Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2020

Health Colorado, Inc.

Quality Improvement Plan FY20-21

1. Purpose/Mission Statement

Health Colorado's (HCI) mission is to help people live their lives to the fullest potential. Everything we do is focused on improving the health of people under our care. Putting people at the center, HCIs system is built on a strong support structure of doctors, nurses, therapists, advocates, and mentors fulfilling Members' behavioral, physical, and social health needs.

Our vision focuses on improving the health and well-being of individuals coping with physical health, mental health, and substance use conditions. We make this vision a reality through recovery-focused programs and effective partnerships with our clients and providers.

Our mission and values guide the way we treat our providers, Members, and each other. They are at the heart of all we do.

We help people live their lives to the fullest potential

- Integrity /We earn trust.
    - We speak honestly and act ethically. Our character guides our daily work. We gain the confidence of others by doing the right thing.
- Dignity /We respect others.
    - We believe in others and see their potential. With the right support, all individuals can achieve their goals.
- Community /We thrive together.
    - We build great teams by leveraging individual strengths. We share, partner, and collaborate with others in the name of mutual goals.
- Resiliency /We overcome adversity.
    - We embrace that our work is hard, and sometimes does not go as planned. We meet these challenges head on and constantly strive to better our services and ourselves.
- Ingenuity /We prove ourselves.
    - We are learners, innovators, and original thinkers. We use our experience, imagination, and wisdom to deliver tangible, positive outcomes.
- Advocacy /We lead with purpose.
    - We start the conversations that matter. We advance the dialogue on important issues and affect change for the better. If not us, then who?

2. Quality Program Leadership

John Mahalik: Director of Quality Improvement 719-226-7795 John.Mahalik@beaconhealthoptions.com	**Jeremy White, MA:** Quality Manager 719-226-7794 Jeremy.White@beaconhealthoptions.com
Kat Fitzgerald: Quality Management Specialist II 719-226-7793 Kathaleen.Fitzgerald@beaconhealthoptions.com	**Courtney Hernandez, MS-HSV:** Quality Management Specialist II Courtney.Hernandez@beaconhealthoptions.com
Quality Management Specialist II Open position	Quality Management Specialist III Open position
Melissa Schuchman, MA: Business Analyst III Melissa.Schuchman@beaconhealthoptions.com	**Jennifer Ryan:** Quality Management Specialist II Jennifer.Ryan@beaconhealthoptions.com

3. Year Objectives/Top Priorities

The top priorities for FY21 will be to address the continued improvement on key functional areas that relate to the RAE contract. Specific areas of focus are:

- Continued improvement on Key Performance Indicators (KPIs)
- Continued improvement on the Potentially Avoidable Costs/Complications (PAC) Plan
- Continued improvement on Behavioral Health Performance Incentive Measures
- Initiation of any new Performance Pool Improvement Projects
- Monitor progress on the goals written to in the HCI annual work plan
- Identify areas for opportunities and potential roadblocks striving for solutions
- Continued hiring and onboarding of Provider Quality Managers as needed

Key Performance Indicators, Performance Pool Improvement Projects, and Behavioral Health Performance Incentive Measures

Performance measurement is a core function of the Quality Management program. The primary goal of the Quality Management Program is to improve patient care and overall health outcomes, ensuring efficient utilization of services. Through data collection, measurement and analysis, aspects of care and service that demonstrate opportunities for improvement, HCI will identify and prioritize quality improvement activities. Data collected for quality improvement projects and activities related to key indicators of quality, primarily focus on high-volume diagnoses or services and high-risk diagnoses, services, or special populations.

Health Colorado, Inc. strives to monitor provider performance based on the KPIs, performance pool improvement projects, and behavioral health performance incentive measures established by Health Care Policy & Financing (HCPF) for the RAE. Our goals are to educate providers, staff, and stakeholders and to continue to develop interventions based upon our committee and provider recommendations as needed to improve performance. HCI will continue to share performance findings with its partners, staff, management team, and stakeholders through regular updates at the Quality Improvement Utilization Management (QIUM) Committee, the Care Coordination Committee, Health Neighborhood Collaborative, and the regional Performance Improvement Advisory Committee (PIAC) as well and other meetings where applicable. HCI will work with practices, shareholders, and other community organizations, as well as care coordination entities to evaluate performance and develop strategies to sustain continued improvement.

Performance Improvement Projects

For FY20, in collaboration with the Health Care Policy & Financing, HCI selected two (performance improvement projects (PIPs). The intent of the PIPs is to conduct one PIP that addresses physical health and one PIP that addresses mental health. The PIP process, the interventions, and the module results were all reviewed at the QIUM Committee quarterly. In FY19-20, the focus of the PIP shifted to the narrow focus or SMART aim provider level. The focus was to analyze PIP related data, identify opportunities and barriers to improvement, examine the successes and challenges of interventions, and work toward continued and sustained improvement. PIPs were paused in March and ultimately ended early due to competing priorities associated with providers' COVID-19 response. The physical health PIP completed seven (7) months of intervention implementation and the mental health PIP completed one (1) month of intervention implementation before the PIPs were ended by HCPF.

HCI will begin work in collaboration with the Department and Health Services Advisory Group (HSAG) to initiate a new performance improvement project in FY21. It was decided that there would only be one PIP in FY21. The PIP topic will address Depression Screening as well as follow-up after a Positive Depression Screen.

The PIPs for FY20 summary below:

Increasing mental healthcare services after a positive depression screening

In FY20, HCI continued to make progress on the implementation and progress with the rapid cycle PIPs. The design of this initiative was to increase mental healthcare services after a positive depression screening. The question HCI sought to answer was: do targeted interventions increase the percentage of Health First Colorado Members who receive a positive depression screening, and complete a follow up mental health appointment within thirty (30) days in a physical health or mental healthcare setting? This study question and methodology was approved by HSAG on February 20, 2019 with the validation of rapid cycle PIP modules one and two. The interventions were not fully implemented due to COVID-19 and the cancelation of the PIP by Health Services Advisory Group.

Increasing Well Checks for adult Members ages 21-64

Beginning in July of 2019, HCI selected a second rapid cycle performance improvement project. This was also a State initiative designed to increase well checks for adult Health First Colorado Members who were between the ages of 21 and 64. The question HCI sought to answer was: do targeted interventions increase the percentage of male Health First Colorado Members between the ages of 21-64 in who received an annual well check. The focus of the SMART aim was that this PIP would increase the rate from 32.33% by 5% to 37.33% for males ages 21-64 who receive an annual well check at Castillo Primary Care.

Audits

HCI conducts ongoing and random behavioral health audits based upon standardized audit tools to evaluate quality of care and compliance with the Health First Colorado (Colorado's Medicaid Program) documentation rules. The purpose of these audits is to ensure that contracted providers are meeting the guidelines established for service provision. The Colorado Department of Healthcare Policy and Financing requires us to evaluate the quality of care our Members receive and the supportive documentation for claims. Audits may also be completed to ensure contractual compliance where needed. Where it is found that audit scores do not meet the minimum required threshold, HCI will educate the provider on deficiencies, offer training to the provider, require a corrective action plan (when warranted), re-audit the provider for continued improvement, and recoup funds if appropriate. These audit activities will continue in FY21.

HCI also undertakes a variety of activities aimed at evaluating and improving the quality of care for Members. Provider treatment record documentation audits will continue quarterly, along with provider education in areas where scores indicate growth opportunities. If improvement is not seen, the corrective action process is initiated. Audits include a review of encounters/claims against the chart documentation.

Education on the topic of Health First Colorado documentation standards was offered to providers throughout the fiscal year and will continue throughout the next fiscal year. The same quality staff who conduct the documentation audits facilitated the educational forums. In addition to offering in-person documentation standards training to our providers, HCI has conducted several SUD and mental health treatment round table discussions where providers have the opportunity to bring questions and issues to the attention of the presenters. Furthermore, as well as offering the round table discussions, there were also three (3), in-person, daylong trainings conducted by the auditors. Many providers had the opportunity to engage in specific discussions and ask clarifying questions about documentation standards. Surveys and sign in sheets provided feedback on the training indicating that providers found it very helpful. To provide further support, HCI has provided provider specific training on-site at the provider facility and via Zoom to allow for a more personalized, agency specific training experience for all staff.

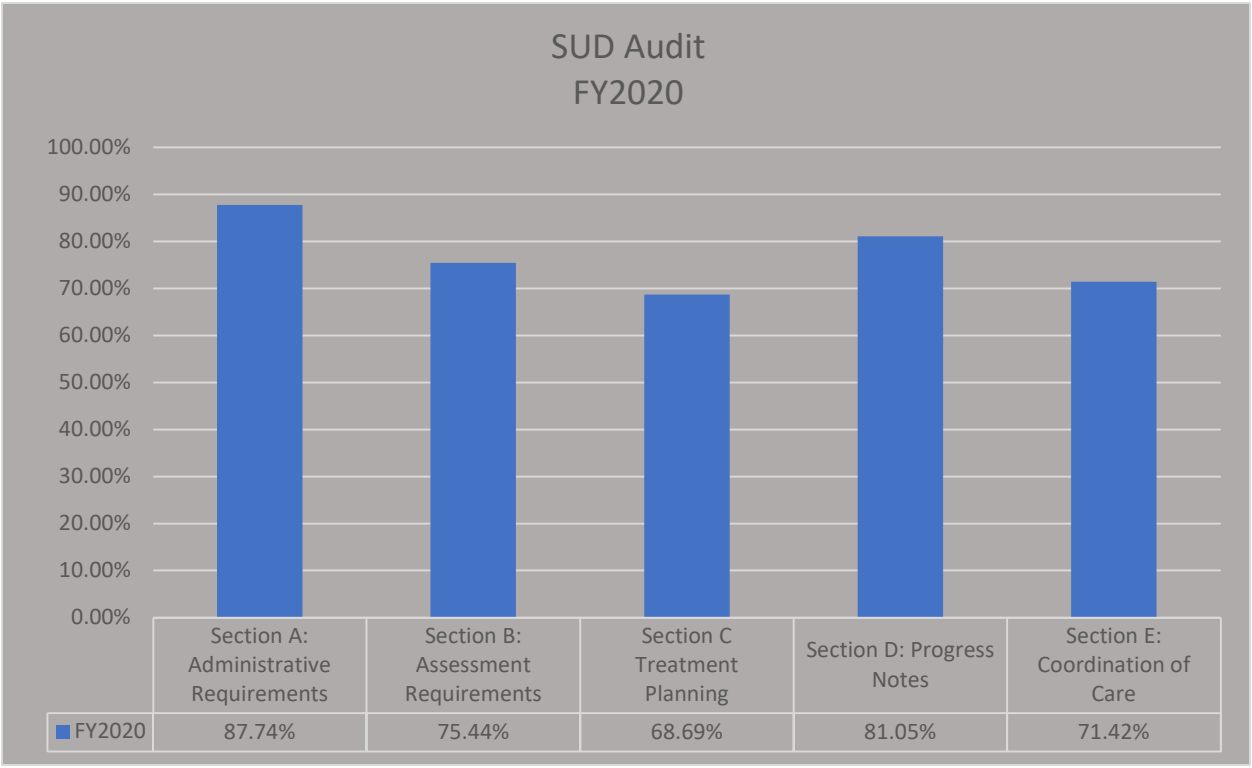
Examples of current audits include but are not limited to:

Substance Use Disorder Audits

To date, twelve SUD outpatient, Medication Assisted Treatment, and SUD Detox providers completed an SUD audit totaling sixty-two (62) Member charts. (See Audit Results in the following charts listed in the subsequent sections of this document). Regular and recurring audits and training will continue throughout the year to ensure proper documentation and support to our provider network.

SUD outpatient audits consist of reviewing five sections of the Member chart (Administrative, Clinical Assessment, Treatment Planning, Progress Notes, and Coordination of Care). In order to pass the audit, the Member must meet medical necessity, and score 80% or better on each of the aforementioned sections. If the provider passes each section with an 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below they will be audited in six (6) months. In addition to a review of written documentation, a claims review is completed to ensure services are provided in accordance with and meets the requirement of the Uniform Service Coding Manual (USCS). A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Recently, on June 8, 2020 an SUD documentation training was held for SUD providers. Over twenty-four (24) providers were trained in Health First Colorado documentation standards in FY20. Several providers have also participated in individualized training sessions offered by HCI auditors.



Summary of Performance

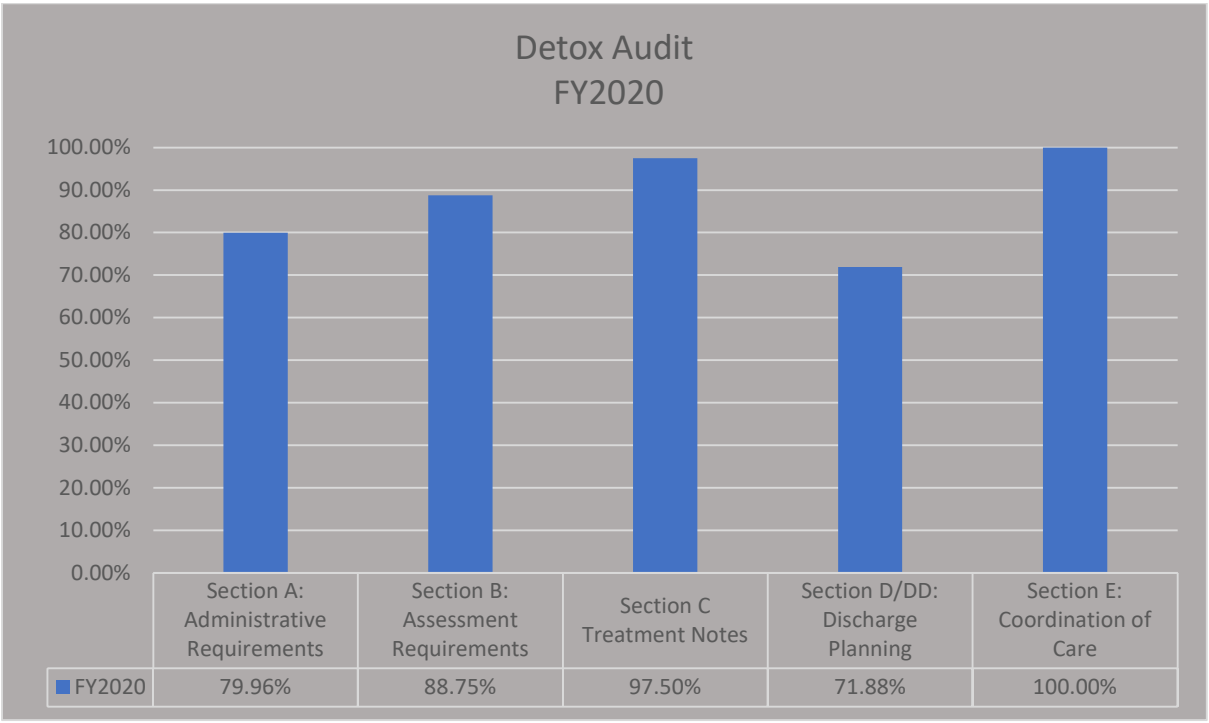
There continues to be improvement in SUD outpatient audit results; however, improvement needs to take place. Clinical Assessments, Treatment Planning, and Coordination of Care although improved, continue to represent weaknesses in documentation requirements. SUD outpatient providers continue to struggle with Medical Necessity for Members who have recently been released from incarceration, as these Members may not present with current use, and auditors have worked diligently to provide further guidance to providers concerning what is required to meet medical necessity for this population. The most common weakness in treatment planning is goal setting with measurable objectives and goals that define the level of change required for the Member to achieve success in treatment. The most common weakness in care coordination is the provider notifying the Member's Primary Care Physician (PCP) of the Members treatment or referring the Member to a PCP if the Member does not currently have a PCP.

