State of Colorado

Department of Health Care Policy and Financing

Quality Assessment and Improvement Strategy

August 2003

HSAG
HEALTH SERVICES ADVISORY GROUP

QUALITY ASSESSMENT AND IMPROVEMENT STRATEGY

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II. Background

This section provides background information on the Quality Strategy monitoring and improvement elements as required by the Balanced Budget Act (BBA) of 1997, and references the appropriate sections in this document that provide further details regarding implementation of the requirements by the Department.

In 1997, the BBA 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) 438.200 requires the Department to implement a quality assessment and improvement strategy for the Medicaid managed care population. It sets forth specifications for quality assessment and performance improvement strategies that the Department must develop to do so. It also establishes standards that the Department and MCOs/ASOs must meet.

The Quality Strategy is a coordinated, comprehensive, and on-going effort to monitor, assess, and improve the performance of all care and services provided through the contracted MCOs/ASOs and primary care case managers. This Quality Strategy incorporates improvement measurement and activities that are provided by other Departments. These activities are integrated into a single Quality Strategy, which applies throughout the Colorado Medicaid managed care service area. The Department oversees the Quality Strategy to verify that the performance of quality improvement functions is timely, constant, and effective.

The Quality Strategy is designed to ensure that services provided to Medicaid members meet established standards for access to care, clinical quality of care, and quality of service; to identify, and document issues related to those standards; and to verify that appropriate corrective actions are taken to address those issues.

Department Responsibilities

The Quality Strategy is designed to fulfill the following Department responsibilities as outlined in the regulations. In contracting with MCOs/ASOs, the Department must:

a. Have a strategy for assessing and improving the quality of managed care services offered by all MCOs/ASOs.

b. Document the strategy in writing.

c. Provide for the input of members and other stakeholders in the development of the strategy, including making the strategy available for public comment before adopting it in final.

d. Ensure compliance with standards established by the Department.

e. Conduct periodic reviews to evaluate the effectiveness of the strategy, and update the strategy as often as the Department considers appropriate, but at least every three years.

f. Submit to CMS the following:
   - A copy of the initial strategy, and a copy of the revised strategy, whenever significant changes are made.
   - Regular reports on the implementation and effectiveness of the strategy, at least every three years.

Quality Strategy Elements

The Quality Strategy must address or include, at a minimum, information relating to the following issues (the references in parentheses crosswalk to the appropriate sections in this document where the required information is located):

a. The MCO/ASO contract provisions that incorporate the standards specified in 42 CFR. (Refer to Sections X, XI, and XII of this Quality Strategy document for details).

b. Procedures that:

- Assess the quality and appropriateness of care and services furnished to all Medicaid members under the MCO/ASO contracts, and to individuals with special health care needs. (Refer to Section X of this Quality Strategy document for details.)
- Identify the race, ethnicity, and primary language spoken of each Medicaid member.
- Require the Department to supply this information to providers for each Medicaid member at the time of enrollment. (Refer to Section IX of this Quality Strategy document for details.)
- Regularly monitor and evaluate the compliance with the standards. (Refer to Section XI of this Quality Strategy document for details.)

c. For MCOs/ASOs, any national performance measures and levels that may be identified and developed by CMS in consultation with the Department and other relevant stakeholders. (Note: At this time, no performance measures have been developed by CMS.)

d. Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each contract. (Refer to Quality Improvement Activities in Section XIV of this Quality Strategy document for details.)

e. For MCOs/ASOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of 42 CFR 438. (Refer to Section XIII of this Quality Strategy document for details.)

f. An information system that supports initial and ongoing operation and review of the Department's Quality Strategy. (Refer to Section XII of this Quality Strategy document).

g. Standards, at least as stringent as those in 42 CFR for access to care, structure and operations, and quality measurement and improvement. (Refer to Sections X, XI, and XII of this Quality Strategy document for details.)

III. Scope

This section establishes the scope of work encompassed by the current Department Quality Strategy program, and defines "significant changes" that will trigger stakeholder input.

The Department currently contracts with two MCOs/ASOs and administers a Primary Care Physician's Program (PCPP), also known as a Primary Care Case Management (PCCM) program, with a targeted geographical service area comprising 63 counties, 11 of which are considered urban, 29 of which are considered rural, and 23 of which are considered frontier (less than 6 people per square mile). The two MCOs/ASOs, along with the providers in the PCCM program, manage and coordinate care for more than 286,600 Medicaid members.

The following are encompassed within the scope of the Quality Strategy:

1. All Medicaid managed care and case managed members, included in all demographic groups and in all service areas for which the MCOs/ASOs and primary care case managers are approved to provide Medicaid services.
2. All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by the Colorado Medicaid Managed Care program.
3. All aspects of MCO/ASO performance relating to access to care, quality of care, and quality of service—including network contracting and credentialing, medical recordkeeping practices, environmental safety and health, health management, and health promotion.
4. All services covered—including inpatient hospital services; outpatient hospital services; Federally Qualified Health Clinic (FQHC) services; Rural Health Clinic (RHC) services; other laboratory and x-ray services; skilled nursing facility (SNF) services; Early Periodic Screening, Diagnosis and Treatment (EPSDT) services; family planning services; physician services; home health services; emergency services; substance abuse services; anesthesia services; vision services; ambulance services; outpatient rehabilitation services; pharmaceutical services; maternal support services; outpatient mental health visits (wraparound fee-for-service).
5. All professional and institutional care in all settings, including inpatient, outpatient, home settings, and dialysis centers.
6. All providers and any other delegated or subcontracted provider type.
7. All aspects of MCO/ASO internal administrative processes which are related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information service, and quality improvement.

This Quality Strategy is comprehensive, systematic, and continuous. It will be amended to reflect changes in scope and identified needs. Significant changes to the Quality Strategy that will require input from members and stakeholders are defined as:

- Any change to the Quality Strategy resulting from legislated, state, federal, or other regulatory authority.
- Any change in membership demographics of 50 percent or greater within one year.
- Any change in the provider network of 50 percent or greater within one year.

IV. Quality Strategy Description

This section describes the formal process the Department uses to obtain beneficiary and stakeholder input and public comment on the Quality Strategy before final adoption, as well as how and how often the Department will update the Quality Strategy based on periodic review of its effectiveness.

The Quality Strategy formulation process is multi-disciplinary, with collaboration among public health representatives, identified stakeholders, and the public. The Quality Strategy will be developed in two parts: an overriding conceptual program and an annual Work Plan.

The Medicaid Advisory Committee-Disabilities (MAC-D), Colorado Department of Public Health and Environment (CDPHE), Colorado Department of Human Services (CDHS), Department of Human Services Mental Health Services (DHSMHS), Primary Care Physician Program (PCPP) Focus Group, MCO/ASO Medical Directors, and QI staff have been identified as stakeholders in the development of the Department's Quality Strategy as have Medicaid members from each plan. A minimum of one Medicaid member from each plan will be identified and confirmed as participants in the stakeholders' meeting. In addition, each plan is required to confirm participation of at least two network providers. These providers should be clinicians rather than administrators and may be primary care providers or other specialists from the following fields: Pediatrics, Internal Medicine, Family Practice, General Practice, and Obstetrics/Gynecology. Each plan's Medical Director and Quality Director are invited to participate in the stakeholders' meeting. No later than 14 days prior to the scheduled meeting date, each MCO/ASO provides stakeholder participant contact information to the Department's Quality Improvement Section Manager:

Laurel Karabatsos, Manager, Quality Improvement Section
Department of Health Care Policy & Financing
1570 Grant Street, Denver, CO 80203
Telephone: 303-866-6320

At the same time, the Department will post the Quality Strategy on the Department Web site and provide public notice so as to afford the public an opportunity to comment before final adoption.

