COLORADO
Department of Health Care Policy & Financing

Quality Strategy 2017

Health First COLORADO™
Colorado's Medicaid Program

TABLE OF ACRONYMS

Name	Acronym
Accountable Care Collaborative	ACC
Agency for Healthcare Research and Quality	AHRQ
All-Payer Claims Database	APCD
Behavioral Health Organization	BHO
Behavioral Quality Improvement Committee	BQuIC
Body Mass Index	BMI
Business Intelligence and Data Management	BIDM
Centers for Medicare and Medicaid Services	CMS
Certified Community Behavioral Health Center	CCBHC
Clinical Quality Measures	CQM
Colorado Business Management System	CBMS
Colorado Cross Agency Collaborative	CCAC
Colorado Department of Human Services	DHS
Colorado Department of Public Health and Environment	CDPHE
Colorado Medicaid Management Innovation and Transformation	COMMIT
Community Living Quality Improvement Committee	CLQIC
Comprehensive Primary Care Plus	CPC+
Community First Choice	CFC
Community Mental Health Center	CMHC
Consumer Assessment of Healthcare Providers and Systems	CAHPS
Early and Periodic Screening, Diagnostic and Treatment	EPSDT
Experience of Care and Health Outcomes	ECHO
External Quality Review Organization	EQRO
External Quality Review	EQR
Emergency Department	ED
Federally Qualified Health Center	FQHC
Fee-for-Service	FFS
Health Information Exchange	HIE
Health Services Advisory Group	HSAG
Healthcare Effectiveness Data and Information Set	HEDIS
Health Care Policy and Financing	HCPF
Home and Community Based Services	HCBS
Hospital Transformation Program	HTP
Key Performance Indicator	KPI
Long-Term Services and Support	LTSS
Major Depressive Disorder	MDD
Managed Care Organization	MCO
Maternal and Infant Health	MIH
Meaningful Use	MU

Medicaid Management Information System	MMIS
Medicaid Provider Rate Review Advisory Committee	MPRRAC
Medical Quality Improvement Committee	MQuIC
Medicare and Medicaid Programs	MMP
National Committee for Quality Assurance	NCQA
Non-emergent Medical Transportation	NEMT
Quality Health Improvement	QHI
Patient Health Questionnaire	PHQ
Performance Improvement Project	PIP
Per Thousand Per Year	PKPY
Pharmacy Benefits Management System	PBMS
Plan, Do, Study, Act	PDSA
Prepaid Ambulatory Health Plan	PAHP
Pre-paid Inpatient Health Plan	PIHP
Primary Care Case Management	PCCM
Primary Care Medical Provider	PCMP
Primary Care Physician Program	PCPP
Prior Authorization Request	PAR
Programs of All-Inclusive Care for the Elderly	PACE
Public Utilities Commission	PUC
Regional Care Collaborative Organization	RCCO
Statewide Data and Analytics Contractor	SDAC
State Innovation Model	SIM
To Be Determined	TBD
Utilization Management	UM

SECTION I: INTRODUCTION

The vision of the Colorado Department of Health Care Policy and Financing (Department) is to ensure all "Coloradans have integrated health care and enjoy physical, mental and social well-being." In alignment with this vision, the Department is committed to its mission of improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. The Department's strategy for Quality and Health Improvement (Quality Strategy) provides a blueprint for advancing this commitment to improving quality health care delivered through Managed Care Organizations (MCOs), Dental Prepaid Ambulatory Health Plan (PAHP), Pre-paid Inpatient Health Plans (PIHPs) and the Primary Care Case Management (PCCM) Entities (also known as the Accountable Care Collaborative). This Quality Strategy highlights the goals, priorities, and guiding principles for continuous measurement, assessment and improvement of health care services for the Health First Colorado (Colorado's Medicaid Program) program.

History of Colorado's Medicaid Managed Care Programs

In 2016, Colorado's Medicaid program was re-branded to Health First Colorado (Colorado's Medicaid Program). The new name reflects the significant changes that have been made to modernize Colorado's Medicaid program to engage members and improve the quality and coordination of care. Even though the name and look of Colorado Medicaid has changed, member eligibility, benefits and access to quality providers remain as key attributes.

Almost all Health First Colorado beneficiaries in Colorado are enrolled in some form of managed care. For over three decades, Health First Colorado has utilized both MCOs and Primary Care Case Management (PCCM) delivery models. Our MCO program began in 1983 and now covers acute, primary and specialty services for Health First Colorado beneficiaries. For many years, the Department offered the Primary Care Physician Program (PCPP), which was available to most non-institutionalized Medicaid beneficiaries statewide. In 2003, the Department introduced Programs of All-Inclusive Care for the Elderly (PACE) in-order to expand the range of services, including Medicare and Medicaid, available to elderly (age 55+) beneficiaries with disabilities in certain regions who meet the nursing home level of care requirement. Denver Health Medicaid Choice was established in 2008 as a risk-based managed care organization for residents of the Denver metropolitan region.

In 1995, the Department implemented the Medicaid Community Mental Health Services program; a mental health prepaid plan to manage behavioral health services for most Medicaid beneficiaries under a 1915B waiver. Now, most Health First Colorado mental health and substance use disorder services are provided through five Behavioral Health Organizations (BHOs), which are PIHPs, under a 1915(b) waiver. The services are paid for on a per-member, per-month basis for each Medicaid member in the BHO's designated geographic region. BHOs contract for services with Community Mental Health Centers (CMHCs) and other providers, such as federally qualified health centers, specialty clinics, private facilities, physicians and other mental health care professionals. The Department sets rates through a combination of negotiation and administrative processes using actuarial analyses. These capitated mental health and substance use disorder services are carved out of the Department's other managed care plan contracts.

