Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2021

Health Colorado, Inc.

Quality Improvement Plan FY21-22

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, guided by the following values:

- 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 , Ph.D., MPA: Director of Quality Assurance [redacted]	**Jeremy White, MA:** Mgr BH Clinical Quality [redacted]
Open position BH Clin Qual Audit Analyst Sr	**Courtney Hernandez, MS-HSV:** BH Clin Qual Audit Analyst Sr. [redacted]
Ky Briggs, LCSW BH Clin Qual Audit Analyst Sr [redacted]	**Edward Arnold, MSN, BSN, BSE, CPHQ** Performance Improvement Analyst [redacted]
Melissa Schuchman, MA: Business Info Analyst II [redacted]	**Victoria Allen-Sanchez, PsyD, LPC** BH Clin Qual Audit Analyst Sr [redacted]

3. Year Objectives/Top Priorities

The top priorities for FY21-22 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 Incentive Performance (BHIP) Measures
- Continued improvement on Performance Pool measures
- Initiation of any new Performance Improvement Project(s)
- Monitor progress on the goals written to in the HCI annual quality work plan
- Adapt to each contract amendment as necessary
- Identify areas for opportunities and potential roadblocks striving for solutions

Key Performance Indicators, Performance Pool Measures, 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 measures, and behavioral health performance incentive measures established by Colorado 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 continuous improvement.

HCI Performance Measures Action Plan (PMAP):

The purpose of the Health Colorado, Inc. (HCI) Performance Measures Action Plan (PMAP) is to serve as a mechanism to further the HCI Performance Measures Strategy Work Group efforts and to drive performance improvement in collaboration with key RAE 4 stakeholders. Serving as a collaborative to promote learning and improvement, the HCI Performance Measures Strategy Work Group will meet bi-monthly at a minimum and report to the HCI QIUM Committee on a monthly basis.

Key stakeholders involved in the PMAP effort are HCI leadership, partners/providers, quality management staff, and members of the HCI QIUM Committee. The work group will be led by a member of the HCI QIUM Committee and/or quality management staff. Over the course of FY 20-21, HCI senior leadership and members of the HCI QIUM Committee focused on establishing a strategic framework to address performance measurement activity for RAE 4 on the following contract-based measures:

- *Key Performance Indicators (KPIs)*
- *Behavioral Health Incentive Program (BHIPs)*
- *Performance Pool (PPs)*

Reviewing HCI performance in relation to benchmarks/goals/targets, the HCI Performance Strategy Work Group will periodically rank order measures, determining which measures to focus performance improvement activity within a rapid cycle framework. The PMAP work group will be comprised of HCI leadership, quality management staff, and key RAE 4 partners/providers identified as strong performers to identify and document best practices as well as partners/providers with opportunities for improvement, who are willing to implement best practices. The PMAP work group will report its activities in the monthly HCI QIUM Committee meetings, including review of HCI and provider-level performance data and identifying potential processes and countermeasures to increase overall performance.

The PMAP template (see next page) will serve as a road map to document and guide the work group's efforts along with the use of additional performance improvement tools (e.g., key drivers' diagram, failure mode, and effects analysis). The initial work group will begin to focus on prioritized measures in early FY21-22. HCI partner/provider representatives will be invited on an ad hoc basis to the work group meetings to review the performance data and make recommendations with feedback and support from the HCI QIUM Committee. Once a meaningful, manageable, and measurable set of interventions are identified and approved by the committee, the work group will coordinate with partners/providers to implement any measures and monitor performance over time, sharing their findings with the HCI QIUM Committee on a monthly basis. The work group will follow a rapid cycle, iterative process of planning, taking action (countermeasures), studying, and monitoring performance, and acting on what is learned.

PMAP Implementation Steps

The PMAP will be implemented (as described above) by the HCI Performance Measures Strategy Work Group using the following steps:

- Perform data analysis of key performance measures to identify intervention targets (KPIs, BHIPs, and PPs).
- Identify and invite partner/provider representatives to review performance data and make recommendations for interventions.
- Develop an implementation plan for approved interventions.
- Coordinate with partners/providers to implement approved interventions and monitor/manage performance.
- Provide monthly performance reports on intervention results to the HCI QIUM Committee.
- Analyze/study results and make changes to implementation plan/strategy, as needed.

Performance Improvement Project

For FY20-21, in collaboration with the Health Care Policy & Financing (HCPF), HCI selected one (performance improvement project (PIP). The intent of the PIP is to conduct a PIP that addresses increasing depression screening and follow-up behavioral health services after a positive depression screen. 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. This PIP will be completed within FY21-22.

The PIP for FY21 summary below:

In FY20-21, HCI began work on a new PIP topic and partnered with Valley-Wide Clinic in Alamosa. The goal of this initiative is to increase the rate at which members are receiving depression screens and the rate at which members are accessing behavioral healthcare services within thirty (30) days of 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 behavioral health appointment within thirty (30) days in a physical health or behavioral

healthcare setting. Following HSAG's approval of Modules 1 and 2 that focused on creating a process map, identifying failure modes and key drivers, the PIP team is currently finalizing the interventions to address these measures. The team will submit Module 3 early in the fiscal year 21-22 and perform the rapid-cycle iterations anticipating Valley-Wide will achieve the goal threshold. The final submission of Module 4 documenting these findings will be submitted by the end of the fiscal year 21-22 with the final intent to establish a baseline set of standard workflows that work to improve screening and follow-up related measures. Ultimately, sharing standard work for adapting/adoption across the region.

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 and that HCI maintains a high-performing network. The Colorado Department of Healthcare Policy and Financing (HCPF) 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 FY21-22 along with the addition of documentation audits for inpatient and residential substance use disorder treatment facilities.

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, there were four (2) 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. Due to COVID and accompanying restrictions placed on traveling and group meetings, one in-person training was conducted via zoom. To provide further support, HCI has provided provider-specific training 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:

