# Department of Health Care Policy and Financing


# Quality Strategy

# 2007

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## I. Department Mission and Goals

The mission of the Colorado Department of Health Care Policy and Financing (the Department) is to purchase cost-effective health care for qualified low-income Coloradans.

The goals of the Department are:

A. The Department will operate its programs to assure the health care the Department purchases is medically necessary, appropriate and cost-effective.
B. The Department will continuously improve the oversight of activities delegated to agencies, counties, and contractors.
C. The Department will partner with public and private entities to maximize the resources to improve the health status of Coloradans.
D. The Department will evaluate client health and satisfaction and will model program design to promote improved health care delivery. Clients will be furnished information about quality of care and general client satisfaction so that they may make informed choices about the care they receive.
E. The Department will value its personnel through effective recruitment, hiring, training, and retention. The Department will allocate its staff and resources in ways to ensure that it addresses the organization's priorities.
F. The Department will appropriately and effectively respond to changing requirements with the federal government, such as the Deficit Reduction Act, while considering client needs and State budgeting concerns.

## II. Objectives

This Section outlines the Quality Improvement (QI) Section objectives related to the Department Goals:

**Goal A: Assure medically necessary, appropriate and cost-effective health care**

**Objectives:**

1. Increase client use of the nurse advice line as an alternative to emergency room care for non-emergency conditions.
2. Increase clients' knowledge and ability to self-manage chronic conditions through participation in disease management programs.
3. Explore the feasibility of routinely reporting utilization measures.
4. Increase focus on outcomes of care and care processes in QI activities.
5. Conduct one intervention designed to improve an aspect of care annually.
6. Refine the prior authorization process performed under contract by the Department's Utilization Management (UM) Contractor so that the process for non-routine requests for services is documented and understood by all involved parties.

**Goal B: The Department will continuously improve the oversight of activities delegated to agencies and contractors.**

**Objectives**

1. Refine the Quality Strategy Team (QST) reporting process so that the managed care plans know the expectations, and so that feedback and follow-up are performed routinely.
2. Develop a mechanism for QI oversight of Home and Community Based Services (HCBS) QI delegated activities.
3. Increase the objectivity of managed care plan site reviews.
4. Adequately and accurately document the site review corrective action process.
5. Explore the feasibility of implementing provider and contractor incentives for quality, utilization, and client satisfaction.

**Goal C: The Department will partner with public and private entities to maximize the resources to improve the health status of Coloradans.**

**Objectives**

1. Seek stakeholder agency input to this Quality Strategy.
2. Seek stakeholder input when designing HCBS quality program.
3. Work with other State Departments and Divisions to maximize resources available to improve the health status of clients.

**Goal D.1: Evaluate client health and satisfaction**

**Objectives**

1. Measure client physical health using selected Health Plan Employer Data and Information Set (HEDIS®) indicators and one focused study.
2. Measure consumer behavioral health outcomes using Colorado Client Assessment Record (CCAR) measures.
3. Measure consumer satisfaction using Consumer Assessments of Health Plans Survey (CAHPS®), Mental Health Statistical Improvement Project (MHSIP) and Youth Services Survey for Families (YSSF) measures.

**Goal D.2: Model program design to promote improved health delivery.**

**Objectives:**

1. Explore the feasibility of implementing managed care plan pay for performance contracting.
2. Develop a mechanism to identify and promote best practices.
3. Develop a quality program for the HCBS waiver programs.
4. Increase provider participation in the Pre-Admission Screening and Resident Review (PASRR) algorithm process.

**Goal D.3: Furnish information about the quality of care and general client satisfaction so that clients may make informed choices about the care they receive.**

**Objectives:**

1. Produce managed care plan Report Card and send to all newly eligible clients.
2. Develop routine QI activity management reporting.

3. Improve the format and type of information on the Department's web site regarding quality of care and client satisfaction.
4. Post QI activity results on QI web pages.

**Goal E: The Department will value its personnel through effective recruitment, hiring, training and retention. The Department will allocate its staff and resources in ways to ensure that it addresses the organization's priorities.**
**Objectives:**

1. Increase QI Section staff knowledge of quality assessment and performance improvement methodologies by participating in educational programs while staying within budget.
2. Participate in Department sponsored employee training.
3. Fill open QI Section positions with qualified staff as soon as possible after notification of an opening.
4. Utilize the Web to investigate and incorporate improvements to practices and to this Strategy.
5. Increase QI Section staff knowledge of Medicaid by inviting other Sections to present at QI Section meetings.
6. Promote cross-functional interaction within the Section whenever possible.
7. Empower QI staff to fulfill their responsibilities by training staff about the following topics: Medicaid, the role of the QI Section; rules, regulations and statutes; applicable contracts and contractors and Department and Division standards and expectations.
8. Train other Department Sections about QI functions and the outcomes.

**Goal F: The Department will respond appropriately and effectively to changing requirements with the federal government, such as the Deficit Reduction Act, while considering client needs and State budgeting concerns.**
**Objectives:**

1. Improve the Technical Report content to align more clearly existing quality activities into the Centers for Medicare and Medicaid Services (CMS) categories of quality outcomes, access to care and services and timeliness of care and services.
2. Participate in CMS sponsored educational meetings when offered.
3. Design and implement a HCBS quality improvement program.

## III. Purpose, Structure and Authority

A. Purpose of the Quality Strategy

This Quality Strategy provides a framework for the ongoing assessment and improvement of the quality, access to and timeliness of care and services provided to Medicaid clients. This framework will guide the state Medicaid agency, state agencies providing and coordinating services to Medicaid clients, the participating managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs), and the participating providers, clients, advocates and stakeholders in conducting and contributing to quality assessment and performance improvement activities for Medicaid clients.

Attachments A through G of this Strategy address the items CMS requires in the Quality Strategy.

B. Structure of the Quality Strategy

Sections II through VIII of this Strategy provide general information about the quality improvement program for the Colorado Medicaid health plans and HCBS waiver programs. Attachment H contains a glossary of terms used in this Quality Strategy. Specific information about the quality program for health plans and waiver programs is contained in Attachments A through I.

The primary organization that supports this Quality Strategy is the QI Section of the Department. The QI Section is part of the Department's Health Benefits Division of the Medical Assistance Office.

This Quality Strategy is supported secondarily by other related program and policy Sections and Divisions of the Department, including the Managed Care Benefits (MCB) Section, the Community Based Long Term Care (CBLTC) Section, the Information Services Section, the Data Section, and the Acute Care Benefits Section.

Stakeholder committees and councils, such as the Medicaid Advisory Council for Persons with Disabilities (MAC-D), the Primary Care Physician Program (PCPP) meeting, the Managed Care Advisory Council, the State Medical Assistance and Services Advisory Council, the Behavioral Health Quality Improvement Committee (BQuIC), the Medicaid Community Mental Health Services Program Advisory Committee and the Managed Care Quality Improvement Committee (MQuIC) provide input, support, and advice regarding the Quality Strategy and quality activities.

Organizations outside of the Department, such as the Colorado Department of Public Health and Environment (DPHE), Colorado Department of Human Services (DHS), and the Colorado Coalition of Health Care Networks also provide input, support and advice on the Quality Strategy and quality activities.

C. Authority for the Quality Strategy

As the single state agency responsible for administration of the state Medicaid program, the Department has the authority to require its contractors meet state and federal quality regulations. 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 Medicaid 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. Appendix H of the HCBS waiver application defines the minimum requirements to meet CMS waiver assurances articulated in 42 CFR Sections 441.301 and 302.

Section 26-4-116, C.R.S. (2005), (Section 25.5-5-405, C.R.S, effective July 1, 2006) 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 Department 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.

## IV. Scope of Quality Strategy

The scope of this Quality Strategy includes:

A. Quality assessment and performance improvement activities for long term care services provided under HCBS waiver programs. These programs are listed in Attachment I.
B. MCO and PIHP delivery of health care and services, as defined by contract (see Attachment A) and regulation.
C. Quality assessment and performance improvement procedures and standards for MCOs, PIHPs and HCBS waiver providers.
D. Quality assessment and performance improvement for all acute care services provided by Medicaid Participating Providers.

## V. Roles and Responsibilities

A. **The Department** is responsible for determining the standards and requirements that define the quality assessment and performance improvement program. This responsibility includes the following components:

1. Authoring a Strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. (42 C.F.R. 438.202(2))

2. Obtaining input from clients and other stakeholders in the development of this Strategy and making the Strategy available for public comment before adopting it in final form. (42 C.F.R. 438.202(b))

3. Assuring that MCOs and PIHPs comply with standards established by the State, consistent with 42 C.F.R 438. Subpart D, Quality Assessment and Performance Improvement. (42 C.F.R. 438.202(c))

4. Assuring that there is an adequate quality assurance/quality improvement program regarding the six assurances mandated by CMS for HCBS waiver programs (42 C.F.R. Section 441.302; 42 C.F.R. Section 441.303; State Medicaid Manual (SMM) 4442.4; SMM 4442.9).

5. Conducting reviews to evaluate the effectiveness of the Strategy and updating the Strategy as a result of these reviews, as needed. (42 C.F.R. 438.202(d))

6. Providing qualified staff, consistent with the State of Colorado's hiring guidelines, to manage and direct quality improvement activities.

7. Submitting the following to the CMS: (42 C.F.R. 438.202(e))
   a) A copy of the initial Strategy and a copy of the revised Strategy whenever significant changes are made.
   b) Reports on the implementation and effectiveness of the Strategy.

8. Evaluating this Strategy consistent with Section VIII, Quality Strategy Evaluation.

9. Overseeing the DHS, Division for Developmental Disabilities (DDD) and Division of Child Welfare (DCW) quality program for HCBS waiver programs.

B. **Other state agencies**, such as DHS, are responsible for providing input and participation as required in quality assessment and performance improvement activities related to programs defined in this Strategy. The DHS-DDD is responsible for the development, implementation, and ongoing direction of the quality program for the following three HCBS waivers: Waiver for Persons Developmentally Disabled, Supported Living Services Waiver, and Children's Extensive Support (CES) Waiver. The Children's Habilitative Residential Program Waiver is managed by the DHS-DCW.

C. Contracted **managed care providers** are responsible for adhering to contract requirements and to federal managed care regulations.

D. **Waiver program providers** are responsible for participating in quality improvement activities as described in this Strategy and in federal regulations.

E. **Clients, advocates and other stakeholders** are responsible for reviewing and commenting on this Strategy, providing feedback regarding the care and services received, providing input to the methods used to assess and improve care and services, and complying with agreed upon care plans as applicable.

F. **Medicaid participating providers** are responsible for participating in quality assessment and improvement activities described in this Quality Strategy.

G. **CMS** is responsible for determining applicable regulations, providing assistance with regulation interpretation, and periodically reviewing actual practice for compliance with regulations.

## VI. Quality Processes and Activities

Standard health care quality assessment and performance improvement processes and tools are used to improve care and services to Medicaid clients. National performance measures are used as listed in Attachment C. Quality improvement is an ongoing cycle of measurement, change and information sharing. The general process used to measure and improve performance is:

1. Collect relevant data
2. Assess data against standards, norms or expectations
3. Determine what to improve
4. Determine how to improve a selected aspect of care or service
5. Test to see if the improvements work as intended
6. Repeat steps 1 – 5 until improvement is achieved
7. Implement necessary changes as a permanent process

A. Managed Care Activities

The **external quality review** assesses and validates MCO and PIHP performance improvement projects and performance measures and is described in Attachment D. The External Quality Review Organization (EQRO) produces an annual Technical Report, which details and assesses the MCOs' and PIHPs' quality of care and services, timeliness of care and services, compliance with regulations and the contract, and access to care and services.

**Focused studies** are conducted by each physical health plan each year. The goal of the focused studies is to measure and improve an aspect of care or service affecting a significant number of physical health plan members. The MQuIC determines focused study topics. The Department's contracted EQRO assists in defining the study and then compiles the results and creates a study report with input from the physical health plans. An agreed upon managed care **intervention** to improve an aspect of care is then implemented.

Behavioral health clinical **performance measurement** is conducted by each behavioral health PIHP. The CCAR is the tool used to measure functional outcomes of care and results compared for all programs. The work plan for performance measurement is contained in Attachment I.

Physical health clinical **performance measurement** is conducted by each MCO and PIHP, the Primary Care Physician Program and the Fee-For-Service Program on an annual basis. HEDIS® measures are used for this performance measurement and results compared for all programs. The work plan for performance measurement is contained in Attachment I.

**Performance improvement projects** are undertaken by each MCO and PIHP. The focus of performance improvement projects is dependent on the results of the measurement and assessments listed in this Strategy and other assessments that may be conducted by the MCO and PIHP (Contract Section II.I.2.k).

**Performance profiling** is conducted for all members of the PCPP. Performance profiling consists of creation of reports showing a physician's (or all clients assigned to a physician)

performance on a current clinical issue. When applicable, the profiles include client contact information so that a physician office can contact clients as necessary. Recent performance profiles have addressed the frequency of emergency room visits, compliance with recommended health screenings and annual health exams.

Client **satisfaction** with services and providers is **measured** for all MCOs, PIHPs, the PCPP and the Fee-For-Service Program.

**Credentialing** is performed on all PCPP members. Credentialing is the process of verifying a physician's education, training and licensure. Once credentialed for the PCPP, members are re-credentialed every three years.

**Quality Compliance Reporting** is done by the MCOs and PIHPs on a routine basis as indicated in the QI Activity Schedule, Section VII, Information and Reporting, page 12, QST Reporting. Managed care health plans report data on network adequacy, enrollment and disenrollment trends, grievances and appeals and money collected from third party carriers. Behavioral health plans report on network adequacy, access to services, grievances and appeals, benefit limit utilization and money collected from third party carriers.