In 2011, the Department introduced the latest managed care model called the Accountable Care Collaborative (ACC), which is a PCCM Entity program. Regional organizations, called Regional Care Collaborative Organizations (RCCOs), contract with primary care providers to coordinate acute, primary and specialty care; pharmacy; and select behavioral health services to Health First Colorado beneficiaries. Within the ACC program, the Department is utilizing payment reform initiatives to improve the delivery of health services. Rocky Mountain Health Plans Prime is a comprehensive, full-risk capitation program for ACC members residing in six counties and Access Kaiser Permanente is a capitation payment for the coverage of most primary care and specialty care services for ACC members residing in three counties who have Kaiser Permanente as their primary care medical provider.

For the next iteration of the ACC, one entity in each of the seven (7) ACC regions will be responsible for promoting physical and behavioral health, including administering the Department's capitated behavioral health benefit. The new regional entities will administer the ACC in compliance with the requirements for both a PCCM Entity and a PIHP. A primary responsibility will be creating a cohesive network of primary care physical health providers and behavioral health providers that work together seamlessly and effectively to provide coordinated health care services to Members. Through their expanded scope of responsibility, the regional entities will promote the population's health and functioning, coordinate care across disparate providers, interface with LTSS providers, and collaborate with social, educational, justice, recreational and housing agencies to foster healthy communities and address complex Member needs that span multiple agencies and jurisdictions.

Overview of Quality Management Structure

The Department's Quality and Health Improvement Unit (QHI) operates within the Client and Clinical Care Office. QHI facilitates and manages varied elements that foster quality of care for Health First Colorado. QHI also works in collaboration with external stakeholders, providers and other State agencies.

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

The Medical Quality Improvement Committee (MQuIC), Behavioral Quality Improvement Committee (BQuIC), PACE Quality Committee and Community Living Quality Improvement Committee (CLQIC) meet routinely to review quality issues, share questions and concerns, and discuss data trends. The groups consist of different committees with representatives from MCO,

BHO plans, PACE organizations, Department staff and various other stakeholders. These meetings provide an opportunity to communicate with the Department and one another about quality concerns, challenges and successes. It is also a time for shared learning and constructive discussions about comparative outcomes, innovations and best practices.

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

The Quality Strategy Team consists of staff from QHI working in collaboration with the Department contract managers to review quality compliance reports. Quarterly reporting addresses grievances and appeals, access to care, network adequacy, stakeholder feedback, member enrollment and disenrollment, member complaints, and other quality assurance and improvement activities. The review focuses on plan performance, including items or issues requiring follow-up by the MCO/PIHP. When questions arise, MCOs/PIHPs are asked for additional information and further action, if necessary. Issues, successes, problems or concerns identified through the review process are documented and communicated with the team and senior management.

Goals and Objectives of the State's Managed Care Program

The 2017 QHI Strategy aligns with the National Strategy for Quality Improvement in Health Care. Additionally, the QHI Strategy fosters a delivery system that works better for clinicians and provider organizations while reducing their administrative burden and helping them collaborate to improve care. The Department has implemented a person-centered approach to its operations with the goal of ensuring that all employees, providers, clients and their families experience person centered policies, practices, and partnerships that respect and value individual preferences, strengths, and contributions. This includes development of in-person and virtual advisory councils to work on person-and family centered projects. The goal is to lead, manage and facilitate performance improvement by closing performance gaps by 10% while identifying specific processes and policies that can become more person-centered. To calculate this goal you would do the (benchmark – performance) = gap; and (gap X .10 = goal). Guided by the Agency for Healthcare Research and Quality (AHRQ) principles, the QHI Strategy is developed with input by stakeholders across the health care system, including Federal and State agencies, local communities, provider organizations, clinicians, patients, businesses, employers, and payers.

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

Triple Aim

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

National Aims

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

National Priorities

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

QHI's Strategic Goals include:

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

QHI will achieve these goals through the Triple Aim framework. For details, please access the Department's 2016/17 Performance Plan at the following link: Performance Plan | Colorado Department of Health Care Policy and Financing

Development and Review of Quality Strategy

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

Prior to implementation of the QHI strategy, the Department collaborated with the following representative stakeholder groups to obtain their review and input:

- State Medical Assistance and Services Advisory Council (created under 42 CFR 431.12)
- Children's Disability Advisory Group
- Children's Services Steering Committee
- MQuIC, BQuIC. CLQIC
- Colorado Behavioral Healthcare Council
- Colorado Department of Public Health and Environment (CDPHE)
- Colorado Department of Human Services (DHS)
- Colorado Community Health Network

438.202(d). This QHI Strategy will be revised when significant change occurs or as a result of the annual evaluation. Significant change refers to compliance with new and amended federal/state regulations, changes to Department programs, policies, and procedures, as well as quality performance review and assessment based on data analytics for improving change.

SECTION II: ASSESSMENT

Quality and Appropriateness of Care

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

The Department also focuses on care for EPSDT eligible children and youth aged 20 and under, with an emphasis on well care, depression screenings and individuals with special health care needs. The definition of "special health care needs" in our EPSDT program refers to "those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."[1] This equates to approximately 19.1% of the current EPSDT population. In budget calculations, the Department defines "special health care needs" for adults over 21 as those who qualify for Social Security benefits.

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

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

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

438.204(b)(2). Client Demographics
Demographics of the Medicaid population in Colorado are collected during enrollment. Demographics are monitored and analyzed annually by the Department. Demographics for March 2016 are presented below. Colorado places the onus on MCOs and PIHPs to assess the race, ethnicity, and primary languages spoken needs for their enrollees and to address those needs accordingly.

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

Colorado Medicaid Demographics - March 2016

Colorado Medicaid Population 1,321,725

Gender	Client Count	Percentage
Female	706,987	53.5%
Male	614,738	46.5%

Race/Ethnicity	Client Count	Percentage
American Indian	21,878	1.7%
Asian	31,453	2.4%
Black or African American	95,790	7.2%
Pacific Islanders	4,680	0.4%
Others	183,281	13.9%
White Non-Hispanic	454,758	34.4%
Hispanic/Latino	366,887	27.8%
Not Reported	162,998	12.3%

Age Distribution	Client Count	Percentage
0-5	187,942	14.2%
6-12	223,074	16.9%
13-17	128,744	9.7%
18-25	164,884	12.5%
26-64	555,152	42.0%
65+	61,929	4.7%

Clinical Guidelines

The Department supports the use of physical and behavioral health clinical guidelines through AHRQ, the Cochrane Collaboration, PubMED, and other evidenced-based sources. The Department also supports Patient Centered Medical Home models, trauma informed care, recovery and resilience, and the SAMSHA model for behavioral and physical health integration.