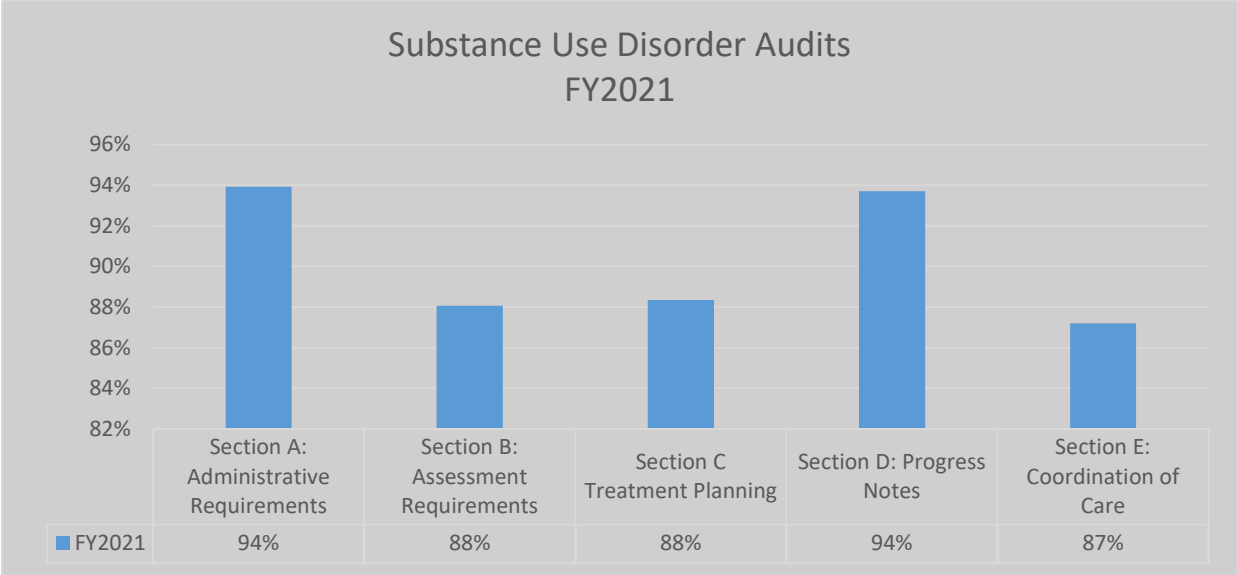
Substance Use Disorder (SUD) Audits

To date, fifteen (15) Substance Use Disorder (SUD) outpatient, Medication Assisted Treatment (MAT), and SUD Detox providers completed a SUD audit totaling seventy-six (76) 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 the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or below 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 Standards (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 21, 2021, an SUD documentation training was held for SUD providers. Several providers have also participated in individualized training sessions offered by HCI auditors.



Summary of SUD Performance

There has been significant improvement in SUD outpatient audit results; however, improvement needs to take place. Medical necessity: although not represented in the scoring algorithm, this represents the most common 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 SUD use, and auditors have worked diligently to provide further guidance to providers concerning what is required to meet medical necessity for this population.

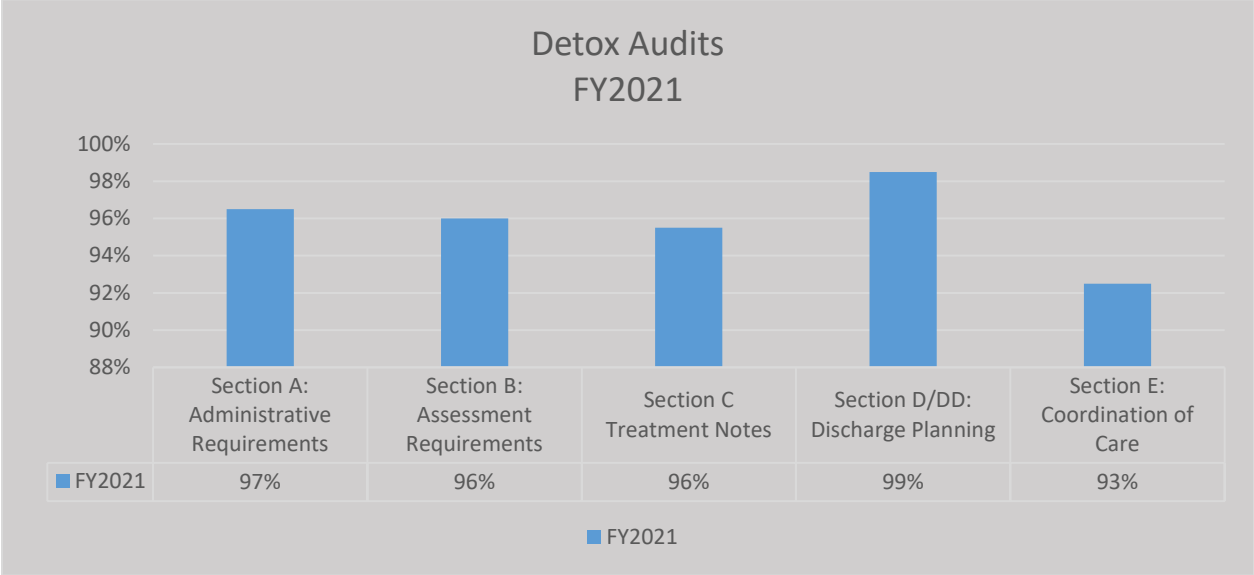
There will be continued focus on the areas of weakness through education and trainings. HCI offers in-person documentation training to its provider network quarterly and has implemented a strategy to reach out to providers with low or failing scores one (1) month after the audit is complete to offer further assistance. In addition, HCI also offers one on one documentation trainings to its network. This

open communication allows for relationship building between practices and HCI. As the new SUD benefit has been initiated as of January 2021, HCI will also continue to 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 eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent 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 tools, readiness for change review, and referral to outpatient provider.



Summary of Detox Performance

Overall, providers met the documentation standards, showing significant improvements in all areas.

Although significant improvements have been made, there will be a continued effort to work closely with detox providers to ensure passing scores continue to be met.

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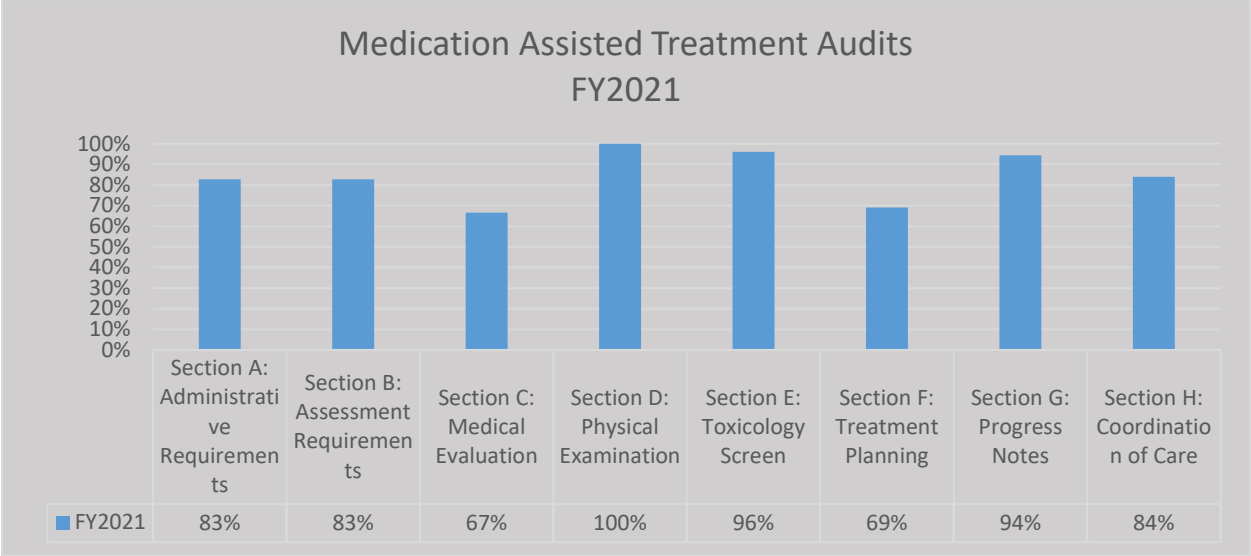
Medication Assisted Treatment (MAT)

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 the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent 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 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.