Quality Compliance Reports are reviewed by the **Quality Strategy Team**, comprised of QI and MCB Section staff. The review focuses on items or issues requiring follow-up by the MCO/PIHP. Whenever questions arise, the MCO/PIHP is asked for additional information and further action if necessary.

The MCOs and PIHPs submit **quality improvement plans** to the Department each year. The plans identify current and anticipated quality assessment and performance improvement activities and integrate findings and opportunities for improvement identified by performance measure data, member satisfaction surveys, performance improvement projects 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.

The **schedule** of quality assessment and improvement activities is listed in Section VII, Information and Reporting, page 13.

**Site reviews** assess MCO and PIHP compliance with state and federal regulations, as well as contract provisions, and are conducted by Department quality improvement and managed care benefits staff. Site reviews consist of several activities: submission and review of documents, a two- to three-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 corrections are completed.

B. HCBS Waiver Program Activities

The CMS regulations at 42 C.F.R. 441 Section 302 and Appendix H of the waiver application set forth requirements that must be part of a waiver program's Quality

Management Strategy. These requirements include statements the Department must "satisfactorily assure" CMS are met in order for CMS to grant a waiver. These requirements are called assurances. The assurances and the activities undertaken by the Department to meet these assurances are discussed in Attachment I.

The mechanisms used by the Department to meet assurance D, the assurance regarding continuous monitoring of the health and welfare of waiver clients, are under development. With the finalization of this Quality Strategy, the Department will implement these activities and processes discussed here and in Attachment I. Using the process listed at the beginning of this Section, the Department will begin quality activities based on the priority list.

Priority will be based on care and services that are:

- high risk to clients or the Department
- provided with high frequency or volume
- high cost
- potential health, safety or risk issues

Stakeholder input is obtained to determine improvement priorities. Stakeholders include consumers, advocates, providers, contract administrators, and researchers, as each of these individuals provide valuable insights to the entire quality improvement process.

**Ongoing reviews by Single Entry Point (SEP) agencies** consist of reviews of the SEP agency case management functions. These function include gathering client information and making community referrals, completing intake/screening, assessing potential clients, developing care plans, providing ongoing case management, monitoring service provisions, conducting re-assessments, and developing resources for clients needing services.

The annual **Department SEP agency site review** is an on-site certification visit that includes an administrative review, a record review, technical assistance and an exit interview. This review is based on six focus areas in accordance with requirements set forth in the Department's rules and in the contract between the Department and the SEP agency. The six focus areas are as follows:

1. The quality of the services provided by the agency;
2. The SEP agency's compliance with program requirements, including compliance with case management standards adopted by the Department;
3. The SEP agency's performance of administrative functions, including reasonable costs per client, timely reporting, managing programs in one consolidated unit, on-site visits to clients, community coordination and outreach, and client monitoring;
4. Whether targeted populations are being identified and served;
5. Financial accountability, and
6. The maintenance of qualified personnel to perform the contracted duties.

**SEP agency designation application process** consists of an annual review of the SEP agency's accomplishments and best practices, a review of the organizational structure that includes a review of the staffing, hiring, and staff turnover, a review of the case management

processes, a record review which includes a breakdown of populations served by waiver population, and compliance issues.

**SEP Agency Monitoring** means real time monitoring by the Department of SEP agency case management activities to include timeliness of continued stay reviews, plans of care, and case management notes to ensure compliance with guidelines set forth in the waiver application.

**Client satisfaction tool** means a survey sent out by the Department, or its designated agent, at least annually to determine the level of client satisfaction with the services provided by the SEP agency. The data gathered from this tool is considered when determining the SEP agency's quality assurance and resource development efforts. Survey results will also be incorporated into the Department's HCBS QI activities.

**Provider Application Approval** means the application process by which a provider is approved to become a certified Colorado Medical Assistance Program service provider.

**Department of Public Health and Environment Occurrence Reporting System** collects and disseminates information regarding sentinel events and client complaints. This information is then analyzed by the Department and will be used in the Department's HCBS QI activities.

## VII. Information and Reporting

Available data is the driver of the Department's quality assessment and performance improvement activities. The principal data sources available for each component of this Quality Strategy are listed on the following page.

**Quality Improvement Data Sources**

| PROGRAM | DATA SOURCE | REPORTING FREQUENCY |
|---|---|---|
| Physical Health | Selected HEDIS® | Annually |
| Physical Health | CAHPS® | Annually |
| Physical Health | Claims and encounter data* | Ongoing |
| Physical Health | Site review findings | Annually |
| Physical Health | Compliance Monitoring findings | Quarterly |
| Physical Health | Ombuds Report* | Monthly |
| Physical Health | Quality Improvement Plans | Annually |
| Physical Health | Quality Improvement Annual Report | Annually |
| Behavioral Health | MHSIP | Annually |
| Behavioral Health | Claims and encounter data* | Ongoing |
| Behavioral Health | YSSF | Annually |
| Behavioral Health | CCAR | Annually |
| Behavioral Health | Site review findings | Annually |
| Behavioral Health | Compliance Monitoring findings | Quarterly |
| Behavioral Health | Ombuds Report* | Monthly |
| Behavioral Health | Quality Improvement Plans | Annually |
| Behavioral Health | Quality Improvement Annual Report | Annually |
| Waiver Programs | Benefits Utilization System (BUS)* | Ongoing |
| Waiver Programs | Claims data | Ongoing |
| Waiver Programs | Site review findings | Annually |
| Waiver Programs | Client feedback and input | Annually |
| Waiver Programs | Client complaints | Ongoing |

*These data sources are not used as discreet data sources but are used by the Department in conjunction with other listed data.

The following table shows the QI Activities undertaken and the State Fiscal Year quarters in which the activities are performed.

## QI Activity Schedule

S=Topic/Measure Selection D=Data Acquisition A=Assessment
R=Reporting to plans/providers **R**=reporting to CMS

| QI Activity | FY07 Q1 | FY07 Q2 | FY07 Q3 | FY07 Q4 | FY08 Q1 | FY08 Q2 | FY08 Q3 | FY08 Q4 | FY09 Q1 | FY08 Q2 | FY08 Q3 | FY08 Q4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Site reviews | S | D, A | D, A, R, **R** | A | S | D, A | D, A, R, **R** | A | S | D, A | D, A, R, **R** | A |
| Clinical Performance Measurement | R, **R** | S, R, **R** | D | D, A | R, **R** | S, R, **R** | D | D, A | R, **R** | S, R, **R** | D | D, A |
| Satisfaction measurement | | S | D | D, A, R | | S | D | D, A, R | | S | D | D, A, R |
| Performance Improvement Plan (PIP) Validation | S, D, A | A | S, D, R | **R** | S, D, A | A | S, D, R | **R** | S, D, A | A | S, D, R | **R** |
| Focused Studies | **R** | S | D | D, A, R | **R** | S | D | D, A, R | **R** | S | D | D, A, R |
| Encounter data | D | D | D | D | D | D | D | D | D | D | D | D |
| QST Reporting | D, A, R, **R** | D, A, R | D, A, R | D, A, R | D, A, R, **R** | D, A, R | D, A, R | D, A, R | D, A, R, **R** | D, A, R | D, A, R | D, A, R |
| QI Intervention | | S | A | R | | S | A | R | | S | A | R |
| PCPP Performance Profiling | R | R | R | R | R | R | R | R | R | R | R | R |
| PCPP Credentialing | | | D, A | R | | | D, A | R | | | D, A | R |
| QI Plans/reports | R | | | | R | | | | R | | | |
| Technical Report | R, **R** | D | D, A | A | R, **R** | D | D, A | A | R, **R** | D | D, A | A |
| QI Strategy Evaluation | D, A, R, **R** | | | | D, A, R, **R** | | | | D, A, R, **R** | | | |

## VIII. Quality Strategy Evaluation

This Strategy and any referenced policies and procedures will be evaluated on an annual basis. The evaluation will take into account the following:

- Compliance with federal and state regulations and protocols
- Effectiveness of the Strategy in achieving its purpose
- Pertinence to current program issues
- Relevance with current practices
- Budgetary considerations
- Quality assessment findings

This Quality Strategy and policies and procedures will be revised as necessary, as result of the annual evaluation.

Annual reports to CMS regarding the implementation and effectiveness of this Strategy will be completed according to the QI Activity Schedule.

## Attachment A. – Contract Provisions

***42 C.F.R. Section 438.204 Elements of State quality strategies.***
*At a minimum, State strategies must include the following:*
*(a) The MCO and PIHP contract provisions that incorporate the standards specified in this subpart (D).*

Following is a list of contract sections applicable to the standards contained in 42 C.F.R. Subpart D:

| Standard | Regulation | Physical Health Contract Provision | Behavioral Health Contract Provision |
|---|---|---|---|
| **Access to care** | | | |
| | Availability to Services (42 C.F.R. 438.206) | Section II. D. Covered Services | Section II.F Service Delivery - Access |
| | | Section II. E. Service Delivery –Access | |
| | | Section II.C. Enrollment and Disenrollment | |
| | Assurance of Adequate Capacity and Services (42 C.F.R. 438.207) | Section II.D. Covered Services | Section II.F. Service Delivery - Access |
| | | Section II.E. Service Delivery | |
| | | Section II.H. Subcontracts | |
| | | Section II.F. Member Issues | |
| | Coordination and Continuity of Care (42.C.F.R. 438.208) | Section II.E. Service Delivery – Coordination and Continuity of Care | Section II.F. Service Delivery - Access |
| | Coverage and Authorization of Services (42 C.F.R. 438.210) | Section II.D Covered Services | Section II.E. Covered Services |
| | | Section II.C. Enrollment and Disenrollment | Section II.G. Member Issues |
| | | Section II.H. Subcontracts | Section II.J Compliance and Monitoring |
| **Structure and** | Provider Selection | Section II.G. | Section II.C |

| Standard | Regulation | Physical Health Contract Provision | Behavioral Health Contract Provision |
|---|---|---|---|
| **operations** | (42. C.F.R. 438.214) | Provider Issues | Subcontracts |
| | | Section II.H. Subcontracts | Section II.D. Enrollment and Disenrollment |
| | | Section II.F. Member Issues | Section II.G. Member Issues |
| | | | Section II.H. Provider Issues |
| | Enrollee Information (42 C.F.R. 438.218) | Section II.F. Member Issues | Section II.G. Member Issues |
| | Confidentiality (42 C.F.R. 438.224) | Section II.E Service Delivery- Access | Section II.G. Member Issues |
| | | Section II.I. Compliance Issues | |
| | Enrollment and Disenrollment (42 C.F.R. 438. 226) | Section II.C. Enrollment and Disenrollment | Section II.D. Enrollment and Disenrollment |
| | Grievance Systems (42 C.F.R. 438. 228) | Section II.F. Member Issues | Section II.G. Member Issues |
| | Subcontractual Relationships and Delegation (42 C.F.R. 438. 230) | Contract Section II.H. Subcontracts | Section II.C Subcontracts |
| **Quality measurement and improvement** | Practice Guidelines (42 C.F.R. 438. 236) | Section II.J. Quality Assessment and Performance Improvement | Section II.I. Quality Assessment and Performance Improvement |
| | Quality Assessment and Performance Improvement Projects (42 C.F.R. 438. 240) | Section II.J. Quality Assessment and Performance Improvement | Section II.I. Quality Assessment and Performance Improvement |
| | Health Information Systems (42 C.F.R. 438. 242) | Section II.I. Compliance and Monitoring | Section II.I. Quality Assessment and Performance Improvement |
| | | Section II.J. Quality Assessment and Performance Improvement | |

## Attachment B. – Policies and Procedures

***42 C.F.R. Section 438.204 Elements of State quality strategies.***

*At a minimum, State strategies must include the following:*

*(b) Procedures that--*

*(1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs (see pages 18 through 43) .*

*(2) Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.*

Client race, ethnicity and primary language spoken is captured in the eligibility system at the time of eligibility determination. This information is reported to the MCOs and BHOs via the ANSI X12N 834 Enrollment information transaction.

*(3) Regularly monitor and evaluate the MCO and PIHP compliance with the standards (see pages 44 through 46 ).*

| IX. Colorado Department of Health Care Policy and Financing<br>Quality Improvement Section | DATE: 09-12-05<br>DATE REVISED: 11-13-06 |
|---|---|
| A. Policy & Procedure for Performance Improvement Projects (PIPs) | SECTION MANAGER APPROVAL<br>K. Brookler |

**Purpose**:

To provide direction to Medicaid Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs) regarding implementation of Performance Improvement Projects (PIPs).

PIPs are the method health plans use to improve care or member services. PIPs provide a structured approach to measuring performance, implementing change to improve performance, and measuring the resulting outcomes. In general, changes that lead to favorable sustained results become permanent standards, practices, or procedures. Changes that are not successful should be revised and remeasured so that improvements are made.

MCO/BHO requirements under the Code of Federal Regulations (42 CFR 423.240) state that PIPs be designed to achieve significant improvement, sustained over time, in clinical and nonclinical areas that are expected to have a favorable effect on health outcomes and/or member satisfaction.

Two documents produced by the Centers for Medicare & Medicaid Services (CMS) serve as PIP resources: *Conducting Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 and *Validating Performance Improvement Projects, A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002. These documents provide protocols to conduct and validate PIPs. The protocols prescribe ten steps that should be taken in order to conduct a valid and reliable PIP.