National Performance Measures

438.204(c). The SIM Office is exploring ways to align SIM and CPC+ operationally so practices can benefit from participation in both programs without duplication of efforts or funds. SIM and CMS agree that the goals and objectives of the two initiatives create natural synergies and, together provider practices with an opportunity to redesign processes and offer comprehensive primary care that integrates behavioral health. Our emerging vision of alignment is one in which practice requirements in certain areas – including practice transformation support, learning collaborative offerings, quality measure alignment and reporting – will be coordinated to reduce provider burden while preserving SIM's focus on the integration of physical and behavioral health.

At this time, the SIM Office is working with CMS to map out participation in both initiatives at an operational level. We are committed to working with our federal partners to create a pathway for practices seeking to pursue both opportunities and will provide additional information to practices as soon as it is available.

In particular, the SIM Office anticipates that practices who participate in both SIM and CPC+ will receive the following supports:

- Opportunity to earn achievement-based payments
- Access to apply to small grants to fund behavioral health integration
- Business consultation support

Maternal and Infant Health Grant

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

Contraceptive Care Measure

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

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

Postpartum Women

Among women ages 15-44 who had a live birth, the percentage that is provided within 3 and 60 days of delivery:

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

Adult and Child Core Measures

The Department reports annually on the CMS Adult and Child Core Measures, as well as all measures for which data are available. The Department reported on the following Adult and Child Core Measures in 2016:

Adult Core Set

- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: HBA1c poor control (>9%)
- Adult Body Mass Index (BMI) assessment
- Antidepressant Medication Management
- Breast Cancer Screening
- Controlling High Blood Pressure
- Cervical Cancer Screening

- Screening for Clinical Depression and Follow-up Plan
- Chlamydia Screening in Women
- Follow-up After Hospitalization for Mental Illness
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Use of Opioids at High Dosage
- Plan All-Cause Readmission
- Timeliness of Postpartum Care
- PQI 01: Admissions for diabetes, short-term complications
- PQI 05: Admissions for chronic obstructive pulmonary disease
- PQI 08: Admissions for congestive heart failure
- PQI 15: Admissions for adult asthma
- Adherence to antipsychotics for individuals with schizophrenia
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Child Core Set

- Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication
- Ambulatory Care – Emergency Department (ED) Visits
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Adolescent Well-Care Visit
- Consumer Assessment of Healthcare Providers and Systems® (CAHPS)
- Child and Adolescent Access to Primary Care Practitioners
- Chlamydia Screening
- Childhood Immunization Status
- Pediatric Central Line Associated Blood Stream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit
- Developmental Screening in the First Three Years of Life
- Frequency of Ongoing Prenatal Care
- Follow-Up After Hospitalization for Mental Illness
- Immunization Status for Adolescents
- Live Births Weighing Less Than 2,500 Grams
- Medication Management for People with Asthma
- Cesarean Rate for Nulliparous Singleton Vertex
- Percentage of Eligibles that Received Preventive Dental Services
- Timeliness of Prenatal Care
- Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents

Monitoring and Compliance

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

Dashboards The Department is creating a reporting strategy for all of its health-plan specific measures to create external-facing interactive dashboards. The purpose of these dashboards is to create accountability, transparency and quality improvement within our Medicaid program. Data presented will come validated measures from various sources, including National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS) and CAHPS. Three-year trends will be provided, as well as national benchmarks, in order to allow for health plan assessment and comparison.

Accountable Care Collaborative Performance Measures. Below are the incentive and other RCCO measures being monitored by the Department in 2016-2017:

ACC Key Performance Indicators (KPI):

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

Other performance measures:

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

Data for these measures are provided by the Statewide Data and Analytics Contractor (SDAC).

HEDIS® Performance Measures. The Department selects HEDIS measures for reporting each year. Reporting organizations include all contracted MCOs, PIHPs, and Health First's FFS program. Measures are selected annually using input from the MCOs, PIHPs and Department staff. Below are the 2017 HEDIS measures selected by the Department:

- Adult BMI Assessment
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
- Childhood Immunization Status Combos 2-10
- Immunizations for Adolescents
- Breast Cancer Screening
- Cervical Cancer Screening

- Non-Recommended Cervical Cancer Screening in Adolescent Females
- Chlamydia Screening in Women
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection
- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
- Use of Spirometry Testing in Assessment and Diagnosis of COPD
- Pharmacotherapy Management of COPD Exacerbation
- Medication Management for People with Asthma
- Asthma Medication Ratio
- Statin Therapy for Patients with Cardiovascular Conditions
- Persistence of Beta-Blocker Treatment After Heart Attack
- Statin Therapy for Patients with Diabetes
- Comprehensive Diabetes Care
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Use of Imaging Studies for Low Back Pain
- Anti-depressant Medication Management
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- Adults' Access to Preventive/Ambulatory Health Services
- Children and Adolescents' Access to Primary Care Practitioners
- Annual Dental Visit
- Prenatal and Postpartum Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care
- Frequency of Selected Procedures
- Ambulatory Care - Outpatient and/or ED
- Inpatient Utilization – General Hospital/ Acute Care
- Antibiotic Utilization
- Annual Monitoring for Patients on Persistent Medications

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

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

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

Performance Improvement Projects (PIPs) are undertaken by each MCO, PCCM Entities and PIHP. Each plan selects at least one PIP and chooses study topics based on data that identifies an opportunity for improvement. The topic may be specified by the Department. The PIP is used to identify and measure a clinical or non-clinical targeted area, implement interventions for improvement and analyze results. PIP benefits include improving performance measure rates, keeping plans focused on improving performance, and improving member satisfaction. PIPs are evaluated and validated by an EQRO (External Quality Review Organization). The EQRO supports the Department in consulting with health plans regarding PIPs in an effort to align plan projects and attain more impact as it relates to quality improvement activities and overall population health. The EQRO also coordinates with the Department to host a conference at the end of every two-year PIP cycle in order to promote quality strategies, share information, and host a keynote speaker relevant to the plan PIPs. PIPs are validated by the EQRO using the methodology outlined in the CMS protocol and regulations found in CFR 438.240.