Summary of MAT Performance

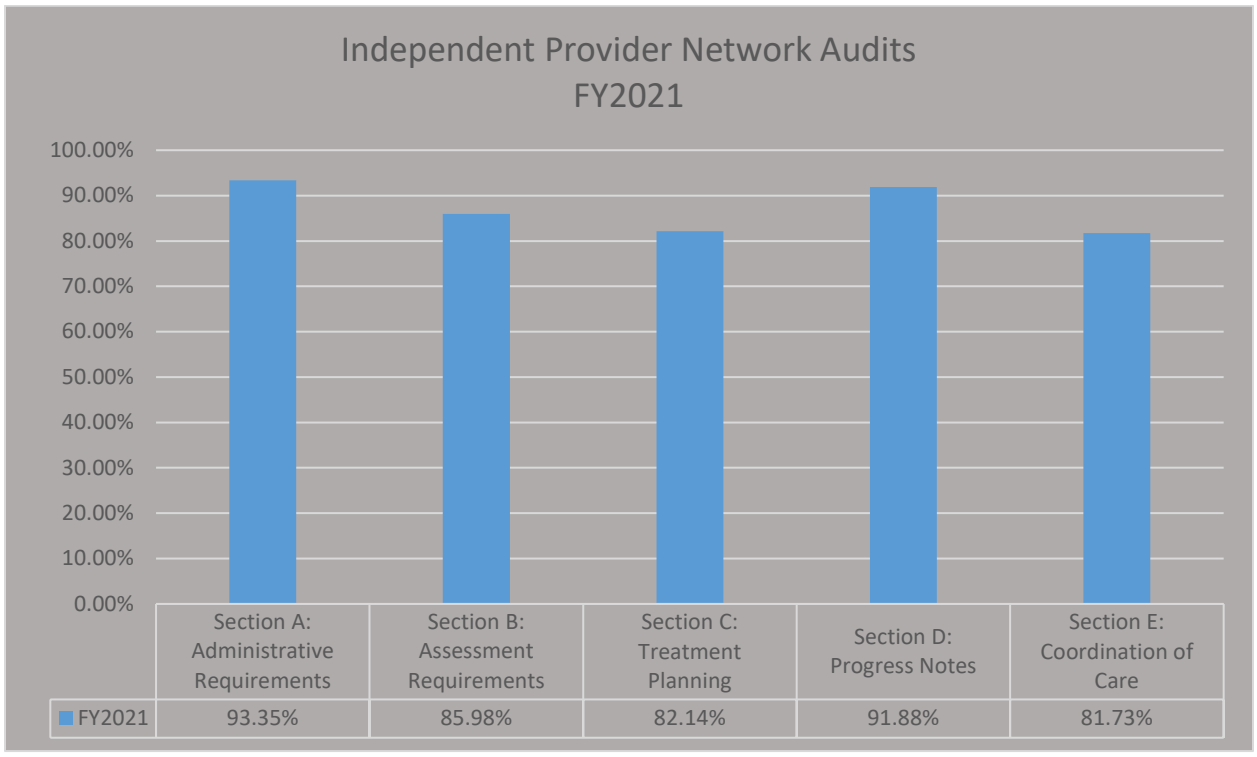
MAT providers have made significant improvements in documentation for all domains increasing their scores in all but two (2) areas whereas the previous year showed no passing domains. Medical evaluations and treatment planning continue to fall below the eighty (80%) percent passing score. Medical evaluations were missing from some provider charts and education has been provided. Treatment planning consistently neglected to provide measurable objectives and goals for which a level of change as it relates to substance use was required for a successful discharge.

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

Mental Health Audits

Routine Mental Health audits continue to be completed for Region 4 Independent Provider Network (IPN) providers. To date, twenty-four (24) providers have been audited. Of those twenty-four (24) providers, eleven of those failed to meet the minimum passing score of eighty (80%) percent or better. Many providers have also participated in individualized training sessions offered by HCI auditors. See Audit Results in the 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 the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in two (2) years. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent 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 meet the requirement of the Uniform Service Coding Standards (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.



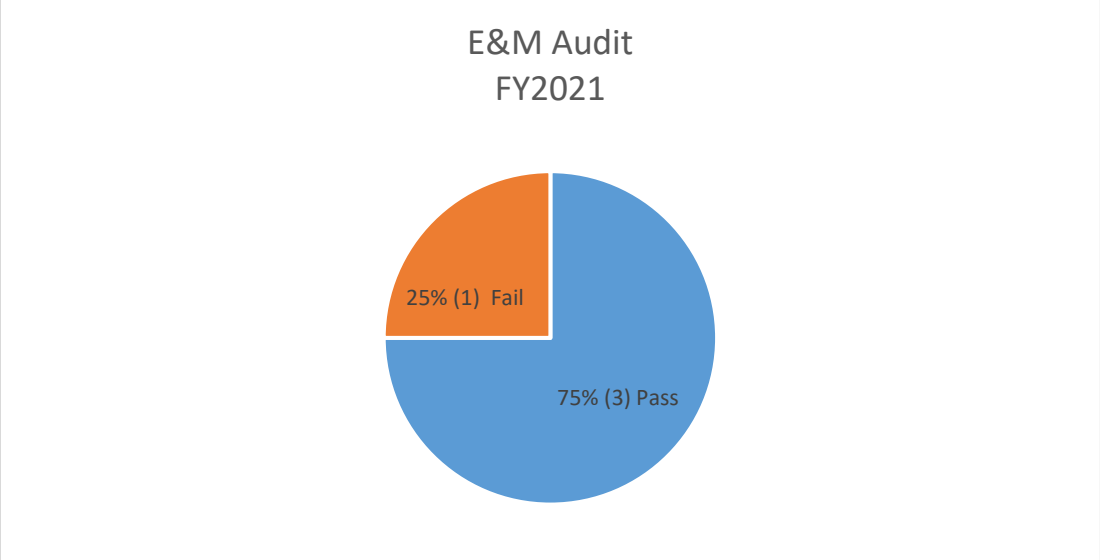
Summary of IPN Performance

Provider aggregate scores demonstrated improvement in the areas of treatment planning and coordination of care from FY19-20 to FY20-21. This can be attributed to increased focus on these elements during provider trainings throughout the year.