**Policy**:

1. Each MCO/BHO will have at least two PIPs in process each year. These may be in varying stages of initiation, implementation, or remeasurement using the Centers for Medicare & Medicaid Services protocol (http://www.cms.hhs.gov/MedicaidSCHIP QualPrac/).

2. The EQRO will validate the PIPs using the CMS' *Validating Performance Improvement Projects* protocol as a guide. Validation will consist of two validation activities from the validation protocol: Activity 1 (Assess the Study Methodology) and Activity 3 (Evaluate Overall Validity and Reliability). Validation protocol Activity 2 (Verify Study Findings),

is not currently required by CMS or the Department. Validation will occur in three steps: preliminary evaluation, resubmission and re-review, and final scoring.

3. PIP topics must be approved in advance by the Department according to the timeframes in Appendix A.

4. Within a period of two state fiscal years, at least one PIP will focus on a clinical area and at least one will focus on a nonclinical area.

    a. Clinical PIPs and nonclinical PIPs: In most cases, a baseline measurement and intervention will be completed by the end of the first year; at least two remeasurements and the data analysis will be completed by the end of the second year.

    b. Focused Studies (for physical health plans only): A Focused Study may be utilized as a PIP. A PIP differs from a Focused Study because a PIP must include a study question, intervention(s) and remeasurement(s).

**Procedure:**

1. For new PIP studies, the plans will submit the first four steps using the validation protocol to the EQRO according to the timeframe in Appendix A.

2. The EQRO will review the submitted documentation and provide input to the plan as to the appropriateness of the submitted documentation according to the timeframe in Appendix A.

3. Plans will submit a *PIP Summary Form* (Appendix B) to the EQRO each year for each PIP in process. The timeframes in Appendix A of this policy provide submission due dates.

4. The EQRO will provide a preliminary validation report for each PIP. The preliminary validation reflects the validation score that will be given when the final reports are produced. Refer to Appendix C for the PIP scoring methodology.

5. PIPs receiving a preliminary validation score of Partially Met or Not Met can be resubmitted with additional or revised information prior to the final report. If this option is chosen, the EQRO will re-validate the PIP with the newest information.

6. Plans will receive a final written report from the EQRO regarding the PIP validation process. A follow-up telephone call will also be conducted to discuss the report, if requested by the plan.

7. Plans are required to take action and provide documentation for any evaluation element receiving a score of *Partially Met* or *Not Met*. The action may include resubmission of additional PIP documentation prior to the final scoring. Future annual PIP submissions should include information to achieve a *Met* Status.

8. Reporting Requirements

    a. Include a summary of the PIP validation results in the Annual External Quality Review Technical Report submitted to the Department.

    b. Include the planned continuation of the PIPs for the next fiscal year in the Annual External Quality Review Technical Report submitted to the Department.

# Appendix A: Activity Timeline for Physical Health Plans 2007

| PIP Tasks | Aug 2006 | Sept 2006 | Oct 2006 | Nov 2006 | Dec 2006 | Jan 2007 | Feb 2007 | Mar 2007 | April 2007 | May 2007 | June 2007 | July 2007 | Aug 2007 | Sept 2007 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Conduct PIP Advance Training** | ♦8/3/06 | | | | | | | | | | | | | |
| **Notify MCOs of PIP Submission** | | ♦9/18/06 | | | | | | | | | | | | |
| **PIPs Submitted to HSAG** | | | ♦10/16/06 | | | | | | | | | | | |
| **Validation of PIPs** | | | ← | ——— | → | | | | | | | | | |
| **Resubmission Process** | | | | ← | ——— | → | | | | | | | | |
| **Report of Findings** | | | | | | ← | ——— | → | | | | | | |
| **Final PIP Reports Due** | | | | | | | | ♦3/9/07 | | | | | | |
| **EQRO Technical Report** | | | | | | | | | | | | | | ♦9/28/07 |

## Appendix A: Activity Timeline for Behavioral Health Plans 2007

| PIP Tasks | Aug 2006 | Sept 2006 | Oct 2006 | Nov 2006 | Dec 2006 | Jan 2007 | Feb 2007 | Mar 2007 | April 2007 | May 2007 | June 2007 | July 2007 | Aug 2007 | Sept 2007 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Conduct PIP Advance Training** | ♦8/3/06 | | | | | | | | | | | | | |
| **Notify BHOs of PIP Submission** | | | | | | ♦1/29/07 | | | | | | | | |
| **PIPs Submitted to HSAG** | | | | | | | ♦2/26/07 | | | | | | | |
| **Validation of PIPs** | | | | | | | ← | → | | | | | | |
| **Resubmission Process** | | | | | | | | ← | → | | | | | |
| **Report of Findings** | | | | | | | | | ← | → | | | | |
| **Final PIP Reports Due** | | | | | | | | | | ♦5/11/07 | | | | |
| **EQRO Technical Report** | | | | | | | | | | | ♦6/29/07 | | | |

## Appendix B: PIP Summary Form 2007

| DEMOGRAPHIC INFORMATION | | | |
|---|---|---|---|
| Plan Name or ID: | **<Full Plan Name>** | | |
| Study Leader Name: _____ | | Title: _____ | |
| Telephone Number: _____ | | E-Mail Address: _____ | |
| Name of Project/Study: | ***<PIP Topic>*** | | |
| Type of Study: | ☐ Clinical | ☐ Nonclinical | |
| _____ Number of Medicaid Consumers<br><br>_____ Number of Medicaid Consumers in Study | | | **Section to be completed by HSAG**<br>_____ Year 1 Validation _____ Initial Submission _____ Resubmission<br><br>_____ Year 2 Validation _____ Initial Submission _____ Resubmission<br><br>_____ Year 3 Validation _____ Initial Submission _____ Resubmission |

| |
|---|
| **A. Activity 1: Choose the study topic.** PIP topics should target improvement in relevant areas of services and reflect the population in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of the disease. Topics may be derived from utilization data (ICD-9 or CPT coding data related to diagnoses and procedures; NDC codes for medications; HCPC codes for medications, medical supplies, and medical equipment; adverse events; admissions; readmissions; etc.); grievances and appeals data; survey data; provider access or appointment availability data; enrollee characteristics data such as race/ethnicity/language; other fee-for-service data; local or national data related to Medicaid risk populations; etc. The goal of the project should be to improve processes and outcomes of health care or services in order to have a potentially significant impact on enrollee health, functional status, or satisfaction. The topic may be specified by the State Medicaid agency or CMS and be based on input from enrollees. Over time, topics must cover a broad spectrum of key aspects of enrollee care and services, including clinical and nonclinical areas, and should include all enrolled populations (i.e., certain subsets of enrollees should not be consistently excluded from studies). |
| **Study topic:** |

| **B. Activity 2: Define the study question(s).** Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. |
| --- |
| **Study question:** |

| **C. Activity 3: Select the study indicator(s).** A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event (e.g., an older adult has not received an influenza vaccination in the last twelve months), or a status (e.g., a consumer's blood pressure is/is not below a specified level) that is to be measured. The selected indicators should track performance or improvement over time. The indicators should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. | |
|---|---|
| *Study Indicator 1* | • **Describe the rationale for selection of the study indicator:** |
| **Numerator** | • |
| **Denominator** | • |
| **First Measurement Period Dates** | • |
| **Benchmark** | • |
| **Source of Benchmark** | • |
| **Baseline Goal** | • |
| *Study Indicator 2* | • **Describe the rationale for selection of the study indicator:** |
| **Numerator** | • |
| **Denominator** | • |
| **First Measurement Period Dates** | • |
| **Benchmark** | • |
| **Source of Benchmark** | • |
| **Baseline Goal** | • |
| *Study Indicator 3* | • **Describe the rationale for selection of the study indicator:** |
| **Numerator** | • |
| **Denominator** | • |
| **First Measurement Period Dates** | • |
| **Benchmark** | • |
| **Source of Benchmark** | • |
| **Baseline Goal** | • |

| |
|---|
| **D. Activity 4: Use a representative and generalizable study population.** The selected topic should represent the entire Medicaid enrolled population, with system wide measurement and improvement efforts to which the PIP study indicators apply. Once the population is identified, a decision must be made whether to review data for the entire population or a sample of that population. The length of a consumer's enrollment needs to be defined in order to meet the study population criteria. |
| **Study population:** |

**E. Activity 5: Use sound sampling methods.** If sampling is to be used to select consumers of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. The true prevalence or incidence rate for the event in the population may not be known the first time a topic is studied.

| Measure | Sample Error and Confidence Level | Sample Size | Population | Method for Determining Size (*describe*) | Sampling Method (*describe*) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**F. Activity 6a: Use valid and reliable data collection procedures.** Data collection must ensure that the data collected on PIP indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement.

**Data Sources**

[ ] Hybrid (medical/treatment records and administrative)

[ ] Medical/Treatment Record Abstraction

Record Type

[ ] Outpatient
[ ] Inpatient
[ ] Other

_____

Other Requirements

[ ] Data collection tool attached
[ ] Data collection instructions attached
[ ] Summary of data collection training attached
[ ] IRR process and results attached

[ ] Other data

_____
_____
_____
_____

Description of data collection staff (include training, experience and qualifications):

_____
_____
_____

[ ] Administrative Data

Data Source

[ ] Programmed pull from claims/encounters
[ ] Complaint/appeal
[ ] Pharmacy data
[ ] Telephone service data /call center data
[ ] Appointment/access data
[ ] Electronic medical record
[ ] Delegated entity/vendor data _____
[ ] Other _____

Other Requirements

[ ] Data completeness assessment attached
[ ] Coding verification process attached

[ ] Survey Data

Fielding Method

[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Other _____

Other Requirements

[ ] Number of waves _____
[ ] Response rate _____
[ ] Incentives used _____

| F. Activity 6b: Determine the data collection cycle. | Determine the data analysis cycle. |
|---|---|
| [ ] Once a year<br>[ ] Twice a year<br>[ ] Once a season<br>[ ] Once a quarter<br>[ ] Once a month<br>[ ] Once a week<br>[ ] Once a day<br>[ ] Continuous<br>[ ] Other (list and describe): | [ ] Once a year<br>[ ] Once a season<br>[ ] Once a quarter<br>[ ] Once a month<br>[ ] Continuous<br>[ ] Other (list and describe): |

**F. Activity 6c. Data analysis plan and other pertinent methodological features.** Complete only if needed.

**Estimated percentage degree of administrative data completeness: _____ percent.**

**Supporting documentation:**

**G. Activity 7a: Include improvement strategies** (interventions for improvement as a result of analysis). List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "Hired four customer service representatives" as opposed to "Hired customer service representatives"). Do not include intervention planning activities.

| Date Implemented (MMYY) | Check if Ongoing | Interventions | Barriers That Interventions Address |
|---|---|---|---|
| | | | |
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| **G. Activity 7b: Implement intervention and improvement strategies.** Real, sustained improvements in care result from a continuous cycle of measuring and analyzing performance, and developing and implementing systemwide improvements in care. Describe interventions designed to change behavior at an institutional, practitioner, or beneficiary level. |
| --- |
| **Describe interventions:**<br><br>**Baseline to Remeasurement 1:**<br><br>**Remeasurement 1 to Remeasurement 2:**<br><br>**Remeasurement 2 to Remeasurement 3:** |

| **H. Activity 8a. Data analysis:** Describe the data analysis process in accordance with the analysis plan and any ad hoc analysis done on the selected clinical or nonclinical study indicators. Include the statistical analysis techniques used and *p* values. |
| --- |
| **Data analysis process:**<br><br>**Baseline Measurement:**<br><br>**Baseline to Remeasurement 1:**<br><br>**Remeasurement 1 to Remeasurement 2:**<br><br>**Remeasurement 2 to Remeasurement 3:** |

| **H. Activity 8b. Interpretation of study results:** Describe the results of the statistical analysis, interpret the findings, discuss the successfulness of the study, and indicate follow-up activities. Also, identify any factors that could influence the measurement or validity of the findings. |
|---|
| **Interpretation of study results:** (Address factors that threaten internal or external validity of the findings for each measurement period.)<br><br>**Baseline Measurement:**<br><br>**Baseline to Remeasurement 1:**<br><br>**Remeasurement 1 to Remeasurement 2:**<br><br>**Remeasurement 2 to Remeasurement 3:** |

**I. Activity 9: Report improvement.** Describe any meaningful change in performance observed during baseline measurement that was demonstrated.