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

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

Annual Quality Summary. Quality improvement plans are submitted by the MCOs and PIHPs to the Department each year. The plans identify current and anticipated quality assessments and performance improvement activities and integrate findings and opportunities for improvement identified by performance measure data, member satisfaction surveys, PIPs and other monitoring and quality activities. These plans are subject to the Department's approval. The MCOs and

PIHPs also submit annual quality improvement reports summarizing actual performance, improvement opportunities and accomplishments from the previous year.

Behavioral Health Organization performance measures are selected each year using input from the PIHPs and Department staff. Measures are calculated by the PIHP in collaboration with the Department, and the data is audited by our EQRO. A list of standard measures calculated and audited in state fiscal year (SFY) 2016 – 2017 are below:

- Suicide risk assessment for major depressive disorder (MDD) in children & adolescents/To Be Determined (TBD)
- Suicide risk assessment for MDD in adults/TBD
- Hospital Readmissions: 7, 30, 90 and 180 days
- Percent of members prescribed redundant or duplicated atypical antipsychotic medication
- Adherence to antipsychotics for individuals with schizophrenia
- ECHO survey
- Penetration rates
- Diabetes screening for individuals with schizophrenia or bipolar disorder who are using antipsychotic medication
- Inpatient utilization
- Emergency department utilization for a mental health condition
- Follow up appointments within 7 and 30 days after hospital discharge for a mental health condition
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Mental Health Engagement
- Various Stretch Measures (example Depression Remission, Substance Screening, Person Centered Advisory Board.

External Quality Review Organization (EQRO)

438.204(d). As the single state agency responsible for administration of the state Medicaid program, the Department has the authority to require its contractors to meet state and federal quality regulations and contract requirements. In 1997, the Balanced Budget Act mandated that states ensure the delivery of quality health care by all Medicaid health plans. Section 1932(c)(l) of the Social Security Act, 42 Code of Federal Regulations (CFR) 438.204 requires the Department to implement a quality assessment and improvement strategy for the Health First Colorado managed care population. This regulation sets forth specifications for quality assessment and performance improvement strategies that the Department must develop. It also establishes standards that the Department and MCOs/PIHPs must meet.

Section 25.5-5-405, C.R.S, (2011) requires the Department to measure quality pursuant to defined criteria and authorizes the Department to promulgate rules and regulations to clarify and administer quality measurements.

State regulations at 10 CCR 2505-10, Section 8.079 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.

438.360(b)(4). In Colorado, Health Services Advisory Group (HSAG), an EQRO, assesses and validates MCO and PIHP performance improvement projects, performance measures and conducts compliance reviews. The Department also uses optional EQR activities like validation of encounter data and consumer surveys of quality of care to assess MCO and PIHP performance. The EQRO produces an annual Technical Report that details and assesses the MCOs' and PIHPs' quality of care and services, timeliness of care and services, and access to care and services. The Technical Report covers managed care services for both physical and behavioral health. This report is submitted to CMS annually.

SECTION III: STATE STANDARDS

Access Standards

438.206. The Department is committed to improving the health outcomes, access to and quality of health care to the Colorado population served by the Health First Colorado programs. The Department uses a combination of strategies to achieve this goal, including: performance measurement that includes health outcomes, increasing provider participation, increasing the continuity of care between Medicaid and CHP+, working with our state partners in achieving health outcomes and partnering on aligned initiatives. The Department is dedicated to building a culture of outcomes while driving policy to better serve members and providers, as well as being a responsible steward of public funds. HCPF's contracts with MCOs requires them to comply with all applicable federal and state laws, rules and regulations including but not limited to all access to care standards in Title 42 CFR Part438, subpart D. In accordance with CMS's final rule on "Methods for Assuring Access to Covered Medicaid Services", (as required under section 1902(a)(30)(A) of the Social Security Act, in accordance with 42 CFR 447.203), the Department authored an Access Monitoring Review Plan (Plan).

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

Several factors complicate the ability to analyze access sufficiency. Medicaid expansion in January 2014 introduced a new member demographic to Medicaid whose utilization patterns are not well understood. Service utilization, in general, does not necessarily indicate access.

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

Availability of Services. A primary focus of the Department is to ensure members have adequate access to care and receive services from appropriate providers. The Department fosters adequate access to care through several programs and projects. One such program is non-emergent medical transportation (NEMT); the Department provides this mandatory state plan benefit that is offered to eligible members in order to receive transportation to covered Health First Colorado services when the members have no other means of transportation. The Department and Public Utilities Commission (PUC) also implemented a new PUC permit to make it easier for NEMT providers to

obtain a permit to provide services while also not changing requirements for existing NEMT providers.

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

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

Assurances of Adequate Capacity and Services. The Department initiated strategies and improvements to expand provider networks serving the Medicaid population. When provider payment rates are reduced or restructured, network adequacy is monitored to ensure access is not diminished. In cases where access is diminished, corrective actions, such as a payment increase, are taken. In 2015, Colorado Revised Statute 25.5-4-401.5 established the Medicaid Provider Rate Review Advisory Committee (MPPRAC) and required the Department to create a Rate Review Process and determine a schedule that ensures an analysis and reporting of each Medicaid provider rate at least every five years. The process includes an analysis of the access, service, quality, and utilization of each service subject to rate review. The analysis compares the rates paid to Medicaid providers with Medicare provider rates, usual and customary rates paid by private pay parties, and other benchmarks, and uses qualitative tools to assess whether payments are sufficient to allow for provider retention and member access and to support appropriate reimbursement of high value services. The findings of this analysis are published annually. The Department authors a second recommendation report to review the analysis report and develop strategies for responding to the findings, including any non-fiscal approaches or rebalancing of rates. The recommendation report includes the Department's recommendations regarding the sufficiency of provider rates and includes the data relied upon in making those recommendations.