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

Evaluation and Management Prescriber Codes Audits

The evaluation and management (E&M) prescriber code audit is an annual pass/fail audit. In this audit, prescriber documentation is reviewed against the code submitted on the claim to ensure all criteria is met. Four (4) E&M prescribers were audited in FY21. Three (3) providers passed their audit meeting all criteria. The provider who failed did so on account of missing documentation for date of service of the claim.

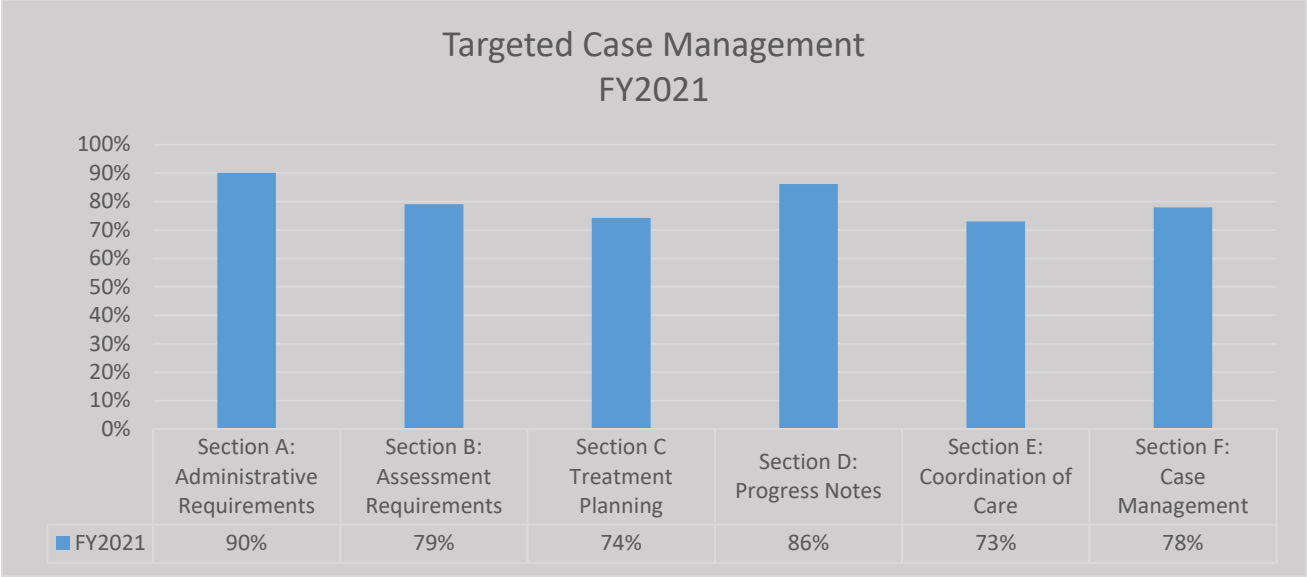


Targeted Case Management (TCM)

Targeted Case Management (TCM) audits have been implemented for FY20-21.

Targeted Case Management audits are similar in nature to substance use and mental health outpatient audits consist of reviewing the five (5) sections of the member chart (administrative, clinical assessment, treatment planning, progress notes, and coordination of care) and further including a review of requirements specific to the TCM billing requirement as outlined in the Uniform Service Coding Standards (USCS). In order to pass the audit, the member must meet medical necessity, and the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent or

below they will be audited in six (6) months. In addition to a review of written documentation, a claims review specific to TCM is completed to ensure services are provided in accordance with and meet the requirement of the 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 TCM Performance

There is a continued need for improvement in Targeted Case Management (TCM) audit results. Lacking documentation including missing assessments and treatment plans was a significant source of the low scores. Treatment planning was generally weak in insuring objectives are measurable and goals are based on a level of change required to successfully complete treatment. Further, case management notes often did not include required information as defined by the USCS.

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

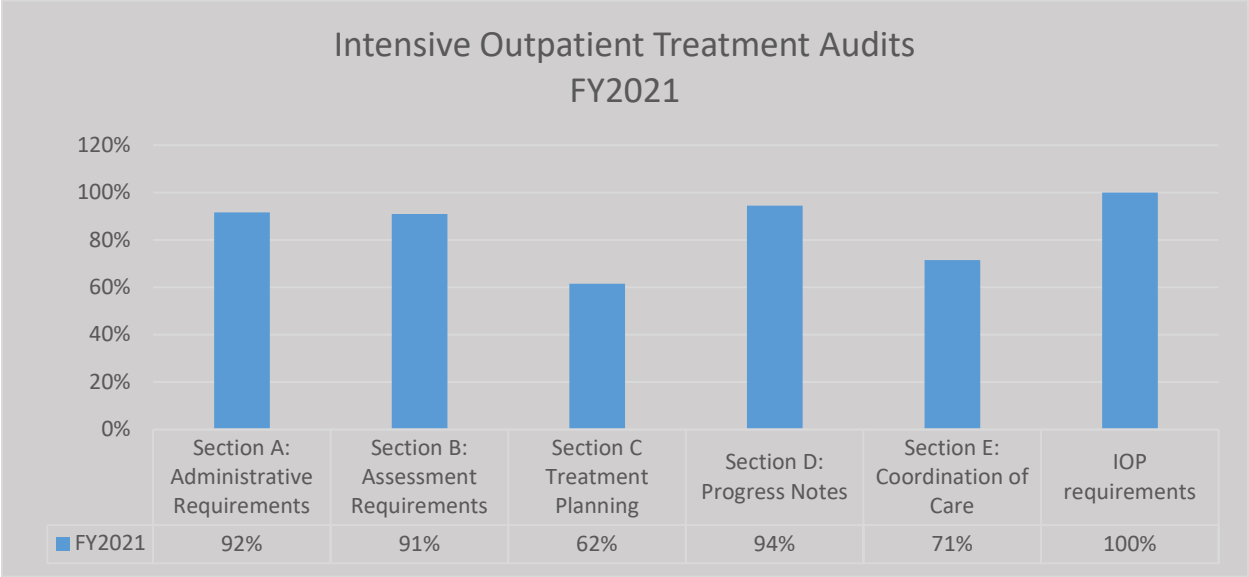
Intensive Outpatient (IOP) Audits

One provider has completed a mental health documentation audit specifically concerning members who had received Intensive Outpatient Services (IOP). There was a decrease in the number of providers audited this fiscal year due to a lack of IOP claims made. We will continue to audit (IOP) providers on a quarterly basis as is appropriate based on claims made.

Intensive outpatient treatment audits consist of reviewing five (5) 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 the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent 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 meet the requirements of the Uniform Service Coding Standards (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.