There will be continued focus on the areas of weakness through education and trainings. HCI offers in person documentation training to its provider network quarterly. In addition, HCI also offers one on one documentation trainings to its network as well as quarterly round table discussions where providers can have an open forum and access to auditors to pose questions. This open communication allows for relationship building between practices and HCI. As the new SUD benefit is to be initiated in January 2021, HCI will also incorporate the new benefit into our audit and training activities.

Detox Audits

Detox audits consist of reviewing five sections of the Member chart (Administrative, Clinical Assessment, Treatment Notes, Discharge Planning/Summary, and Coordination of Care). In order to pass the audit, the Member must meet medical necessity, and score 80% or better on each of the aforementioned sections. If the provider passes each section with an 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below they will be audited in six (6) months. A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Although the categories for Detox audits are similar in nature to SUD outpatient audits, there are several Detox specific requirements reviewed that include but are not limited to; initial health screen, vital signs check in accordance with standards based on Member symptoms, Clinical Institute Withdrawal Assessment (CIWA), Clinical Opiate Withdrawal Scale (COWS), or other monitoring tool, readiness for change review, and referral to outpatient provider.



	Section A: Administrative Requirements	Section B: Assessment Requirements	Section C Treatment Notes	Section D/DD: Discharge Planning	Section E: Coordination of Care
FY2020	79.96%	88.75%	97.50%	71.88%	100.00%

Summary of Performance

Overall, providers meet the documentation standards; however, improvements need to be made in the Administrative Requirements and Discharge Planning requirements. Administrative documents fell short in providing Member emergency contact information and personal belongings inventories. Discharge planning largely did not include documentation of Member's receiving a scheduled

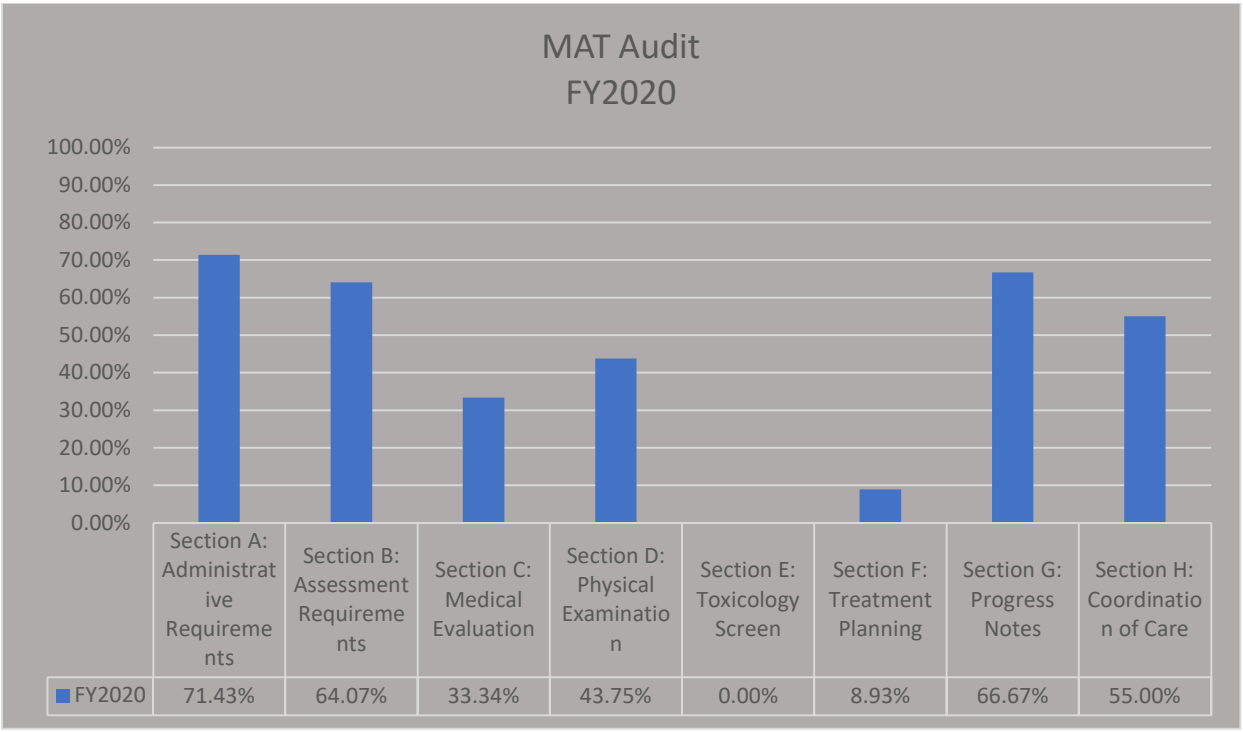
appointment for SUD outpatient services or documentation the Member refused and, in some cases, a discharge plan could not be found in the chart at all.

There will be continued focus on the areas of weakness through provider education, quarterly round table discussions, quarterly documentation standards trainings and one on one trainings. As the new SUD benefit is to be initiated in January 2021, HCI will also incorporate the new benefit into our audit and training activities.

Medication Assisted Therapy

Medication Assisted Treatment (MAT) audits consist of reviewing eight sections of the Member chart (Administrative, Assessment, Medical Evaluation, Physical Examination, Toxicology Screen, Treatment Planning, Progress Notes, and Care Coordination). In order to pass the audit, the Member must meet medical necessity and score 80% or better on each of the aforementioned sections. If the provider passes each section with an 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below they will be audited in 6 months. A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Although the categories for MAT audits are similar in nature to SUD outpatient audits, there are several MAT specific requirements reviewed that include but are not limited to, medical evaluation, physical examination, and toxicology screening.



	Section A: Administrative Requirements	Section B: Assessment Requirements	Section C: Medical Evaluation	Section D: Physical Examination	Section E: Toxicology Screen	Section F: Treatment Planning	Section G: Progress Notes	Section H: Coordination of Care
FY2020	71.43%	64.07%	33.34%	43.75%	0.00%	8.93%	66.67%	55.00%

Summary of Performance

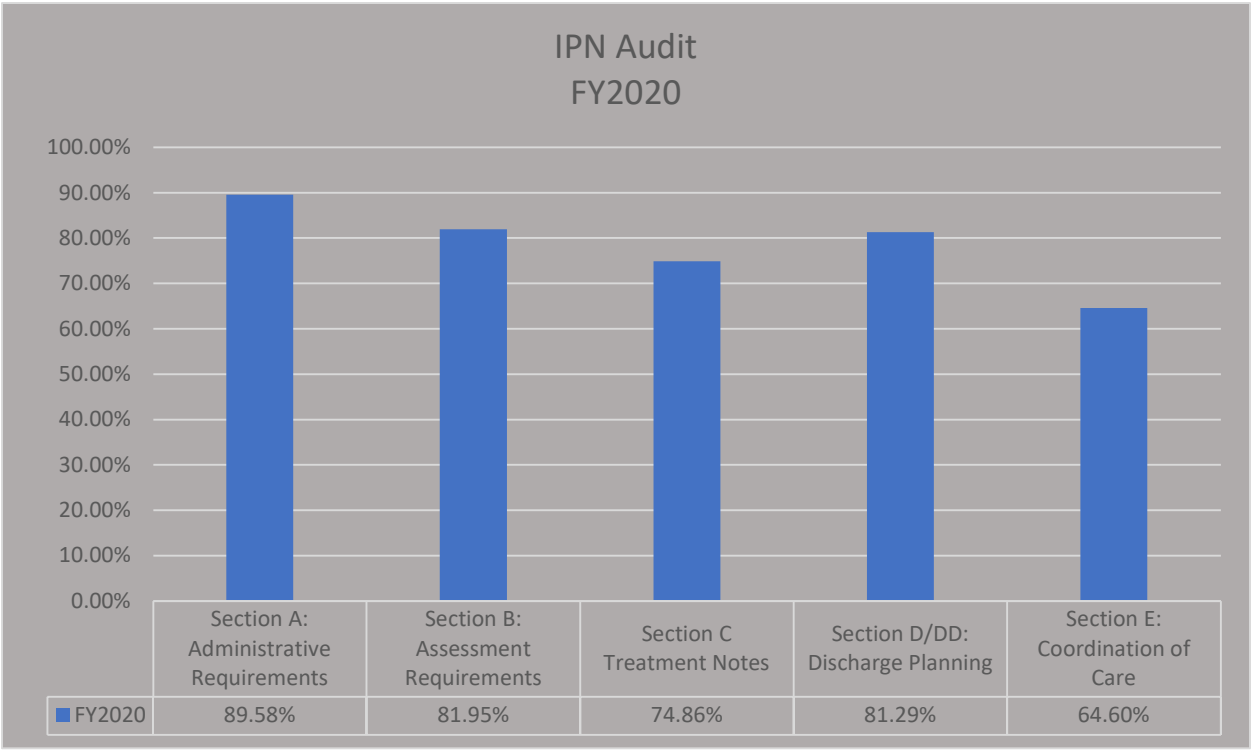
MAT providers continue to need significant improvement in documentation as all areas fell below 80% across the board. Clinical assessments failed to meet the majority of requirements. In some cases, the medical evaluation, physical examination, toxicology screens, and treatment plans were missing entirely from the treatment record. Further, evidence suggests MAT providers did not understand the requirement for Members to receive therapeutic services beyond receiving medication.

There will be continued focus on the areas of weakness through provider education, quarterly round table discussions, quarterly documentation standards trainings and one on one trainings. As the new SUD benefit is to be initiated in January 2021, HCI will also incorporate the new benefit into our audit and training activities.

Mental Health Audits

Routine Mental Health audits continue to be completed for Region 4 IPN providers. To date twenty-two (22) providers have been audited. In addition, over twenty-four (24) providers were trained in Health First Colorado documentation standards over FY20. Many providers have also participated in individualized training sessions offered by HCI auditors. See Audit Results in following charts for an aggregate summary of provider performance. Regular and recurring audits and training will continue throughout the year in order to ensure proper documentation and support to our provider network will continue to be supplied.

Mental Health outpatient audits consist of reviewing five sections of the Member chart (Administrative, Clinical Assessment, Treatment Planning, Progress Notes, and Coordination of Care). In order to pass the audit, the Member must meet medical necessity, and score 80% or better on each of the aforementioned sections. If the provider passes each section with an 80% or better, the provider will be audited in two years. Providers who fail any category as outlined in the audit tool with 79% or below they will be audited in 6 months. In addition to a review of written documentation, a claims review is completed to ensure services are provided in accordance with and meet the requirement of the Uniform Service Coding Manual (USCM). A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.



Summary of Performance

There continues to be improvement needed in IPN outpatient audit results; however, improvement also needs to be made in the area of care coordination. Lacking documentation concerning Primary Care Physician (PCP) information or referral to a PCP seems to be a theme. Further, treatment planning has been generally weak in insuring objectives are measurable and goals are based on a level of change required to successfully complete treatment.

There will be continued focus on the areas of weakness through provider education, quarterly round table discussions, quarterly documentation standards trainings and one on one trainings.

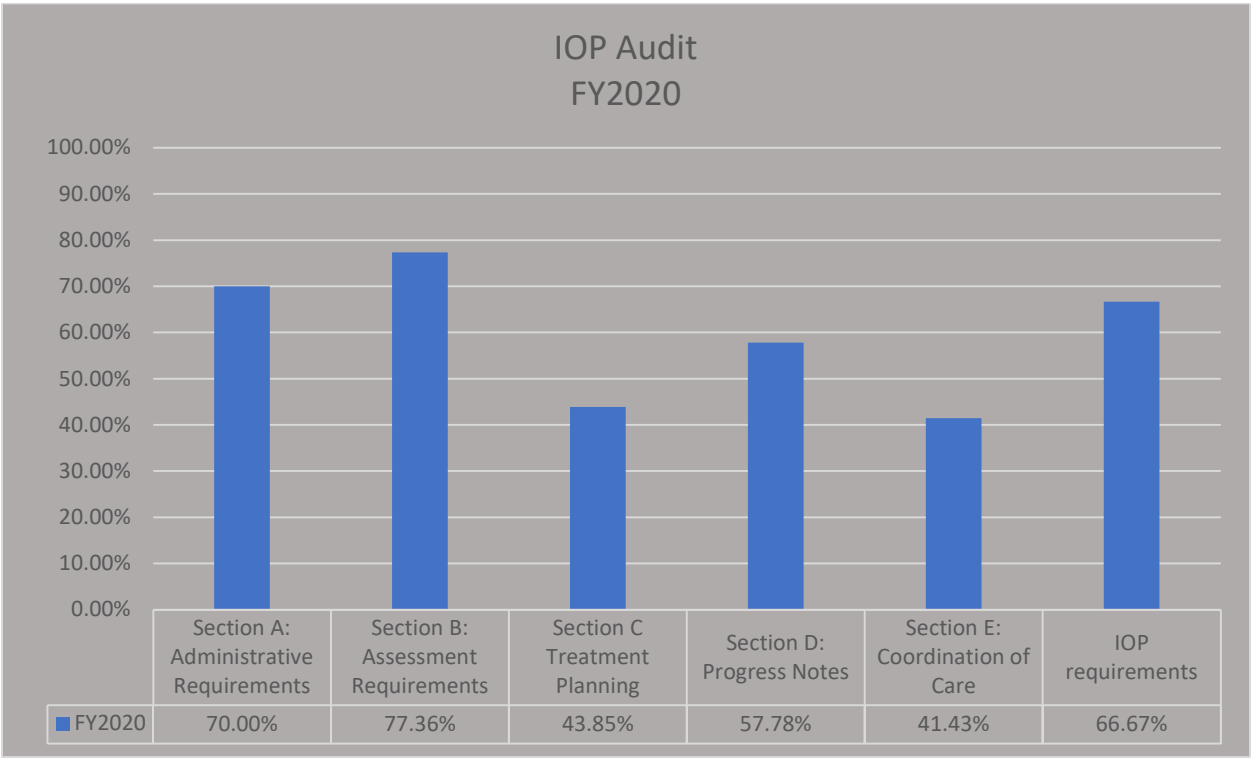
Intensive Outpatient Audits

One provider has completed a mental health documentation audit specifically concerning Members who had received Intensive Outpatient Services for a total of [redacted] Member chart. There was a decrease in number of providers audited this fiscal year due to a lack of intensive outpatient claims made. We will continue to audit intensive outpatient (IOP) providers on a quarterly basis as is appropriate based on claims made.