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

Access issues are identified through the analysis conducted and within MPRRAC meetings, by engaging with the provider, stakeholder, and beneficiary community.

Recurring provider rate reviews analyzing utilization, access and quality, and rate comparison by service are also performed. Our goal through the Primary Care Medical Provider (PCMP) Outreach and Enrollment Program is to increase the number of providers available as PCMPs. Rural PCMPs are targeted through outreach at rural health center events and financial incentive

strategies. The Department will be supporting SIMs goal of recruiting 400 primary care practices and helping them transition to care delivery models that integrate physical and behavioral health care.

Coordination and Continuity of Care. The Department is committed to delivering a member-focused Medicaid program that improves health outcomes and member experience while delivering services in a cost-effective manner. This goal leverages proven reforms to health care delivery models, such as care coordination, payment incentives, and advances in health information technology to improve member health and well-being. To achieve this goal, the Department recently changed its managed care contract management approach from compliance-centric, to performance-driven. The Department established a contract knowledge center to support better facilitation of contractual processes and program activities related to contract performance.

Coverage and Authorization of Services. The Colorado Prior Authorization Request (PAR) Program for utilization management (UM) is an effective way to ensure robust management of Health First Colorado benefits. These guidelines help clients receive the right services and supports at the right time and for the correct duration. This program also improves quality of care and saves taxpayer money by reducing unnecessary and duplicative services. In FY 2016-17, the Department continues to work with eQHealth Solutions (the Department's UM vendor) to further improve the PAR process through a data-driven, evidence-based approach. eQHealth Solutions identified numerous initiatives to decrease inappropriate utilization of benefits. The Department expects to see inappropriate benefit utilization and cost reductions as collaboration, process efficiencies, program alignment, and policy enforcement efforts increase.

Structure and Operations Standards

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

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

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

The RCCOs work with individual practitioners and clinics to encourage participation and expand capacity in addition to promoting providers who demonstrate exemplary access capacity. RCCOs share the common goal of supporting positive provider experiences, provider engagement and provider satisfaction. RCCOs meet with providers to evaluate provider network needs.

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

Enrollee information. The Department requires the contractor 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 Contractor must provide a member handbook to all enrollees, and the handbook must include information about services offered. The information in the handbook is provided at a 6th grade reading level, is translated into other non-English languages prevalent in the service area and may be in alternative formats. Oral interpretation services are also made available to members. The Contractor must also include information stating that enrollment is voluntary and provide instructions on disenrollment.

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

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

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

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

Measurement and Improvement Standards

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

Practice Guidelines. The MCO contractors are required to develop practice guidelines for perinatal, prenatal and postpartum care for women, conditions related to persons with a disability or special health care needs, and well child care. The contractor ensures that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field. The guidelines consider the needs of the member and are adopted in consultation with participating providers. The contractor reviews and updates the guidelines at least annually and disseminates the practice guidelines to all affected providers and, upon request, to members, clients, the Department and the public at no cost. Decisions regarding utilization management, member education, covered services and other areas are consistent with the guidelines.

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

The Department's FY 2016 PIP Transition of Care process for the MCO's is detailed in the list below.

2016 Performance Improvement Projects

- Access and Transition to Behavioral Health Services
- Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider
- Adolescent Depression Disorder Screening and Transition to a Behavioral Health Provider
- Depression Screening and Transition to a Behavioral Health Provider
- Improving Follow-up Communications Between Referring Providers and Pediatric Obesity Specialty Clinics
- Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release
- Improving Transition from Jail to Community Based Behavioral Health Treatment
- Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility
- Improving the Transition Process for Children Aging Out of the CHP+ HMO Plan
- Medical Respite Care for Homeless RCCO Members Discharged from Hospital In-Patient Stay
- Transition of Care for CHP+ Members with Special Health Care Needs as they Transition from CHP+ Coverage

The Department's Performance Measures are herein incorporated to this QHI Strategy. NCQA-licensed audit organizations validated, at a minimum, the set of performance measures selected by the Department. HEDIS measures follow the definitions outlined in NCQA's HEDIS 2016 Technical Specifications, Volume 2, and the reporting method required by the Department.

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

The health information technology and data analytics emerging from COMMIT will advance our ability to improve member health outcomes and reduce health care costs. As an initiative aligned with the State Health Information Exchange strategic plan, and integrated with broader statewide enterprise architecture development, COMMIT will contribute to expansion of health information technologies throughout the state. COMMIT went live on March 1, 2017.

SECTION IV: IMPROVEMENT AND INTERVENTIONS

As the primary strategic innovation for the Department, the ACC program saved the State an estimated $139 million since 2011 by holding regional organizations accountable for delivering high-quality, patient-centered, coordinated care to Health First Colorado clients (this calculation accounts for payments to providers and contractors). See ACC Legislative Report.

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

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

Intermediate Sanctions

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

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

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

- to a limit of twenty-five thousand dollars ($25,000.00) for each determination of failure to adhere to contract requirements
- to a limit of one hundred thousand dollars ($100,000.00) for each determination of a failure to adhere to contract requirements

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

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

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

Health Information Technology

438.204(f). Health Information Technology is an essential part of the quality measurement process. The Department will soon launch a procurement for a Master Person Index and a Master Provider Index (collectively, the Indexes). The Indexes will allow Colorado to achieve a unified view of Medicaid provider and member data across the Health Information Exchange (HIE) networks, improving the quality of data, patient to provider attribution, care coordination, and reducing costs. The Indexes will create a suite of data records and services allowing the Department to link and synchronize a Health First Colorado member, provider, and organization data to HIE sources. This effort will result in a single, trusted, authoritative data source.