Subsequent to the public notice and stakeholders' meeting, the proposed Quality Strategy will be provided to the Centers for Medicare & Medicaid Services (CMS) for approval no later than August 13, 2003. The finalized Quality Strategy will become effective on August 13, 2003, and will be reviewed by the Department at least quarterly, as a standing agenda item, during regularly scheduled MCO/ASO meetings and teleconferences. The Department, in turn, will provide periodic updates to CMS with regard to the status of the Department's Quality Strategy and will provide CMS with written revisions to the Quality Strategy whenever significant revisions are made. The program is reviewed and evaluated annually, or more often, as additional information becomes available.

V. Colorado Medicaid Managed Care Quality Mission

This section reviews the Colorado Medicaid Managed Care Quality Mission and goals, and sets the priorities within which the Quality Strategy program operates.

Colorado's Department of Health Care Policy and Financing strives for a healthier Colorado. To that end, the overall mission of the Department is to purchase cost-effective health care for qualified, low-income Coloradoans. The Colorado Medicaid Program, administered by the Department, utilizes a multi-faceted approach to improving the care of its Medicaid members through the coordination of quality initiatives meaningful to Colorado's Medicaid population.

The objectives of the Department are to provide comprehensive health care services to Colorado Medicaid members while improving access to quality care services, controlling escalating costs, averting unnecessary utilization, and diminishing inappropriate use of services.

Goals of the Department

The Department has built a strategic plan based on the stated goals of CMS. In order to be compatible with the federal goals, the Department will:

1. Evaluate cost control mechanisms now operating in its programs to ascertain if it is getting the maximum value and cost benefit.
2. Avail itself of opportunities and resources to further the goal of improved health status of vulnerable Coloradoans while achieving cost effectiveness.
3. Evaluate member health and satisfaction; and will model program design and purchase of service decisions in such a way to promote improved care delivery.
4. Maximize resources available for purchasing or financing health care and related services.
5. Value its human assets through effective recruitment, hiring, and retention.

VI. Quality Strategy Purposes

This section defines the overall and specific purposes of the Quality Strategy in relation to the activities required by the BBA. The Department's overall purposes of the Quality Strategy are:

- To define and implement strategies for assessing and improving the quality of managed care services provided by Medicaid MCOs/ASOs and PCCMs.
- To promote opportunities for partnerships with public and private entities involved in quality improvement efforts.

The specific purposes of the Quality Strategy are to:

1. Provide direction and guidance for all staff in the pursuit of the Quality Strategy goals.
2. Provide guidance for determination of activities for the special health care needs populations.
3. Provide guidance to identify race, ethnicity, and primary languages spoken.
4. Assure an information system is in place that will support the efforts of the Quality Strategy.
5. Establish and maintain standards for quality of care, access to care, and quality of service.
6. Verify that services provided to Medicaid members conform to professionally recognized standards of practice and code of ethics.
7. Provide Medicaid members a means by which they may seek resolutions of perceived failure by providers or personnel to provide appropriate health care services, access to care, or quality of care.
8. Establish, maintain, and enforce a policy regarding public review, input, and feedback on Quality Strategy activities.
9. Establish, maintain, and enforce a policy for protection of confidential member and provider information.

VII. Goals and Objectives of the Quality Strategy

This section clarifies the goals and objectives of the Quality Strategy in terms of outcomes, continuous quality improvement, collaboration (strategic partnerships), and systematic monitoring.

Goals

1. Consistent application of professionally recognized standards of care and code of ethics.
2. Continuous improvement in the health status of Medicaid members.
3. Improved quality of care.
4. Improved quality of services.
5. Improved access to care and services.
6. Improved member satisfaction.
7. Improved provider satisfaction.

Improvement Objectives

1. Identify and pursue opportunities for improving the health status of the enrolled population through preventive care services, chronic disease and special needs management, and health promotion.
2. Identify, review, monitor, and pursue opportunities to resolve all quality of care problems that directly or indirectly affect member care, and implement actions to prevent the recurrence of such problems.
3. Identify and pursue opportunities for improving quality of service.
4. Identify and pursue opportunities for improving accessibility of care and member satisfaction with care and service.
5. Evaluate the Quality Strategy annually and modify it as necessary to achieve effectiveness.

Collaboration Objectives

1. Identify and pursue opportunities to partner with public health entities and integrate common goals into the Quality Strategy.
2. Implement a multi-disciplinary approach to provide systematized, collaborative processes to improve Medicaid members' health, involving the public, provider stakeholders, member advocates, and outside partners who have a direct concern and impact on access, quality of care, and quality of service.

Systematic Monitoring Objectives

1. Implement a systematic method for monitoring and evaluating providers' performance against established standards for quality, accessibility, and appropriateness of clinical care.
2. Monitor performance of providers in promoting and providing quality of care, access to care, and service activities, through the use of performance monitors, member satisfaction reports, performance improvement projects and studies, and analysis of administrative data.

3. Monitor Medicaid members' satisfaction with their care, accessibility of care, and service. (See Work Plan Table 53 for details.)
4. Address all functional areas of delivery systems that directly affect quality of care, access to care, and quality of service including, but not limited to, the following: utilization review, case management, medical management, marketing, member services, preventive services, pharmacy, mental health, credentialing, health education, provider development, and information technology activities involved in the monitoring. Section XI of this Quality Strategy document discusses the relevant contract provisions that are required for compliance during an annual on-site review.
5. Prioritize monitoring activities for each of the areas listed based upon the population served and the most recent monitoring findings, and at the direction of the Department and the stakeholders.
6. Monitor compliance with regulatory requirements of other appropriate Department and federal agencies with respect to quality improvement requirements.
7. Monitor to assure that qualified practitioners are included in the networks. Monitor the established mechanisms for credentials review of network providers.
8. Monitor to assure contracts between the MCOs/ASOs and their delivery networks meet the minimum qualifications to assure compliance with benefits delivery and operations.

VIII. Quality Strategy Functions and Activities

This section delineates the functions and activities planned to carry out the Quality Strategy program, and designates responsible parties. Table 1 demonstrates responsibility for the described functions and activities.

Table 1—Responsibility for Functions and Activities

Functions and Activities	Responsibilities	
	MCO/ ASO	The Department
1. Perform performance improvement and related activities, with emphasis on children's and adolescent care, women's care, chronic illness care, and care of Medicaid members with special needs.	✓	✓
2. Perform and/or monitor member satisfaction surveys and take action, where appropriate, to improve satisfaction.	✓	✓
3. Receive, investigate, and resolve member appeals and grievances as related to access to care, quality of care, and service issues.	✓	✓
4. Monitor and evaluate covered health care services rendered to Medicaid members through the use of audits, data collection, performance improvement activities, and outcomes assessments.	✓	✓
5. Conduct contract compliance reviews of MCOs/ASOs for structure and operational compliance with the standards.		✓
6. Review a sample of network providers' member medical records to achieve compliance with standards for medical record-keeping practices, continuity of care, health promotion, health management, preventive services, and other aspects of care.		✓
7. Identify instances of potential quality issues. Review and resolve potential quality issues as appropriate.	✓	✓
8. Review utilization review activities to ensure that these activities do not have a negative impact on quality of care.	✓	✓
9. Review the credentialing activities of the MCOs/ASOs and their subcontractors and providers.		✓
10. Review MCOs'/ASOs' internal practices regarding the handling of medical record information to achieve compliance with confidentiality policies and member rights.		✓
11. Review MCOs'/ASOs' quality improvement activities to achieve compliance with the requirements of the MCO/ASO contract.		✓
12. Conduct an annual evaluation of the Quality Strategy activities and effectiveness and report to CMS, stakeholders, and other interested public groups.		✓
13. Prepare an annual Quality Strategy Work Plan describing the activities to be undertaken in the upcoming year.	✓	✓
14. Make modifications to the conceptual Quality Strategy as needed.		✓