Intensive Outpatient (IOP) audits consist of reviewing five sections of the Member chart (Administrative, Assessment, Treatment Planning, Progress Notes, and Coordination of Care). In order to pass the audit, the Member must meet medical necessity, and score 80% or better on each of the aforementioned sections. If the provider passes each section with an 80% or better, the provider will be audited in one

year. Providers who fail any category as outlined in the audit tool with 79% or below they will be audited in 6 months. In addition to a review of written documentation, a claims review is completed to ensure services are provided in accordance with and meet the requirements of the Uniform Service Coding Manual (USCM). A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Although the categories for IOP audits are similar in nature to IPN and SUD Outpatient audits, there is one IOP specific requirement reviewed: IOP requirements, which reviews the amount of treatment per week the Member is receiving.



Summary of Performance

There continues to be the need for improvement in IOP outpatient audit results in all areas across the board. In most cases, the clinical assessment did not provide a clear clinical formulation providing person specific evidence for the Members need for treatment. Treatment plans did not provide measurable objectives nor goals identifying the level of change needed for the Member to be considered successful in treatment. Progress notes were generally vague and did not provide information concerning progress towards individual goals. Further, the Member did not meet the requirements for the IOP level of treatment.

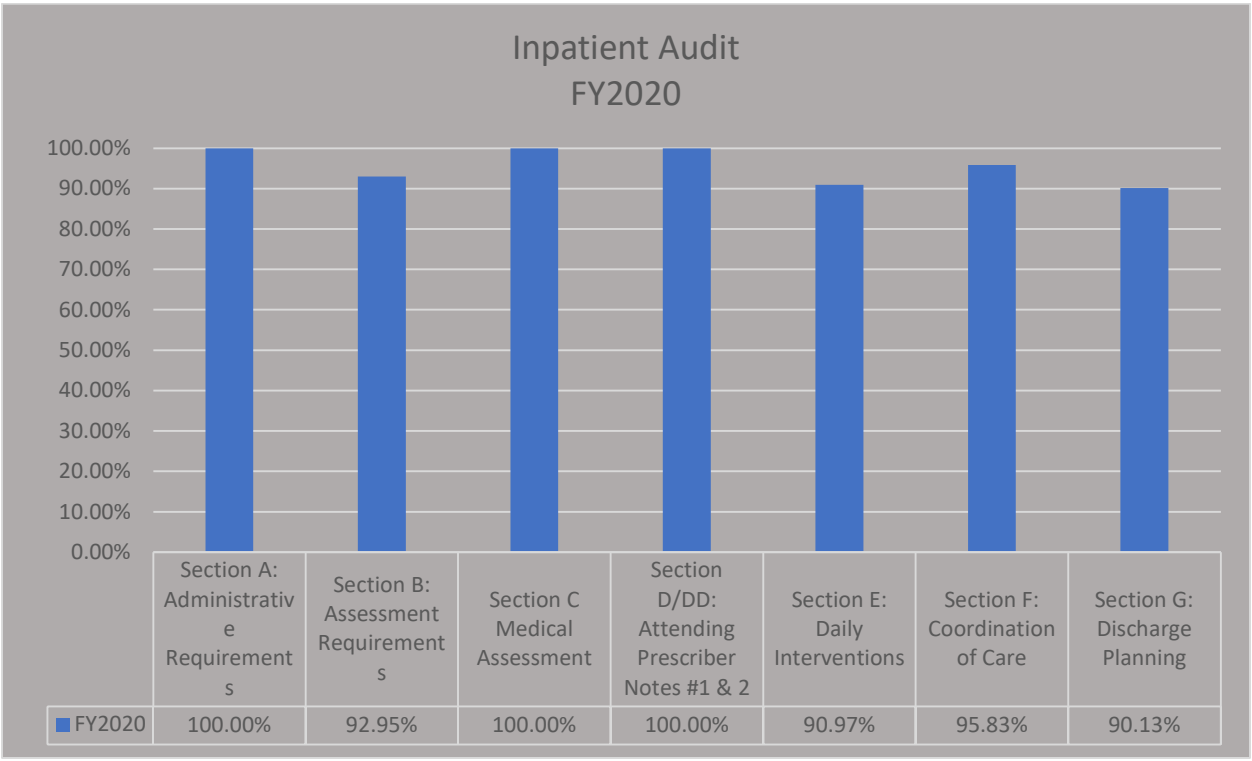
There will be continued focus on the areas of weakness through provider education, quarterly round table discussions, quarterly documentation standards trainings and one on one trainings. As the new

SUD benefit is to be initiated in January 2021, HCI will also incorporate the new benefit into our audit and training activities.

Inpatient Audits

Inpatient Treatment audits consist of reviewing seven sections of the Member chart (Administrative, Assessment, Medical Assessment, Attending Prescriber Notes, Daily Interventions, Coordination of Care, and Discharge Planning). In order to pass the audit, the Member must meet medical necessity, and score 80% or better on each of the aforementioned sections. If the provider passes each section with an 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below they will be audited in six (6) months. A failed audit could result in consequences to include, but not limited to, required education, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Two providers have completed a mental health documentation audit specifically concerning Members who had received services at an inpatient facility for [redacted] Member charts. Efforts have been made through re-auditing records to monitor a Corrective Action Plan in order to facilitate best practice standards in the facility.



Summary of Performance

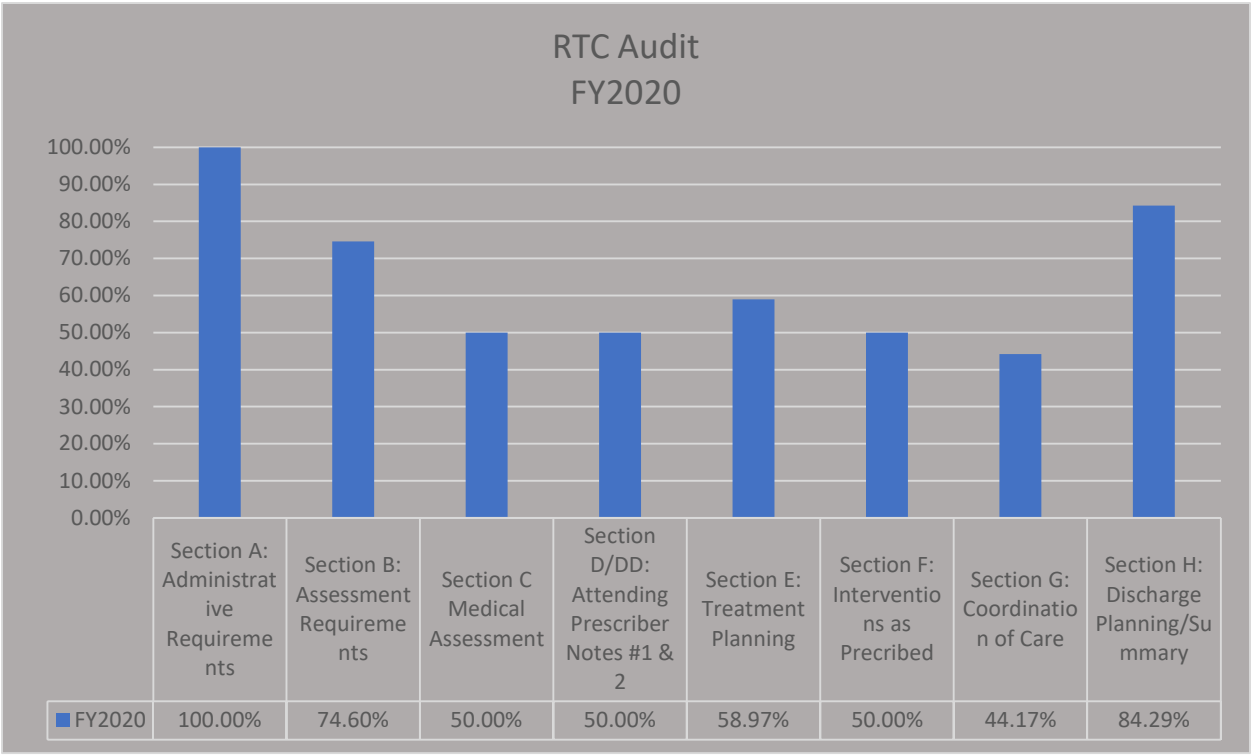
Inpatient facilities have made significant improvements across the board. Daily interventions appear to have the weakest outcome as in some cases; there was no evidence of family therapy when appropriate and lack of daily prescriber notes.

There will be continued focus on the areas of weakness through provider education, quarterly round table discussions, quarterly documentation standards trainings and one on one trainings. As the new SUD benefit is to be initiated in January 2021, HCI will also incorporate the new benefit into our audit and training activities.

Residential Treatment Center Audits

Residential Treatment audits similarly to that of Inpatient treatment audits consist of reviewing seven sections of the Member chart (Administrative, Assessment, Medical Assessment, Attending Prescriber Notes, Interventions, Coordination of Care, and Discharge Planning). In order to pass the audit, the Member must meet medical necessity, and score 80% or better on each of the aforementioned sections. If the provider passes each section with an 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below they will be audited in 6 months. A failed audit could result in consequences to include, but not limited to, required education, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

Two Residential Treatment Facilities (RTF), for [redacted] Member charts, have been audited to ensure Member documentation meets standards. This audit will continue to be conducted throughout the year as appropriate based on claims made.



Summary of Performance

HCI understands that there is a need for continued improvement in RTF audit results, to include all areas with the exception of administrative requirements and Discharge Planning. It was found that assessments were minimal and did not reflect an effort to gain collateral information. In some cases, a medical assessment, documented interventions, evidence of coordination of care, nor prescriber progress notes could be found in the chart.

There will be continued focus on the areas of weakness through provider education, quarterly round table discussions and quarterly documentation standards trainings and one on one trainings. As the new SUD benefit is to be initiated in January 2021, HCI will also incorporate the new benefit into our audit and training activities.

Care Coordination Audits

Care Coordination audits consist of reviewing four sections of the Member chart (Care Plan Elements, Care Coordination Evidence, Evidence of Education on using PCMP and Nurse Advise Line, and Policies and Procedures). In order to pass the audit, the Member documentation must score 90% or better on each of the aforementioned sections. If the provider passes each section with a 90% or better, the provider will be audited in six (6) months. Providers who fail any category as outlined in the audit tool with 89% or below they will be audited in three (3) months. A failed audit could result in consequences to include, but not limited to, required education, recoupment, corrective action plan (CAP), and referral to Provider Relations or other licensing agency.