The Department is also researching the automated entry of electronic clinical quality measures (CQM) to improve the HIE data collection foundation for supporting the transition to automated Meaningful Use (MU) reporting for Health First Colorado providers. The Department plans to leverage infrastructure of the HIE to support CQM reporting to CMS and to implement CQM analytics for Health First Colorado providers and other care coordination organizations participating in the Medicaid ACC. The Department's approach includes updating infrastructure to effectively collect existing CQM data, additional data elements, and support MU reporting directly from the clinical health record from Health First Colorado providers. The data will be aggregated, normalized, and validated at the HIE Foundation, and ultimately shared as appropriate with the Health First Colorado enterprise data management solution (MMIS-BIDM). This improvement of data will be used to support advanced risk stratification analysis, enhance care coordination infrastructure and activities, and measure provider performance and outcomes within Health First Colorado programs. Updated CQM reporting will support Transitions of Care,

Continuity of Care Documents, and the capability to run analytics on the CQMs submitted by Eligible Professionals and Eligible Hospitals, with enhanced reporting and data validation services.

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

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

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

BIDM System Overview

In November 2014, the Department selected Truven Health Analytics as the contractor to design, develop and implement the new BIDM system which replaces SDAC on May 1, 2017. The Department desired a system that hosts data from the new Colorado interChange (formerly known as the MMIS), from other Colorado state agencies and from other sources within Colorado and nationally. The BIDM is intended to be the premier Medicaid analytics solution in the country, allowing the Department and its stakeholders unprecedented capabilities to better manage Medicaid programs. The new system will eventually incorporate the current SDAC, which hosts data to support the Medicaid Accountable Care Collaborative (ACC). In addition, BIDM solution brings:

- Dedicated staffing – The BIDM contract incorporates a full-time Analytics Manager and 18 dedicated staff for analytics, operations, and system projections. In addition, Truven will provide web portal training and dedicated help desk support
- Accessibility to stakeholders, especially providers – The provider community will have access to BIDM reporting via single sign-on from the new Colorado interChange Provider Portal

- Integration of new data – BIDM will directly interface existing and future Medicaid data systems (Colorado Business Management System (CBMS), interChange, and PBMS)) while building capacity to exchange health information with numerous other data sources inside and outside of the State domain (e.g. HL7 clinical data)
- Innovative program integrity – Comprehensive statistical profiling of health care delivery and utilization patterns by providers allows users to set, monitor, and report on performance benchmarks that demonstrate progress in the detection of fraud and abuse that may result in recoveries and cost avoidance

Additionally, the State's use of proactive quality measurement led to national recognition for reporting on initial CHIPRA metrics (more than any other state) and improved managed care contracts projected to save millions of dollars and improve care over time. Lastly, the Federal Money Follows the Person Rebalancing Project included quality improvement and technical assistance for over 30 states that have CMS grants for transitioning persons to community living.

SECTION V: DELIVERY SYSTEM REFORMS

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

The Accountable Care Collaborative (ACC). The ACC is the Department's primary delivery system platform. The Department contracts with the RCCOs and PCMPs to manage the medical and nonmedical needs of enrolled clients with an emphasis on addressing the social determinants of health. As part of the financing structure in the program, the Department implemented incentive payments that reward cost containment, provision of comprehensive primary care, participation in integrated care initiatives and more.

The next phase of the ACC (Phase II) will bring together the functions performed by the PCCM Entities and the PIHPs under a single administrative entity to improve client health and life outcomes and to use state resources wisely. The entities in each of seven regions will be responsible for promoting physical and behavioral health and performing the duties originally contracted by the PCCM Entities and PIHP in their region. These new entities will create a cohesive network of primary care physical health providers and behavioral health providers that work together seamlessly and effectively to provide coordinated health care services to Members. Information on Phase 2 of the ACC can be found here: ACC Phase 2

Behavioral Health Quality Improvement Strategy. The Department, in collaboration with the DHS's Office of Behavioral Health, is in the process of implementing a coordinated behavioral health improvement strategy. Medicaid Behavioral Health services are predominantly rendered under a risk managed care system. Contracts for the managed care program are being updated to include pay-for-performance incentives in addition to the full risk capitation rates. Simultaneously, the DHS is implementing provider level contract changes to align with the Medicaid managed care contract reforms. The complementary incentive structures build on work with the provider community that initially was intended to support the state's efforts to pursue the Certified Community Behavioral Health Center Demonstration; even though the state was not selected for participation in the demonstration, this work ultimately evolved into a state-wide behavioral health quality improvement strategy.

The initial proposed quality metrics for the Medicaid BHO incentive performance measures are listed below:

Incentive Performance Measures

- Mental Health Engagement (all members excluding foster care)
- Mental Health Engagement (ONLY foster care)
- Engagement of Substance Use Disorder Treatment

- Follow-up appointment within 7 days after a hospital discharge for a mental health condition
- Follow-up appointment within 30 days after a hospital discharge for a mental health condition
- Emergency Department Utilization for Mental Health Conditions
- Emergency Department Utilization for Substance Use Conditions

Incentive Process Measures

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

State Innovation Model (SIM). Colorado was the recipient of a SIM grant that allows the Department to engage in a multi-payer initiative to improve access to integrated physical and behavioral health services and to promote public health initiatives. Colorado's plan under SIM, entitled "The Colorado Framework," creates a system of clinic-based and public health supports to spur innovation. The Department will improve the health of Coloradans by:

- providing access to integrated primary care and behavioral health services in coordinated community systems
- applying value-based payment structures
- expanding information technology efforts, including telehealth
- finalizing a statewide plan to improve population health

Colorado Opportunity Project. The Colorado Opportunity Project is a cross-agency collaborative among the Department, CDPHE, DHS and Department of Labor and Employment. It establishes a common set of indicators so government agencies and private initiatives can work toward the same goals with the same understanding of what needs to be done.