IX. Quality Strategy Tactics

This section summarizes the tactics identified to achieve the Quality Strategy monitoring and improvement objectives. Specific tactics to achieve the goals and objectives for 2003–2004 include the following:

1. **Support and maintain an information system compatible with established standards.**
   - The Department will continue to utilize the information system and established eligibility processes to collect and identify race, ethnicity and primary language spoken and report this information to contracted MCOs/ASOs.
   - The Department will work with the Colorado Benefits Management System (CBMS) project manager to determine how the upcoming eligibility information system changes may enhance the process used to collect race, ethnicity and primary language spoken information.
   - After the new system is reviewed, assessed, and strengths and weaknesses are identified, the Department will develop action steps to enhance the process for collecting race, ethnicity and primary language spoken information.

2. **Monitor pediatric and adolescent care services and develop action plans for Quality Strategy when indicated.**

   The Department will use the Health Plan Employer Data and Information Set (HEDIS®) and other methodologies to monitor rates of the pediatric and adolescent care services provided to Colorado Medicaid members annually. Contract year 2003–2004 will be the third year of monitoring childhood immunizations for the Government Performance and Results Act (GPRA) Project. The certified audits of the HEDIS measures are followed by corrective action plans when appropriate. Results of the 2002 *Adolescent Well Care Qualitative Study* will also be used to evaluate feasibility of interventions regarding access to care for adolescents, adolescent appropriate quality services, coordination of services, and adolescent participation. Other measurements may be necessary for data compilation and measurement in specific areas. See Work Plan Tables 46 through 48 for details.

3. **Monitor Women's Care Services and develop action plans for Quality Strategy when indicated.**

   The Department will use HEDIS and other methodologies to monitor the rates of women's care that its Medicaid members receive annually. The measures are trended against previous years' data and may lead to further improvement projects with corrective action as appropriate. See Work Plan Table 49 for details.

4. **Develop and implement interventions in the Living with Illness and Pediatric Care Services dimensions. The following conditions have been selected as Performance Improvement Projects:**
   - Diabetes Quality of Care
   - Well-Child Visits

The Department and the MCOs/ASOs/PCCMs will use recommendations from the 2002 focused study, *Diabetes Quality of Care*, to improve the levels of care provided to members with chronic illness. The *Diabetes Quality of Care* study ranges across a wide group, which is representative of Colorado's Medicaid Managed Care population demographics and epidemiology. The diabetes interventions may be continuations of studies that were underway. See Work Plan Table 51 for details.

In addition to these performance improvement projects, the Living with Illness dimension will also track measures for Medicaid members with cardiovascular disease. See Work Plan Table 51 for details.

The monitoring measures referred to in Tactics numbers 2, 3, and 4 above are divided into four different dimensions of care: Pediatric and Adolescent Care, Women's Care, Living With Illness, and Living with Disabilities. These dimensions comprise important groupings and reflect the dimensions model used by the Foundation for Accountability (FACCT). This approach to the monitoring is designed to encourage consideration of the quality measures as a whole rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance. See Work Plan Tables 46 through 49 and Tables 51 and 52.

5. **Track performance monitoring standards and provider reporting related to member complaints, member satisfaction, claims payment, and encounter data and develop action plans for Quality Strategy when indicated.**

   The Department will monitor member complaints and appeals to assure members are receiving benefits based upon the Medicaid managed care services offered and rendered within quality parameters. See Work Plan Tables 53 and 54 for details.

   The Department will monitor claims reporting to assure health plans are compliant with statutory requirements for payment of clean claims within 45 days in order to maintain provider satisfaction.

   The Department will monitor encounter data for timely and complete submission. Encounter data, based on service dates from a 12-month interval, shall be submitted to the Department on January 15 and July 15. See Work Plan Table 54 for details.

   Encounter data submitted to the Department shall include the following categories: Early Periodic Screening, Diagnosis, and Treatment; inpatient hospital; outpatient hospital; medical group practices/clinics; physicians, non-physician practitioners; medical equipment; ambulatory surgical centers; family planning clinics; independent laboratories; optometrists; podiatrists; home health; dialysis centers; Federally Qualified Health Centers (FQHCs); freestanding rehabilitation centers, pharmacies; and skilled nursing facilities.

6. **Conduct annual contract structure and operations compliance audits to determine the MCO's/ASO's compliance with the standards set forth in the agreement between the Department and the contractors.**

   The site review process consists of a desk audit and an on-site visit to each MCO/ASO. Plans are required to submit material 30 days prior to the on-site review. Once submitted, material is reviewed and the Department staff members generate specific questions. To the extent possible, questions are shared with the plans prior to the on-site visits. At the time of the on-site visit, MCO/ASO staff members are interviewed and chart reviews are performed. Participating

providers may be contacted to assess how well the MCO/ASO has conveyed contractual requirements to its network providers.

Deficiencies noted by the Department during the site review process result in required actions that necessitate a corrective action plan by the MCOs/ASOs. The Department reviews the corrective action plan to ensure that the corrective action meets the required action and is within a reasonable timeframe. All required actions are monitored until contract compliance is obtained by the MCO/ASO. Section XI of this Quality Strategy document discusses relevant contract provisions that are reviewed by the Department during an annual on-site review.

The Site Review Focus Areas are as follows:

- Member Handbook and Welcome Packet
- Utilization Management (as part of Pharmacy Services)
- Access to Services, Geographic Access, 24-hour Availability of Services, Scheduling and Wait Times, Provider Network Report, and Selection and Assignment of Primary Care Providers
- Children with Special Health Care Needs (CSHCN) and Accommodations of Enrolled Populations with Special Health Care Needs
- Cultural And Linguistic Competency And Requirements for Accommodations Due to Physical and Communication Barriers
- Member Services, Complaints, and Confidentiality
- General Organizational Structure and Accountability
- Enrollment and Disenrollment
- Third Party Payer Liability
- Fraud Referrals
- Pharmacy (reviewed under Utilization Management)
- Wraparound Benefits
- Coordination and Continuity of Care
- Coordination with EPSDT Program
- Quality Assessments and Performance Improvement

7. Conduct periodic surveys of member access to health care services.

Annual Consumer Assessment of Health Plans (CAHPS®) surveys or other member satisfaction surveys that include questions regarding members' experience with health care services are used by the Department to monitor member perception of access to care. Selected CAHPS® indicators, which will be evaluated through the survey, include Getting Needed Care, Getting Care Quickly, Customer Service, Referral to Specialist, and Overall Rating of Health Plan. (Refer to Work Plan Table 54).

8. **MCO/ASO/PCCM profiling will be conducted annually through member report cards based upon a combination of all measures, audits, and studies.**

9. **An intermediate sanction system will be further developed based upon the results of profiling.** Refer to Section XIII of this Quality Strategy document for details.