**Quantifiable Measure No. 1:**

| Time Period Measurement Covers | Baseline Project Indicator Measurement | Numerator | Denominator | Rate or Results | Industry Benchmark | Statistical Test and Significance* Test statistic and p-value |
|---|---|---|---|---|---|---|
| | *Baseline:* | | | | | |
| | **Remeasurement 1** | | | | | |
| | **Remeasurement 2** | | | | | |
| | **Remeasurement 3** | | | | | |
| | **Remeasurement 4** | | | | | |
| | **Remeasurement 5** | | | | | |

**Quantifiable Measure No. 2:**

| Time Period Measurement Covers | Baseline Project Indicator Measurement | Numerator | Denominator | Rate or Results | Industry Benchmark | Statistical Test and Significance* Test statistic and p-value |
|---|---|---|---|---|---|---|
| | *Baseline:* | | | | | |
| | **Remeasurement 1** | | | | | |
| | **Remeasurement 2** | | | | | |
| | **Remeasurement 3** | | | | | |
| | **Remeasurement 4** | | | | | |
| | **Remeasurement 5** | | | | | |

**Quantifiable Measure No. 3:**

| Time Period Measurement Covers | Baseline Project Indicator Measurement | Numerator | Denominator | Rate or Results | Industry Benchmark | Statistical Test and Significance* Test statistic and p-value |
|---|---|---|---|---|---|---|
| | *Baseline:* | | | | | |
| | **Remeasurement 1** | | | | | |
| | **Remeasurement 2** | | | | | |
| | **Remeasurement 3** | | | | | |
| | **Remeasurement 4** | | | | | |
| | **Remeasurement 5** | | | | | |

* Specify the test, *p* value, and specific measurements (e.g., baseline to Remeasurement 1, Remeasurement #1 to Remeasurement 2, etc., or baseline to final remeasurement) included in the calculations.

| **J. Activity 10: Describe sustained improvement.** Describe any demonstrated improvement through repeated measurements over comparable time periods. Discuss any random year-to-year variation, population changes, sampling error, or statistically significant declines that may have occurred during the remeasurement process |
| --- |
| **Sustained improvement:** |

## Appendix C. Scoring Methodology

Validating PIPs involves a review of the following 10 activities:

| | |
|---|---|
| Activity 1. | Appropriate Study Topic |
| Activity 2. | Clearly Defined, Answerable Study Question |
| Activity 3. | Clearly Defined Study Indicator(s) |
| Activity 4. | Use a Representative and Generalizable Study Population |
| Activity 5. | Valid Sampling Techniques (If Sampling was Used) |
| Activity 6. | Accurate/Complete Data Collection |
| Activity 7. | Appropriate Improvement Strategies |
| Activity 8. | Sufficient Data Analysis and Interpretation |
| Activity 9. | Real Improvement Achieved |
| Activity 10. | Sustained Improvement Achieved |

All PIPs are scored as follows:

| | |
|---|---|
| *Met* | (1) All critical elements were *Met*,<br>**and**<br>(2) 80 percent to 100 percent of all critical and noncritical elements were *Met*. No action required. |
| *Partially Met* | (1) All critical elements were *Met*,<br>and 60 percent to 79 percent of all critical and noncritical elements were *Met*,<br>**or**<br>(2) One critical element or more was *Partially Met*. Requires revision and resubmission of the PIP. |
| *Not Met* | (1) All critical elements were *Met*,<br>and <60 percent of all critical and noncritical elements were *Met*,<br>**or**<br>(2) One critical element or more was *Not Met*. Requires revision and resubmission of the PIP. |
| *N/A* | *N/A* elements (including critical elements if they were not assessed) were removed from all scoring. |

B. PIP Scores

Each activity is reviewed and scored according to HSAG's validation methodology. The following table displays the scores for each review activity and becomes a component of the final PIP validation report.

**Table C-1—FY 06-07 Performance Improvement Project Scores**
***for* <PIP Topic>**
***for* <Full Name>**

| Review Activity | Total Possible Evaluation Elements (Including Critical Elements) | Total Met | Total Partially Met | Total Not Met | Total N/A | Total Possible Critical Elements | Total Critical Elements Met | Total Critical Elements Partially Met | Total Critical Elements Not Met | Total Critical Elements N/A |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Appropriate Study Topic | 6 | | | | | 1 | | | | |
| 2. Clearly Defined, Answerable Study Question | 2 | | | | | 1 | | | | |
| 3. Clearly Defined Study Indicator(s) | 7 | | | | | 3 | | | | |
| 4. Use a Representative and Generalizable Study Population | 3 | | | | | 2 | | | | |
| 5. Valid Sampling Techniques | 6 | | | | | 1 | | | | |
| 6. Accurate/Complete Data Collection | 11 | | | | | 1 | | | | |
| 7. Appropriate Improvement Strategies | 4 | | | | | No Critical Elements | | | | |
| 8. Sufficient Data Analysis and Interpretation | 9 | | | | | 2 | | | | |
| 9. Real Improvement Achieved | 4 | | | | | No Critical Elements | | | | |
| 10. Sustained Improvement Achieved | 1 | | | | | No Critical Elements | | | | |
| **Totals for All Activities** | **53** | | | | | **11** | | | | |

| Table C-2—FY 06-07 Performance Improvement Project Overall Score *for* <PIP Topic> *for* <Full Name> | |
|---|---|
| **Percentage Score of Evaluation Elements Met*** | **%*** |
| **Percentage Score of Critical Elements Met**** | **%**** |
| **Validation Status***** | ***<Met/Partially Met/Not Met>****** |

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

**The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

****Met* equals confidence/high confidence that the PIP was valid.
*Partially Met* equals low confidence that the PIP was valid.
*Not Met* equals reported PIP results that were not valid.

| HEALTH CARE POLICY AND FINANCING<br><br>**Quality Improvement Section** | Origination Date: 4/99<br><br>Revised Date: 4/99, 2/01, 3/02, 1/03, 12/06 |
|---|---|
| Policy and Procedure<br><br>**HEDIS® Measure Selection** | Approved by:<br>K. Brookler, QI Manager |

I. PURPOSE

To select Healthplan Employer Data and Information Set (HEDIS®) measures annually to be calculated by each Managed Care Organization (MCO), health plan Prepaid Inpatient Health Plan (PIHP) and by the External Quality Review Organization (EQRO) for those clients in the Primary Care Physician Program (PCPP) and the Fee-For-Service program.

II. AUTHORITY

HEDIS® measures, developed by the National Committee for Quality Assurance (NCQA), are used to measure the effectiveness of care delivered by health plans. Managed care Contractors and the Department (for the PCPP and Fee-for-Service populations) must comply with 42 C.F.R. Section 438.240(c) which states that each plan must measure and report on its performance using standard measures.

Health plans that hold Medicaid contracts provide input into the selection of the measures, recognizing that areas of identified weakness will require quality improvement activities. The measures selected should be consistent with the Quality Strategy, relevant to the plan members and of value in improving the quality of health care delivered to Medicaid clients.

III. PROCEDURE

A. Obtain the current list of Medicaid HEDIS® measures from NCQA's web site, www.ncqa.org. If the funds are available, consider ordering a current copy of the measure specifications.

B. Distribute a listing of the published HEDIS® measures to the Medical Quality Improvement Committee (MQuIC) and any other interested parties, indicating which measures have been used in recent years.

C. Obtain input from the interested groups. To determine the quality and quantity of measures to be calculated, the following should be taken into account:

1. The interests of the Department;

2. Contractual requirements;

3. Previously identified areas of measure and "core" areas of consistent measure as listed in the Quality Strategy;

4. The cost of calculating measures and conducting an audit;

5. Usefulness of data gained from selecting individual measures;

6. Measures being requested by external stakeholders in setting the community standard;

7. The measures plans are wanting to calculate for internal reasons;

8. Quality improvement studies, including Department initiatives, conducted where HEDIS® results may indicate change in previously measured quality studies;

9. The HEDIS® rotation schedule implemented by NCQA for health plan accreditation; and

10. Current research and national initiatives on individual measures demonstrating applicability to Medicaid populations.

D. Meet with community data partnerships, such as the Colorado Business Group on Health (CBGH) to discuss what measures are being required by their organizations for the plans in their membership. The purpose of doing this is to assess community standard and provide input into the selection of measures plans that have more than one product line are required to program and calculate.

E. Prepare a list of measures being considered in order to narrow the options to a workable number (see example attached). The pros and cons submitted by all interested parties should be discussed at the designated MQuIC meeting.

F. The measures should be finalized after considering everyone's input to facilitate programming and calculation of measures by the plans. When the measures are finalized, an official Department notification will be sent to each of the Quality Improvement managers at the contracted plans and to the EQRO indicating which measures have been selected.

G. Clarify with all participants that calculated HEDIS® measures are to be audited by a certified HEDIS® auditor. The date for audited data to be submitted to the Department is June 15 of every year, unless other arrangements have been made. It is required in contract that all plans submit data in accordance with NCQA specifications.

H. Upon receipt, the data should be analyzed for reporting purposes. The report format should be as clear and complete as possible. This report draft will be provided to the MCOs and the EQRO for review and comments are due two weeks (14 calendar days) after receipt of the data. Comments will be incorporated wherever possible.

I. When comments from external stakholders have been incorporated, the report is distributed internally for clearance and input. If applicable, a summary report of HEDIS® measures comparing all plans will be generated to identify and report trends.

J. Plans are required to analyze their results and report that analysis and opportunities for intervention in order to improve quality of care. Plan responses should conform to the requirements outlined for Quality Improvement Plans.

Draft 2007 HEDIS® measures bolded (most utilization measures omitted)

| HEDIS® Measure | Participants | Type | Years used | Comments |
|---|---|---|---|---|
| Children and adolescents' access to primary care practitioners | | Admin | 02, 05, 06 | CHP+ 06 Adolescent well care will be a substitute measure for this in 07. |
| 12-24 months | | | | |
| 25 months – 6 years | | | | |
| 7-11 years | | | | |
| 12-19 years | | | | |
| **Childhood immunization status** | **Plans, CHP+ and HCPF** | **Hybrid** | **02, 03, 04, 05, 06** | |
| DTP rate | | | | |
| MMR rate | | | | |
| IPV rate | | | | |
| HIB rate | | | | |
| Hepatitis B rate | | | | |
| VZV rate | | | | |
| Combo 1 rate | | | | |
| Combo 2 rate | | | | |
| **Appropriate treatment for children with upper respiratory infection** | **Plans, CHP+ and HCPF** | **Admin** | **05, 06** | **CHP+ 06** |
| **Well child visit in the 1st 15 months of life** | **Plans, CHP+ and HCPF** | **Admin** | **02, 03, 04, 05, 06** | **CHP+ 06** |
| Zero visits | | | | |
| One visit | | | | |
| Two visits | | | | |
| Three visits | | | | |
| Four visits | | | | |
| Five visits | | | | |
| Six or more visits | | | | |
| **Well child visit in the 3rd, 4th, 5th and 6th years of life** | **Plans, CHP+ and HCPF** | **Admin** | **02, 03, 04, 06** | **CHP+ 06** |
| **Appropriate testing for children with pharyngitis** | **Plans, CHP+ and HCPF** | **Admin** | | **CHP+ 06** |
| **Adolescent immunization status** | **Plans, CHP+ and HCPF** | **Hybrid** | **02, 03, 04, 05, 06** | |
| **Adolescent well care visits** | **Plans, CHP+ and HCPF** | **Hybrid** | **02, 03, 04, 05, 06** | **CHP+ 06** |
| **Use of Appropriate** | **Plans, CHP+** | **Admin** | **04** | **CHP+ 06** |

| HEDIS® Measure | Participants | Type | Years used | Comments |
|---|---|---|---|---|
| **medications for people with asthma** | **and HCPF** | | | **May be a focused study for 07** |
| Ages 5-9 | | | | |
| Ages 10-17 | | | | |
| Ages 18-56 | | | | |
| Combined | | | | |
| Frequency of ongoing prenatal care | | | | |
| **Prenatal/postpartum care** | **Plans and HCPF** | **Hybrid** | **03, 04, 05, 06** | **May be a focused study for 07** |
| Adults' access to preventive/ambulatory health services | | | 02, 03, 04, 06 | |
| Ages 20-44 | | | | |
| Ages 45-64 | | | | |
| Ages 65+ | | | | |
| Annual dental visit | | | 05, 06 | |
| **Breast cancer screening** | **HCPF** | **Admin** | **03, 04, 05** | |
| Cervical cancer screening | | | 03, 04, 05 | |
| Chlamydia screening in women | | | 02, 03, 04 | |
| Ambulatory Care (visits/1000 members) | | | 02, 03, 04, 05, 06 | |
| **Beta blocker treatment after heart attack** | **HCPF** | **Admin** | **02** | |
| **Controlling high blood pressure** | **Plans and HCPF** | **Hybrid** | **02, 03, 04, 05, 06** | **Increase to 25th percentile** |
| **Comprehensive diabetes care** | **Plans and HCPF** | **Hybrid** | **03, 05, 06** | |
| HbA1c testing | | | | |
| Poor HbA1C control | | | | |
| Eye exam | | | | |
| Lipid profile | | | | |
| LDL-C level <130 mg/dL | | | | |
| LDL-C level <100 mg/dL | | | | |
| Monitoring for diabetic neuropathy | | | | |
| **Cholesterol management after acute events** | **HCPF** | **Admin** | **02, 03, 04, 06** | |
| Antidepressant medication | | Admin | | |

| HEDIS® Measure | Participants | Type | Years used | Comments |
|---|---|---|---|---|
| management | | | | |
| Antibiotic utilization | | | | New measure for 06 – by drug class |
| General IP utilization | | Admin | | |

Site Review Policy and Procedure and the QST review process procedure belong here when finalized.

## Attachment C. – National Performance Measures

***42 C.F.R. Section 438.204 Elements of State quality strategies.***
*At a minimum, State strategies must include the following:*
*(c) For MCOs and PIHPs, any national performance measures and levels that may be identified and developed by CMS in consultation with States and other relevant stakeholders.*

**Behavioral Health**
There are few existing national performance measures for behavioral health. The Colorado behavioral health performance measures of member satisfaction are based on a survey created at the national level, the Mental Health Statistics Improvement Program, or MHSIP.

**Physical Health**
Each physical health plan (MCO and PIHP) collects performance measures that are nationally recognized. The measures are developed and standardized through the National Committee for Quality Assurance (NCQA). The Health Plan Employer Data and Information Set (HEDIS®) measures the care provided to the members related to access, timeliness and quality in respect to physical and developmental needs. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures consumer experience and satisfaction with the health provider and the health plan. NQCA provides technical specifications for the collection of data and requires that health plans using HEDIS® and CAHPS® complete a HEDIS® Compliance Audit™. NCQA identifies national benchmarks to enable comparison among plans and states.