The Colorado Opportunity Project coordinates and aligns the interventions of government, private, non-profit and community partners through a life stage indicator-based framework. The project's framework creates a thoughtful, broadly integrated health care delivery system that incorporates key social determinants of health. Each life stage in the framework identifies key benchmarks or metrics that need to be met to create successful outcomes, such as healthy birthweight, school readiness, social emotional health, stable housing and positive workforce development. Community access to evidence-based program bundles in a life stage model creates a synergy or increased trajectory towards successful outcomes to the next life stage.

The goal of the project is to remove roadblocks to economic self-sufficiency by delivering evidence-based interventions in an integrated system of health, social, and educational well-being so everyone has the opportunity to reach and maintain their full potential.

Primary Care Payment Reforms. As part of the Department's efforts to shift providers from volume to value, the Department is developing a structure to make differential FFS payments based on performance, to give providers greater flexibility, reward performance while maintaining transparency and accountability, and create alignment across the delivery system. Under the proposed model, providers can earn higher reimbursement when designated as meeting

specific criteria or performing on quality metrics. Progress within this framework not only encourages higher organizational performance but also helps the ACC achieve its respective programmatic goals.

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

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

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 that are designed to increase provider flexibility in delivering care while holding providers accountable for client outcomes.

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

Goals of HTP:

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

ACC Medicare and Medicaid Programs (ACC: MMP). The CMS Innovation Center awarded Colorado and 14 other states the opportunity to better coordinate care for clients who are eligible for both Medicare and Medicaid. Goals include:

- Improved care coordination
- Improved client experience

- Improved health outcomes for this population
- Decreased costs associated with unnecessary and duplicative services

The ACC: MMP performance measures include:

Model Core Measures

- All Cause Hospital Readmission
- Ambulatory Care-Sensitive Condition Hospital Admission
- ED Visits for Ambulatory Care-Sensitive Conditions
- Follow-Up after Hospitalization for Mental Illness
- Depression screening and follow-up care
- Screening for fall risk
- Initiation and engagement of alcohol and other drug dependent treatment:
    (a) initiation,
    (b) engagement

State-Specific Process Measures

- Care Coordination/Plan of Care: Percentage of enrollees with a Service Coordination Plan within 90 days of connecting with a RCCO
- Training on Disability, Cultural Competence, and Health Assessment: Percentage of providers within a RCCO who have participated in training for disability, cultural competence, or health assessment
- Hospital Discharge and Follow Up: Percentage of enrollees who received first follow-up visit within 30 days of hospital discharge

State-Specific Demonstration Measures

- Client/Caregiver Experience of Care: Percentage of enrollees reporting that their doctor or health care provider do the following:
    (a) Listen to you carefully?
    (b) Show respect for what you had to say?
    (c) Involve you in decisions about your care?
- AHRQ/CAHPS
- Care for Older Adults; Percentage of enrollees 66 years and older who had each of the following during the measurement year: advance care planning, medication review, functional status assessment, and pain screening (HEDIS)
- Percent of high-risk beneficiaries receiving community-based Long-term Services and Supports (LTSS)
- Percent of high-risk beneficiaries receiving LTSS services in Skilled Nursing Facility/other non-HCBS setting

Colorado Choice Transitions. This program is part of the federal Money Follows the Person Rebalancing Demonstration. The primary goal of this five-year grant program is to facilitate the transition of Medicaid clients from nursing or other Long-Term Care facilities to the community using Home and Community Based Services (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 an HCBS waivers, so long as they remain Medicaid eligible.

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

SECTION VI: CONCLUSIONS AND OPPORTUNITIES

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

Appendix A: Contract Language on Culturally and Linguistically Appropriate Care

1.1.1.1. The Contractor shall facilitate culturally and linguistically appropriate care, by implementing the following requirements:

1.1.1.1.1. **Establish and maintain policies to reach out to specific cultural and ethnic Members for prevention, health education and treatment for diseases prevalent in those groups.**

1.1.1.1.2. Maintain policies to provide health care services that respect individual health care attitudes, beliefs, customs and practices of Members related to cultural affiliation.

1.1.1.1.3. Make a reasonable effort to identify Members whose cultural norms and practices may affect their access to health care. Such efforts may include inquiries conducted by the Contractor of the language proficiency of Members during the Contractor's orientation calls or being served by Participating Providers, or improving access to health care through community outreach and Contractor publications.

1.1.1.1.4. Develop and provide cultural competency training programs, as needed, to the network Providers and Contractor staff regarding all of the following:

- Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services.
- The medical risks associated with the Client population's racial, ethical and socioeconomic conditions.

1.1.1.1.5. Make available written translation of Contractor materials, including Member handbook, correspondence and newsletters. Written Member information and correspondence shall be made available in languages spoken by prevalent non-English speaking Member populations within the Contractor's Service Area as directed by the Department or as required by 42 CFR 438.

1.1.1.1.6. Develop policies and procedures, as needed, on how the Contractor will respond to requests from Participating Providers for interpreter services by a Qualified Interpreter. This shall occur particularly in Service Areas where language may pose a barrier so that Participating Providers can:

- Conduct the appropriate assessment and treatment of non-English speaking Members, including Members with a Communication Disability.
- Promote accessibility and availability of Covered Services, at no cost to Members.

1.1.1.1.7. Develop policies and procedures on how the Contractor will respond to requests from Members for interpretive services by a Qualified Interpreter or publications in alternative formats.

1.1.1.1.8. **Make a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse and culturally competent clinical Providers that represent the racial and ethnic communities being served.**

1.1.1.1.9. Provide access to interpretative services by a Qualified Interpreter for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services.

1.1.1.1.10. Develop and maintain written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.

1.1.1.1.11. Arrange for Covered Services to be provided through agreements with non-Participating Providers when the Contractor does not have the direct capacity to provide Covered Services in an appropriate manner, consistent with Independent Living, to Members with Disabilities.