10. **The Annual Quality Assessment and Improvement Evaluation will be conducted for the previous fiscal year following receipt of the Quality Improvement Plans.** The annual Work Plan will be built from the Evaluation.

X. Contract Provisions and Department Standards for Access to Care

This section outlines and discusses the contract provisions that must be met by contracted MCOs/ASOs regarding Department standards for access to care and services, including availability of services; assurances of adequate capacity and services; coordination and continuity of care; and coverage and authorization of services. It also addresses identification of persons with special care needs, and treatment plans for persons with special care needs.

Availability of Services

The Department has implemented programs and processes to monitor and assure that members' access to care is not restricted. Contracts with MCOs/ASOs contain provisions that incorporate access and availability standards and protocols. In addition, contracted MCOs/ASOs are required to comply with access requirements outlined in Title 10, Colorado Revised Statutes (C.R.S.) and Managed Care Regulation 42 CFR.

MCO/ASO contracts stipulate that the contractor shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the residence of members so as not to result in unreasonable barriers to access and to promote continuity of care, taking into account the usual means of transportation ordinarily used by members. The contractor shall have providers located throughout the contractor's service area within 30 miles or 30 minutes travel time to the extent such services are available. Network hospitals must be within 45 miles of the member's primary residence for both metropolitan and non-metropolitan areas.

MCO/ASO contracts also state that female members must be provided with direct access to a woman's health specialist within the contracted MCO's/ASO's network for covered routine and preventive health care services. When a second opinion is necessary, contracted MCOs/ASOs must provide for one with a contracted qualified health care professional or arrange for one outside the network.

When covered services are not available from contracted MCO/ASO providers, the contract requires the MCO/ASO to provide adequate and timely services out of network, and coordinate payment with the out-of-network provider.

MCOs/ASOs are required by contract to verify that all participating providers meet licensing and certification requirements through a formal credentialing program that complies with the standards of the National Committee for Quality Assurance (NCQA) for initial credentialing and recredentialing of providers. All MCO/ASO contracted laboratory testing sites are required to have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

Department contracts stipulate that contracted MCOs/ASOs are required to have policies and procedures for ensuring access to appropriate services 24 hours per day, 7 days per week for all members including members with disabilities and special health care needs. In addition, non-urgent health care must be scheduled within 2 weeks; urgent care must be scheduled within 48 hours of PCP or MCO/ASO notification; and adult, non-symptomatic, routine physical exams must be scheduled within four months.

The Department has detailed contract requirements for MCOs/ASOs to facilitate the provision of culturally and linguistically appropriate care to members. MCO/ASO policies and procedures must reach out to specific cultural and ethnic members and respect individual attitudes, beliefs, customs, and practices. Translation of MCO/ASO member materials into languages spoken by prevalent

non-English speaking member populations is also contractually required. Policies and procedures for the provision of interpreter services is required, as well as TDD for members with a hearing impairment. For members with visual impairments, materials are required to be in Braille, large print, or audiotapes.

Assurance of Adequate Capacity and Services

To ensure an appropriate network of providers that is sufficient to provide adequate access to all covered services, the Department requires contracted MCOs/ASOs to maintain specific caseload ratios for participating Primary Care Physicians (PCPs), provider specialists, and obstetrics and gynecology (OB/GYN) providers. Member to provider ratios for PCPs and specialists must be 1:2000; for OB/GYNs they must be 1:1600.

MCO/ASO primary care providers must include Family Medicine, General Practitioners, Internal Medicine, and Pediatrics. Specialist providers must include Cardiology, Otolaryngology/ENT, Endocrinology, Gastroenterology, Neurology, Orthopedics, Pulmonary, General Surgery, Ophthalmology, and Urology. OB/GYN includes OB/GYN providers and providers in a clinic or practice setting that provide specialty obstetric and/or gynecological services.

Prior to expanding into a new service area or expanding the eligibility categories served, the contracted MCO/ASO must complete and provide the Department with a service plan analysis which includes the proposed county or counties for expansion of categories of populations to be served, and an analysis of the capability of its provider network to adequately serve its expanded membership.

In addition, each contracted MCO/ASO is required to submit to the Department a detailed written report of the MCO's/ASO's network adequacy within 10 business days following the close of each quarter. At a minimum, this report must include:

- Anticipated enrollment;
- Actual and expected health care utilization;
- Number of network providers by service area;
- Number of network providers not accepting new members;
- Calculated distance for members to travel from their primary residence to PCPs, specialists, and hospitals;
- Calculated caseload ratios for PCPs, specialists, and OB/GYN providers in each service area;
- Types of transportation that members ordinarily use for each service area; and
- Number of providers with physical access for members with disabilities for each service area.

Coordination and Continuity of Care

MCO/ASO contracts specify that members shall select their PCP, but if the member does not select a PCP, the MCO/ASO must select one for the member and notify the member of the PCP's name, location, and office telephone number. Contracted MCOs/ASOs are also required to have written policies and procedures for timely coordination of the provision of all covered services to their members. The MCO/ASO must also develop and implement policies and procedures for ensuring

member access to EPSDT benefits even when they are not a covered benefit under the MCO's/ASO's contract with the Department.

Contracted MCOs/ASOs are required to establish and maintain policies and procedures to coordinate health care services for members with special health care needs with other agencies (e.g., mental health and substance abuse, public health, transportation, home and community-based care, developmental disabilities, local school districts, child welfare, Individuals with Disabilities Education Act (IDEA) programs, Title V, families, caregivers, and advocates).

MCO/ASO contracts clearly specify that the confidentiality of all member records and other materials, in any form, including electronic shall be protected. The contracts also require that, except for purposes directly connected with the administration of the Medicaid program, MCOs/ASOs may not disclose information about or obtained from any member in a form identifiable with the member without the prior written consent of the member or a minor's parent or guardian. An exception to this would be the disclosure of information in summary, statistical, or other form that does not identify particular individuals.

MCOs/ASOs contracted with the Department must have procedures and the capacity to implement the provision of individual needs assessment after enrollment and any other time, in order to assess the existence of special health care needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems).

Contracts also stipulate that MCOs/ASOs develop and implement mechanisms to assess each member identified as having special health care needs to detect any ongoing special conditions that require a course of treatment or regular care monitoring. The MCO/ASO must also use appropriate health care professionals to perform the assessment. Following completion of the needs assessment, MCOs/ASOs are required to develop an individual treatment plan based on the results of the assessment. The treatment plan must include treatment objectives, ensure treatment follow-up, monitor outcomes, and be revised as necessary.

MCOs/ASOs are required to allow members with special health care needs, who use specialists frequently for their health care, to maintain these types of specialists as PCPs, or be allowed direct access/standing referral to specialists for the needed care.

Coverage and Authorization of Services

The MCO/ASO contract includes a separate attachment, which lists all of the services that an MCO/ASO is required to provide its Medicaid members. All services included on the list must be provided or the MCO/ASO must arrange for them to be provided. The following services are included:

- Inpatient hospital services
- Outpatient hospital services
- Rural Health Clinic (RHC) services
- Federally Qualified Health Clinic (FQHC) Services
- Other laboratory and x-ray services
- Skilled nursing facility (SNF) services
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) services
- Family planning services
- Maternal support services

- Outpatient mental health visits (wrap around fee-for-service)
- Physician services
- Home health services
- Emergency services

MCOs/ASOs are further required to ensure that the services provided are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. In addition, the MCO/ASO must provide the same standard of care for all members regardless of eligibility category, and shall make all covered services to members as accessible in terms of timeliness, amount, duration, and scope as those services are accessible to non-member Medicaid members within the same area.