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 IOP Performance

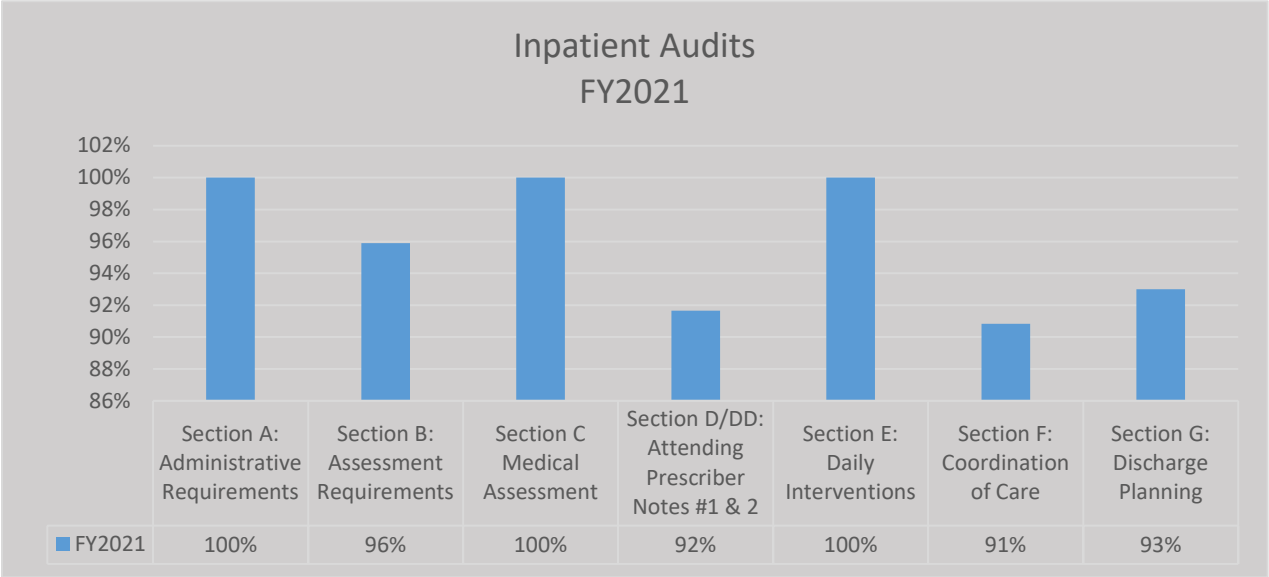
There has been significant improvement in IOP outpatient audit results in all areas across the board; although, providers continue to fall below the eighty (80%) percent passing score in two (2) domains. In most cases, treatment plans did not provide measurable objectives nor goals identifying the level of change needed for the member to be considered successful in treatment. Providers further struggled to ensure care coordination was taking place with the member's primary care physician and/or outside agency providers.

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

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 the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with scores less than eighty (80%)

percent 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.



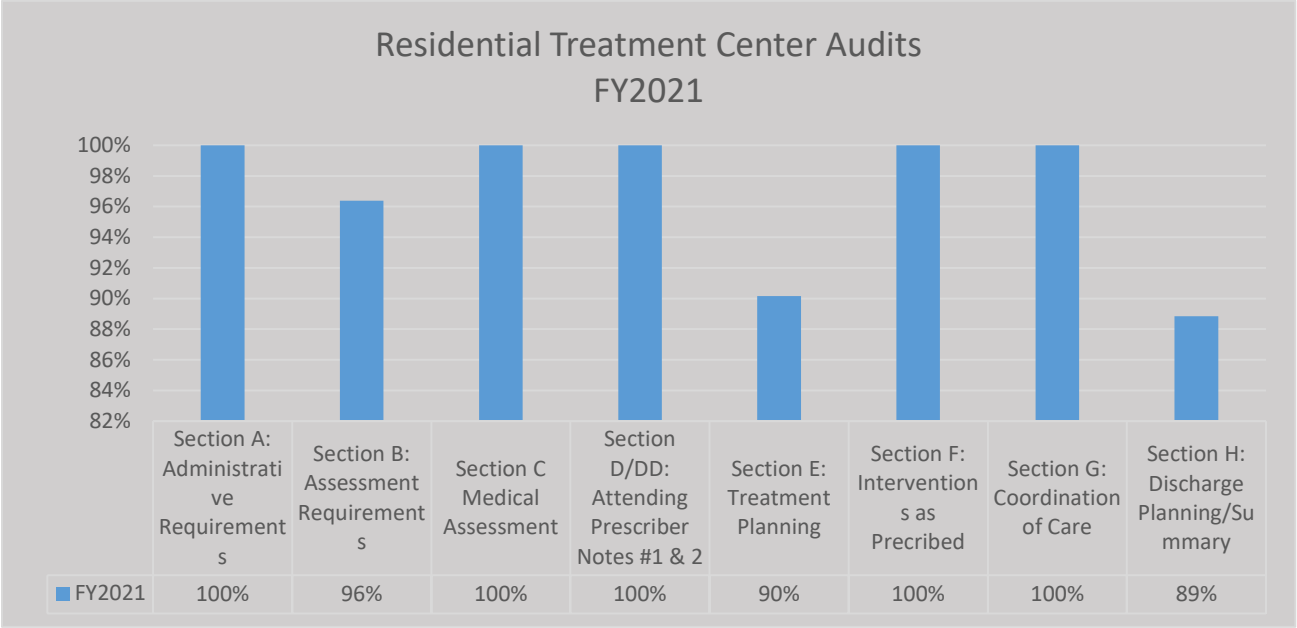
Summary of Inpatient Performance

Inpatient facilities continue to pass all domains required. Daily interventions appear to have the weakest outcome as in some cases; there was no evidence of family therapy. Discharge planning was also one of the lower scoring domains due to the lack of scheduling of follow-up appointments with outside providers. It should also be noted, in many cases, there was no evidence of care coordination with the member's capitated community mental health center.

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

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 the provider must score eighty (80%) percent or better on each of the aforementioned sections. If the provider passes each section with eighty (80%) percent or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with seventy-nine (79%) percent 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.



Summary of Residential Treatment Center Performance

Residential treatment has made significant improvements passing all domains required for this audit. Discharge planning was one of the lower scoring domains due to the lack of scheduling of follow-up appointments with outside providers.

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

Care Coordination Audits

Care coordination involves identifying the needs of members especially those with complex care needs and chronic conditions and providing them with the care and resources that meet these needs. It is sub-divided into care navigation and care management. Care navigation entails removing barriers to accessing care that members may encounter and linking them up with services and resources that they need. On the other hand, care management entails supporting members with complex care needs and chronic conditions by ensuring they get the care they need, and they are engaged with the care process to improve their health outcomes.

Care coordination audits were placed on a temporary hold during FY20-21 to ensure new regulations and guidelines are included in the auditing tool. HCI has been meeting to develop a plan for continuing the audit in FY21-22.

