Table of Contents

State/Territory Name: Colorado

State Plan Amendment (SPA) #: CO-22-0035

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

November 15, 2022

Cristen Bates
Interim Medicaid Director
Colorado Department of Health Care Policy and Financing
Medicaid & Child Health Plan Plus (CHP+)
1570 Grant Street
Denver, CO 80203-1818

Dear Ms. Bates:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), CO-22-0035, submitted on March 29, 2022, with additional information submitted on October 27, 2022, has been approved. This SPA has an effective date of July 1, 2021.

Through SPA CO-22-0035, Colorado eliminates its statewide managed care network that provided coverage to presumptively eligible beneficiaries prior to their CHIP eligibility determination and enrollment into a contracted managed care organization (MCO). The state now automatically enrolls all individuals into an MCO.

Additionally, SPA CO-22-0035 updates Colorado's strategic objectives and goals in section 9 of the state plan to align with the state's CHIP Annual Report. This SPA also removes outdated objectives and goals from the state plan that Colorado no longer includes in the CHIP Annual Report. The strategic objectives Colorado proposes to measure include increasing the use of preventive care and increasing access to care. The corresponding goals set by the state in order to meet these objectives are to:

- Increase the percentage of child and adolescent well care visits;
- Increase the percentage of age-appropriate immunizations for children;
- Increase the percentage of enrolled children under age 21 who had one or more preventive oral evaluations during the previous 12 months;
- Increase the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment;
- Increase the percentage of women with a recent live birth who reported receiving a postpartum visit on or between 7 and 84 days after delivery; and
- Increase the number of CHIP children and pregnant women who receive any dental service by 10% over 5 years.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Sarah deLone/

Sarah deLone
Director

SPA # 35

Date Amendment # 35 Submitted: **03/28/2022**
Date Amendment # 35 Approved: **XXXXXX**
Date Amendment # 35 Effective: **07/01/2021**

Effective July 1, 2021, Colorado amended its State Plan to report amendments in the healthcare delivery system for CHIP eligible beneficiaries. Beginning July 1, 2021, Colorado eliminated the statewide managed care network, and enrolls all CHIP eligible beneficiaries into a contracted managed care organization. Additionally, Colorado amended Section 9 of the State Plan to update and align Strategic Objectives and Performance Goals with the state's annual CARTS report.

1.4 **Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.**

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The State included consultation on this SPA in the tribal consultation log dated February 18, 2022. A copy of the relevant page of the consultation log is attached.

3.1. **Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

Managed Care Organizations

State legislation (House Bill 97-1304) requires that only plans willing to contract with Medicaid are eligible to serve CHP+ clients. This will ensure that clients are not forced to change providers each time their financial situation changes the program for which they are eligible (Medicaid or CHP+). The CHP+ program contracts with managed care organizations serving a significant number of commercial and Medicaid clients statewide. These plans vary in structure, service area and membership.

Contract standards are based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and Quality Improvement System for Managed Care (QISMC) standards.

CHP+ MCO contractors have to pass the examination of three entities: the Colorado Division of Insurance (DOI), the Department of Public Health and Environment (CDPHE) and the Colorado Department of Health Care Policy and Financing (HCPF). The DOI grants MCO licenses based on a review of financial stability, adequate provider subcontracts, access to care and quality of care. The DOI subcontracts the quality and access review to the CDPHE. When a licensed plan applies for a Medicaid contract, HCPF reviews several aspects of the plan's operation including provider network, utilization, management, access to care, quality improvement and grievance procedures. HCPF reviews the Medicaid plans that apply to serve CHP+ clients. Where CHP+ contract standards vary from those of DOI and HCPF, the Department conducts additional reviews in coordination with the Medicaid, DOI, CDPHE, or other purchaser reviews.

Essential Community Providers: As required by state legislation (House Bill 97-1304), CHP+ only contracts with MCOs that are willing to contract with the Colorado Medicaid program. To retain their Medicaid contracts, these MCOs must fulfill the statutory requirements of SB 97-75 with regard to use of ECPs. Therefore, the CHP+ managed care network includes these providers. ECPs include community health centers, community mental health centers, public health agencies, school-based clinics, family planning clinics, and other indigent care providers.

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☒ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only

appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
- ☒ Capitation payment Each MCO has their own actuarially sound rate
  Describe population served: All CHIP eligible populations

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
- Capitation payment
- Other (please explain)
- Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

☒ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
- ☒ Capitation payment: PAHP is only for Dental services. All CHIP eligible populations, except the CHIP presumptive eligible population.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

CHIP MCOs use managed care utilization standards to assure that enrollees only receive appropriate and medically necessary care.