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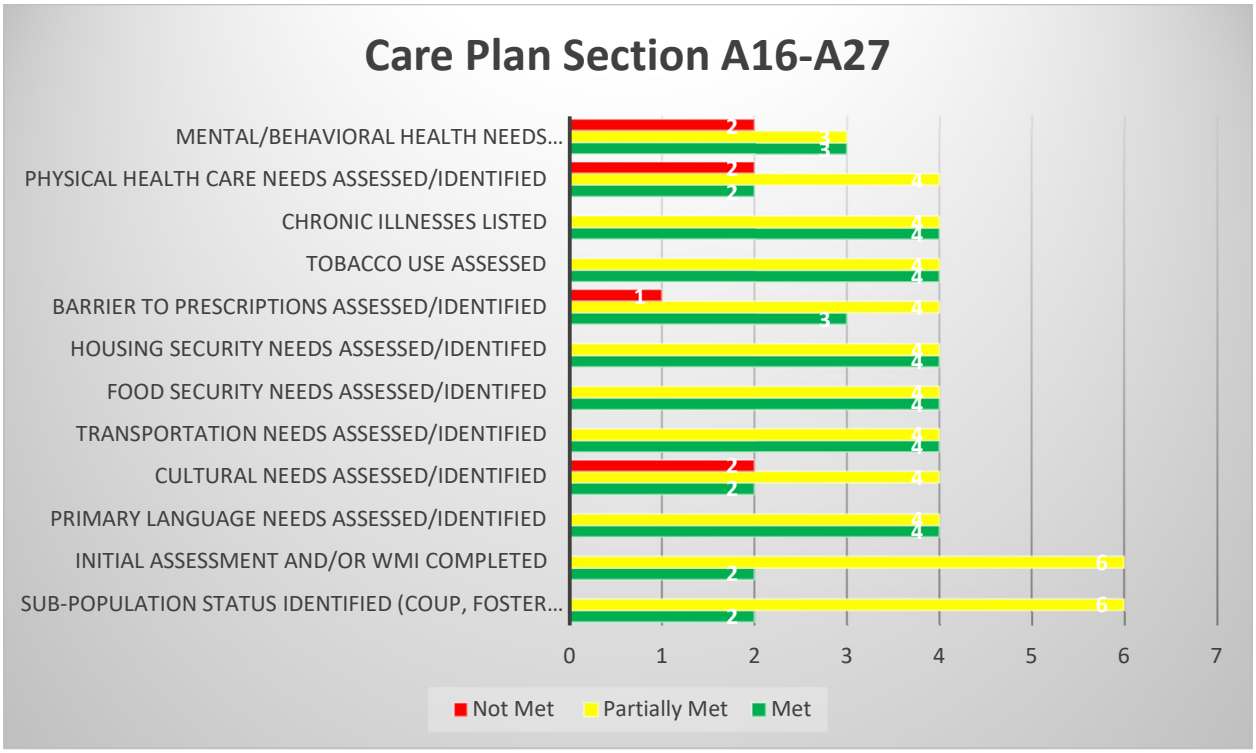
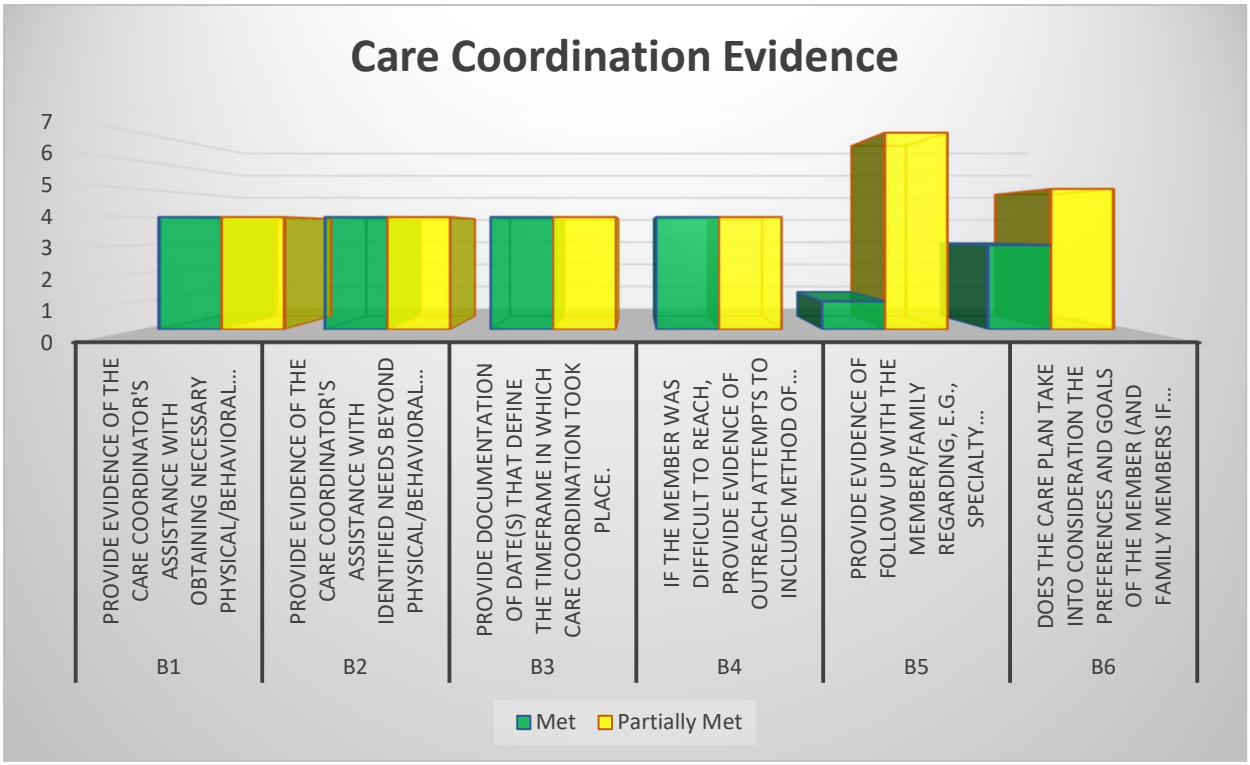
All eight Care Coordination entities have been audited twice in fiscal year 2020 to ensure compliance with contractual requirements. This audit will continue to be conducted throughout the year as appropriate. The graphs below represent the most recent audit results.





Summary of Performance

Through a regular and ongoing audit process, we have identified that there is room for improvement across all care coordination entities. The most common issue found in the audits is lack of a care plan in the chart as well as, lack of coordination of care specific documentation. Armed with this information, HCI can address deficiencies in care coordination services. As seen in the Care Coordination Evidence graph included above, it can be seen that half of the care coordination entities are meeting standards B1 through B4.

HCI will continue its efforts to train the provider network on proper documentation standards for the audits addressed above. HCI believes that through continued auditing and education that audit scores will show improvement.

411 Audits

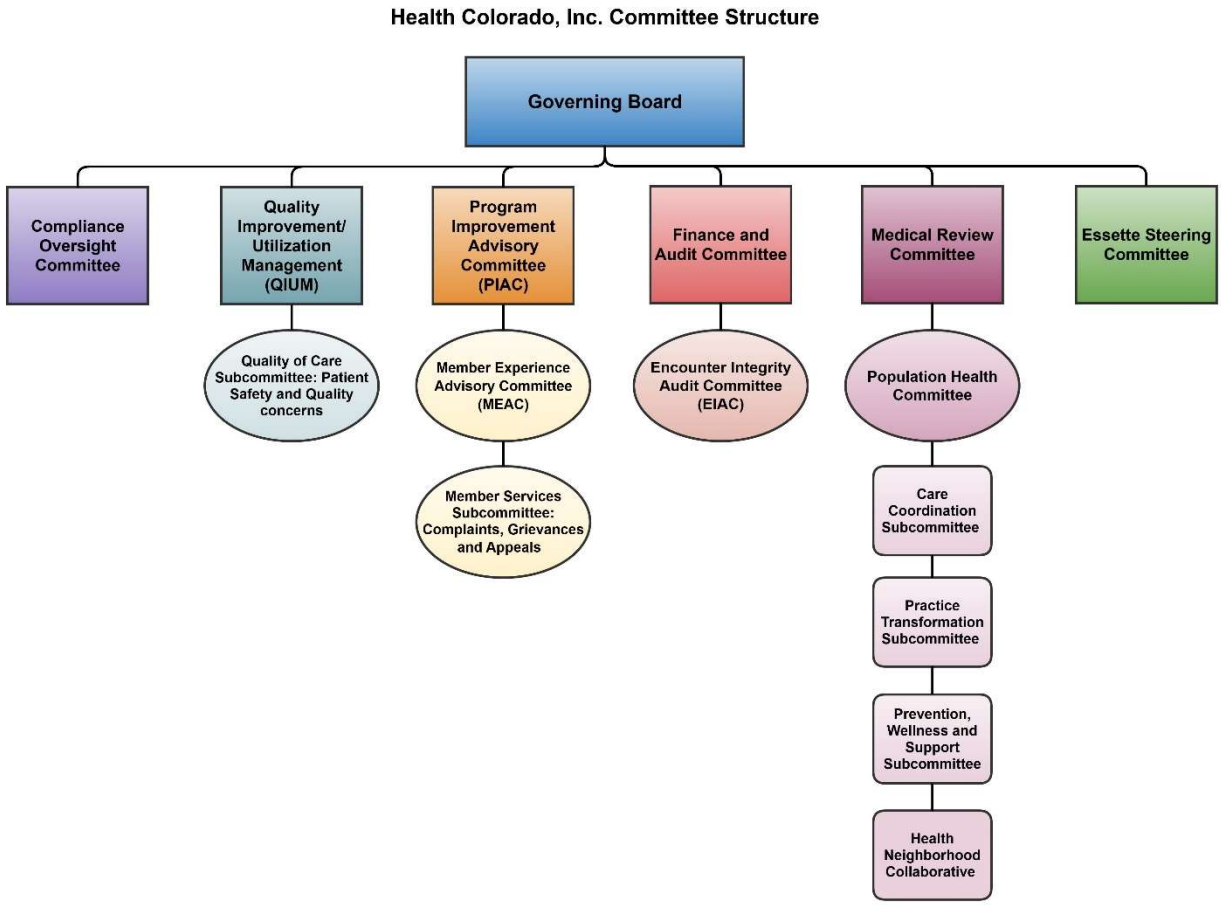
In an effort to continue process improvement on submitted claims and encounters, HCI has begun work on a quality improvement process (QuIP) to address rates that fell below 90% stemming from the annual 411 claims and encounter audit. The annual audit netted one service category that fell below the established standard of 90%. The procedure code encounter data type for the Prevention and Early Intervention service category scored 87%. To date HCI has submitted sections 1 and section 2 of the QuIP. Both sections have been approved by Health Services Advisory Group. HCI is currently working on

implementing interventions for section 3 of the QuIP. In this section, HCI has identified two Mental Health Centers (MHCs) to work with to address process improvement. These two MHCs are Health Solutions and Solvista. These two MHCs were selected as they drove the rates for the 411 audit.

Training will be provided at the provider level to include RAE provider audits, provider webinars, tip sheets and provider education and corrective action issuance. This will include training on the areas of coding deficiency that were found in the 411 audit. We can also address and process improvement that has been made by the provider since results of the last 411 audit. This can lead to the study if changes in process improvement are evident in the audits starting in November. This can then be used to demonstrate consistency in improved audit scores conducted in November, December, and January. Final results will be reported to Health Services Advisory Group by March 15th, 2021.

Committee and Subcommittee Structure

Various committees and subcommittees have been established to assist in meeting the goals of the Quality Management Program. Cross-representation on committees has been a key to effective committee work, and having the Quality Director serving as a member of the Coordination of Care Subcommittee has provided insight into challenges, as well as improved clarity around the KPIs and behavioral health measures. A Medical Review Committee will also address quality plans and evaluation. These are just a couple of examples of this cross-representation on committees. Please see the below updated HCI Committee Structure.



In addition, ad hoc meetings with providers has begun to get input from a point of care perspective and will continue. HCI has created a work plan for continued process improvement, which is reviewed quarterly at the HCI QIUM. The details of the work plan as well as the committee reporting structure are outlined in the annual quality report.

In FY20, various stakeholder work groups were held with providers to discuss problem-solving techniques surrounding specific KPI measures. Specific topics addressed were related to what initiatives have been attempted to address obtaining care compacts and increasing dental services. Another topic for discussion was emergency department (ED) utilization: what are the most common reasons for avoidable ED visits; what has been done to reduce avoidable ED visits; and what interventions have worked to reduce avoidable ED visits. At these stakeholder meetings, shareholders came together to identify barriers to KPI performance, to understand potential roadblocks, and to address possible areas of strength that would directly affect a positive trend upon KPI performance. Also, in FY20 stakeholder work groups where held with providers to discuss problem solving techniques surrounding specific KPI measures and the impact that the COVID-19 pandemic had upon the performance on the measures. It was determined that the use of telehealth services was essential to providing continued care to our Members. In an effort to educate providers about the use of the telehealth and how to submit a claim

with the telehealth place of service code, several provider support calls were held, and email alerts were distributed. At these calls, telehealth coding as well as provider specific questions were discussed. These efforts will continue and include the Performance Pool initiatives of HCPF as well as continued evaluation and strategy on behavioral health measures.

Quality of Care Issues:

Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Providers, HCI staff, or other concerned parties can all report quality of care issues, typically through an Adverse Incident reporting form submitted to the Quality Department. All quality of care issues are documented, as are results of investigations. Corrective actions are tracked and monitored. Reporting, investigation, and tracking of adverse incidents through the Quality Management Department continued during the past fiscal year and will continue with reporting to HCPF as required.

An adverse incident may feed into the quality of care process based on investigation results. All providers are required to report adverse incidents; HCI received seventy-six (76) adverse incident reports during FY2020; a decrease from the one-hundred thirty-six (136) reported the previous year. These care-monitoring initiatives, along with treatment record reviews and training, are conducted with the goal of ensuring Members receive the best care possible and will continue to be maintained by the Quality Management Department in FY21.

Reference Key: Blue: FY20 updates Green: FY21 plans

Goal	Fiscal Year 2021 Project/Initiative	Targeted Completion Date	Status
Performance Improvement Projects			
In FY19-20, HCI conducted two PIPS. The first PIP was to increase Well Checks for adult male (ages 21-64) Members from 32.33% to 37.33% at Castillo Primary Care by 6/30/2020. HCI will work with the department to	Increasing Well Checks for males ages 21-64. For FY20-21, HCI and the Department will engage in the new rapid cycle PIP topic: Depression Screening and Follow-up after a Positive Depression Screen.	The final write up for the PIP close out was submitted to Health Services Advisory Group on June 29, 2020.	**Summary assessment of results and key findings:** In order to meet the State of Colorado's quality stagey, as well as to improve access and to increase well check screenings, HCI continued its work on the Performance Improvement Project (PIP) of increasing the rate in which Health First Colorado Members receive well checks. The well check completion rate for males ages 21-64 did not meet the goal in any month of the measurement period. The completion rates for

establish a new PIP in September 2020.		For the Rapid Cycle process there will be four modules. The only established due date is for module 1. The established due date is December 7, 2020.	Castillo Primary Care (SMART AIM Provider) were close to the baseline at 33.27% in the first month of intervention then showed a slow rise across the next four months to 34.62% before a slight dip in January 2020 (33.41%) and then returned to 34.61% in February 2020. The intervention for this project was to outreach to male Members, age 21-64, who were attributed to Castillo Primary Care who had not received a well-check visit within the past year. Our PIP involved up to three phone calls from a care coordinator at Health Solutions (who is the delegated care coordination entity for Castillo Primary Care) to remind Members of the need for a well visit and assist them in scheduling an appointment. Care coordinators were asked to outreach 40 Members each month. See Appendix A for the well check completion rate for males ages 21-64. The table demonstrates that the PIP did not meet the goal in any month and was discontinued due to COVID-19. For FY21 HCI and the Department will engage in the new rapid cycle PIP topic: Depression Screening and Follow-up after a Positive Depression Screen.
In FY19-20, HCI worked on two PIPS. The second PIP established the goal of by June 30, 2020, increase the percentage of Members who receive mental health services in a physical or mental health care setting after a positive depression screening at Health Solutions Medical Center (from	Behavioral Health Services following a positive depression screen. For FY21 HCI and the Department will engage in the new rapid cycle PIP topic: Depression Screening and Follow-up after a Positive Depression Screen	The final write up for the PIP close out was submitted to Health Services Advisory Group on June 29, 2020. For the Rapid Cycle	**Summary assessment of results and key findings**: In order to meet the State of Colorado's quality stagey, as well as to improve access and to increase to behavioral healthcare services; HCI had selected as its Performance Improvement Project (PIP) to increase the rate in which Health First Colorado Members receive mental health services in a physical or mental health care setting after a positive depression screening. Claims data continued to show few depression screens included in the data meaning that it is impossible to interpret the significance of

72.65% to 80.00%). HCI will work with the department to establish a new PIP in September 2020.		process there will be four modules. The only established due date is for module 1. The established due date is December 7, 2020.	increase or decrease in the rate of positive depression screens with BH follow-up completed within 30 days. Therefore, data collected from Health Solutions Medical Center (HSMC) was used to track progress on this PIP. This data does show an increase in the rate of positive depression screens with BH follow-up completed within 30 days from 72.65% at baseline to 85.5% at the end of February. As seen in Appendix A, the data does show an increase in the rate of positive depression screens with BH follow-up completed within 30 days from 72.65% at baseline to 85.5% at the end of February. For FY21 HCI and the Department will engage in the new rapid cycle PIP topic: Depression Screening and Follow-up after a Positive Depression Screen.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2020