1.1.1.1.12. Provide access to TDD or other equivalent methods for Members with a hearing impairment in such a way that it will promote accessibility and availability of Covered Services.

1.1.1.1.13. Make Member information available for Members with visual impairments, including, but not limited to, Braille, large print or audiotapes. For Members who cannot read, member information must be available on audiotape.

APPENDIX B: Access to Care Standards Crosswalk

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.206	Availability of Services	CO Quality Strategy pg 15
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	Contract §§ 2.5.1.1.2, 2.5.1.1.2
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist	Contract § 2.5.1.1.5
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	Contract § 2.5.1.1.6
§438.206(b)(4)	Adequately and timely coverage of services not available in network	Contract § 2.5.1.2.1
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	Contract § 2.5.1.2.2
§438.206(b)(6)	Credential all providers as required by §438.214	Contract §§ 3.2.1.2, 3.2.1.3
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	Contract § 2.5.1.3.1
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service	Contract § 2.5.1.4.1
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week	Contract §§ 2.5.1.4.1, 2.5.1.4.1.2
§438.206(c)(1)(v)	Mechanisms/monitoring to ensure compliance by providers	Contract§ 2.5.1.4.1
§438.206(c)(2)	Culturally competent services to all enrollees	Contract §§ 2.5.4.3.1.4, 2.5.6.3
§ 438.207	Assurances of Adequate Capacity and Services	CO Quality Strategy pg 16
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	Contract § 2.5.2.4
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	Contract § 2.5.2.4.1.
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	Contract § 2.5.2.4.2
§ 438.208	Coordination and Continuity of Care	CO Quality Strategy pg 17
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	Contract § 2.5.4
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP	Contract § 2.5.4.1

§438.208(b)(4)	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	Contract § 2.5.5.2
§438.208(b)(6)	Protect enrollee privacy when coordinating care	Contract § 2.5.4.1
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	Contract § 2.5.5.3
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	Contract§§ 2.5.5.3, 2.5.5.4
§438.208(c)(3)	If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards	Contract § 2.5.5
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	Contract § 2.5.5.4
§438.210	Coverage and Authorization of Services	CO Quality Strategy pg 17
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	Contract § 2.4, Exhibit D
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	Contract § 2.4.1.2
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	Contract § 2.4.1.1
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	Contract § 2.4.1.3
§438.210(a)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	Contract § 2.4.2.1
§438.210(a)(5)	Specify what constitutes “medically necessary services”	Contract § 2.4, Exhibit D
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	Contract § 2.2.3
§438.210(b)(2)(i)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	Contract § 2.6.1.2
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	Contract § 2.6.1.5

§438.210(c)	Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	Contract § 2.6.1.2
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	Contract §§ 2.6.1.1, 2.6.1.2
§438.210(e)	Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	Contract §§ 2.6.1.1, 3.2.4.1
§438.214	Provider Selection	CO Quality Strategy pg 17
§438.214(a)	Written policies and procedures for selection and retention of providers	Contract§ 3.2.1.1
§438.214(b)(1)	Uniform credentialing and re-credentialing policy that each MCO/PIHP must follow	Contract§ 3.2.1.2
§438.214(b)(2)	Documented process for credentialing and re-credentialing that each MCO/PIHP must follow	Contract § 3.2.1.3
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	Contract § 3.2.1.6
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	Contract§ 3.2.5.13.1
§438.10	Enrollee Information	CO Quality Strategy pg 18
§438.10	Incorporate the requirements of §438.10	Contract Exhibit F: Member Handbook
§438.224	Confidentiality	CO Quality Strategy pg 18
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	Contract § 3.1.1.6.1
§438.56	Enrollment and Disenrollment	CO Quality Strategy pg 18
§438.56	Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitation in §438.56	Contract § 2.3.2-2.3.5.10.2
§438.228	Grievance Systems	CO Quality Strategy pg 18
§438.228(a)	Grievance system meets the requirements of Part 438, subpart F	Contract § 3.1.1.5
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	Contract § 3.1, Exhibit J
§438.230	Subcontractual Relationships and Delegation	CO Quality Strategy pg 18

§438.230(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	Contract § 2.2.1
§438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	Contract § 2.2.1
§438.230(b)(2)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate	Contract § 2.2.2
§438.230(c)(3)(1)	Monitoring of subcontractor performance on an ongoing basis	Contract § 2.2.3
§438.230(c)(1)(iii)	Corrective action for identified deficiencies or areas for improvement	Contract § 2.2.4
§438.236	Practice Guidelines	CO Quality Strategy pg 19
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	Contract §§ 2.7.2.1.2-2.7.2.1.4
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees	Contract §§ 2.7.2.13
§438.330	Quality Assessment and Performance	CO Quality Strategy pg 19
§438.330(a)(1)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement	Contract §§ 2.7.2.2.1-2.7.2.2.4
§438.330(a)	Each MCO and PIHP must conduct PIPs and measure and report to the state its performance List out PIPs in the quality strategy (See CO Quality Strategy pg 20)	Contract § 2.7.2.2.3 CO Quality Strategy pg 20
§438.330(a)(3)	Each MCO and PIHP must measure and report performance measurement data as specified by the state List out performance measures in the quality strategy (See CO Quality Strategy pg 20-21)	Contract § 2.7.2.3 CO Quality Strategy pg 20-21
§438.330(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	Contract § 2.7.2.5.1

§438.330(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs	Contract §§ 2.5.5.3, 2.5.5.4
§438.330(e)	Annual review by the state of each quality assessment and performance improvement program If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.	Contract §§ 2.7.2.8.1
§438.242	Health Information Systems	CO Quality Strategy pg 20
§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 dis-enrollments for other than loss of Medicaid eligibility	Contract§ 2.7.21.1
§438.242(b)(2)	Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	Contract § 2.7.2.11.2
§438.240(b)(3)	Each MCO and PIHP must ensure data received is accurate and complete	Contract § 4.4.1