The MCO/ASO contract clearly states that "Medically Necessary" shall mean as defined in the Department's rules at 10 CCR 2505-10, § 8.205.11 as stated below:

> Medical Necessity - A covered service shall be deemed medically necessary if, in a manner consistent with accepted standards of medical practice, it:
>
> 1. Is found to be an equally effective treatment among other, less conservative, or more costly treatment options, and
> 2. Meets at least one of the following criteria:
>
> a. The service will, or is reasonably expected to, prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability;
>
> b. The service will, or is reasonably expected to cure, correct, reduce, or ameliorate the physical, mental, cognitive, or developmental effects of an illness, injury, or disability;
>
> c. The service will, or is reasonably expected to, reduce or ameliorate the pain or suffering caused by an illness, injury, or disability;
>
> d. The service will, or is reasonably expected to, assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living.
>
> A course of treatment may include mere observation or, where appropriate, no treatment at all.
>
> The MCO/ASO and the member's PCP, in consultation with the member or member's guardian, shall determine the medical necessity of a covered service. In the PCCM, the member's PCP and the review entity designated by the Department, in consultation with the member or member's guardian, shall determine the medical necessity of a covered service.

Contracted MCOs/ASOs are required to follow the Department's rules at 10 CCR 2505-10, §8.079.82, and have policies and procedures to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider when appropriate. MCOs/ASOs are further required to maintain and provide the Department internal documents that demonstrate they are following this requirement.

MCOs/ASOs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. The contract also requires MCOs/ASOs to ensure that a physician familiar with standards of care in Colorado reviews and signs all utilization denials.

XI. MCO/ASO Contract Provisions and Department Standards for Structure and Operations

This section outlines and discusses the contract provisions that must be met by contracted MCOs/ASOs regarding Department standards for structure and operations at the health plan including provider selection, member information, confidentiality, enrollment and disenrollment, grievance systems, and subcontractual relationships.

Provider Selection and Retention

MCOs/ASOs are required to have written policies and procedures governing the selection and retention of providers. All MCO/ASO participating providers must meet licensing and certification requirements through a formal credentialing program that complies with the standards of the NCQA for initial credentialing and recredentialing of providers. Information from the accreditation of primary care clinics by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) may also be used to assist in meeting NCQA credentialing standards. All MCO/ASO contracted laboratory-testing sites are required to have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.

The MCO's/ASO's credentialing program must include policies and procedures for detecting and reporting incidents of questionable practice, in compliance with Colorado Statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards. In addition, MCOs/ASOs are prohibited from discriminating against providers who serve high-risk populations or specialize in conditions that require costly treatment.

Member Information

MCOs/ASOs are contractually required to provide to all members, including new members, a Member Handbook that must include general information about services offered by the MCO/ASO and complete statements concerning member rights and responsibilities within a reasonable time after the MCO/ASO is notified of the member's enrollment.

MCOs/ASOs are also required to provide periodic updates to the Member Handbook, when needed, to explain changes to policies. Prior to printing, the MCO/ASO must submit the updated handbook to the Department for review and approval, at least 30 calendar days prior to the targeted printing date, and notify the member regarding changes in information at least 30 days prior to the change effective date. Minimum requirements for information to be included in the member handbook are listed in Appendix A.

MCOs/ASOs are required to ensure that written information provided to members is, to the extent possible, written at the sixth grade level, unless otherwise directed by the Department, translated into other non-English languages prevalent in the MCO's/ASO's service area, and provided in alternative formats.

MCOs/ASOs must ensure that members understand that enrollment in the MCO/ASO is voluntary, and provide information to members about how to request disenrollment. Members must also be provided sufficient information for them to understand their benefits; how to access covered services including authorization requirements; what benefits may be obtained from out-of-network providers; what constitutes an emergency medical condition; how to access emergency care after hours; the fact that emergency services do not require prior authorization; policies on referrals for specialty care; and any cost sharing requirements.

Confidentiality

Contracted MCOs/ASOs are required to protect the confidentiality of all member records and other materials, in any form, including electronic that are maintained in accordance with their contract with the Department. Except for purposes directly connected with the administration of the Medicaid program, no information about or obtained from any member in possession of the MCO/ASO can be disclosed in a form identifiable with the member without the prior written consent of the member or a minor member's parent or guardian. The exception to this is the disclosure of information in summary, statistical, or other form that does not identify particular individuals. The MCO/ASO is required to have written policies governing access to and duplication/dissemination of all such information. The MCO/ASO must also advise its employees, agents and subcontractors that they are subject to these confidentiality requirements. In addition, MCOs/ASOs must provide its employees, agents, and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

MCOs/ASOs must comply with the requirements of 45 CFR 205.50, as amended, and to Article 16, Title 10 paragraph 423, C.R.S., as amended, and 45 CFR Parts 160 and 164, as amended, and 42 CFR 431.304–431.307, as amended, regarding confidentiality of health information about any member.

Enrollment and Disenrollment

The Department has established a process to enroll and disenroll members, and includes comprehensive enrollment and disenrollment requirements in MCO/ASO contracts. Enrollment requirements cover: the fact that enrollment is voluntary; the MCO's/ASO's obligation to reenroll a member who has been disenrolled due to loss/reinstatement of Medicaid coverage within a 2 month or less period; statements prohibiting the MCO/ASO from discriminating on the basis of race, color, national origin, health status, or need for health services; the 12 month lock-in requirement; readability requirements for written materials; the conditions under which the MCO/ASO may elect to not accept new members (except newborns); enrollment effective date requirements; newborn enrollment requirements; and conditions under which the MCO/ASO may postpone enrollment due to an inpatient hospital stay.

Disenrollment requirements cover: the fact that a member may disenroll within 90 days of enrollment with the MCO/ASO or every 12 months without cause; notification requirements regarding the member's right to disenroll every 12 months; conditions under which a member may disenroll; disenrollment effective date requirements; requirement for postponing disenrollment due to an inpatient hospital stay; and notification requirements when a member moves outside the service area.

The Department also includes in MCO/ASO contracts procedures for verifying Medicaid eligibility and member enrollment, and requirements for the MCO/ASO to provide quarterly reports of enrollment and disenrollment activities to the Department.

Complaints, Grievance, and Appeals

MCOs/ASOs are required to establish an internal complaints process under which a member may challenge the denial of coverage of, or payment for, services in accordance with 42 CFR 434.32, and comply with all requirements of the Department's complaint process specified at 10 CCR 2505-10, §8.209. MCOs/ASOs are further required to use the Department's MCO/ASO complaint data reporting tool to record, track, resolve, and assess members' complaints and appeals. MCOs/ASOs must also use Department defined data elements, sequence order, and response codes to record

complaint and appeal information. The completed data reporting form must be submitted to the Department within 30 calendar days following the end of each quarter, along with a completed Department complaint-reporting questionnaire that provides a written analysis of complaint data.

Department procedures for the review of MCO/ASO grievances and appeals files, and for identifying systematic problems is as follows:

1. The Department shall review a random sample of the MCO's/ASO's grievance and appeal files during the annual site review process.
2. Each file is reviewed to determine whether grievance and appeal regulations have been followed, the appropriateness of the resolution/disposition of the grievance or appeal, and any overall patterns related to the nature/topic of the complaints.
3. The results of each file review are documented on a checklist and the MCO/ASO is given an overall score for compliance in this area.
4. Any systematic problems with the entities grievance and appeal process or patterns of complaints are documented in the Department's final site visit report and a corrective action is required.