Goal	Fiscal Year 2021 Project/Initiative	Targeted Completion Date	Status
Performance Measurement Data Driven Projects			
PAC Plan goals are developed based on Prometheus episode data	Key Performance Indicators • Potentially Avoidable Complications (PAC) Plan Reduce costs for the three highest cost episodes: ○ Substance Use Disorder: Our target goal is to reduce ED and hospital costs associated with SUD through the addition of a continuum of SUD services currently lacking in this area of the HCI region. ○ Diabetes: Our target goal is to reduce ED and inpatient visit costs associated with diabetes ○ Maternity: Our target goal is to reduce the preterm birth rate in the region and reduce potentially avoidable costs associated with lack of preterm engagement.	**6/30/2021**	**Summary:** For the FY20 PAC plan, Health Colorado (HCI) selected three of the region's five highest potentially avoidable complication (PAC) episodes for intervention: • SUD • Diabetes • Pregnancy Ranking was by split PAC cost using the added FY18 through FY19 Prometheus claims database. **Progress/Interventions:** **Substance Use Disorder** Due to the prevalence and associated PAC costs of SUD in this region, the addition of key services is being addressed. Data provided by the Department shows that SUD is the highest split PAC cost in region 4. Inpatient admissions and emergency department visits were the highest avoidable cost services. To reduce these costs and improve care availability, Health Colorado planned to provide substance use treatment services that address a long-standing regional gap in the continuum of care for substance use disorders in our rural and frontier communities. The Solvista Health Chaffee County Regional Assessment Center (RAC) will provide new and highly coordinated services for individuals requiring a higher level of care than can be managed solely with community-based, intensive outpatient treatment. The RAC will provide new local resources to community health partners including hospitals and law enforcement. The RAC will co-locate and integrate a 24/7 crisis stabilization unit (CSU), treating individuals who

			have mental health or co-occurring mental health/substance use disorders, a withdrawal management unit (WMU) for substance abuse, and a transitional residential treatment (TRT) program to create a comprehensive continuum of care that will better match our service mix to client needs, interrupt costly recidivism in emergency departments and hospitals, create better health outcomes, and bend the cost curve substantially for both public and private payers. The availability of these services locally means Medicaid Members are served at the point of contact rather than sending them elsewhere (e.g. Pueblo), allowing Health Colorado better management of local treatment and wrap-around services (MAT, sober-living houses, etc.) as well as the medical services so often needed in this population. The COVID-19 pandemic, construction delays, and the delay in the anticipated funding of the additional Medicaid SUD benefit hindered this particular intervention. Nevertheless, Health Colorado, Inc. was able to submit letters in support of the RAC that were collected by Solvista as well as the RAC guidelines and communications that Solvista shared at stakeholder meetings and with community partners. **Diabetes** Diabetes-related episodes were identified as second highest split PAC for region 4. Inpatient and outpatient emergency room use were some of the highest avoidable costs that the plan aimed to reduce. Stakeholder input was gathered as planned from providers and Members. Practices with the lowest diabetes PAC costs in Pueblo County were interviewed for best practices. Due to the COVID-19 pandemic, the Department asked HCI to submit a revised scope of work in early April.

			Best practice findings and resources in the form of a diabetes toolkit were shared electronically with providers on Health Colorado's website and made available to care coordinators via a link in their care coordination tool (Essette). Feedback from the two diabetes registry pilot sites helped to inform the actionable data milestone. HCI is expanding the availability of actionable information that care coordinators currently access (Complex Member and Population Health Files), by continuing to add claims data to the Essette tool. Claims data in Essette supports the assessment of provider visit dates to ensure engagement with the Member's PCMP and specialists. Availability of ER visit dates helps care coordinators assess utilization and address the need for emergency care. Pharmacy claims information supports the monitoring of medication adherence. Efficacy monitoring (hospital admission rates and ER rates) was also initiated as planned. **Pregnancy** Pregnancy-related episodes were identified as the third highest split PAC in the region. Plans were made to reduce the pre-term delivery rate by improving pregnancy identification, tracking and early prenatal engagement. Stakeholder input was collected, and initial contact was made with community partners to improve pregnancy identification, but the COVID-19 crisis temporarily suspended further work. HCI used this opportunity to provide alternative ways of identifying and engaging women early in their pregnancy through website education, links to resources and a phone app called Text4Baby for pregnant Members. A report describing regional care coordination/condition management strategies was submitted to the Department, and efficacy monitoring (preterm delivery rate) was initiated as planned. **Outcomes:**

			All of HCIs PAC milestones and the associated documentation were submitted as evidence of successful completion of PAC requirements. In FY21 HCI will continue to focus on substance use disorder, diabetes, and pregnancy as the areas of focus for the PAC. Interventions for the SUD initiative include: • New SUD benefits are being added for Health First Colorado Members. HCPF has established a readiness assessment tool to ensure that the RAEs are prepared to take on the responsibility of managing these benefits scheduled to begin January 1, 2021. • Stakeholder feedback which includes data, information, and plan presented to relevant stakeholders such as Medical Management Committee, HTP, Health Neighborhood, Healthy Family Connections, MEAC, and PIAC. • Develop, distribute, educate and post written communications, workflows, and guidelines regarding the new SUD benefits, ASAM criteria, and utilization processes, etc. for hospitals, SUD treatment facilities, PCMPs, care coordinators, community partners, emergency responders, and other healthcare entities/providers. • As of January 1, 2021, Utilization Management will be implemented for the new SUD benefits for the higher level of care based on ASAM criteria. • Further analysis of data that include (but not limited to): Post D/C from inpatient setting: Re-admission time frames (30/60/90 days), transition of care (step down from inpatient to next level of care), time frame from inpatient d/c to admission to next level of care, engagement in care, ER visits post D/C

			from inpatient (30/60/90 days), engagement with PCMP, Behavioral Health engagement. Retro Review of services prior to inpatient SUD admission: utilization of SUD services within previous 12 months, utilization of behavioral health services within previous 12 months, number of ER visits and outcome of visit(s), engagement with PCMP and services rendered. Utilize data to obtain a better understanding of the Members utilizing SUD benefits and for risk stratification. Interventions for the Diabetes initiative include: • Evaluate and document current state of the population through data analysis. This will include evaluating the number of Members with Type 1 or Type 2 Diabetes. Information will be captured on their associated PCP and specialty care utilization patterns. Adherence to evidence-based interventions (eye and foot exams, A1c, cardiovascular risk evaluation and risk reduction). Evaluation of cost, risks and best data sources will be analyzed. • Stakeholder input and feedback, which includes data, information, and plan, presented to relevant stakeholders such as Medical Management Committee, HTP, Health Neighborhood, Healthy Family Connections, MEAC, and PIAC. Information about the Condition Management Project and the Diabetes PAC Plan along with updates will be shared at the various stakeholders' meetings which occur on a monthly or quarterly basis based on their scheduled meeting times during the year. • Evaluate current Delegated entity staffing models ensuring appropriate level of care capacity to serve the population.

			• Enhance standard screening and assessment tools. • Enhance current interventions based on evaluation of population needs. • Evaluate Cost of Care, hospitalizations, ED utilization, and glycemic control. Interventions for the pregnancy initiative include: • Implementation plan with pilot facility which includes best practices/protocol from Maternity 4 milestone FY19-20 PAC Plan. • Stakeholder feedback which includes data, information, and plan presented to relevant stakeholders such as Medical Management Committee, HTP, Health Neighborhood, Healthy Family Connections, MEAC, and PIAC. • Evaluation of pilot intervention to include key outcome measures and ROI analysis.
Achieve an improvement of 5% (Tier 2) or greater over fiscal year 2020 performance for each KPI. (Tier 1 = 1% improvement)	Performance goals for the KPIs listed below were determined following calculation of baselines by HCPF: • Emergency Department Visits (visits/1000 Members) ○ Baseline: 571.57 ○ Tier 1: 565.85 ○ Tier 2: 542.99 • Behavioral Health Engagement ○ Baseline: 0.78% ○ Tier 1: 0.79% ○ Tier 2: 0.83%	**6/30/2021**	**Summary:** **KPI Updates** HCI continues to work with our QIUM Committee as well as our KPI work group to evaluate the performance on the key performance indicators. HCI works to identify projects and areas where quality improvement can be utilized. **Progress\Interventions:** Through committee and provider education efforts, we have received questions and feedback involving codes/methodology that have been passed on to the Department. **Emergency Department Visits (visits/1000 Members):**

	• Well Visits
	  ○ Baseline: 23.08%
	  ○ Tier 1: 23.31%
	  ○ Tier 2: 24.23%
	• Prenatal Engagement
	  ○ Baseline: 41.82%
	  ○ Tier 1: 42.24%
	  ○ Tier 2: 43.91%
	  ○
	• Dental Visits
	  ○ Baseline: 32.26%
	  ○ Tier 1: 32.58%
	  ○ Tier 2: 33.87%
	• Health Neighborhood
	  ○ Baseline: 3.52%
	  ○ Tier 1: 3.56%
	  ○ Tier 2: 3.70%
			In an effort to continue to demonstrate success in the ED visit measure, HCI sends out a daily Admit, Discharge and Transfer (ADT) list to care coordination entities. This list informs care coordinators of embers who have been discharged from the ED, admitted to inpatient care, or transferred to another facility, and facilitates appropriate follow up. In addition, Health Solutions has created a dashboard that demonstrates how they are performing on each measure and its requirements. Health Solutions tracks every Member that needs follow-up and within how many days that follow up is needed and how long it takes. These registries help the clinicians stay aware of Member needs for follow-up, and engagement. Health Solutions is also creating a Healthcare Plus team that will be located in the community. The team will consist of an RN and 2 case managers conducting assessments and care plans in the home. The focus will be complex clients with diabetes. The goal is to improve overall health, Quality of Life and decrease costs.
			
			Health Solutions continues to give out the wallet insert cards called, “The Small Book of Crisis Survival Skills.” This booklet is provided to Members and offers strategies as an alternative to ED use to those who are experiencing, “difficult feelings and situations” that might typically result in an emergency department visit. These cards continue to be given out and are the most popular education/promotional item that health Solutions creates. The demand has been so high from Members that Health Solutions orders 1,500 of them every quarter. These cards have also been translated into Spanish.
			
			HCI’s current performance rate at the end of May 2020 met the Tier 2 level at 504.35 ED visits per thousand Members per year.

			Behavioral Health Engagement: BH Engagement efforts continue through engagement following foster care eligibility, positive depression screens, behavioral/physical co-location synergies, and care coordination efforts. The ADT report previously described provides information to support care coordination efforts to engage Members who are experiencing a mental health crisis or are in need of substance use treatment. In addition, the Depression Screening behavioral health measure and the associated Performance Improvement Project described above support the engagement of Members in behavioral health treatment. Additional data is available to care coordinators indicating whether a Medicaid Member has a behavioral health diagnosis and their treatment provider to further facilitate behavioral health treatment when needed. Current BH engagement rates, based on medical claims only at this time, continued a slight upward trend, reaching 3.23% at the end of May 2020. **Well Visits:** HCI's rate remained steady across contract quarters and met the Tier 2 goal in most quarters. We see that this increase may be attributed to the well visits PIP. HCI anticipates a change in this measure as well as other measures as an unintended consequence of COVID-19. HCI continues to work toward improving the percent of Members who have a well visit during the year through the well-check PIP, Member communication of benefits, and care coordination efforts. HCIs rate as of May 2020 was at 22.66%. This slight downward trend is due to unintended consequence of COVID-19. **Prenatal Engagement:** Accurate and early identification of Health First Colorado Members who are pregnant is a prenatal engagement emphasis for HCI. Maternity is also a high complication episode

			identified through the Prometheus tool and has been identified as an FY20 PAC initiative. HCI's prenatal engagement rate shows a steady increase over time and currently has exceeded Tier 2. We are aware of the associated challenges that accompany the data and timely and accurate identification of pregnant women and continue to explore solutions for improvement in this measure and within the community. Prenatal engagement is an area of focus for Healthy Communities, who also participates in the RAE Region 4 PIAC and has engaged in conversation regarding this measure. HCI continues to explore solutions for improvement in this measure and within the community. KPI performance reflected a positive trend, surpassing the Tier 2 goal at 70.06% at the end of May 2020. **Dental Visits:** In order to increase the rate at which Members are receiving dental services, HCI has undergone many efforts. One of those efforts was to form a relationship with Colorado Dental Health Association and conduct dental clinics at the Member drop in center Recovery Solutions. Other efforts include work with DentaQuest to advertise the dental benefit to Members on our Facebook and RAE webpage. HCI strategically placed information on the RAE website to direct Members to where they could learn more about their dental benefits. Various other activities have occurred, including working to form a relationship with a traveling registered dental hygienist (RDH) in the region and exploring a dental text campaign, mobile dentistry and having dental providers present at the HCI PIAC. HCI continues to work with dental organizations to better address rural and frontier shortages, as this is a current area of focus. Healthy Communities, in their work with HCI Members, also promotes oral health through reminders and referrals for annual dental visits.