## Attachment D. – External Independent Review

### *42 C.F.R. Section 438.204 Elements of State quality strategies*

*At a minimum, State strategies must include the following:*

*(d) Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract.*

The Department contracts with an EQRO to conduct an external independent review of the quality outcomes and timeliness of, and access to, the services covered under each physical and behavioral health plan (MCO and PIHP) contract. The information used to perform this review includes results and findings from: site reviews, performance measures, performance measure validations and performance improvement project validations. These results and findings are summarized, evaluated and included in the Technical Report, which is produced on an annual basis, consistent with 42 C.F.R. 438.350.

The following table lists the data sources and quality improvement activity used to measure and assess quality outcomes, timeliness of care and services and access to care and services:

| DATA SOURCE | QI ACTIVITY |
|---|---|
| **Quality outcomes** | |
| Contract - Provider Issues | Site Reviews |
| Contract - Practice Guidelines | Site Reviews |
| Contract - Access and Availability | Site Reviews |
| Contract - Utilization Management | Site Reviews |
| Contract - Continuity of Care | Site Reviews |
| Contract - Quality Assessment and Performance Improvement | Site Reviews |
| Contract - Grievances, Appeals and Fair Hearings | Site Reviews |
| Contract - Credentialing | Site Reviews |
| Plan specific performance improvement projects | PIP Validation |
| HEDIS® results<br>CAHPS® results | Performance Measure Validation |
| HEDIS® Compliance Audits | Performance Measure Validation |
| MHSIP results | Performance Measure Validation |
| CCAR results | Performance Measure Validation |
| YSSF results | Performance Measure Validation |
| Focused study topics | Focused Studies |
| Enrollment and Disenrollment trending | QST Reporting |
| Grievance and Appeal trending | QST Reporting |

| DATA SOURCE | QI ACTIVITY |
|---|---|
| **Timeliness of services** | |
| Contract - Access and Availability | Site Reviews |
| Contract - Covered Services | Site Reviews |
| Contract - Continuity of Care | Site Reviews |
| Contract - Member Rights and Responsibilities | Site Reviews |
| Contract - Grievance and Appeal | Site Reviews |
| Contract - Provider Issues | Site Reviews |
| Contract - Utilization Management | PIP Validation |
| HEDIS® and CAHPS® results | Performance Measure Validation |
| NCQA HEDIS® Compliance Audit | Performance Measure Validation |
| Annually selected study topic | Focused Studies |
| Network Adequacy trending | QST Reporting |
| Enrollment and Disenrollment trending | QST Reporting |
| Grievances and Appeals trending | QST Reporting |
| **Access to services** | |
| Contract - Utilization Management | Site Reviews |
| Contract - Continuity of Care | Site Reviews |
| Contract - Grievances, Appeals and Fair Hearings | Site Reviews |
| Contract - Member Rights and Responsibilities | Site Reviews |
| Contract - Compliance and Monitoring | Site Reviews |
| Network Adequacy trending | QST Reporting |
| Enrollment and Disenrollment trending | QST Reporting |
| Grievances and Appeal trending | QST Reporting |
| Inpatient Benefit Limits trending | QST Reporting |
| BHO penetration rate | Performance Measure Validation |

## Attachment E. – Intermediate Sanctions

***42 C.F.R. Section 438.204 Elements of State quality strategies.***
*At a minimum, State strategies must include the following:*
*(e) For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.*

The following language is taken from Section IV of the MCO contracts:

**INTERMEDIATE SANCTIONS**
The Department may choose to impose any of the following intermediate sanctions:

a. Civil monetary penalties to a limit of $25,000 for each determination of failure to adhere to contract requirements as stated in Sections IV.B.1, IV.B.4, IV.C.4 and IV.C.5.

b. Civil monetary penalties to a limit of $100,000 for each determination of a failure to adhere to contract requirements as stated in sections IV.C.2 and IV.C.3.

c. Civil monetary penalties to a limit of $15,000 for each Client the State determines was not Enrolled because of a discriminatory practice under Section IV.C.2, up to a limit of $100,000.

d. Civil monetary penalties to a limit of $25,000, or double the amount of excess charges, whichever is greater, for excess charges under Section IV.C.1.

e. Imposition of temporary management, if the Contractor has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act. Temporary management will continue until it has been determined that the Contractor can ensure that the sanctioned behavior will not recur. Enrollees will be granted the right to terminate enrollment without cause and notify the affected enrollees of their right to terminate enrollment.

f. Allow Members the right to terminate Enrollment without cause with notification to the Members of their right to terminate Enrollment, for each failure to adhere to contract requirements as stated in Section IV.C.6.

g. Suspension of all new Enrollments, after the effective date of the sanction for each failure to adhere to contract requirements as stated in Section IV.C.6 until necessary services or corrections in performance are satisfactorily completed as determined by the Department.

h. Suspension of payment for Enrollments after the effective date of the sanction for each failure to adhere to contract requirements as stated in Section IV.C.6 until the necessary services or corrections in performance are satisfactorily completed as determined by the Department.

## Attachment F. – Information Systems

***42 C.F.R. Section 438.204 Elements of State quality strategies.***
*At a minimum, State strategies must include the following:*
*(f) An **information system** that supports initial and ongoing operation and review of the State's quality strategy.*

The Department has two major information systems that support the ongoing operation and review of the Quality Strategy: the Medicaid Management Information System (MMIS) and the Colorado Benefits Management System (CBMS).

The MMIS is the system that adjudicates and pays provider claims services provided to Medicaid fee for service clients. The MMIS pays claims based upon detailed algorithms, which in turn are based upon the State Plan and 10 CCR 25405-10, et al. Details of these claims and resultant payments are maintained in the MMIS for a period of three years with five years claims history available in the decision support system. A decision support system, Business Objects Application (BOA), provides the capability to access the data by any stored data elements. This broad access to data supports the ongoing operation and review of the Quality Strategy by providing ad hoc reporting capabilities.

The CBMS determines Medicaid eligibility and retains information on clients determined eligible. Eligibility data is sent to the MMIS on a daily basis. The CBMS retains eligibility information for a period of ten years. This data can also be accessed via a decision support system compatible with BOA.

## Attachment G.– Standards

***42 C.F.R. Section 438.204 Elements of State quality strategies.***
*At a minimum, State strategies must include the following:*
*(g) Standards, at least as stringent as those in the following sections of this subpart, for access to care, structure and operations, and quality measurement and improvement.*

Following is a list of contract requirements applicable to access to care, structure and operations and quality measurement and improvement:

| Standard | Regulation | Physical Health Contract Provision | Behavioral Health Contract Provision |
|---|---|---|---|
| **Access to care** | | | |
| | Availability to Services (42 C.F.R. 438.206) | Section II. D. Covered Services | Section II.F Service Delivery - Access |
| | | Section II. E. Service Delivery –Access | |
| | | Section II.C. Enrollment and Disenrollment | |
| | Assurance of Adequate Capacity and Services (42 C.F.R. 438.207) | Section II.D. Covered Services | Section II.F. Service Delivery - Access |
| | | Section II.E. Service Delivery | |
| | | Section II.H. Subcontracts | |
| | | Section II.F. Member Issues | |
| | Coordination and Continuity of Care (42.C.F.R. 438.208) | Section II.E. Service Delivery – Coordination and Continuity of Care | Section II.F. Service Delivery - Access |
| | Coverage and Authorization of Services (42 C.F.R. 438.210) | Section II.D Covered Services | Section II.E. Covered Services |
| | | Section II.C. Enrollment and Disenrollment | Section II.G. Member Issues |
| | | Section II.H. Subcontracts | Section II.J Compliance and Monitoring |
| **Structure and** | Provider Selection | Section II.G. | Section II.C |

| Standard | Regulation | Physical Health Contract Provision | Behavioral Health Contract Provision |
|---|---|---|---|
| **operations** | (42. C.F.R. 438.214) | Provider Issues | Subcontracts |
| | | Section II.H. Subcontracts | Section II.D. Enrollment and Disenrollment |
| | | Section II.F. Member Issues | Section II.G. Member Issues |
| | | | Section II.H. Provider Issues |
| | Enrollee Information (42 C.F.R. 438.218) | Section II.F. Member Issues | Section II.G. Member Issues |
| | Confidentiality (42 C.F.R. 438.224) | Section II.E Service Delivery- Access | Section II.G. Member Issues |
| | | Section II.I. Compliance Issues | |
| | Enrollment and Disenrollment (42 C.F.R. 438. 226) | Section II.C. Enrollment and Disenrollment | Section II.D. Enrollment and Disenrollment |
| | Grievance Systems (42 C.F.R. 438. 228) | Section II.F. Member Issues | Section II.G. Member Issues |
| | Subcontractual Relationships and Delegation (42 C.F.R. 438. 230) | Contract Section II.H. Subcontracts | Section II.C Subcontracts |
| **Quality measurement and improvement** | Practice Guidelines (42 C.F.R. 438. 236) | Section II.J. Quality Assessment and Performance Improvement | Section II.I. Quality Assessment and Performance Improvement |
| | Quality Assessment and Performance Improvement Projects (42 C.F.R. 438. 240) | Section II.J. Quality Assessment and Performance Improvement | Section II.I. Quality Assessment and Performance Improvement |
| | Health Information Systems (42 C.F.R. 438. 242) | Section II.I. Compliance and Monitoring | Section II.I. Quality Assessment and Performance Improvement |
| | | Section II.J. Quality Assessment and Performance Improvement | |

# Attachment H.-Glossary of Terms

**ACCESS**: The degree to which clients have the ability to obtain medically necessary care and services. Access is be measured by several factors, including the number of providers, the geographic distribution of providers, the number of providers accepting new clients, the time and distance required to reach a provider and the type of providers available in a given area.

**ANNUAL QUALITY REPORTS**: The MCO and BHO submit two reports to the Department related to Quality Improvement:

1. Program Impact Analysis and Annual Report – details the techniques the plans used to improve performance, the outcome of each performance improvement project and the overall impact and effectiveness of the quality assessment and improvement program.
2. Quality Improvement Plan – delineates current and future quality assessment and performance improvement activities.

**BOA**: Business Objects Application is the decision support system utilized by the Department.

**CAHPS®:** The Consumer Assessment of Healthcare Providers and Systems **(**CAHPS®) program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Health care organizations, public and private purchasers, consumers, and researchers use CAHPS® results to:

- Assess the patient-centeredness of care;
- Compare and report on performance; and
- Improve quality of care.

CAHPS® surveys are developed for three defined populations: Adults, Children or Children with Chronic Needs. Colorado Medicaid MCOs, the Primary Care Physicans Program (PCPP) and the Fee-for-Service (FFS) populations, use CAHPS®. Annual survey selection of CAHPS® is determined in the MQuIC with final Departmental approval. The HEDIS® audit also reviews the CAHPS® data collection processes.

**CCAR**: The Colorado Client Assessment Record is a tool used to measure and assess the functional status of clients receiving behavioral health services. The CCAR is completed for behavioral health consumers at 12-month intervals during care and when there are significant changes in the consumer's status.

**CMS**: The Centers for Medicare and Medicaid Services, a federal government agency of the Department of Health and Human Services, is the agency which provides partial funding and oversight for the Colorado Medicaid Program.

**COMPLIANCE REPORTING**: Compliance reports are a collection of information about selected aspects of health plan contract performance. Quarterly reports include data and analysis of operational issues such as enrollment and disenrollment, network adequacy and grievances and appeals. The reports are reviewed by the QST.

**FOCUSED STUDIES:** A focused study is the measurement of a defined topic related to the care or services provided to Medicaid clients. Topics for focused studies are recommended through the MQuIC and final department approval is required. Topics can be based on HEDIS® or CAHPS® results, problem areas, high service utilization, high claims costs, defined populations or special needs. There are two studies conducted each year, at least one of the studies uses data collection from medical records.

**HEDIS®:** HEDIS® (Health Employer Data and Information Set) is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to compare reliably the performance of managed health care plans. The performance measures in HEDIS® are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes. HEDIS® also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims possessing. HEDIS® is sponsored, supported, and maintained by the National Center for Quality Assurance.

Colorado Medicaid selects ten HEDIS® measures to collect annually. The measures selected are based on most frequent diagnoses, utilization, demographics, and timely topics such as immunization rates. Input is obtained from the MCOs, the PCPP, and the EQRO during the MQuIC meetings. A minimum of four of the selected measures are hybrid measures, which require medical record abstraction. Data to compute the other six measures are derived from claims data. All MCOs are required to obtain validation of their HEDIS® measures through a certified NCQA HEDIS® Compliance Audit Vendor.

**MCO:** Managed Care Organization is a term defined by CMS that means an entity that has, or is seeking to qualify for a comprehensive risk contract, and that is:

(1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of Title 42 of the Code of Federal Regulations or

(2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.

(ii) Meets the solvency standards of 42 C.F.R. Section 438.116.

**MEDICALLY NECESSARY:** A covered service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs. 10 CCR 2505-10, Section 8.200.1

**MHSIP**: The Mental Health Statistics Improvement Program survey, which measures consumer satisfaction with services provided by Behavioral Health Organizations. MHSIP is administered annually to a sample of adult consumers.

**MQuIC**: The Medical Quality Improvement Committee is comprised of quality representatives from contracted managed care organizations, prepaid inpatient health plans and the primary care physician program. The MQuIC discusses quality issues, reporting deadlines, EQRO activities and site review activities.

**PASRR**: The Pre-Admission Screening and Resident Review process assesses mental health level of functioning and cognitive ability and assigns scores used to determine a level of care need.

**PIHP:** Prepaid Inpatient Health Plan is a term defined by CMS that 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.