Subcontractor Relationships and Delegation

The Department has established requirements for MCO/ASO oversight of subcontractors. MCOs/ASOs are responsible for all work performed under their contract with the Department, including work performed by subcontractors. MCOs/ASOs are required to evaluate the subcontractor's ability to perform delegated activities before entering into a subcontractor relationship, and oversee performance once the subcontract is in place.

A written agreement with each subcontractor must stipulate the activities the MCO/ASO has delegated to the subcontractor and the subcontractor's reporting responsibilities. The written agreement must also include specifications for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

Written oversight policies and procedures, which are subject to Department approval, must include monitoring of covered services for quality, appropriateness, and patient outcomes, and subcontractor compliance with requirements for medical records, data reporting, and other applicable provisions of the MCO's/ASO's contract with the Department. If the MCO/ASO identifies deficiencies or areas for improvement, the MCO/ASO and subcontractor must take corrective action.

XII. Contract Provisions and Department Standards for Quality Measurement and Improvement

This section of the Quality Strategy outlines and discusses the contract provisions that must be met by the MCOs/ASOs regarding Department standards for performance measurement and improvement systems.

Practice Guidelines

The Department has established policies for the development and use of practice guidelines. MCOs/ASOs are required to adopt practice guidelines for perinatal, prenatal and postpartum care; conditions related to persons with a disability or special health care needs; and well-child care. MCOs/ASOs must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; consider the needs of the member; are adopted in consultation with participating providers; and are reviewed and updated annually.

Practice guidelines must be disseminated to all affected providers and, upon request, to members and potential members. The guidelines must be available to the Department and members at no cost. MCOs/ASOs may charge a cost for guidelines to non-members and the public. Decisions regarding utilization management, member education, covered services and other areas to which the guidelines apply must be consistent with the guidelines.

Quality Assessment and Performance Improvement Program

The Department requires MCOs/ASOs to conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and nonclinical care and services that are expected to have a favorable effect on health outcomes and member satisfaction. Performance improvement projects must include:

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

MCOs/ASOs must also conduct performance improvement projects on topics selected by the Centers for Medicare & Medicaid Services (CMS) when the Department is directed to focus on a particular topic.

MCOs/ASOs are required to report the status and results of each performance improvement project in an annual quality report and upon request of the Department. The results of each performance improvement project must be submitted in sufficient detail so that the Department can validate the projects. Performance improvement projects must also be completed in a reasonable time period in order to facilitate the integration of project findings and information into the overall quality assessment and improvement program and to produce new information on quality of care each year.

MCOs/ASOs must implement and maintain mechanisms to assess the quality and appropriateness of care for persons with special health care needs.

MCOs/ASOs are required to implement and maintain a system for detecting the over-utilization and under-utilization of health care services. The system should include MCO/ASO policies and procedures for detecting and addressing the over-utilization and under-utilization of services shall be submitted during the annual site visit process. The Department shall review policies and procedures and request copies of internal reporting on utilization monitoring as well as evidence of how the MCO/ASO manages/corrects problem cases. If the Department identifies that utilization is not being adequately monitored and/or corrected, then the detection of over-utilization and under-utilization will be identified as a required corrective action item. The Department shall approve all corrective action plans to address deficits in detecting and addressing over-utilization and under-utilization of services and monitor the corrective action through completion.

MCOs/ASOs are required to investigate any alleged quality of care concerns, upon request of the Department. A brief but clear description of the issue, the efforts that the MCO/ASO took to investigate the issue, and the outcome of the review must be submitted to the Department. The outcome review must include whether or not the issue was found to be a quality of care issue and what action the MCO/ASO intends to take.

MCOs/ASOs are required to calculate and submit specified HEDIS performance measures. MCOs/ASOs must analyze and respond to results indicated in the HEDIS measures and submit audited HEDIS results to the Department on June 30th of each contract year for the previous reporting year. In addition to HEDIS measures, MCOs/ASOs must calculate additional performance measures as developed and required by CMS. MCOs/ASOs must also monitor member perceptions of accessibility and adequacy of services through the use of member satisfaction surveys, anecdotal information, grievance and appeals data and enrollment and disenrollment information. MCOs/ASOs must develop a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious compliant is reported.

MCOs/ASOs must maintain a process for evaluating the impact and effectiveness of the quality assessment and improvement program on at least an annual basis. An annual report must be submitted to the Department detailing the findings of the program impact analysis. The report shall describes the MCO's/ASO's techniques to improve performance, the outcome of each performance improvement project and the overall impact and effectiveness of the quality assessment and improvement program. The Program Impact Analysis and Annual Report must provide sufficient detail for the Department to validate the MCO's/ASO's performance improvement projects according to 42 CFR parts 433 and 438, External Quality Review of Medicaid Managed Care Organizations.

Quality Monitoring Elements

MCOs/ASOs are required to participate in the annual external independent review of quality outcomes, timeliness of, and access to the services covered under this contract. The external review may include but not be limited to all of any of the following: medical record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators, administrative data analyses and review of individual cases. MCOs/ASOs must also participate in the development and design of any external independent review studies to assess and assure quality of care. Final study specifications are at the discretion of the Department.

Health Information System

The Department has mechanisms in place to ensure that contracting MCOs/ASOs maintain a health information systems that collect, analyze, integrate, and report data, and can achieve the objectives of the Medicaid Program. Systems include data on member enrollment spans, provider characteristics, and services rendered.

The MCOs/ASOs are required to have available a claims processing and management information system sufficient to support provider payments and data reporting between the MCO/ASO and the Department. The MCO/ASO should be capable of controlling, processing, and paying providers for services rendered to MCO/ASO members. The MCO/ASO must collect service-specific procedures and diagnosis data, price specific procedures or encounters (depending on the agreement between the provider and the MCO/ASO), and maintain detailed records of remittances to providers. Data accuracy and completeness is assessed. The baseline assessment tool and on-site audit specifically focus on the accuracy and timeliness of reported data; the completeness, logic, and consistency of the data; and the extent to which the data is collected in standardized formats. The MCO/ASO is required to annually submit Colorado HEDIS-specific reports, according to the most current NCQA specifications and timelines, utilizing Colorado-specific samples of members. Additionally, each MCO/ASO is obligated to contract with an NCQA-certified HEDIS auditing vendor and undergo a full audit of its HEDIS reporting process.

XIII. Intermediate Sanctions

This section describes an intermediate sanction system that will be applied based upon the results of MCO/ASO quality/monitoring activities. It describes how the Department uses intermediate sanctions in support of its Quality Strategy and addresses the requirements specified in 42 CFR 438 Subpart I, and reviews the methodology for using sanctions to address identified quality of care problems.

MCO/ASO contracts require that the contractor comply with all provisions of the contract and its amendments, if any, and act in good faith in the performance of the provisions. The MCOs/ASOs agree that failure to comply with the contract provisions may result in the application of remedial actions and/or termination of the contract. The following constitute grounds for remedial action:

- A failed audit that nullifies more than three required HEDIS measures*.
- Substantial failure to provide medically necessary services that the contractor is required to provide, under law or this contract, to a member.
- Imposition on members' premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Actions that discriminate among members on the basis of their health status or need for health care services.
- Misrepresentation or falsification of information furnished to the Department, the Centers for Medicare & Medicaid Services, members, potential members, or providers.
- Failure to provide medical records and other requested documents for non-emergency review within 30 calendar days of the date of the written request.
- Direct distribution or indirect distribution, through any agent or independent contractor, of any marketing materials that have not been approved by the Department or that contain false or materially misleading information.
- Failure to satisfy the scope of work found in the contract, as determined by the results of monitoring activities or audits described in Section II.H. of the contract.
- Failure to comply with the requirements for physician incentive plans.
- Violation of any other applicable requirements of Sections 1903(m) or 1932 of the Social Security Act and its implementing regulations.