			Next steps are to evaluate other areas for mobile clinics to travel to and provide services, and to continue to identify other mobile clinics working in the region and engage in discussions for collaboration. In addition, HCI works with Rocky Mountain Network of Oral Health (RoMoNOH) providers and medical staff. Staff have received, training for Cavity free and 3, which offers free in-person or online training for Colorado providers, resources, and support to help medical and dental providers deliver preventive dental health services. There is a registry built which identifies patients eligible for fluoride varnish and that can be applied at the time of visit. We are also working on creating workflows that track referrals from medical to dental to increase the amount and quality of preventative oral health services and connect patients to a dental home. Dental case managers have recently been placed under the direction of the Enabling Services Case Management Supervisor in order to be more consistent with overall case management workflows. Opportunities that have been identified are to engage Care Coordination to evaluate their ability to assist in locations that Valley-Wide is unable to cover, current discussions have occurred with Sol Vista to provide this assistance and to increase awareness and engagement of school staff to increase the number of consents being signed and returned so that a higher number of children can be treated. Next steps are to evaluate other areas for mobile clinics to travel and provide services, continue to identify other mobile clinics working in the region and engage in discussions for collaboration. Dental visit data by county and age was provided

			for assistance in determining areas for mobile dentistry. Due to the COVID pandemic, the mobile clinics are on hold at this time and some dental care alternatives are being considered such as providing dental education in the schools. Dental sealants have been an aerosol-generating procedure and another consideration is placing glass ionomer sealants without producing aerosols so that children can continue to receive the benefit of dental sealants in the COVID-19 world. Will look for directive and recommendations from the Sealant Advisory Board, who will meet the end of June. Health First Members are receiving automated calls from DentaQuest encouraging them to see their dental and medical providers. DentaQuest has also provided children's Dental Kits to a variety of organization throughout our region. Performance on this KPI exceeded the Tier 2 goal, improving to 35.23% as of May 2020. **Health Neighborhood:** HCI continues to communicate the value of and requirements for care compacts; this goal has not been met. Performance on the claims-based portion of this measure is improving. HCI ended May 2020 with a rate of 2.94%. Efforts to analyze specialty claims data are ongoing. For example, the Health Neighborhood KPI is a measure that HCI noticed through the trending and tracking of the data that performance was below standard. HCI met with key personnel in a multi-department effort to address how to best impact the measure. Health Colorado, Inc. (HCI) has revised their care compact initiative to focus on notifying PCPs of specialty providers that are serving a high volume of their attributed Health First Colorado Members. In order to make a positive impact on the performance of the care compact measure we have shifted focus to an approach that utilizes data. The data we have

			pulled essentially examines which specialist provider's Members are seeking care from in RAE Region 4 and then looking to see the PCP the Member is attributed to. We then look to see if a current care compact has been established between PCP and specialist. If one does not exist, we are reaching out to the PCP first via email to inform them that their Members are seeing this (and possibly other) specialist provider(s), that no care compact currently exists, and that we are willing and able to offer support to help establish a care compact. We also offer a zoom option if the PCP has any questions regarding the process. If after some time passes and we do not receive any communication from the PCP, we will conduct further outreach to help to establish a connection. HCI will continue to monitor KPI performance when data becomes available for Q1 FY21. In addition to initiatives mentioned, and based upon performance results, HCI will work with practices to positively impact KPI and Performance Pool performance. On September 25th, 2020, HCI's Board of Directors convened to address the Key Performance Indicators and upcoming Performance Pool measures as well as to address process improvement. HCI's current performance reflects a strong accomplishment across all measures with exception of one, the Health Neighborhood measure. It was determined that HCI in conjunction with key stakeholders will form a focus group to address forming relationships with key specialists within the region to advance performance in the region.
Goal	**Fiscal Year 2021 Project/Initiative**	**Targeted Completion Date**	**Status**
Performance Measurement Data Driven Projects			

Achieve an improvement of 10% over the performance gap for each BH measure by 6/30/2021	BH Performance Incentive Measures and goals for FY20-21 • Engagement in SUD Treatment: Baseline: 47.93% Goal 49.19% Performance: 43.73% • Follow-up within 7 days of an inpatient hospital discharge for a MH condition: Baseline:74.36 % Goal :75.10% Performance: 76.83% • Follow-up within 7 days of an Emergency Department visit for SUD: performance data is not available • Follow-up within 30 days after a positive depression screen:	**6/30/2021**	**Summary:** Health Colorado, Inc. engages in the Behavioral Health Incentive Measures in order to demonstrate improvement in key performance behavioral health metrics. HCI has not yet received FY19-20 behavioral health performance rates from the Department. We have used internal data to approximate performance for three of the measures for which HCI has data available, listed below, along with a brief summary of the performance trend. **Progress/Interventions:** **SUD Engagement:** Based on the available data, performance trend has ended Quarter 4 at 43.73%, which is below the established FY19-20 goal of 49.19%%. HCI's efforts to impact the SUD engagement measures include ongoing monitoring and follow up with the largest SUD provider in Region 4. SUD engagement expectations have been conveyed through documentation training for all providers. **Follow-up within 7 Days of Inpatient Hospital Discharge for a Mental Health Condition:** Spec changes for the methodology of this measure changed to include denied claims and subsequently performance rates increased for this measure. Performance has improved over the year and exceeded the established goal of 75.10% ending Quarter 4 with a rate of 76.83%. We continue to distribute daily mental health discharge lists to providers to facilitate outreach, and to assess the data and tracking methodology. Claims data for SUD-related ED visits is not currently available to the RAE so performance on this BH incentive measure is not currently available. The ADT reports noted earlier in this document do provide some opportunity for ED

	Baseline: 43.64% Goal:45.20% Performance: 24.89% • Behavioral health screening or assessment for children in the foster care system within 30 days of ACC enrollment: Baseline: 24.93% Goal:25.18% Performance: 23.53%		follow-up outreach efforts through the care coordination process and by SUD providers. **Follow-up within 30 days after a positive depression screen:** Depression screen performance appears to be below the goal of 45.20%. However, the full data set needed to identify completed follow-up visits is not currently available to the RAE, due to the removal of claims that include any SUD diagnosis or treatment. The Depression Screen measure was aligned with our behavioral health PIP topic for RAE Region 4. We have also worked with practices around the coding and submission of depression screens. The limited data available shows HCI ending Quarter 4 with a rate of 24.89%. **Behavioral health screening or assessment for children in the foster care system within 30 days of ACC enrollment:** Foster Care Behavioral Health Assessment performance has been highly variable and ended Quarter 4 with a rate of 23.53%, just slightly below the goal of 25.18%. Early concerns with consistent tracking of foster care eligibility have improved. We continue to work with DHS and providers to assure follow-up within the 30-day timeframe and to problem solve any barriers these participants encounter. HCI exceeded the goal for two months (October and November) then ended Quarter 4 with a rate of 23.53%. HCI staff continue to utilize the previously established point of contact for child welfare offices to connect with the individual county offices, regional director's meetings as well as the newly formed CHDS and RAE collaborative meetings. We have learned through these meetings that it is helpful for the directors to have a point of contact at the RAE offices. HCI and DHS have found our participation in the regional meetings helpful in that it allows for

			discussion of more broad changes and future plans. Many of the individual offices have asked HCI to attend their county staff meetings to address issues that are more specific to their individual counties as well as to staff very specific cases where there have been challenges. The themes we have noticed across the counties are: attribution of foster care youth, access to Medicaid services when a youth is outside their assigned RAE, medical necessity, and when to access care coordination. The CHDS and RAE collaboration has been particularly helpful as it relates to larger issues such as attribution and how disruptive it has been for the foster care population. DHS offices have specifically sought our assistance with supporting caseworkers as they try to navigate locating services for youth who are placed outside of their county and/or RAE regions. Alamosa DHS has brought a number of examples to us where providers in other RAE regions are refusing to see youth for services stating that the provider will "not get paid". We have been able to utilize our provider relations and care coordination teams to work with these providers, educate them, and find alternate services if needed as well as secure contracts for services as needed. The DHS offices find it a real relief to have a resource to come to with complicated issues so their staff do not have to feel unsupported or trying to navigate what can be a complicated system. HCI also works with the individual CMHCs to identify new foster care youth within each county office and outreach them to conduct an assessment within 30 days. Weekly lists are automated to each of the CMHC Care Coordination point of contacts who then initiate contact with Members. HCI has identified a number of challenges with the data including changes in the date of enrollment between the weekly lists sent out and the date when the 90-day claims match is run. HCI continues to educate

			the CMHCs regarding the various types of foster care cases as indicated by the aid codes in the data, as well as why multiple aid codes are included in the measure that are not indicative of a newly enrolled Member (adoption and emancipation cases). Additionally, HCI has been the bridge between the work on this measure and the individual DHS county offices so they can better understand why the CMHCs are outreaching on these cases. This ongoing communication has facilitated better connections between the CMHCs who serve the majority of these youth and the DHS offices. The child welfare population may be a small percentage of our total Membership, but they are a high-risk population who, in our opinion, warrant the additional care support and attention we are providing through these collaborations. HCI will continue to monitor performance on the behavioral health incentive measures through the tracking and trending of performance data. When performance data becomes available for Q1 FY20-21 and based upon performance results, HCI will work with facilities to positively impact measure performance where needed.
Member Experience of Care Improvement Driven Projects			
HCI will work with the Department to support survey initiatives, evaluate responses, and formulate interventions to address areas of low satisfaction.	CAHPS: Practices were contacted and supplied survey information regarding potential Member contact. HCI will continue to support the department in this initiative. Survey results have been received and are being evaluated and formatted	**6/30/2021**	**Summary:** Health Colorado, Inc. has taken the results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program. The CAHPS survey is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ). Its purpose is to support investigator-led research to better understand patient experience with health care and develop scientifically valid and feasible strategies and tools to: • Assess patient experience.

	for presentation and review.		• Report survey results. • Help organizations use the results to improve the quality of care. **Progress\Interventions:** Low-scoring areas on the CAHPS survey were addressed at the QIUM committee. It was determined that low scoring elements for Valley-Wide Health Systems would be examined. HCI and Valley-Wide met to address areas where their performance was below the mean for providers in their region. It is important to note that while Valley-Wide's scores were below the mean, their scores were still high and considered high performance. Valley-Wide determined that they would like to focus on areas in the survey that were related to access to care for children. Valley-Wide will focus on the following questions: Question 13. In the last 6 months, when you contacted this provider's office to get an appointment for care your child needed right away, how often did you get an appointment as soon as your child needed? Question 15. In the last 6 months, when you made an appointment for a check-up or routine care for your child with this provider, how often did you get an appointment as soon as your child needed? Question 18. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day? The Provider Relations department will share access to care audit results of Valley-Wide audits with the Quality Management team. These results will be shared with Valley-Wide in an effort to address specific provider and location access to care concerns.

			The 2020 CAHPS data shows that performance decreased for questions 13 and 18; with an increase in question 15. The results for questions 13, 15 and 18 reflect that the scores were lower than the CO RAE 2020 Average for Valley-Wide. Valley-Wide's scores did go down for question 18. The responses to question 15 went up. Question 13 results remained steady with previous year's results. HCI will continue to work with Valley-Wide to address areas of low performance. Beginning in May of 2020 and continuing every 6 months, Valley-Wide clinics are contacted via telephone to inquire about appointment availability. The first test Valley-Wide underwent was passed.
HCI evaluates web-based survey responses and conducts follow-up where indicated and upon Member request.	Member Survey: Your Opinion Matters is an internal survey that seeks to gain Member insight into access related issues and opinions on satisfaction with services rendered.	6/30/2021	**Summary:** The Your Opinion Matters survey aims to collect information on Member interest to improve their healthcare, and perceptions of satisfaction and access issues for both physical health and behavioral healthcare services delivered in person and via tele-health. HCI continues to conduct outreach to Members who indicate on the survey that they would like a follow up contact. **Progress\Interventions:** In FY20, 44 Members have taken the survey and [redacted] Members have indicated that they would like to receive more information about their Health First Colorado Benefits or to speak to someone regarding their questions or concerns. When Members were asked, "what would make your healthcare better" [redacted] Members indicted through the survey that they were happy with the services that they received through HCI. The next highest response category was more providers in my area ([redacted]) and better understanding of my health care ([redacted]).

			In addition to the survey being taken and reviewed at QIUM, this survey was taken to the Member Improvement Advisory Council meeting where the survey was reviewed with Members. Members provided the following feedback which will be taken into consideration when it is time to update the survey. The responses to the survey, (where and when applicable) will be used to address any comments and concerns relayed by the Member. The Member Improvement Advisory Council felt the following questions should be added: • Did you receive a referral at your appointment? Did the referral happen timely? • Do you feel your personal health information was protected and kept confidential? • Did you feel you were respected and listened to during your visit? • Did your provider use your preferred pronouns? Another suggestion was to highlight the box for contact information so people would see that they had to add their contact information. The final comment on the survey was that the survey flowed really well. It could be completed quickly and easily. HCI will begin to take the results of this survey to its QIUM committee twice per year. The survey will also be taken before the Member Experience Advisory Committee (MEAC). It is at MEAC that the survey will be discussed with Members to gain their perception of the survey. If after this review occurs, there are any pertinent changes that need to be made, HCI will incorporate into the survey.

Achieve performance greater than 70% for ECHO survey responses when the ECHO survey is determined to begin again.	HCI reviewed the ECHO survey results for adults and children based off information received in FY20. The Health Services Advisory Group established a benchmark of low performance as responses that fell below 65%. HCI will implement strategies to affect the identified areas of lower performance. Alternative treatment options and the inclusion of family in treatment are the two areas that HCI will focus on.	The completion date is to be determined, as the State will not conduct the ECHO survey in FY21.	**Summary:** The Experience of Care & Health Outcomes (ECHO) Survey asks health plan enrollees about their experiences with behavioral health care and services. Health Colorado, Inc. takes the results of the ECHO survey and addresses possible interventions to help to improve scores. **Progress\Interventions:** ECHO: HCI found that two areas of low reporting satisfaction on the ECHO survey correlated to the questions addressing the availability of other treatment options and the rate at which family Members were involved in treatment. HCI continues efforts to affect the positive responses received from Members on these two elements. In order to make Members aware of the availability of alternative treatment options and the importance of involving the family in treatment HCI took on the following activities. 1. Met with region providers to discuss the initiatives and discuss the interventions that would be meaningful. 2. Created email communications to network providers addressing the importance of the involvement of family in therapy and where their Members could find information on alternative treatment options. 3. Posted information for the Member on the HCI Face Book page to let Members know about alternative treatment options and to ask their therapist about involving their family in their therapy. 4. Presented information about family therapy and alternative treatment options at Provider Relation led practice support calls.

			5. Created a brochure that was sent out to practices for Members to read that promoted the importance of their family participating in their treatment. 6. Presented this information at QIUM asking those in attendance to pass along the ECHO interventions to their clinicians. HCI will continue to monitor the results of the survey response rates to assess the impact of its interventions when the next iteration of the survey is completed. HCI will continue to address interventions as warranted.
Under and Over Utilization of Services Projects			
Improve overutilization through implementation of COUP pilots; evaluate the effectiveness of the COUP pilot programs by increasing the number of Members in the COUP pilot program recommended for lock in status	The COUP Pilot Program continues to operate in RAE Region 4 for COUP Members to address overutilization of services. The COUP pilot program was revamped to include a look at the over utilization of services that would make a Member appropriate for lock in services through the RAE. The details of the altered COUP pilot program are addressed in the status section. The care coordination entities in Region 4 responsible for the highest volume of COUP Members were identified and agreed to implement the new COUP pilot program: the entities were Health Solutions and Valley-Wide Health Systems. If the	**6/30/2021**	**Summary:** The COUP pilot program will be considered a diversion program to the lock-in program. It is our intent that Members who meet the established criteria will receive six-months of intensive interventions in order to avoid being placed on the lock-in list. In addition to being a diversion program, it is the intent of the pilot program to lower total cost of care, to affect better health outcomes, to support the RAE's condition management program and to aid Members in avoiding placement onto the complex Member list. We will work with the current RAE Accountable Entities participating in the pilot program to implement the program changes and ensure that the care coordination with these Members reflect their unique needs. In RAE region 4, Health Solutions and Valley-Wide will continue to serve as the pilot program collaborators, with the possibility of other care coordination entities entering the program as warranted.