4.3 Methodology. Describe the methods of establishing and continuing eligibility and

enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Enrollment in Health Plans

All CHIP eligible children and pregnant individuals are enrolled into managed care organizations. At the time of eligibility determination and annually at the time of redetermination, members are notified which MCO they have been passively enrolled into. If the member wants to change MCO enrollment, members who live in service areas with multiple MCOs participating will have 90 days from the effective date of MCO enrollment at the time of eligibility determination and redetermination to contact the Department or its designee in order to select a different MCO. Once a member has selected an MCO or upon expiration of the 90-day period, the enrollee shall remain enrolled in that MCO until the time of redetermination.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☑ Quality standards
7.1.2. ☑ Performance measurement
7.1.2 (a) ☒ CHIPRA Quality Core Set
7.1.2 (b) ☐ Other

7.1.3. ☑ Information strategies
7.1.4. ☑ Quality improvement strategies

CHP+ will use quality standards, performance measures, information strategies, and quality improvement studies to assure high-quality care for CHP+ enrollees. The CHP+ program will use quality assurance methods and tools such as NCQA accreditation standards, National Association of Insurance Commissioners (NAIC) standards, Quality Improvement System for Managed Care (QISMC), Healthplan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plans Survey (CAHPS) data, standard Division of Insurance reports and quality improvement study data. CHP+ will use standards, performance measures, consumer information, and quality improvement methods for MCOs.

The Department Contractors are required to perform Quality Assurance activities. The

Contractors provide consulting services that incorporate Federal and State requirements that address ongoing quality assessment and improvement strategy for the CHP+ Program contracting program. The strategy, among other things, will include:

- Performance based contracting standards
- HEDIS analysis for all plans

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

The CHP+ prior authorizations are consistent with commercial packages. The contracted managed care organizations are required to comply with the State regulations set forth by the Division of Insurance.

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Strategic objectives are to:

1. Increase the use of preventive care.
2. Increase access to care.

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Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

1. Increase the use of preventive care.
   Performance Goals:
   - Increase the percentage of children and adolescent well care visits (W30, WCV) above the NCQA Mean until the 90th percentile has been reached.
     - DATA SOURCE: HEDIS Measure W30 "Well-

Child Visits in the First 30 Months of Life" assesses children who turned 15 months old during the measurement year and had at least six well-child visits and assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician.

- Increase the percentage of children combo 10 vaccines (CIS) to above the NCQA Mean.
    - DATA SOURCE: HEDIS Measure CIS, "Childhood Immunization Status" is the percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
- Increase the percentage of adolescent combo 2 vaccines (IMA) to the NCQA Mean
    - DATA SOURCE: HEDIS Measure IMA, "Immunization for Adolescents" assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

2. Increase access to care

<u>Performance Goals:</u>

- Increase the percentage of enrolled children under age 21 who had one or more preventive oral evaluation as a dental service during the past 12 months to the NCQA Mean (OEV-CH)
    - DATA SOURCE: Child Core Set Annual Report
- Increase the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment (PPC-CH) in the organization to the NCQA Mean.
    - DATA SOURCE: HEDIS Measure PPC-CH
- Increase the percentage of women with a recent live birth who reported receiving a postpartum visit on or between 7 and 84 days after delivery (PPC-AD) and the NCQA Mean.

  DATA SOURCE: HEDIS Measure PPC-AD
- Increase the number of CHP+ children and pregnant women that receive any dental service by 10% over the 5-year life of the contract.

- DATA SOURCE: dental claims data from HCPF.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Each of the program goals have specific, measurable, and objective methods to evaluate and compare. In addition to the above data sources for SMART goal calculations, we will use the below performance measurements checked off. In preparation of full core sets reporting by 2024, our annual HEDIS report will include those adult and child core set measures in fiscal year 2021-2022. We use individual MCO data for comparison and to drive performance improvement. In addition, the state is starting to collect performance measure indicator data such

as contraceptive care not only for the post-partum person. Other measures, such as well child visit data may indicate performance improvement in other areas such as immunization and developmental screening, where those claims numbers may not match state data.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

☐ **9.3.1.** The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☐ The reduction in the percentage of uninsured children.

☐ **9.3.3.** The increase in the percentage of children with a usual source of care.

9.3.4. ☑ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☑ HEDIS Measurement Set relevant to children and adolescents younger than 19.

☐ **9.3.6.** Other child appropriate measurement set. List or describe the set
☒ used.

9.3.6.1. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- ☒ **9.3.6.2.** Immunizations
- ☒ **9.3.6.3.** Well childcare
- ☐ **9.3.6.4.** Adolescent well visits
- ☐ **9.3.6.5.** Satisfaction with care
- ☐ **9.3.6.6.** Mental health
- ☒ **9.3.6.7.** Dental care
- ☐ **9.3.6.8.** Other, list:

☐ **9.3.7.** Performance measures for special targeted populations.

9.4. ☑ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. ☑ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The State works with a vendor to analyze survey results from the American Community Survey to estimate the percentage of children who are eligible for CHP+ but not enrolled.

The State uses HEDIS to measure changes in health outcomes and health care related goals. In order to comply with upcoming requirements to collect all child and adult core set data, the CHP+ program is using the 2022 fiscal year to implement performance measures reporting systems among all managed care organizations. Utilizing updated HEDIS specifications and input from internal and external subject matter experts, the Colorado CHP+ program is striving to proactively improve performance and ensure compliance with all federal requirements.

The state used US Census, American Community Survey data to calculate the eligible but not enrolled rate of children in Colorado. This rate is compared to previous years and state and external social and economic factors are considered.

In addition to participating in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the state CHP+ and Medicaid programs conduct an annual quality review of state-defined focus areas, and each managed care organization develops a quality improvement plan for the year. As performance measure data collection improves, we look forward to driving performance improvement by integrating existing assessments into the development of program goals and targets.

9.6. ☑ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed

necessary by CMS, the states, advocates, and other interested parties.

9.10 Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)