If deficits in compliance are identified, the Department requires that the MCO/ASO develop a corrective action plan to address the identified deficits. All corrective action plans are submitted to the Department for approval and are monitored by Department staff for a pre-determined amount of time. If, at the end of the time period, Department staff identifies a deficit in MCO/ASO performance that is not successfully addressed through the corrective action process, staff will document the issues, efforts made by the Department to address the issue(s) with the MCO/ASO, and make a recommendation to management to utilize contract remedies. Department staff that identifies a severe deficit in the MCO/ASO, such as those which will seriously impact the health and welfare of its members, may make emergency recommendations to management to utilize contract remedies.

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* Refer to Work Plan Tables to see required HEDIS measures. The required measures are those included in the Performance Improvement Projects (PIP).

Contract remedies include:

- Withholding of payment to contractor until the necessary services or corrections in performance are satisfactorily completed;
- Impose monetary fines,
- Impose temporary management of the contractor,
- Allow members the right to terminate enrollment without cause,
- Suspension of member enrollment, or
- Termination of the contract.

The application of remedies is a matter of public record.

The use of intermediate sanctions for non-compliance is described in Section 1932(e) of the Social Security Act as enacted in the BBA Section 4707(e). This provision states that a hearing must be afforded to contractors before termination of a contract under this section can occur. The Department must notify members of such a hearing and allow members to disenroll, without cause, if they choose.

XIV. Quality Strategy Monitoring and Evaluations

This section explains how the Department will regularly monitor and evaluate MCO/ASO compliance with Department standards for access, structure and operations, and quality measurement and improvement activities.

Program Organizational Structure

1. The Department approves the Quality Strategy and maintains ultimate authority for overseeing its management and direction. The Quality Strategy supports the authority and responsibility of the Department for the development and implementation of effective management of the Quality Strategy. The Department is responsible for reporting Quality Strategy activities, findings, and actions to the stakeholders, public, legislators, governor, and CMS.
2. The Department oversees the Quality Strategy's overall effectiveness and staff performance in carrying out the requirements, and reviews and approves the Quality Strategy itself.
3. The Quality Improvement Section of the Department has management responsibilities for the Quality Strategy. This Section also reviews and reports issues, formulates policies and procedures, and makes recommendations to the Department. The Quality Improvement Section is responsible for developing processes that track and measure the efficiency and effectiveness of care and service. They are also responsible for overseeing the work of the EQR vendor, and for reviewing and approving the EQR contract deliverables.
4. Multi-disciplinary committees may be formed to address specific quality initiatives and/or issues.

Department Annual Quality Strategy Evaluation

At least annually, an EQR by a qualified vendor reviews data and reports of the Quality Strategy activities and findings to assess the effectiveness of the Quality Strategy. This evaluation includes a review of completed Quality Strategy activities, trending of clinical and service monitors, effectiveness of the Quality Strategy monitoring and review activities, effectiveness of the Quality Strategy in identifying quality of care performance issues, and the success of the Quality Strategy in improving member care and provider performance. The specific EQR activities include conducting two focused studies; completing up to 15 cases for individual care review; performing the peer review functions of the credentialing process; calculating and auditing HEDIS and PCCM, measures; conducting member satisfaction surveys, and implementing one quality improvement intervention. The current EQR contract ends on June 30, 2004.

In addition to the EQR activities, the Department conducts an annual site survey of each health plan to finalize the Quality Strategy Evaluation by completing the assessment of areas not reviewed by the EQR. The evaluation is completed following the collection of the calendar year HEDIS data and CAHPS® survey results. The evaluation is reported to the stakeholders and members and made available to the public. The evaluation is the basis for establishing the next year's Quality Strategy and Work Plan.

Work Plan

Each year a Quality Strategy Work Plan (Work Plan) is prepared based on the results of the Annual Evaluation. The Department approves the Work Plan. The Work Plan is not a static document. It will be updated as processes change and activities are completed. The Work Plan will reflect progress throughout the year. The Work Plan describes:

1. The objectives, scope, methodology, and planned activities to be undertaken in the coming year.
2. Plans for monitoring previously identified issues and tracking issues over time.
3. Timeframes for completing activities, writing reports, and accomplishing results.
4. The entity responsible for each activity.
5. Plans for evaluating the Quality Strategy.

Quality Improvement Activities

Annual NCQA HEDIS Compliance Audits™ – Performance Measurement Validation

NCQA HEDIS Compliance Audits™ are developed and performed by an EQRO for the PCPP and/or an independent plan vendor in coordination with the Department Quality Improvement Section and the MCOs/ASOs. The HEDIS measures that are selected for monitoring are listed in the Work Plan. These measures may vary from year to year.

Annual Consumer Assessment of Health Plans (CAHPS®)

A consumer satisfaction survey is conducted annually. The population that is surveyed will vary from year to year.

MCO/ASO Contract Compliance Performance

The Department conducts annual Medicaid Managed Care Program Operations related oversight of the quality of MCO/ASO services. Site Reviews shall be conducted by the Department for the purpose of determining compliance by the Contractor with applicable Department regulations and the requirements of this contract. The Department is also responsible to conduct follow-up in those areas requiring a Corrective Action Plan (CAP). Intermediate sanctions may be necessary and are defined in the contractual relationship with the Department.

Corrective Action Plan (CAP)

A process or quality improvement plan will be requested from the MCOs/ASOs in cases for which the process or monitor reviewed does not reach performance standards. The CAP should include clearly stated objectives and timeframes for completion. The CAP may include but are not limited to:

- Education, by oral or written contact, or through required further training
- Recertification for procedures or services that require certification
- Required submission of a corrective action plan, with subsequent monitoring or reauditing to confirm compliance with said action plan
- Prospective or retrospective trend analysis of the patterns or trends

- In-service training
- Provider education
- Modification, suspension, restriction, or termination
- Intensified review
- Changes to administrative policies and procedures, as appropriate.

Continuous Monitoring and Reassessment

To prevent recurrence of corrected quality issues, the MCO/ASO is monitored and/or reassessed to confirm that the corrective action has resolved the issues. Quality issues remain an open item until resolved. Improvements in patient care and service resulting from corrective action are documented appropriately.

Quality Improvement Projects

Performance Improvement Projects have been identified and will be managed through phases of activities over time. Focused studies may be initiated to determine whether a performance improvement project should be conducted. The Work Plan describes the identification and rationale of projects.

Additional Activities of the Strategy

Additional activities may include but are not limited to the following:

- Conduct improvement projects by diagnosis or procedure codes
- Review contracting and credentialing/recredentialing
- Review member appeals/grievances
- Educate staff, providers, Medicaid members
- Provide feedback to health professionals and MCO/ASO staff
- Monitor key measures
- Work cooperatively with the public health system/private partners on projects
- Review of the QI strategy, annually
- Utilize HEDIS hybrid methodology
- Conduct customer satisfaction surveys
- Coordinate the contract compliance audits to assure adequate structure and operations of the MCOs/ASOs

Conflict of Interest

No member of a Quality Strategy development team or the review entity will have a conflict of interest. Members will not review or participate in the review of their own services, MCO/ASO, or direct competitors, or be associated through financial arrangements.