**PIP**: A Performance Improvement Project is an activity that measures, analyzes and improves an aspect of care or services.

**QUALITY:** The degree to which care and services meets standards, regulations and expectations. There are three aspects to quality: structure, process and outcome. Structure relates to existence of policies, procedures, care plans and reporting mechanisms. Process relates to the degree of compliance with the structural aspects of care and services. Outcome relates to the results of the structure and process of care and services.

**QST**: The Quality Strategy Team is a team of Department staff whose specialty is either quality improvement or managed care contracting. The QST meets on a quarterly basis to review MCO and PIHP quarterly reports related to the timelines and access to care and services. The MCO or PIHP is contacted about any issues, adverse trends or questions that arise. QST members are informed of the MCO or PIHP response and further follow up is taken as indicated.

The QST also conducts MCO and PIHP site reviews. The knowledge gained during the year through review of quarterly reporting augments the contract and regulation compliance site reviews. This team also provides input on the Quality Strategy.

**SEP Agency**: Single Entry Point Agency is a single access or entry point within a local area where a current or potential long-term care client can obtain long-term care information, screening, needs assessment and referral to appropriate long-term care programs and case management services.

**TIMELINESS**: The degree to which clients can access medically necessary care and services when necessary or desired.

**YSSF**: The Youth Services Survey for Families is a behavioral health client satisfaction survey. The YSSF is administered annually to a sample of parents whose children have received BHO services in the last twelve months.

# Attachment I. – Quality Improvement Work Plan

This Quality Improvement Work Plan provides an overview of the timeframes in which objectives will be met and performance measurement will occur.

## Objectives

Some objectives have defined end dates and others are ongoing as indicated in the chart below.

| Objective | FY07 | FY08 | FY09 |
|---|---|---|---|
| **Goal A: Assure medically necessary, appropriate and cost-effective health care** | | | |
| **Objectives:** | | | |
| 1. Increase client use of the nurse advice line as an alternative to emergency room care for non-emergency conditions. | √ | √ | √ |
| 2. Increase clients' knowledge and ability to self-manage chronic conditions through participation in disease management programs. | √ | √ | √ |
| 3. Explore the feasibility of routinely reporting utilization measures. | √ | √ | |
| 4. Increase focus on outcomes of care and care processes in QI activities. | | √ | |
| 5. Conduct one intervention designed to improve an aspect of care annually. | √ | √ | √ |
| 6. Refine the prior authorization process contracted to the Department's Utilization Management (UM) Contractor so that the process for non-routine requests for services is documented and understood by all involved parties. | | √ | |
| | | | |
| **Goal B: The Department will continuously improve the oversight of activities delegated to agencies and contractors.** | | | |
| **Objectives** | | | |
| 1. Refine the Quality Strategy Team (QST) reporting process so that the managed care plans know the expectations, and feedback and follow-up are performed routinely. | √ | | |
| 2. Develop a mechanism for QI oversight of Home and Community Based Services (HCBS) QI delegated activities. | | √ | |
| 3. Increase the objectivity of managed care plan site reviews. | √ | √ | |
| 4. Adequately and accurately document the site review corrective action process. | √ | √ | √ |
| 5. Explore the feasibility of implementing positive provider and contractor incentives for quality, utilization, and client satisfaction. | √ | √ | |

| Objective | FY07 | FY08 | FY09 |
|---|---|---|---|
| **Goal C: The Department will partner with public and private entities to maximize the resources to improve the health status of Coloradans.** | | | |
| **Objectives** | | | |
| 1. Seek stakeholder agency input to this Quality Strategy. | √ | | |
| 2. Seek stakeholder input when designing HCBS quality program. | √ | √ | |
| 3. Work with other State Departments and Divisions to maximize resources available to improve the health status of clients. | √ | √ | √ |
| | | | |
| **Goal D.1: Evaluate client health and satisfaction** | | | |
| **Objectives** | | | |
| 1. Measure client physical health using selected Health Plan Employer Data and Information Set (HEDIS®) indicators and one focused study. | √ | √ | √ |
| 2. Measure consumer behavioral health outcomes using Colorado Client Assessment Record (CCAR) measures. | √ | √ | √ |
| 3. Measure client satisfaction using Consumer Assessments of Health Plans Survey (CAHPS®), Mental Health Statistical Improvement Project (MHSIP) and Youth Services Survey for Families (YSSF) measures. | √ | √ | √ |
| | | | |
| **Goal D.2: Model program design to promote improved health delivery.** | | | |
| **Objectives:** | | | |
| 1. Explore the feasibility of implementing managed care plan pay for performance contracting. | √ | | |
| 2. Develop a mechanism to identify and promote best practices. | √ | √ | √ |
| 3. Develop a quality program for the HCBS waiver programs. | √ | | |
| 4. Increase provider participation in the Pre-Admission Screening and Resident Review (PASRR) algorithm process. | √ | √ | |
| | | | |
| **Goal D.3: Furnish information about the quality of care and general client satisfaction so that clients may make informed choices about the care they receive.** | | | |
| **Objectives:** | | | |
| 1. Produce managed care plan Report Card and send to all newly eligible clients. | √ | √ | √ |
| 2. Develop routine QI activity management reporting. | | √ | |
| 3. Improve the format and type of information on the Department's web site regarding quality of care and | √ | √ | √ |

| Objective | FY07 | FY08 | FY09 |
|---|---|---|---|
| client satisfaction. | | | |
| 4. Post QI activity results on QI web pages. | √ | √ | √ |
| | | | |
| **Goal E. The Department will value its personnel through effective recruitment, hiring, training and retention. The Department will allocate its staff and resources in ways to ensure that it addresses the organization's priorities.** | | | |
| **Objectives:** | | | |
| 1. Increase QI Section staff knowledge of quality assessment and performance improvement methodologies by participating in educational programs while staying within budget. | √ | √ | √ |
| 2. Participate in Department sponsored employee training. | √ | √ | √ |
| 3. Fill open QI Section positions with qualified staff as soon as possible after notification of an opening. | √ | √ | √ |
| 4. Utilize the Web to investigate and incorporate improvements to practices and to this Strategy. | √ | √ | √ |
| 5. Increase QI Section staff knowledge of Medicaid by inviting other Sections to present at QI Section meetings. | √ | √ | √ |
| 6. Promote cross-functional interaction within the Section whenever possible. | √ | √ | √ |
| 7. Empower QI staff to fulfill their responsibilities by training staff about the following topics: Medicaid, the role of the QI Section; rules, regulations and statutes; applicable contracts and contractors and Department and Division standards and expectations. | √ | √ | √ |
| 8. Train other Department Sections about QI functions and the outcomes. | √ | √ | √ |
| | | | |
| **Goal F: The Department will respond appropriately and effectively to changing requirements with the federal government, such as the Deficit Reduction Act, while considering client needs and State budgeting concerns.** | | | |
| **Objectives:** | | | |
| 1. Improve the Technical Report content to align more clearly existing quality activities into the Centers for Medicare and Medicaid Services (CMS) categories of quality outcomes, access to care and services and timeliness of care and services. | √ | √ | √ |
| 2. Participate in CMS sponsored educational meetings when offered. | √ | √ | √ |
| 3. Design and implement a HCBS quality improvement program. | √ | √ | √ |

## Performance Measurement

In determining the topics used to measure performance two factors are taken into account: available performance measures and the Medicaid caseload.

The available physical health performance measures fall into the following categories: care for children, care for adults, care for clients with chronic diseases, satisfaction with care for children, satisfaction with care for adults, satisfaction with care for disabled clients, utilization measures and value of care. The available behavioral health performance measures fall into the following categories: functional outcomes, access, satisfaction with care for children, satisfaction with care for adults and utilization measures.

Medicaid caseload as of October 2006
(Source: Age ratios based on BOA query on 11/6/06 applied to MARS 4600 report of Medicaid caseload.)

| Medicaid Caseload | Number | % |
|---|---|---|
| Total number of clients under age 21[1] | 220,748 | 71.6% |
| Total number of clients aged 21-65[2] | 46,771 | 15.2% |
| Total number of clients aged 66 and above[3] | 40,763 | 13.2% |
| Total number of clients | 308,282 | 100.0% |
| | | |
| Disabled individuals under age 21 | 9,740 | 20%[4] |
| Disabled individuals aged 21 – 65 | 38,871 | 79.9%[5] |
| Total disabled individuals | 48,611 | 99.9% |
| Percent of disabled clients | | 15.8% |

[1]AND/AB, AFDC-C, BC, QMB
[2]AND/AB, QMB
[3]OAP-A, AND/AB, QMB
[4]Percent of total disabled individuals
[5]Percent of total disabled individuals

Available performance measure categories

| Performance Measure Category | FY06 | FY07 | FY 08 | FY 09 |
|---|---|---|---|---|
| Physical Health | | | | |
| Care for children | √ | √ | √ | √ |
| Care for adults | √ | √ | √ | √ |
| Care for clients with chronic diseases | √ | √ | √ | √ |
| Satisfaction with care for children | √ | √ | | √ |
| Satisfaction with care for adults | √ | √ | | √ |
| Satisfaction with care for disabled clients | | | √ | |
| Utilization of services | √ | √ | √ | √ |
| Value of care | | | √ | √ |
| **Performance Measure Category** | **FY06** | **FY07** | **FY 08** | **FY 09** |
| Behavioral Health | | | | |
| Functional outcomes | √ | √ | √ | √ |
| Access | √ | √ | √ | √ |
| Satisfaction with care for children | √ | √ | √ | √ |
| Satisfaction with care for adults | √ | √ | √ | √ |
| Utilization of services | | | √ | √ |

# Attachment J. – HCBS QI Program

## Waiver Programs

The Department operates ten Home and Community Based Services (HCBS) waivers listed below. This Quality Strategy encompasses all services provided under these waivers. The services provided under these waivers are listed in Exhibit 1.

| WAIVER NAME | WAIVER CONTROL NUMBER |
|---|---|
| Brain Injury | 0288.90.R1.02 |
| Children's Extensive Support* | 4180.90 |
| Children's Home and Community Based Services | 4157.9.R.1 |
| Children's Home and Residential Program** | 0305.90 |
| Children with Autism | 0434 |
| Developmental Disabilities* | 0007.91.R4 |
| Elderly, Blind and Disabled | 0006.90.R3 |
| Mental Illness | 0268.90.R1 |
| Persons Living with Aids | 0211.90.02 |
| Supported Living Services* | 0239.90 |

*These waiver programs are operated by the DHS, Developmental Disabilities Division
**This waiver program is operated by the DHS, Division of Child Welfare

## Introduction

The CMS waiver process lays out the structure for waiver program quality activities, including two major sections: Service Dimensions and Waiver Components. Each waiver application must contain a description of the quality activities undertaken for the waiver using the defined structure. This attachment contains the quality section of waiver program applications and includes additional CMS suggestions regarding quality activities.

## Service Dimensions

CMS has identified seven dimensions of service that are integral to any HCBS quality improvement effort. The Department will include service dimension measures when designing performance improvement activities. The design process begins by examining existing quality activities in order to determine if each service dimension is measured. Each performance improvement project will include all of the service dimensions, with the goal of attaining the desired outcomes. The quality activities listed below reflect current and future activities and may be modified as necessary to achieve the desired outcomes.

| SERVICE DIMENSIONS | QUALITY ACTIVITIES | DESIRED OUTCOMES |
|---|---|---|
| Participant Access | • Performance improvement projects as determined by prioritization table | • Individuals have access to home and community-based services and supports in their communities.<br>• Improve outcomes |
| Participant Centered Service Planning and Delivery | • Department on-site visits to SEP agencies.<br>• Department comparison of service plan to billed services<br>• SEP agency designation process<br>• Performance improvement projects as determined by prioritization table | • Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.<br>• Assure participants receive the service plan services<br>• Assure the SEP agency has providers to provide all services<br>• Improve outcomes |
| Provider Capacity and Capabilities | • Provider licensure or certification verified upon initial application and annually thereafter<br>• Mandatory training of all providers<br>• Performance improvement projects as determined by prioritization table | • There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.<br>• Minimum standard for all providers applied<br>• Minimum knowledge base is established for all providers<br>• Improve outcomes |
| Participant Safeguards | • Instances of abuse, neglect and exploitation are identified and acted upon.<br>• Monitoring use of restraints and seclusion<br>• Performance improvement projects as determined by prioritization table | • Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.<br>• Eliminate instances of abuse, neglect and exploitation.<br>• Assure appropriate safeguards are implemented<br>• Improve outcomes |

| SERVICE DIMENSIONS | QUALITY ACTIVITIES | DESIRED OUTCOMES |
|---|---|---|
| Participant Rights and Responsibilities | • Performance improvement projects as determined by prioritization table | • Participants receive support to exercise their rights and in accepting personal responsibilities.<br>• Improve outcomes |
| Participant Outcomes and Satisfaction | • Participant complaint reporting<br>• Performance improvement projects as determined by prioritization table<br>• Client satisfaction survey | • Participants are satisfied with their services and achieve desired outcomes.<br>• Improve outcomes<br>• Identify potential areas for improvement |
| System Performance | • Performance improvement projects as determined by prioritization table | • The system supports participants efficiently and effectively and constantly strives to improve quality.<br>• Improve outcomes |

## CMS Quality Strategy Components

CMS requires that the Quality Strategy for each waiver application address five components:

1. How the state will determine that each waiver assurance is met during the period that the waiver is in effect
2. The roles and responsibilities of the parties involved in measuring performance and making improvements
3. The processes that are employed to review findings from discovery activities, use those findings to establish priorities and to develop strategies for remediation and improvements
4. How quality management information is compiled and how frequently this information is communicated to waiver participants, families, service providers, other interested parties and the public
5. How and when the Quality Strategy will be periodically evaluated and revised as necessary and appropriate

These five components are listed below with an explanation of how each component is accomplished.

