

Rule 8.079 Quality Improvement

8.079.1 Definitions

Incentive payment means an annual payment made to PIHP contractors based on performance measures agreed upon by the Department and the contracted entity. The criteria for the incentive payment must meet all state and federal statutes and regulations.

Managed Care Organization (MCO) means, for purposes of Section 8.079, any person, public or private institution, agency or business concern with which the Department does business pursuant to a capitated reimbursement contract.

Prepaid Inpatient Health Plan (PIHP) means an entity that- (1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.

Provider means a Provider, as defined in [8.050.1.4](#).

Pre-paid Ambulatory Health Plan (PAHP) means any entity that provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates.

Primary Care Case Manager (PCCM) a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries.

8.079.2 External Quality Review (EQR)

Providers, PCCM, PAHP, PIHP and Managed Care Organizations shall comply with annual EQR and non-EQR activities. EQR may include, but is not limited to the following activities:

1. Performance improvement projects.
2. Performance improvement project validation.
3. Performance improvement measurement.
4. Performance improvement measurement validation.
5. Consumer satisfaction survey.
6. Medical record review.
7. Review of individual cases.
8. PCPP credentialing and recredentialing.
9. On-site visits to monitor for compliance with federal, State, and contractual healthcare regulations.

8.079.3 Monitoring and Review

8.079.3.A All Providers, PCCM, PAHP, PIHP and Managed Care Organization shall comply with the efforts of the Department, its designees, any investigative entity, or the Medicaid Fraud Control Unit to monitor performance through site visits, reviews, desk audits, emergency site visits, profiling, compliance reporting requirements and other quality and program integrity review activities. Monitoring activities shall be conducted for the purpose of determining compliance with state and federal requirements, contracts or Provider agreements, Medicaid service provision and billing procedures, and/or Medicaid Bulletins and Provider Manuals.

1. PCCMs; PAHP; PIHP and MCOs shall be subject to annual site visit to determine compliance with established standards. The annual site visit process shall consist of a desk audit component and an onsite visit. Entities and/or its subcontractors shall, upon request, provide and make available staff to assist in the audit or inspection efforts and provide adequate space on the premises to reasonably accommodate review personnel.
2. Providers – Providers shall be subject to the compliance monitoring provisions of [8.076.2](#).
3. The Department reserves the right to deem other State agencies or private accreditation organizations approved reviews to constitute compliance with specific contractual obligations or regulatory requirements.
4. The Department may delegate monitoring activities.
5. The Department may conduct emergency site visits when the Department has concerns about patient safety, quality of care (QOC), fraud, abuse, or Provider financial failure.
6. **The Department may require additional surveys and review activities as determined.**

8.079.4 Quality Based Incentive Payments For Contracts

Performance measures eligible for incentive payment may include but are not limited to measures of quality and effectiveness of care, including process and outcomes; client satisfaction; use of services; and care outcomes; with the intent to provide incentive for delivering the highest quality care with the best outcomes at the best value for Colorado Medicaid and CHP+ clients enrolled in an MCO, PIHP, PAHP, or PCCM plan. Measures shall be credible, comparable and actionable for the purpose of the incentive program.

8.079.4.A. Such performance measures may include but are not limited to:

1. Healthcare Effectiveness Data and Information Set (HEDIS) measures;
2. Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures;
3. In-patient hospitalizations for ambulatory sensitive conditions such as: urinary tract infections, immunization preventable disease in pediatric clients, asthma, etc.
4. Standardized Clinical Quality Measures such as readmissions or National Quality Forum (NQF) measurements or Federal standards required under Early Periodic Screening Diagnostic and Treatment (EPSDT).
5. Behavioral Health Organizations' penetration rates for both children and adults by region;
6. Other measures related to quality of care, such as the CMS Early Periodic Screening Diagnostic and Treatment 416 reporting tool, use of services and care outcomes.

8.079.4.B. In order to be eligible for any incentive payments, contractors must meet minimum performance measure criteria determined by the Department. Minimum performance criteria shall include minimum national percentile benchmarks for specific measures, and/or alternate minimum standards for non-HEDIS measures, as determined by the Department and agreed upon by the contractor at the outset of the contract period.

8.079.4.C. Performance measures and minimum performance criteria shall be agreed upon at the outset of the contract period and may vary by agreement at the discretion of the Department to reflect differences in contract type or model (e.g., BHO vs Health Plan, network vs. group/staff system, risk vs. non-risk), as well as targeted performance improvement or maintenance objectives.

8.079.4.D Provision of any incentive payment is contingent upon the continuing availability of state funds for the purpose thereof.

8.079.5 Corrective Action Plans (CAPs)

8.079.5.1 Corrective action plans may be required when plans are not meeting rules.

8.079.5.2 Corrective action plans must include data analysis, program analysis, corrective actions, implementation, and monitoring and evaluation.

8.079.5. Corrective action plans must be approved by the department.