Upon request, information regarding the Quality Strategy is available to Medicaid members and practitioners. The Department will provide the public with written information.

XV. Approval

The Strategy was reviewed and approved by the following Department members:

Stakeholder Meeting	August 5, 2003
Order of Publication for Public Comment	1. HCPF Web Site 2. Stakeholder Meeting 3. Written Commentary
Comments Received	Comments at the time of the stakeholder meeting included clarification of activities delineated to the EQRO and the health plans, clarification of provider satisfaction surveys, and clarification in specific areas that incorporated contract language into the strategy. No written commentary received. Changes incorporated as a result of commentary were mainly editing of the original text, which clarified the roles of EQRO, Department, and health plans.
Submitted to CMS	August 13, 2003

Approvals by the Department

Signature	Date
Vivianne M. Chaumont, Director Medical Assistance Office	

Signature	Date
Laurel Karabatsos, Manager Quality Improvement Section	

Member Handbook Requirements

To inform members of their rights and responsibilities, the MCO/ASO shall publish and distribute to all members a Member Handbook that shall include but is not limited to the following information:

1. A complete statement of member rights and responsibilities as specified in the Colorado Code of Regulations (CCR).
2. Covered services and any additional benefits and services offered by the contractor;
3. Excluded or non-covered services;
4. Information about the contractor's standards for the availability and accessibility of services including points of access for primary care, specialty, hospital, and other services and how to request accommodations for special needs, including materials in alternative formats;
5. Hours of service;
6. Location of facilities/offices;
7. Appropriate use of and procedures for obtaining care after hours care and emergency care within the service area;
8. Appropriate use of and procedures for obtaining care after hours care and emergency care when out of the service area;
9. Instructions about accessing urgently needed services;
10. The phone number that can be used for assistance in obtaining emergency care, including the 9-1-1 number if that number is operable within the service area;
11. Enrollment procedures of the contractor, including how to change primary care providers, and disenrollment information as required in Section III of the contract to ensure that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so and members are informed about how to access the Department concerning disenrollment;
12. Complaint Form;
13. Maximum number of days between appointment request and actual visit with appropriate Provider, as follows:
    A. Urgent care within 48 hours;
    B. Non-urgent care and EPSDT screens within 2 weeks;
    C. Adult non-symptomatic well care physical examinations within four months.
14. Policies on referrals for specialty care;
15. Informal and formal procedures and timeframes to voice a complaint, file a grievance or obtain a fair hearing related to coverage, benefits, or any aspect of the member's relationships to the Contractor through both the Contractor's internal grievance process and the Department's or the State's external process(es) to include:
    A. The requirements and timeframes for filing a grievance or appeal;
        1. The availability of assistance in the filing process;
        2. The toll-free numbers that the member can use to file a grievance or an appeal by phone;
        3. The fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and the fact that the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

4. Any appeal rights that the State chooses to make available to providers to challenge the failure of the organization to cover a service.

A. For State fair hearing:
   1. The right to hearing;
   2. The method for obtaining a hearing;
   3. The rules that govern representation at the hearing.

B. Additional information that is available upon request, including the following:
   1. Information on the structure and operation of the MCO
   2. Physician incentive plans.

16. Information about the contractor's utilization management program and how it is used to determine medical necessity of services. Information shall include: appropriate points of contact with the utilization management program; contact persons or phone numbers for information or questions; and information about how to initiate appeals related to utilization management decisions.
17. EPSDT services;
18. Family planning policies;
19. Procedures for obtaining the names, qualifications, and titles of professionals providing and/or
20. Responsible for members' care;
21. Circumstances under which members may have to pay for care;
22. Procedures for arranging transportation;
23. How members will be notified of any change in benefits, services, or service delivery offices/sites;
24. Information regarding the member's right to formulate advanced directives, according to applicable statutes and regulation and the contractor's policies respecting the implementation of such rights.
25. How to request information about the contractor's Quality Management and Improvement Program;
26. A list of the contractor's participating providers, who serve members, may be provided as an attachment or addendum to the Member Handbook. The list shall include the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
27. Information regarding member participation on the contractor's consumer advisory committee, and notification of right to attend meetings of the committee. Such information shall include telephone contact number.
28. Information concerning a member's responsibility for providing the contractor with written notice to the contractor after filing a claim or action against a third party responsible for illness or injury to the member.
29. Information concerning a member's responsibility for following any protocols of a liable third party payer prior to receiving non-emergency services.
30. Information on restrictions, if any, on the member's freedom of choice among network providers.

Table B-1—Acronyms, Terms, and Abbreviations		
This acronym, term, or abbreviation...	means this...	with this clarification or caveat...
—— A B ——		
ASO	Administrative Service Organization	
AHCPR	Agency for Health Care Policy and Research	
BBA	The Balanced Budget Act of 1997 (Public Law 105-33)—legislation signed into law by President Clinton in August 1997.	The BBA enacts the most significant changes to the Medicare and Medicaid Programs since their inception 30 years ago. It also expands HCFA (now CMS) services through the new Child Health Insurance Program (Title XXI).
—— C ——		
CAHPS®	Consumer Assessment of Health Plans	CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
CAP	Corrective Action Plan	
CBMS	Colorado Benefits Management System	
CCR	Colorado Code of Regulations	
CDHS	Colorado Department of Human Services	
CDPHE	Colorado Department of Public Health and Environment	
CFR	Code of Federal Regulations	
CHCP	Comprehensive Health Care Program	
CLIA	Clinical Laboratory Improvement Amendments	
CSHCN	Children with Special Health Care Needs	
CMS	Centers for Medicare & Medicaid Services	Formerly the Health Care Financing Administration (HCFA) Federal agency within Department of Health and Human Services (DHHS) that regulates requirements and procedures for External Quality Review of MCOs

—— D E ——		
DHSMHS	Department of Human Services Mental Health Services	
EPSDT	Early and Periodic Screening, Diagnosis and Treatment	
EQR	External Quality Review	
EQRO	External Quality Review Organization	
—— F G ——		
FACCT	Foundation for Accountability	
FQHC	Federally Qualified Health Clinic	
FFS	fee for service	
GPRA	Government Performance and Results Act	
—— H ——		
HCFA	Health Care Finance Administration	Now called Centers for Medicare & Medicaid Services
HEDIS	Health Plan Employer Data and Information Set, the most widely used set of performance measures in the managed care industry	HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
HIPAA	Health Insurance Portability and Accountability Act	
HMO	health maintenance organization	
HSAG	Health Services Advisory Group, Inc.	
—— I J K L M ——		
IDEA	Individuals with Disabilities Education Act	
JCAHO	Joint Commission on Accreditation of Health Care Organizations	
MAC-D	Medicaid Advisory Committee-Disabilities	
MCO	managed care organization	
—— N O P ——		
NASHP	National Academy for State Health Policy	
NCQA	National Committee for Quality Assurance	
OB/GYN	Obstetrics and Gynecology	

PCCM	Primary Care Case Management	
PCP	Primary Care Physician	
PCPP	Primary Care Physician Program	
——Q R S——		
QI	Quality Improvement	
QIC	Quality Improvement Committee	
RHC	Rural Health Clinic	
SNF	Skilled Nursing Facility	
——T U V W X Y Z——		
the Department	Colorado Department of Health Care Policy and Financing	