**Component 1: How the state will determine that each waiver assurance is met during the period that the waiver is in effect**

Each waiver assurance that must be addressed in this Quality Strategy is listed below in italics. A description of how the Department will determine the assurance is met is included after each statement of assurance.

### *ASSURANCE A: LEVEL OF CARE DETERMINATION*

The State contracts with SEP agencies to evaluate the level of care needed for each potential waiver participant. This evaluation is performed utilizing the ULTC 100.2 functional assessment form. Since this tool is required for each participant when entering a waiver and periodically thereafter, it allows for clear documentation of the level of care (LOC) determination. Each waiver participant is re-evaluated by SEP agency case managers at least annually to determine if there remains a constant level of care need.

The SEP agencies are reviewed annually by the Department, which includes an audit of the ULTC 100.2 level of care determination documentation. Information from the ULTC 100.2 is entered into the Benefits Utilization System (BUS) on a real-time basis, which is accessible by the SEP agencies and the Department. The annual reviews and processes are listed at 10 CCR 2505-10, Section 8.394. The following chart describes the level of care determination processes.

| Assurance Requirement | Monitoring Activity (Frequency) | Monitoring Responsibility | Information Used | Management Reports | Report Frequency |
|---|---|---|---|---|---|
| An evaluation of LOC is provided to all applicants for whom there is a reasonable indication that services may be needed in the near future. | Ongoing review of LOC evaluation in BUS | Community Based Long Term Care | BUS | Survey Results/Findings | Not less than annually |
| | Annual Department SEP agency site review | Community Based Long Term Care | SEP agency Audit Monitoring Tool- Conformance to Standard Client Records | Frequency and type of deficiencies cited by case management agency | Annually |
| Enrolled participants are reevaluated at least annually. | BUS is reviewed to determine activity from case manager | Community Based Long Term Care | Electronic data from BUS | BUS Reports | Annually |
| | Annual Department SEP agency site review | Community Based Long Term Care | SEP agency Audit Monitoring Tool- Conformance to Standards | Frequency and type of deficiencies cited by case management agency | Annually |
| The process and instruments described in the approved waiver are applied to determine LOC | Annual Department SEP agency site review | Community Based Long Term Care | SEP agency Audit Monitoring Tool- Conformance to Standard ULTC 100.2. | Frequency and type of deficiencies cited by case management agency | Annually |

| Assurance Requirement | Monitoring Activity (Frequency) | Monitoring Responsibility | Information Used | Management Reports | Report Frequency |
|---|---|---|---|---|---|
| The state monitors LOC decisions and takes action to address inappropriate level of care determinations | Annual Department SEP agency site review | CBLTC | SEP agency Audit Monitoring Tool- Conformance to Standard ULTC 100.2. | Frequency and type of deficiencies cited by case management agency | Annually |

### *ASSURANCE B. SERVICE PLAN*

Waiver participants' assessed needs and personal goals are addressed through a service plan that identifies goals and client choices for the care needed, services needed, and appropriate service providers. The SEP agency Case Manager provides information regarding the service providers available in the client's geographic area. (Refer to Appendix D for a complete explanation of the Service Plan Development process) The SEP agency Case Manager is required to assess the client as indicated at 10 CCR 2505-10, Section 8.393.2 D 1-14 to determine the appropriate service plan. The following chart describes the processes involved in service plan development.

| Assurance Requirement | Monitoring Activity | Monitoring Responsibilities | Information Used | Management Reports | Frequency |
|---|---|---|---|---|---|
| Service Plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means | Ongoing provider reviews by SEP agencies and Annual Department SEP agency site review | SEP agencies and Community Based Long Term Care Section | Client Records and SEP agency Site Review Tool | Onsite Review Results | Annually The SEP agency review the service plan and contact providers at least every six months |
| | SEP agency designation application process | Community Based Long Term Care | SEP agency Designation Compliance Data | Annual SEP agency Designation Compliance Report | Annually |
| State monitors service plan development in accordance with its policies and procedures and take appropriate action when it identifies inadequacies in the service plan. | SEP agency Monitoring | Community Based Long Term Care | BUS and Client Records/Charts | Survey Results/Findings; CAP | Annually |
| Service plans are updated/revised when warranted by changes in the participant's needs. | Ongoing Case Management by SEP Agency SEP Monitoring | SEP agency and Community Based Long Term Care | Client Records and BUS | Survey Results/Findings; CAP | At Least Annually |
| | Client satisfaction tool sent | Community Based Long Term Care | Client Satisfaction tool data | Roll up of Client Satisfaction data | Annually |

| Assurance Requirement | Monitoring Activity | Monitoring Responsibilities | Information Used | Management Reports | Frequency |
|---|---|---|---|---|---|
| | annually | | | | |
| Service plans describe the type, scope, amount, duration and frequency of services and services are delivered per the service plan. | Internal Policies of SEP agency and Annual Department SEP agency site review | SEP agencies and Community Based Long Term Care | Comparison of billed services to service plan. | Prior Authorization Reports, Service Plan Reports, Itemization of Services Received | Annually and As Needed |
| Participants are afforded choice between waiver services and institutional care, and a choice of waiver services and providers. | Case Management by SEP agency and Annual Department SEP agency site review | Community Based Long Term Care | SEP agency site review tool | Survey Results/Findings | Annually |

### *ASSURANCE C. QUALIFIED PROVIDERS*

Provider licensure and/or certification standards are defined in the Provider Participation Agreement and state rules and regulations. The Department assures providers meet these standards through surveys conducted on an ongoing basis by the Department of Public Health and Environment per an interagency agreement and by requiring all providers to sign and adhere to the Provider Participation Agreement. All waiver service providers are licensed or certified by the State, hence there is not a need for monitoring of uncertified or unlicensed providers. The Department does not contract with providers that do not meet these licensure and/or certification standards. The Department monitors the results of audits and recommendations from the Department of Public Health and Environment. The Department's Community Based Long Term Care Section reviews these reports.

Whenever it is discovered that a provider is out of compliance with licensure and/or certification standards the Department of Public Health and Environment notifies the Department of Health Care Policy and Financing within 2 business days unless clients are placed in immediate jeopardy. In cases of immediate jeopardy the Department of Public Health and Environment will act within Federal guidelines as appropriate by implementing an immediate corrective action plan prior to the inspector leaving the facility. Refer to the following chart for a description of the processes involved in licensure or certification of providers.

| Assurance Requirement | Monitoring Activity | Monitoring Responsibilities | Information Used | Management Reports | Frequency |
|---|---|---|---|---|---|
| State verifies on a periodic basis that providers meet required licensing and/or certification standards and adhere to other state standards | Provider Application Approval | Community Based Long Term Care | Service agency application data | Annual Initial Program Approval Data Report | Initial Program Approval Only |
| | Annual Department SEP agency site review | Community Based Long Term Care | SEP agency site review tool | SEP agency site review management report | Annually |
| State monitors non-licensed/non-certified providers to assure adherence to waiver requirements | Not applicable as all waiver providers are certified or licensed | N/A | N/A | N/A | N/A |
| State identifies and rectifies situations where providers do not meet requirements | Monitoring activities conducted by the Department of Public Health and Environment | Community Based Long Term Care | On Site Reviews conducted by the Department of Public Health and Environment | Annual Reports submitted by the Department of Public Health and Environment | Ongoing |

| Assurance Requirement | Monitoring Activity | Monitoring Responsibilities | Information Used | Management Reports | Frequency |
|---|---|---|---|---|---|
| State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver | Monitoring activities conducted by the Department of Public Health and Environment per an interagency agreement. | Community Based Long Term Care | On Site Reviews conducted by the Department of Public Health and Environment | Annual Reports submitted by the Department of Public Health and Environment | Ongoing |

### *ASSURANCE D. HEALTH AND WELFARE*

The health and welfare of waiver participants is monitored by the SEP agency per the rules located at 10 CCR 2505-10, Section 8.393. The Department conducts annual on-site reviews of the SEP agencies to determine if appropriate methods were used to ensure the health and welfare of waiver participants is maintained. Reviews are conducted to ensure participants have access to the appropriate services as indicated in the service plan. The BUS is also utilized to provide real time data to the Department and the SEP agency.

On a continuing basis the Department ensures the SEP agency is conducting comprehensive client assessments to identify abuse, neglect or exploitation. This is noted during the annual on-site review of the SEP agency where a statistically valid sample of cases is reviewed. If an allegation of abuse, neglect, or exploitation is received by the DPHE an investigation will be conducted per the interagency agreement. The following chart describes how the health and welfare of waiver participants is monitored.

| Assurance Requirement | Monitoring Activity | Monitoring Responsibilities | Information Used | Management Reports | Frequency |
|---|---|---|---|---|---|
| On a continuous basis the State monitors the health and welfare of participants and initiates remediation actions when appropriate | Ongoing Complaint Monitoring | Community Based Long Term Care | Complaint Log Monthly tracking data | Number and Type of Complaints | Quarterly and Annually |
| | Department of Public Health and Environment Occurrence Reporting System | Community Based Long Term Care | Occurrence reports and aggregate data Complaint Investigation Reports | Occurrence Report Summary Data | Quarterly and Annually |
| State on an ongoing basis identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation | Ongoing Complaint Monitoring | Community Based Long Term Care | Complaint Log | Number and type of complaints | Quarterly and Annually |
| | Department of Public Health and Environment Occurrence Reporting System | Community Based Long Term Care | Occurrence reports and Complaint Investigation Reports | Occurrence Report Summary Data | Quarterly and Annually |
| | Client Satisfaction Surveys | Community Based Long Term Care | Aggregate data from surveys | | Annually |
| State monitors use of restraints, seclusion, medication administration and management | Department of Public Health and Environment Site Visits to care facilities | Community Based Long Term Care | Data from On Site Reviews | Site Review Reports | Annually |

***ASSURANCE E. ADMINISTRATIVE AUTHORITY***

The State must demonstrate that:

If an agency other than the State Medicaid agency has operational responsibility for the waiver program:

There is an interagency agreement or memorandum of understanding between the State Medicaid agency and the operating agency that delineates the roles and responsibilities of each party.

The State Medicaid agency assumes responsibility for all policy decisions regarding the waiver, as well as monitoring their implementation by the operating agency.

Both the administering and operating agencies provide the information and data needed to carry out the interagency agreement or memorandum of understanding. For example, the State Medicaid agency may need to provide to the operating agency information pertaining to the Medicaid program, Federal requirements for waiver programs (e.g. Health and Welfare Assurances and other Basic Assurances, Level of Care Eligibility Determinations, Freedom of Choice, Plan of Care requirements). Likewise, the operating agency may be required to provide reports or data to the State Medicaid agency.

The State Medicaid agency monitors the interagency agreement or the memorandum of understanding to assure that the provisions specified are executed.

*Action on this assurance is in process with the Colorado Department of Human Services.*

***ASSURANCE F - FINANCIAL ACCOUNTABILITY***

The Department's system for assuring financial accountability of the waiver program has three ongoing monitoring activities, which are described below:

| Assurance Requirement | Monitoring Activity | Monitoring Responsibilities | Information Used | Management Reports | Frequency |
|---|---|---|---|---|---|
| Claims for FFP in the cost of waiver services are based on state payments for waiver services that have been rendered to waiver participants authorized in the service plan and properly billed by qualified waiver providers in accordance with the approved waiver | Conducting post-payment and/or concurrent reviews. | Program Integrity | MMIS Reports and BOA Reports | Case Summary Reports | Ongoing |
| | Verifying Provider adherence to professional licensing and certification requirements. | Program Integrity | Department of Regulatory Agencies Reports | Case Summary Reports | Ongoing |
| | Reviewing services rendered for fraud and abuse. | Program Integrity | MMIS Reports and BOA Reports | Case Summary Reports | Ongoing |

**Component 2:** **The roles and responsibilities of the parties involved in measuring performance and making improvements.** Refer to Section V (page 6) of this document.

**Component 3:** **The processes that are employed to review findings from discovery activities, use those findings to establish priorities and to develop strategies for remediation and improvement**

**Discovery, Remediation and Improvement**
CMS defines the quality management functions as discovery, remediation and improvement. In order to easily implement these quality management functions across a broad spectrum of stakeholders, the Department's adaptation of these functions is spelled out in the table below using the FOCUS/PDCA process. The FOCUS/PDCA process is an extension of the Deming cycle for improving processes.

The chart below indicates the steps associated with the FOCUS/PDCA improvement process and shows how this process fits the CMS quality management functions:

| FOCUS/PDCA | CMS Quality Management Functions |
|---|---|
| **F**ind a process improvement opportunity | Discovery |
| **O**rganize a team who understands the process | Discovery |
| **C**larify the current knowledge of the process | Discovery |
| **U**ncover the root cause of variation/poor outcomes | Discovery |
| **S**tart the "plan/do/check/act" cycle | Remediation |
| **P**lan the process improvement | Remediation |
| **D**o the improvement, data collection and analysis | Remediation |
| **C**heck the results and lessons learned | Remediation |
| **A**ct by adopting, adjusting or abandoning the change | Improvement |

**Prioritization**

The focus of quality activities is determined based on the priority of the service to the client and the Department. These activities are prioritized utilizing the prioritization matrix shown in Exhibit 2.