Early in FY21-22, the Department released policy guidance regarding Extended Care Coordination (ECC). These elements will be combined with professional standards of care to develop an audit tool for care coordination. This tool will be presented to regional care coordination entities during the monthly Care Coordination Subcommittee meeting. Following a period of orientation and training, audits will be scheduled for all care coordination entities. If an entity achieves the established threshold, the next

scheduled audit will be conducted in the next year. If an entity does not achieve the established threshold, the care coordination entity will be advised of the areas for improvement and a repeat audit will be performed within six (6) months. Providers who fail a subsequent audit may be subject to required education, recoupment, corrective action plan (CAP), or a referral to Provider Relations or other licensing agency.

External Quality Review Organization (EQRO)

In April of 2021, HCI underwent an external audit conducted by Health Services Advisory Group (HSAG) who is the EQRO contracted with the Department. The Quality Assurance and Performance Improvement (QAPI) program was one (1) of the four (4) areas of focus for the audit. The QAPI program earned a perfect score of one hundred (100%) percent across all seventeen (17) requirements within the standard. HSAG noted that "HCI's quality assessment and performance improvement requirements were supported through detailed policies, procedures, and complex reporting both at the corporate level and information that was disseminated to individual departments and the provider network. HCI was also audited on three other standards. HCI earned ninety-four (94%) percent for the Provider Participation and Program Integrity standard, ninety-four (94%) percent for the Credentialing and Recredentialing standard, and seventy-five (75%) percent for the Sub contractual Relationships and Delegation standard. All sections combined for an average compliance score of ninety-four (94%) percent.

HCI quality functions were delegated to Beacon with HCI oversight. Delegation monitoring was accomplished through an annual delegation audit and routine reporting to HCI's Board of Directors.

Key changes noted in calendar year (CY) 2020 included the onboarding of Beacon's IT and quality directors who added increased focus on Lean Six Sigma approaches, such as streamlining data requests, storage, and data production procedures, with the ultimate goal to provide staff members with timely and meaningful information.

Quality topics were addressed in a variety of meeting venues such as with the HCI Board of Directors; Compliance Oversight Committee; Quality Improvement/Utilization Management (QIUM); Performance Improvement Advisory Committee (PIAC); Member Experience Advisory Committee (MEAC); and the Member Services Subcommittee that discussed complaints, grievances, and appeals. HCI noted approaches to increase member attendance and comfort levels at the MEAC, including efforts to start local MEAC groups.

HCI's Quality Improvement Plan and Annual Quality Report describes a comprehensive quality assurance and performance improvement (QAPI) program that included strategies aimed to improve the health of the region's members. Mechanisms to address member over and underutilization of services included various reports and associated procedures, such as a report that featured HCI's top 50 users of services. Underutilization was monitored through specialized care management programs for various diagnoses, and chart audits for behavioral health (BH) and SUD services were used to further assess quality of care.

HCI adopted and disseminated clinical practice guidelines (CPGs) based on reliable evidence, including nationally recognized professional organizations and scientific bodies, and with input from the scientific review committee (SRC). These CPGs were reviewed and voted on by the SRC (every two (2) years or as necessary), then presented to the corporate medical management committee (CMMC) for final

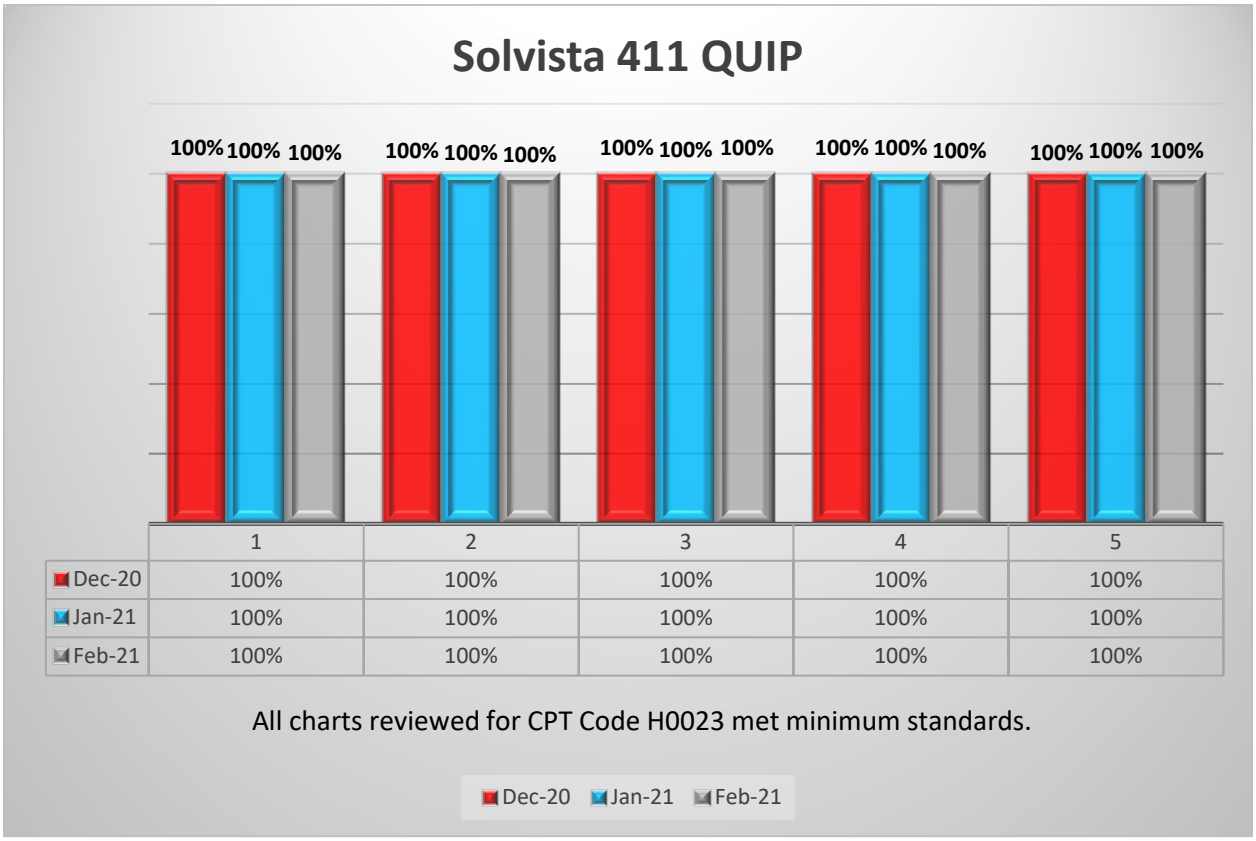
approval. HCI established a policy outlining how the CPGs are used in care management decisions and as an indicator of quality of care in the recredentialing process for providers. This process will continue for FY21-22.

