE contract? If the exception no longer applies and the RAEs would be required to meet additional requirements related to persons with SHCNs, do we need to make sure the contract is update to reflect this? This would mean the necessary components of 438.208(c) and adding a definition of Persons with SHCNs to the contract. Note: a definition exists in the MCO contracts (by referencing state reg) because the MCOs didn't qualify for an exception.	The Department will include these definitions into the 2024 CMS Quality Strategy.
Will the public comments be shared with MEAC Members?	Yes; when the Public Comment period ends, the State will compile a list of all comments and our response/action. This will be added as an Appendix to the CMS QS and be communicated to external partners, in addition to being posted on our external website.