	COUP pilot program is found to be, appropriate to extend to other Care Coordination entities that will be addressed at that time.		**Progress\Interventions:** The COUP Pilot program altered its course of action in April of 2020. The focus will no longer be strictly on Members who have been on the COUP list for two consecutive quarters, who have high emergency department utilization, and who have high opioid use. The new focus will be on Members who have been on the COUP list for two consecutive quarters, who have high emergency department utilization and who have a diagnosis of anxiety. This focus will allow for an additional concentration into emerging costs. Health Solutions and Valley-Wide will continue to serve as the care coordination entities for this program. As seen in Appendix A, there were a total of 1322 unique Members on the COUP list in FY20; There were 848 Members (64%) on the COUP list for 1 only quarter, 260 Members (20%) on the COUP list for 2 quarters, 118 Members (9%) on the COUP list for 3 quarters, 55 Members (4%) on the COUP list for 4 quarters, and 41 Members (3%) on the COUP list for 5 or more quarters. For FY20 there was a total 71 Members (non-unique) on the quarterly Lock-in Diversion List. Care coordination assignment was split between, Health Solutions (49), San Luis Valley Health ([redacted]), Southeast MHC ([redacted]), and Valley-Wide Health Systems ([redacted]). Lock-in Diversion List Membership had a high rate of change from quarter to quarter. There were [redacted] Members who were on the list for the first time, [redacted] Members dropped from the list due to change in Medicaid status, [redacted] Members continued on the list for multiple quarters and 34 Members were removed from the list because they no longer met the needs threshold for needing Lock-in Diversion List services. HCI has also added a new provider into

Monitor and improve underutilization through demonstrated through an improvement of 10% over the performance gap in identified BH measures	Under-utilization: BH Incentive Measure 1—Engagement in OP SUD treatment—An initiation encounter plus 2 or more services within 30 days of the initiation. The RAE is collecting this data with specific provider-level detail. Poor performance on this indicator will direct follow-up efforts. The RAE is monitoring 7-day ambulatory follow-up after hospital discharge (BH Incentive Measure 2). Poor performance on this metric will result in	**6/30/2021**	the COUP pilot. That provider is San Luis Valley Mental Health Center. **Summary:** Care coordination outreach efforts continue; these are tracked and reported as required. We continue to refine our knowledge of this population and effectiveness of interventions, provide support with assistance from the Provider Relations Department, and work toward improved management of this population. Training is provided to practices on how to access and use the DAP portal to monitor utilization at the practice level via KPI data with Member-level detail. The COUP Pilot Program will continue into FY21. When appropriate, other accountable care coordination entities will be asked to join the program. HCI will continue to use the data from the COUP lock in diversion program to drive efforts to impact overutilization of services and the lock in process. **Progress\Interventions:** BH utilization trends by Member, facility, and service type are monitored on a monthly basis and reviewed at the monthly QIUM committee. Chart audits are regularly conducted over a wide variety of service modalities. HCI audits mental health providers, substance use providers, residential treatment facilities, in-patient facilities, intensive out-patient facilities, and medication assisted therapy. All audits have a focus on the appropriateness of services provided in order to ensure proper utilization. Fraud, Waste and Abuse are also areas that these audits can point to. The rates for engagement in SUD Treatment for FY20 is 43.73%. In an effort to increase the rate,

	QI/Clinical follow-up. MHC partners are provided with daily inpatient census and daily hospital discharge reports.		HCI provided data to one of the largest SUD providers in RAE region 4, Crossroads. Supplying of data and targeted conversations on performance improvement were held in an attempt to drive the follow up rate in a positive direction. Performance has improved over the year for follow-up within 7 days of an inpatient hospital discharge for a MH condition and exceeded the established goal of 75.10% ending Quarter 4 FY20 with a rate of 76.83%. We continue to distribute daily mental health discharge lists to providers to facilitate outreach, and to assess the data and tracking methodology. HCI will continue to monitor performance on these measures through the tracking and trending of performance data. When performance data becomes available for Q1 FY21 and based upon performance results, HCI will work with facilities to positively impact measure performance.
Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs Projects			
Auditing for EPSDT will occur during behavioral health treatment record audits. The goal for compliance with the question, "For clients under 21, evidence that provider educated client/parent about EPSDT services as needed", is 80% compliance.	Behavioral health providers are expected to complete assessments to identify and recommend treatment for individuals with special health care needs. Members with special needs are supported through case management where needed to assure care is well coordinated and communication between providers is occurring. Providers are audited for EPSDT compliance during	**6/30/2021**	**Summary:** In order to ensure that EPSDT services communicated to HCI Members, education and auditing occurred over fiscal year 20. **Progress\Interventions:** During FY20, HCI has conducted several trainings across several modalities. The trainings that HCI has conducted are: • Four in-person substance use disorder and mental health documentation standards trainings for the HCI provider network. During this training EPSDT is covered. Providers are educated about EPSDT and provider responsibilities for EPSDT services. Audits are conducted quarterly.

	regularly conducted chart audits.		• Six one on one provider trainings • Three provider round table discussions and • Several providers have participated in courtesy chart reviews to improve their documentation. In FY20, [redacted] charts were audited for EPSDT requirements. Out of the [redacted] charts, [redacted] of the charts met the EPSDT requirement for a compliance rate of 86%. HCI will continue to audit for EPSDT services in FY21 as well as provide training to providers to ensure that EPSDT requirements are communicated. EPSDT services are addressed at the quarterly mental health and documentation trainings that are offered by HCI. At these trainings, HCI addresses the EPSDT requirement.
Quality of Care Concern Monitoring			
Identify and address potential Quality of Care issues and concerns.	HCI undertakes a variety of activities aimed at evaluating and improving the quality of care for Members. The Quality of Care Committee (QOCC) is a sub-committee of the QI UM Committee. The purpose of this committee is to identify, investigate, monitor, and resolve quality of care issues and patterns of poor quality within the system of care. Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Provider treatment record documentation training, audits	**6/30/2021**	**Summary:** Investigations of potential quality of care issues are conducted through the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Providers and HCI staff can report quality of care issues, or other concerned parties typically through an Adverse Incident reporting form submitted to the Quality Department. All quality of care issues are documented, as are results of investigations. Corrective actions are tracked and monitored. Reporting, investigation and tracking of adverse incidents through the Quality Management Department continued during the past fiscal year. An adverse incident may feed into the quality of care process based on investigation results.

	and provider education are ongoing and occur individually in areas where scores indicate problems are evident. If improvement is not seen, the corrective action process is initiated. Audits include a review of encounters/claims against the chart documentation.		All providers are required to report adverse incidents; HCI received 76 adverse incident reports during FY2020; a decrease from the 136 reported the previous year. These care-monitoring initiatives, along with treatment record reviews and training, are conducted with the goal of ensuring Members receive the best care possible. **Progress\Interventions:** Meetings to evaluate quality of care issues and adverse events are scheduled quarterly or as needed. Quality of Care data is presented at the QI UM Committee where trends are analyzed. Training and education on QOC and the adverse indecent reporting process is covered at all documentation training sessions. Overall, there has been a gradual decrease in adverse incidents and quality of care issues over the past year. For FY20, HCI received 76 adverse incident reports. Due to the significant decrease, providers are reminded and trained on the Quality of Care and Adverse Incident reporting process at all quarterly documentation training events. The dates of the trainings were: • October 16, 2019 • March 17, 2020 • June 8, 2020 • September 23, 2020 Quality of care issues including concerns raised by the Department of Health Care Policy and Financing (Department), provider-raised concerns or RAE discovered concerns continue to

Goal	Fiscal Year 2020 Project/Initiative	Targeted Completion Date	Status
			be investigated thoroughly. HCI will continue to work with HCPF to address and report any concerns. Furthermore, HCI will continue to work with the Department to finalize and then utilize the QOC reporting template.
External Quality Review Driven Projects			
HCI will collaborate with HSAG and the Department on the completion of the annual External Quality Review and complete corrective actions as determined by Health Services Advisory Group.	Health Colorado underwent an external quality review (EQRO) audit in March of 2020 and will continue to undergo audits annually. HCI was given eight corrective actions that stemmed from the 2020 Health Services Advisory Group (HSAG) EQRO audit. One CAP was issued for the Coverage and Authorization of Services. One CAP was issued for the Access and Availability standard. Six CAPs were issued for the Grievances and Appeals standard. The required action for standard I requirement 15: HCI must ensure that the NOABD in its entirety is written in language that is easy for a Member to understand. The required action for standard II requirement 13: HCI must develop a more robust mechanism for regular monitoring/surveying of providers to ensure that its providers meet the State standards for timely access to care and services (i.e., appointment standards). HCI must also ensure	**6/29/2020** (initial CAP plan submission) 10/06/2020 (CAP document submission)	**Summary:** In 2020 HSAG conducted an audit for HCI covering the following categories: • Coverage and authorization of Services • Access and Availability • Grievances and Appeals **Progress\Interventions:** HCI scored 90% in this audit. The CAP process is underway. The CAP plans as outlined in CAP step 3 was submitted on June 29, 2020. HSAG has asked for clarification on the CAP plans for the CAPs associated to standards I and II. These updates were returned on August 6, 2020. The documents that will be used as evidence of completion or the corrective action plans will be submitted by October 6, 2020 The proposed plan of action for standard I requirement 15 is: **Planned Interventions**: Staff training on Member correspondence, standardize denial statements that have been checked for reading level via the Flesch-Kincaid grading system, audit 10 denial records post staff

	implementation of CAPs for providers that do not comply with this access to care standards. The required action for standard VI requirement 13: HCI must develop a mechanism to ensure that the description of the grievance resolution in grievance resolution letters thoroughly addresses a Member's stated complaint. The required action for standard VI requirement 26: HCI must clarify information in its appeal resolution letter and *SFH Guide* regarding how the Member may request continued benefits during an SFH. HCI must also remove information regarding the Member's right to request an SFH from its overturned appeal decision letters. The required action for standard VI requirement 27: HCI must correct its *SFH Guide* to remove the phrase "before you file an appeal" from the circumstances for requesting an SFH if the health plan does not meet the appeal processing time frames. The required action for standard VI requirement 29: HCI must clarify information in its *SFH Guide* to accurately represent the requirements for requesting continued benefits during an SFH. The required action for standard VI requirement 30: HCI must revise its *SFH Guide* to remove the clause "you do not request an SFH and		training to ensure content standards are met. **Person(s)/Committee(s) Responsible and Anticipated Completion Date**: Tiffany Jenkins, UM Manager; Steve Coen, Clinical Director; Completed by June 8, 2020 **Training Required**: Staff training on Policy 307-Member Information Requirements **Monitoring and Follow-Up Planned**: Regular review/editing of denial letters, audit a sample of post-training letters for reading level **Documents to be Submitted as Evidence of Completion**: Staff meeting agenda/minutes showing correspondence training, list of common denial reasons and corresponding Member-friendly statements with reading level scores, improved letter templates, post training audit results, Policy 307-Member Information Requirements. The proposed plan of action for standard II requirement 13 is: **Planned Interventions**: HCI has created a policy "Access to Care Analysis and Reporting" to outline the monitoring of provider to ensure they meet the State standards for timely access to care and services. This includes implementation of CAPs for providers who are not in compliance, and actions taken for continued non-compliance after CAP. HCI will provide training to behavioral health and primary care providers on

	continued services within 10 days of an appeal decision not in your favor" from the description of how long benefits will continue during an SFH. The required action for standard VI requirement 35: HCI must revise the grievance and appeal information in the provider handbook to correct inaccuracies related to continuing benefits during an SFH, as outlined in findings related to 42 CFR 438.420 (a-b)—element #29 in the compliance monitoring tool.		the importance of access to care standards and provider monitoring process. HCI will provide training to Provider Relations staff on the policy. The Standard Operating Procedure for this policy will be reviewed with the staff to show the operational process to conduct the monitoring and track the activities. The tracking will be reviewed periodically to ensure policy is followed consistently and conduct potential coaching. **Person(s)/Committee(s) Responsible and Anticipated Completion Date**: Alma Mejorado. Anticipate completion by August 30, 2020. **Training Required**: HCI will provide training to behavioral health and primary care providers on the importance of access to care standards and provider monitoring process. HCI will train Provider Relations staff on policy and operational process for provider monitoring. **Monitoring and Follow-Up Planned**: Provider Relations will monitor the results of the access to care audit results on a monthly basis. **Documents to be Submitted as Evidence of Completion**: Policy PRCO 007 Access to Care Analysis and Reporting, Provider Training Materials and training attendance sheet, Provider Relations' Standard

			Operating Procedure, and tracking system. The proposed plan of action for standard VI requirement 13 is: **Planned Interventions**: HCI has updated the Complaint Resolution Letter Template and provided a training to Advocates on the importance of addressing the stated complaint in the resolution letter. HCI has requested that Advocates send in the complaint receipt and resolution letters to HCI to review the content of the letters and provide coaching to ensure that the resolution matches the complaint. **Person(s)/Committee(s) Responsible and Anticipated Completion Date**: Lynne A. Bakalyan. The training was provided on May 12, 2020. The complaint resolution letter templates have been updated. **Training Required**: Training was provided on May 12, 2020. **Monitoring and Follow-Up Planned**: The Member Engagement Specialist and Member Services Director will monitor the complaint resolution letters on a monthly basis. **Documents to be Submitted as Evidence of Completion**: Complaint Resolution Letters. Member Services Subcommittee Minutes. The proposed plan of action for standard VI requirement 26 is: **Planned Interventions:** HCI has updated the State Fair Hearing (SFH)

			Guide to state that Members can contact HCI to request continuation of benefits. HCI has updated the Appeal Decision Letter to state how a Member can request continuation of benefits during a SFH and has flagged the template when an appeal decision is overturned. **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** The Member Engagement Specialist will update the Appeal Job Aid and train the back-up staff for appeal processing. This has already been completed as of June 1, 2020 **Monitoring and Follow-Up Planned:** The Member Services Director will review all Appeal Decision Letters prior to being sent. Documents to be Submitted as Evidence of Completion: **The SFH guide and the Appeal Decision Letter Template.** The proposed plan of action for standard VI requirement 27 is: Planned Interventions: HCI has corrected its State Fair Hearing guide and removed the phrase “before you file an appeal” to “If Health Colorado does not follow the appeal time frames, you may then request a State Fair Hearing.” **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** Lynne A. Bakalyan. This has already been completed as of June 1, 2020 **Training Required:** None