HCI used grievance data and population-based analyses to identify member access, needs, and monitored members' perceptions of health status through a variety of surveys as demonstrated in the QAPI program materials. Examples included the Experience of Care and Health Outcomes (ECHO®) survey, the Your Opinion Matters survey, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The QIUM committee discussed results from the surveys for monitoring and planning and presented the Your Opinion Matters survey to the MEAC for feedback. HCI used this feedback and data analysis to produce member educational materials, such as brochures that reminded members about family therapy and alternative treatment options. Low scoring providers were addressed through CAPs as necessary. Quality of care (QOC) concerns were handled by the quality department and sometimes investigated concurrently with the grievance department.

The Beacon Data Flows document demonstrated the HCI workflow used for the collection, analysis, integration, and reporting of data from internal and external sources. HCI sent necessary encounter files to the Department in the required 837 and flat file format before reporting back to provider groups, finance, and administration through the use of an Encounters Data Report Card. These effective methods will continue for FY21-22.

411 Audits

In an effort to continue process improvement on submitted claims and encounters, HCI worked with two (2) Community Mental Health Centers on a quality improvement process (QUIP) to address rates that fell below ninety (90%) percent stemming from the FY19-20 annual 411 claims and encounter audit. The annual audit netted one (1) service category that fell below the established standard of ninety (90%) percent. The procedure code encounter data type for the Prevention and Early Intervention service category scored eighty-seven (87%) percent. As demonstrated in the graphs below, HCI increased its scores in all service categories where they had previously been noted as needing improvement through the interventions (training and charts audits) that each Community Mental health Center underwent. HCI implemented targeted interventions in order to positively impact the overall scores associated with the FY20-21 411 audit. For this project, HCI focused on the procedure code encounter category for the prevention/early intervention service classification as this was the only score to fall below the ninety (90%) percent threshold established by Health Services Advisory Group (HSAG). For the prevention/early intervention service category in FY20-21, the overall HCI rate was eighty-seven (86.9%) percent. In the months of November 2020, December 2020, and January of 2021 the rate for the facilities that HCI worked with (Health Solutions and Solvista) rose to one hundred (100%) percent. This is an increase of thirteen (13.1%) percent which indicates that the interventions put into place had a positive effect on the final outcome and will be carried over for the next and subsequent audit cycles. As HCI exceeded the recommended goal of ninety percent (90%) compliance in all service categories in the FY20-21 audit, HCI was not expected to complete another QUIP. HCI will continue to offer training to providers to continue their strong performance on the annual claims and encounter validation audit.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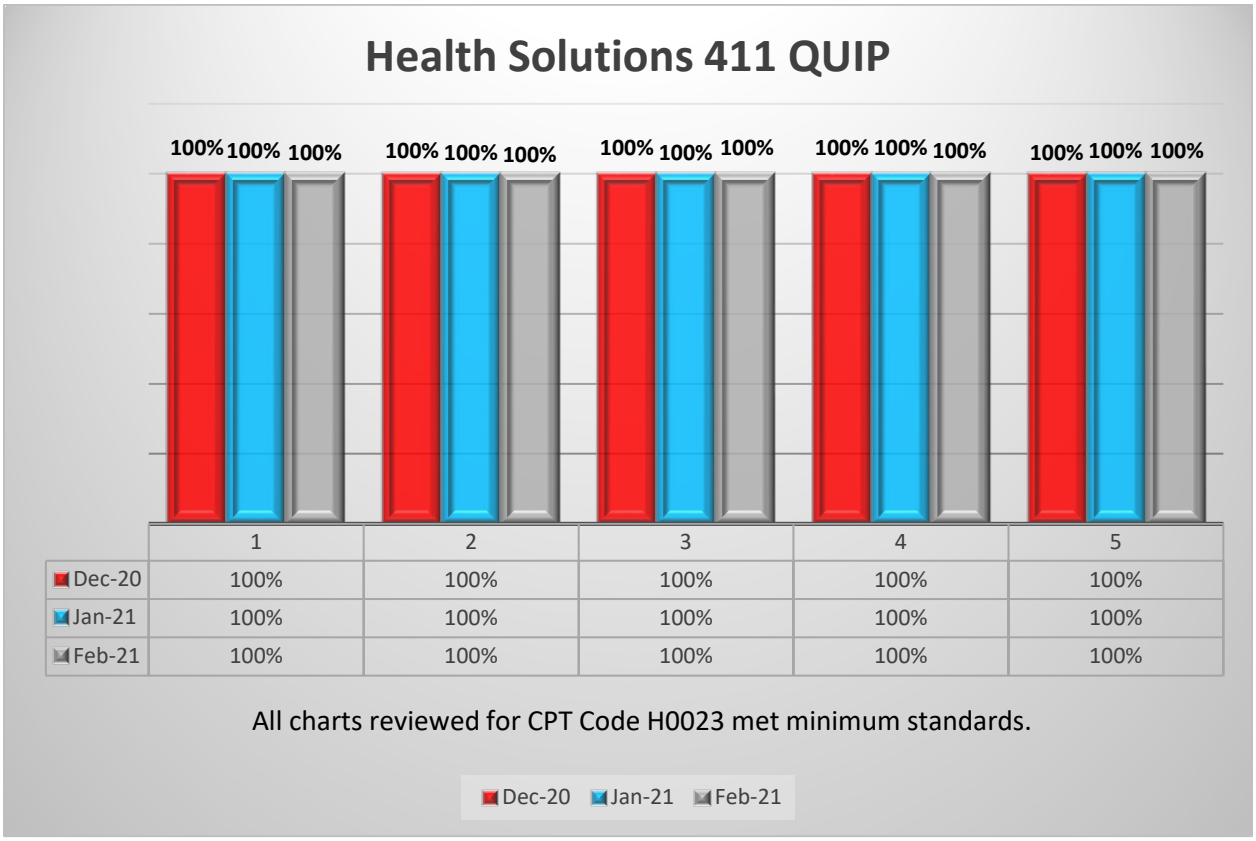


In FY20-21, HCI also conducted its annual 411 audit. The audited services categories s were inpatient services, psychotherapy services, and residential services. Inpatient services and psychotherapy services were new categories to the annual audit in FY20-21.

Psychotherapy

As presented in the psychotherapy table below, HCI observed a high level of accuracy in the psychotherapy section of the audit. HCI achieved accuracy scores between ninety-four (94%) percent and ninety-nine (99%) percent, with an average percentage of accuracy of ninety-eight (98%) percent. HCI's strongest categories of performance, which all achieved accuracy scores of ninety-nine (99%) percent were:

- Unit
- Start Date
- End Date
- Appropriate Population
- Duration
- Staff Requirement

In order to continue with stellar performance in the psychotherapy service category, HCI will continue to provide education to its provider network on documentation standards that are associated with the

annual claims and encounter validation audit. In the event that performance falls below the established benchmark of ninety percent (90%), HCI will implement corrective action plans to bring provider performance back into compliance with established standards. The table below presents the audit scoring summary for HCIs response data file for psychotherapy encounter lines.