**Component 4: How quality management information is compiled and how frequently this information is communicated to waiver participants, families, service providers, other interested parties and the public**

This aspect of the Quality Strategy is currently being developed. Quality measurement results will be posted to the Department's website, as it is for all other Department quality activities. Currently public and stakeholder groups obtain existing Department reports upon request. The Department will continue to communicate with the CMS annually through the 373 reports and with periodic updates to this Quality Strategy. The Department communicates to waiver providers through a monthly Provider Bulletin.

The following table describes a schedule for the quality improvement activities designed to ensure the CMS mandated assurances are being met.

| QI ACTIVITY | FY06 Q3 | FY06 Q4 | FY07 Q1 | FY07 Q2 | FY07 Q3 | FY07 Q4 | FY08 Q1 | FY08 Q2 | FY08 Q3 | FY08 Q4 |
|---|---|---|---|---|---|---|---|---|---|---|
| QI Program Development | | X | X | X | | | | | | |
| Stakeholder Input+ | X | X | X | X | X | X | X | X | X | X |
| Site Reviews | X | X | X | X | X | X | X | X | X | X |
| Performance Improvement Projects | | X | | | | X | | | | X |
| Ongoing Monitoring Activities | X | X | X | X | X | X | X | X | X | X |
| Plan of Care Reviews | X | X | X | X | X | X | X | X | X | X |
| Updates to Waiver Providers* | X | X | X | X | X | X | X | X | X | X |
| Client Satisfaction Survey | | X | | | | X | | | | X |

*Waiver providers are updated as necessary through the Provider Bulletin printed monthly by the Department.

+The Medicaid Advisory Committee for Persons with Disabilities is the forum for stakeholder input into the design and implementation of the HCBS Quality Improvement Program. This Committee meets on a monthly basis. Once the quality program is designed it is anticipated that a HCBS Quality committee will be formed and will be required to meet on a quarterly basis to review and provide input to quality activities and results.

**Component 5:** **How and when the Quality Strategy will be periodically evaluated and revised as necessary and appropriate..**Refer to Section VIII (page 12) of this document.

**Exhibit 1**
**Home and Community Based Benefits list by Waiver**
**January 2006**

(List approved by the Community Based Long Term Services Section of HCPF 1/06)

| HCBS Benefit | Brain Injury | Children's Extensive Support* | Children's Habilitation Residential Program* | Children's HCBS | Persons with Developmental Disability* | Elderly Blind and Disabled | Mental Illness | Persons Living with Aids | Supported Living Services* |
|---|---|---|---|---|---|---|---|---|---|
| Adult Day Services | X | | | | | X | X | X | |
| Alternative Care Facility | | | | | | X | X | | |
| Assistive Technology | X | X | | | | | | | X |
| Behavior Services | | X | | | | | | | |
| Behavioral Management | X | | | | | | | | |
| Community Connection Services | | X | X | | | | | | |
| Consumer Directed Attendant Support | X | | | X | | X | X | X | |
| Counseling and Therapeutic Services | | | X | | | | | | X |
| Day Treatment | X | | | | | | | | |
| Electronic Monitoring | X | | | | | X | X | X | |
| Employment Services | | | | | | | | | X |
| Environmental Modification | X | X | | | | X | X | | X |

| HCBS Benefit | Brain Injury | Children's Extensive Support* | Children's Habilitation Residential Program* | Children's HCBS | Persons with Developmental Disability* | Elderly Blind and Disabled | Mental Illness | Persons Living with Aids | Supported Living Services* |
|---|---|---|---|---|---|---|---|---|---|
| Habilitation Services ** | | | X | | X | | | | X |
| Homemaker | | | | | | X | X | X | |
| In Home Support Services | | | | X | | X | | | |
| Independent Living Skills | X | | X | | | | | | |
| Mental Health Counseling | X | | | | | | | | X |
| Non-medical Transportation | X | | | | X | X | X | X | |
| Personal Assistance | | X | | | | | | | X |
| Personal Care Services | X | X | X | | | X | X | X | |
| Respite Care | X | | X | | | X | X | | |
| Specialized Medical Equipment and Supplies | | X | | | X | | | | |
| Substance Abuse Counseling | X | | | | | | | | |
| Supported Living Consultations | | | | | | | | | X |
| Supported Living Program | X | | | | | | | | |
| Targeted Case Management | | | | X | | | | | |
| Transitional Living | X | | | | | | | | |

*Operated by the Department of Human Services.

** Habilitation Services include –

SLS waiver – specialized day habilitation services, pre-vocational and supported employment.

DD waiver - specialized day, pre-vocational and supported employment as well as 24-hour residential habilitation – individual and group.

CHRP waiver – Residential services include – Individual Residential services and supports, and Group Residential Services and Supports as well as independent living training, self advocacy training, cognitive services and communication services, emergency assistance, travel services and community connections services.

**Home and Community Based Benefits list by Waiver**
**Exhibit 2**
**Quality Improvement Chart for**
**Prioritizing Performance Improvement Projects**

The chart will be utilized in conjunction with other information in order to prioritize HCBS performance improvement projects. The chart described below allows the Department to categorize the amount of risk associated with a specific waiver function either clinical or administrative. Along with the risk chart, the Department will consider additional factors when assessing performance improvement projects. These additional factors include but are not limited to the number of potential clients that are effected (recipients of waiver services), and the number of waiver populations (number of waivers that offer the service) effected.

The definitions provided below allow for a systematic way to determine which areas of the HCBS program can be classified as high, moderate, or low risk.

**High**: High risk can be either clinical or administrative. A clinical high risk is a situation that poses a real possibility of substantial or serious harm to the immediate physical or mental health, safety or well being of a waiver population or service recipient. An administrative high risk is a situation that would expose the Department of Healthcare Policy and Financing to a risk of losing Federal matching funds.

**Moderate**: Moderate risk can be either clinical or administrative. A clinical moderate risk is a situation that poses a long standing low risk or poses a limited possibility of harm to the physical or mental health, safety, or well being of a waiver population or service recipient. An administrative moderate risk would expose the Department of Healthcare Policy and Financing to some risk of losing Federal matching funds.

**Low**: Low risk can be either clinical or administrative. A clinical low risk is a situation that creates an inconvenience to the waiver participant. An administrative low risk would expose the Department of Healthcare Policy and Financing to a slight risk of losing Federal matching funds.

**Tools Utilized to Prioritize HCBS QI Projects for HCBS Waivers Operated by the Department of Health Care Policy and Financing**

This chart is a tool utilized by the Department to prioritize HCBS performance improvement projects. The numbers across the top of the chart indicate the maximum number of clients eligible in each waiver program. The numbers along the left side, listed by the waiver benefit, indicate the number of waiver programs each HCBS benefit is offered. The numbers in parentheses indicate the maximum number of clients eligible for receiving the service. The columns labeled 'C' are designated clinical risk. The columns labeled 'A' are designated administrative risk. Shaded boxes indicate the service is a waiver benefit.

| **HCBS Benefit Number of Waivers** (Maximum Number of Clients) | **Brain Injury** 400 | | **Children's HCBS** 1106 | | **Elderly Blind and Disabled** 19981 | | **Mentally Ill** 2883 | | **Persons Living with Aids** 110 | | **Children with Autism** 75 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **C** | **A** | **C** | **A** | **C** | **A** | **C** | **A** | **C** | **A** | **C** | **A** |
| Electronic Monitoring **4** (26276) | | | | | | | | | | | | |
| Personal Care Services **4** (23374) | | | | | | | | | | | | |
| Adult Day Services **4** (23374) | | | | | | | | | | | | |
| Non-medical Transportation **4** (23374) | | | | | | | | | | | | |
| Homemaker **3** (23374) | | | | | | | | | | | | |
| Environmental Modification **3** (23264) | | | | | | | | | | | | |
| Respite Care **3** (23264) | | | | | | | | | | | | |
| Alternative Care Facility **2** | | | | | | | | | | | | |

| **HCBS Benefit Number of Waivers** (Maximum Number of Clients) | **Brain Injury** **400** **C** | **A** | **Children's HCBS** **1106** **C** | **A** | **Elderly Blind and Disabled** **19981** **C** | **A** | **Mentally Ill** **2883** **C** | **A** | **Persons Living with Aids** **110** **C** | **A** | **Children with Autism** **75** **C** | **A** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| (22864) | | | | | | | | | | | | |
| In Home Support Services **2** (21087) | | | | | | | | | | | | |
| Assistive Technology **1** (400) | | | | | | | | | | | | |
| Day Treatment **1** (400) | | | | | | | | | | | | |
| Independent Living Skills 1 (400) | | | | | | | | | | | | |
| Mental Health Counseling **1** (400) | | | | | | | | | | | | |
| Substance Abuse Counseling **1** (400) | | | | | | | | | | | | |
| Supported Living Program **1** (400) | | | | | | | | | | | | |
| Transitional Living **1** (400) | | | | | | | | | | | | |
| Behavioral Therapies (75) 1 | | | | | | | | | | | | |

***DD, CES, SLS, & CHRP waiver quality programs managed by the Department of Human Services, Division of Developmental Disabilities.

## Description of Services

**Adult Day Services** (ADS) means health and social services, individual therapeutic and psychological activities furnished on a regularly scheduled basis in an adult day services center, as an alternative to long-term nursing facility care.

**Alternative Care Facility** (ACF) means a provider agency as defined at 8.485.50, A, GENERAL DEFINITIONS, which has met all the following additional standards for alternative care facility providers such as providing safe, cost-effective services including but not limited to the following:

A. Twenty-four hour residential care support services;
B. Adequate sleeping and living areas;
C. Adequate recreational areas and opportunities;
D. Three nourishing meals per day, with provision for special diets when those diets have been prescribed as part of a medical plan;
E. Assistance with the arrangement of transportation when needed;
F. Protective oversight;
G. Social and recreational services as prescribed to meet the participant's needs and as documented in the participant's care plan.
H. Participants have the right to choose not to participate in social and recreational activities; and
I. Alternative care services, as defined above, sufficient to meet the resident's needs.

**Assistive Technology** includes equipment which meets one of the following criteria:

A. Is useful in augmenting an individual's ability to function at a higher level of independence and lessen the number of direct human service hours required to maintain independence;
B. Is necessary to ensure the health, welfare, and safety of the individual;
C. Enables the individual to secure help in the event of an emergency;
D. Is used to provide reminders to the individual of medical appointments, treatments, or medication schedules; or
E. Is required because of the individual's illness, impairment or disability, as documented on the screening assessment form and the plan of care.

**Behavioral Programming** is an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the individual's ability to remain integrated in the community.

**Behavioral Therapies** are one service of combined therapies necessary for the treatment of the individual illness and that is not available under Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) coverage, Medicaid State Plan benefits, other third party liability coverage, other federal or state funded programs, services or supports. The senior therapist, lead therapist and line staff shall work in tandem throughout the treatment process to deliver the one service combined therapies.

Behavior therapies include intensive developmental behavioral therapies that are developed specific to the child's needs. Behavior therapies include treatment goals that are consistent with building elementary verbal skills, teaching imitation, establishing appropriate toy play, interactive play with other children, teaching appropriate expression of emotions and behaviors, and where necessary,

reducing self stimulation and aggressive behaviors. Speech therapy is not included as a benefit under these behavior therapies. One on one behavior therapies will be conducted with the child and line staff, following a specific protocol established by the lead therapist. Techniques include conditioning, biofeedback or reinforcement. Line staff will be responsible for teaching parents or guardian how to continue the behavioral therapies in the home.

**Day Treatment** means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the recipient lives.

**Electronic Monitoring Services** mean the installation, purchase, or rental of electronic monitoring devices which:

A. Enable the individual to secure help in the event of an emergency;
B. May be used to provide reminders to the individual of medical appointments, treatments, or medication schedules;
C. Are required because of the individual's illness, impairment, or disability, as documented on the ULTC-100 form and the care plan form; and
D. Are essential to prevent institutionalization of the individual.

**Environmental Modification** means specific adaptations or installations in an eligible client's home setting which:

A. Are necessary to ensure the health, welfare, and safety of the individual;
B. Enable the individual to function with greater independence in the home;
C. Are required because of the individual's illness, impairment, or disability, as documented on the screening assessment and care plan form; and
D. Prevent institutionalization of the individual.

**Homemaker Services** mean general household activities provided in the home of an eligible client provided by a Homemaker Provider Agency to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

**Independent Living Skills** may include training in personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone, using sign language, facilitated communication, reading, and letter writing.

**In Home Support Services (IHSS)** means services that are provided by an attendant and include Health Maintenance Activities and support for activities of daily living which include homemaker and personal care services.

**Mental Health Counseling** is the provision of professional counseling services, involving the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology of mental illness and dysfunctional behavior to waiver participants, for the purposes of treating psychopathology and promoting optimal mental health.

**Non-Medical Transportation Services** means transportation which enable eligible clients to gain personal physical access to non-medical community services and resources, as required by the care plan to prevent institutionalization.

**Personal Care Services** means services which are furnished to an eligible client in the client's home to meet the client's physical, maintenance and supportive needs, when those services are not skilled personal care, do not require the supervision of a nurse, and do not require physician's orders.

**Respite Care** means services provided to an eligible client on a short-term basis because of the absence or need for relief of those persons normally providing the care.

**Substance Abuse Counseling** are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the waiver participant which, if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

**Supported Living Program** means assistance or support provided by a 24 hour residential facility or Supported Living Care Campus.

**Targeted Case Management** means assistance provided by a case management agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports, including In-Home Support Services, to enable the child to remain in his/her community-based setting.

**Transitional Living** means programs, which occur outside of the client's residence, designed to improve the client's ability to live in the community by provision of 24 hour services, support and supervision. Program services include but are not limited to assessment, training, and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household. Programs are normally limited in duration to six months.