			Monitoring and Follow-Up Planned: None **Documents to be Submitted as Evidence of Completion:** State Fair Hearing Guide The proposed plan of action for standard VI requirement 29 is that HCI has updated the State Fair Hearing Guide to accurately reflect the continuation of benefits during a state fair hearing. The SFG states, "Can I Continue to Receive Services During a State Fair Hearing?" Yes, as long as you have been receiving services during the appeal process. If you want your services to continue while the State Fair Hearing is pending, you must ask that your services continue within ten (10) days from the date Health Colorado mailed you the appeal decision letter that was not in your favor. Your provider cannot make this request on your behalf. You can contact HCI at 888-502-4185 to request that your services continue. **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** Lynne A. Bakalyan. The SFH guide has been updated as of June 1, 2020 **Training Required:** None **Monitoring and Follow-Up Planned:** None **Documents to be Submitted as Evidence of Completion:** SFH Guide The proposed plan of action for standard VI requirement 30 is:

			Planned Interventions: HCI has revised the SFH Guide to remove the clause that Members must request a SFH within ten (10) days and changed it to they must request continuation of benefits within ten (10) days. Person(s)/Committee(s) Responsible and Anticipated Completion Date: Lynne A. Bakalyan. This has already been completed as of June 1, 2020. **Training Required:** None **Monitoring and Follow-Up Planned:** None **The proposed plan of action for standard VI requirement 35 is Planned Interventions:** HCI has updated the Provider Handbook to update when a Member can request continuation of benefits during a State Fair Hearing. **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** Member Services has already sent in revisions to Provider Relations Department. The provider handbook was completed on June 30, 2020. **Training Required:** An annual training for providers will be held covering state fair hearings, appeals and complaints. **Monitoring and Follow-Up Planned:** None **Documents to be Submitted as Evidence of Completion:** Provider Handbook HCI will finalize the corrective action plan process with Health Services Advisory Group and will participate in

Goal	Fiscal Year 2021 Project/Initiative	Targeted Completion Date	Status
			the EQRO audit that will take place in April 2021. If there are any associated corrective actions warranted, HCI will complete the corrective action process in conjunctions with Health Services Advisory Group and the Department.
Internal Advisory Committees and Learning Collaborative Strategies and Projects			
Oversee and participate in current HCI committees that communicate best practices and share information and feedback that is key to the delivery of effective healthcare in the region.	The Regional PIAC is comprised of Members, family Members, partners, providers, hospitals, community agencies and a variety of stakeholders who represent the populations of the region and local communities. The role of this committee is to guide and inform program administration to include, input into performance with a focus on performance measures, population health, program development, quality of care, and service. This committee serves the important function of vetting the annual Performance Improvement Plan, the Performance Improvement Project progress, and possible performance improvement initiatives that will directly affect the quality of Member care, Member engagement or Member experience of care. Issues that might arise for discussion within the PIAC include but are not limited to: Member needs around medical care, transportation, community services such as food, peer support,	**6/30/2021**	**Summary:** Regional PIAC meetings for Health Colorado, Inc. are held monthly. Due to the impact of COVID-19, all meetings have occurred via web-based platforms. Stakeholder participation in these meetings continues to grow with the initiative to include Member representatives. **Progress/Interventions:** HCI staff consistently attend the State Learning Collaborative meetings. HCI has also hosted learning collaboratives that have centered on the performance measures, along with provider support calls for physical and behavioral health providers. At these provider support calls; Quality Management discussed the importance of care compacts as well as other key performance metrics. In addition, as the SUD updated benefit is in the final approval phase, the Quality Department will begin providing updates and training to aid providers in preparing for the administration of the new benefit.

	financial assistance, clothing, and cultural and religious considerations. In order to ensure the Quality Management program is effectively serving Members and providers, Health Colorado will participate in multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the program overall and guiding the improvement of program performance. Health Colorado will also periodically hold learning collaboratives to educate and better understand network challenges related to performance improvement, initiatives and interventions, and other topics relevant to stakeholders.		HCI will continue to participate in committees where best practices are shared, and host committees to share best practices. HCI will continue to participate in State run learning collaboratives and PIAC meetings.

The goals for the FY21 QI work plan have also been created and approved by the QIUM. The performance goals for FY21 are as follows.

GOAL #1: Further develop the continued monitoring of Key Performance Indicators (KPI's) and performance incentive measures. Implement targeted interventions where applicable.

GOAL #2: Ongoing production and monitoring of Behavioral Health incentive measures. Implement targeted interventions where applicable.

GOAL #3: Quarterly or when applicable, monitor results of performance improvement projects and implement targeted interventions where applicable.

GOAL #4: Conduct regularly scheduled documentation audits and offer education based upon audit results.

GOAL #5: New or revised P&Ps that have the potential to impact HCI quality operations or performance will be distributed to the QI UM Committee for informational purposes, clarification or input where needed.

GOAL #6: By June 30, 2021, all UM policies will be reviewed and updated as required to ensure compliance with the RAE's contract requirements. Policies that require significant modification will be forwarded to HCPF contract administrators for their review.

GOAL #7: All UM staff will complete the annual Inter-Rater Reliability Test and achieve a passing score of 80% or greater. Staff who do not meet the 80% threshold will complete required remediation training to achieve proficiency.

GOAL #8: HCI's UM staff will provide regular updates on the utilization of behavioral health. services.

GOAL #9: In collaboration with the Provider Relations Department and HCI leadership, explore opportunities to expand upon the existing practice transformation framework and associated initiatives.

GOAL #10: Complete QM program documents annually

GOAL #10A: An evaluation on the progress on the previous year's goals will be completed and used to determine goals for the upcoming year.

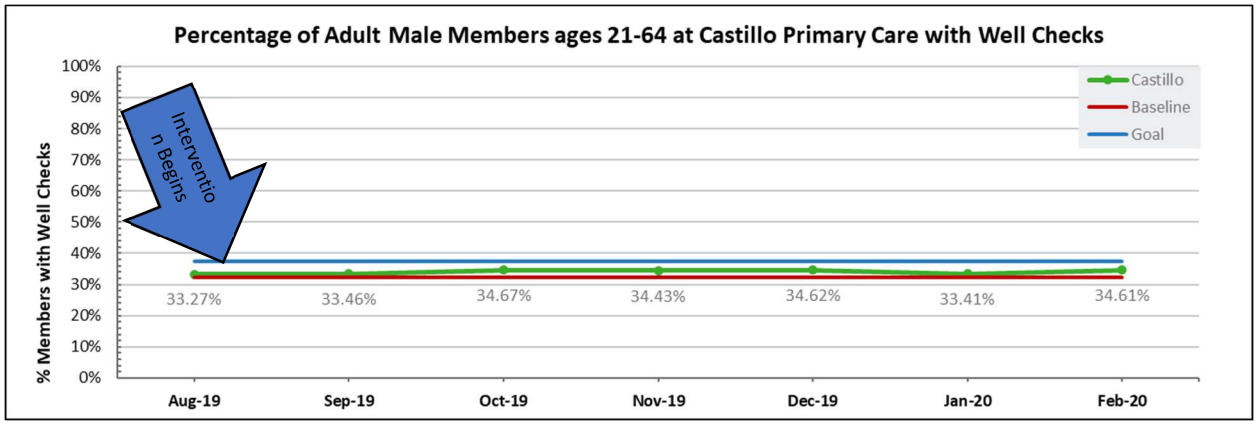
GOAL #11: Ongoing monitoring of goals listed in the R4 Quality Improvement Plan. Implement targeted interventions where applicable.

GOAL #12: Quarterly or when applicable, monitor the average turnaround time for complaints and grievances

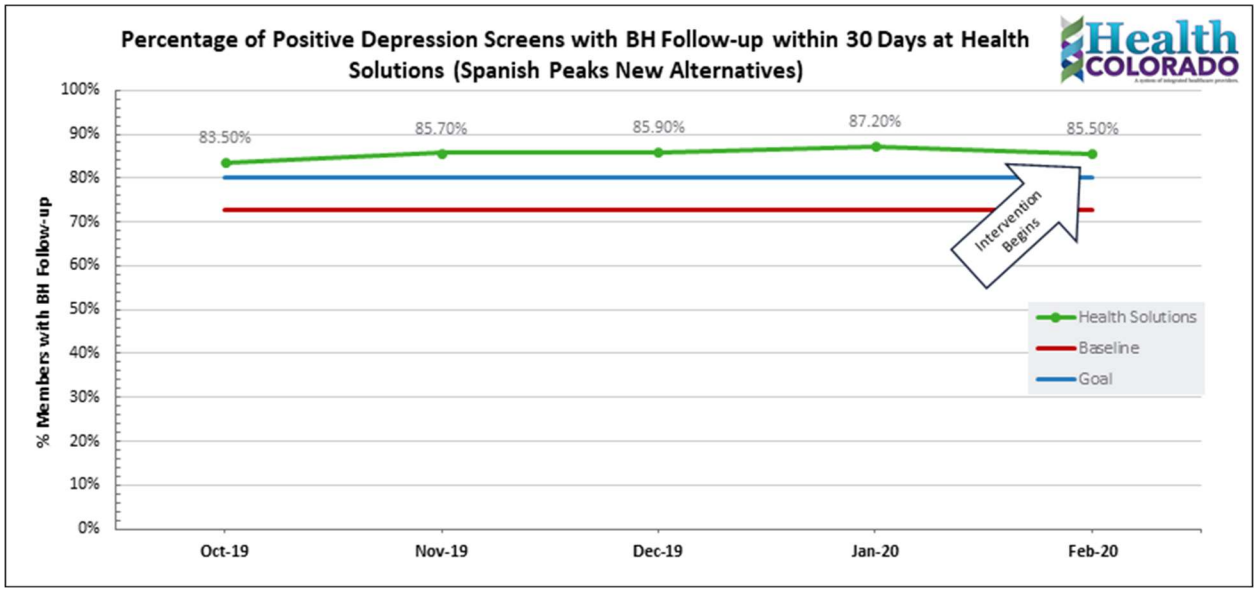
GOAL #13: Further develop the continued monitoring of the Performance Pool Measures. Implement targeted interventions where applicable

Appendix A

Performance Improvement Project Run Charts

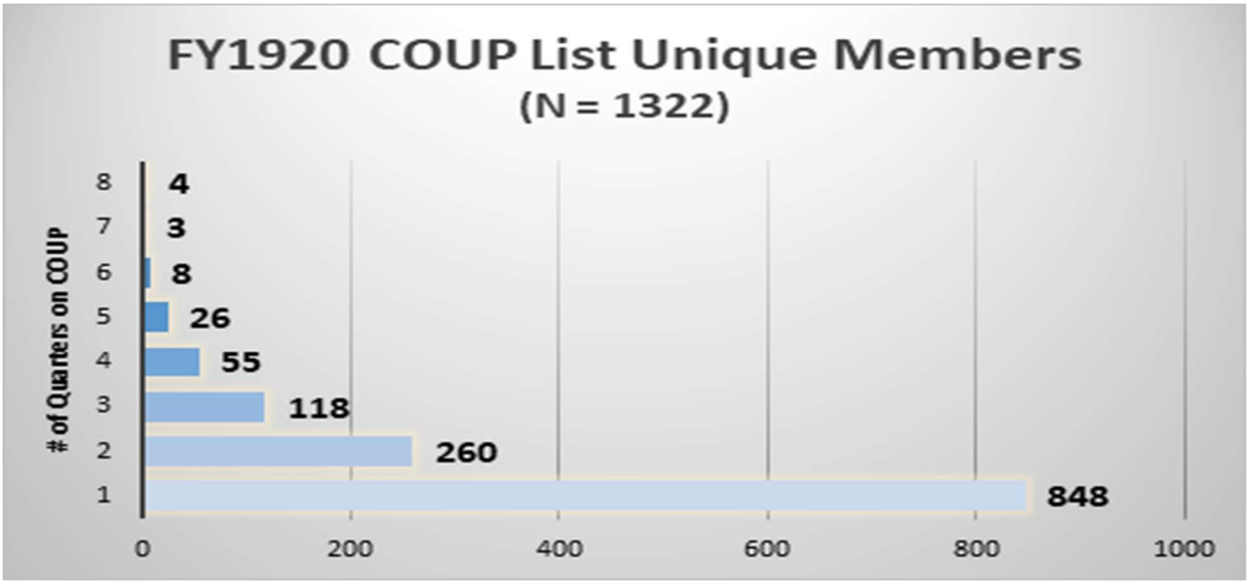


The well check completion rate for males ages 21-64 did not meet the goal in any month. The completion rates for Castillo Primary Care were close to the baseline at 33.27% in the first month of intervention then showed a slow rise across the next four months to 34.62% before a slight dip in January 2020 (33.41%) and then return to 34.61% in February 2020. However, the denominator also decreases across time and may be responsible for any increase in well check completion rates. While the intervention may have increased the completion rate marginally, it needed to be more widely applied to achieve the level needed to meet the goal.



It is unclear if the intervention had an impact on the follow-up rates for behavioral health (BH) appointments. Claims data continues to have so few screens included that it is impossible to interpret the significance of increase or decrease in the rate of positive depression screens with BH follow-up completed within 30 days. Therefore, data collected from Health Solutions Medical Center (HSMC) aka Spanish Peaks New Alternatives was used to track progress on this PIP. This data does show an increase in the rate of positive depression screens with BH follow-up completed within 30 days from 72.65% at baseline to 85.5% at the end of February. However, the rates were at least that high for the three months prior to the intervention. Data collection issues also impact our ability to interpret results. The number of assessments included in the current data pull is higher than the number of assessments included at the time of the baseline data pull. There are several changes that could account for this difference: 1) HSMC switched their EHR system from AdvancedMD to NextGen during this project; 2) KPI scope changes and bug fixes to the measure logic; and 3) an improved source of eligibility was utilized. In addition, it is possible that the statewide KPI impacted the performance on this measure before our intervention was initiated and the limited intervention period due to the COVID-19 outbreak makes it difficult to determine intervention effectiveness.

COUP Program List of Unique Members



There were a total of 1322 unique Members on the COUP list in FY20; There were 848 Members (64%) on the COUP list for 1 only quarter, 260 Members (20%) on the COUP list for 2 quarters, 118 Members (9%) on the COUP list for 3 quarters, 55 Members (4%) on the COUP list for 4 quarters, and 41 Members (3%) on the COUP list for 5 or more quarters.