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Procedure Code'	R4	Psychotherapy	130	137	95%
'Diagnosis Code'	R4	Psychotherapy	129	137	94%
'Place of Service'	R4	Psychotherapy	129	137	94%
'Service Category Modifier' (Procedure Modifier 1)	R4	Psychotherapy	130	137	95%
'Unit'	R4	Psychotherapy	136	137	99%
'Start Date'	R4	Psychotherapy	136	137	99%
'End Date'	R4	Psychotherapy	136	137	99%
'Appropriate Population'	R4	Psychotherapy	136	137	99%
'Duration'	R4	Psychotherapy	136	137	99%
'Staff Requirement'	R4	Psychotherapy	135	137	99%

Residential

As presented in the residential table below, HCI observed a very high level of accuracy in the residential section of the audit. HCI achieved accuracy sores of ninety-nine (99%) percent across all ten (10) encounter categories.

In order to continue with stellar performance in the residential service category, HCI will continue to provide education to its provider network on documentation standards that are associated with the annual claims and encounter validation audit. In the event that performance falls below the established benchmark of ninety percent (90%), HCI will implement corrective action plans to bring provider performance back into compliance with established standards.

The table below presents the audit scoring summary for HCIs response data file for Residential encounter lines.

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Procedure Code'	R4	Residential	136	137	99%
'Diagnosis Code'	R4	Residential	135	137	99%
'Place of Service'	R4	Residential	136	137	99%
'Service Category Modifier' (Procedure Modifier 1)	R4	Residential	136	137	99%
'Unit'	R4	Residential	136	137	99%
'Start Date'	R4	Residential	136	137	99%
'End Date'	R4	Residential	136	137	99%
'Appropriate Population'	R4	Residential	136	137	99%
'Duration'	R4	Residential	136	137	99%
'Staff Requirement'	R4	Residential	136	137	99%

Inpatient

As presented in the inpatient table below, HCI observed a very high level of accuracy in the inpatient section of the audit. HCI achieved accuracy scores between ninety-nine (99%) percent and one hundred (100%) percent. HCIs strongest categories of performance, which all achieved accuracy scores of one hundred (100%) percent, were:

- Principal Surgical Procedure Code
- Revenue Code
- Start Date
- End Date

The table below presents the audit scoring summary for HCIs response data file for Inpatient encounter lines.

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Principal Surgical Procedure Code'	R4	Inpatient	137	137	100%
'Primary Diagnosis Code'	R4	Inpatient	135	137	99%
'Revenue Code'	R4	Inpatient	137	137	100%
'Discharge Status'	R4	Inpatient	136	137	99%
'Start Date'	R4	Inpatient	137	137	100%
'End Date'	R4	Inpatient	137	137	100%

No aggregate scores for HCI for the elements audited were under ninety-four (94%) percent.

Based upon the scores presented within this document, HCI considers there to be a high level of validity and reliability between the submitted claims and encounters and the audited sample of randomly selected charts for the measurement period of July 1, 2019, through June 30, 2020. In addition, to assist in creating a positive impact on the next 411 audit, HCI sent out training to providers on the 411 audits,

its service categories, and common areas of concern. HCI will plan on conducting this activity in FY 21-22 as well.

Potentially Avoidable Complications/Costs (PAC)

Health Colorado, Inc. (HCI) selected the following three episodes of care for intervention:

- Substance Use Disorder (SUD)
- Diabetes
- Pregnancy

These conditions were all ranked in the top five (5) episodes for split PAC expenses from FY18-19 which guided last year's PAC Plan. However, pregnancy fell out of the highest-ranking episodes with the release of FY19-20 data. HCI believes that pregnancy remains a critical episode for Medicaid members and potentially impactable. Upon consultation with HCPF, HCI obtained approval to continue its work on the pregnancy episode of care along with the other two (2) episodes.

Substance Use Disorder (SUD)

SUD continues to be the most significant source of avoidable costs throughout the region. Data provided by the Department utilizing the Optumas algorithm revealed that SUD continued to be the highest-ranking episode of care for avoidable costs. Inpatient care represented the care setting with the highest costs followed by outpatient emergency room (ER). Pueblo County represented nearly half (forty-eight (48%) percent) of the avoidable expenses. Similar to last year and this geographic concentration, Parkview Medical Center and Catholic Health Initiatives Colorado were the rendering providers with the two (2) highest avoidable costs. Last year's PAC Plan focused on the implementation of the new SUD benefit that provided reimbursement for several levels of care that had previously been unavailable to Health First Colorado members. Last year's interventions identified that the 3.2WM level of care (i.e., social detox) was a key cost driver for SUD treatment. Active utilization management of the SUD population through these levels of care will continue.

Upon review of the most recent PAC data provided by the Department, HCI plans to refine the analysis toward the hospitalizations that produce the highest PAC costs. Further efforts will be conducted to understand the factors that contribute to these hospitalizations or increase their complexity. Finally, the team will develop a pilot project from evidence-based recommendations and identify partners to test the impact of the intervention. This pilot may involve harm reduction programs, peer support programs, or other options that have yet to be discovered.

Diabetes

Similar to last year, diabetes-related episodes were the second highest split PAC for Region 4. Inpatient, professional services and durable medical equipment (DME) use were the care settings with the highest avoidable costs in FY19-20. HCI continued to develop and implement interventions to target inpatient and ER encounters.

Last year the diabetes PAC plan focused on continued refinement of the care coordination pilot. That pilot work recently completed with Health Solutions Inc. focusing on Pueblo County. The current year's

plan will begin with an analysis of the FY19-20 Optumas data for potential trends. Guided by that analysis, the care coordination program refined last year will be deployed throughout the region, and an interim report on the status of that deployment is planned. This will include workflows using the Essette platform. As the implementation of condition management expands, there will be a coordinated effort to collect stakeholder feedback regarding this adjunct to typical primary care models. HCI recognizes the role of primary care clinicians and the efforts focused on diabetes outcomes by several clinics facilitated by the practice transformation team. A synthesis of this quality improvement work utilizing the Plan-Do-Study-Act (PDSA) cycle will be compiled to disseminate throughout the region for other primary care clinicians to consider implementing. In addition to this work focused on the outpatient arena, HCI will begin some exploration of the ability to impact hospital admissions that were identified as the greatest portion of PAC diabetes dollars by collecting stakeholder feedback on hospital transition processes.

Pregnancy

Although pregnancy-related care was one of the top three most costly PAC episodes in FY18-19, this episode fell out of the ten most costly PAC episodes in FY19-20. The reason for the change may be due to a number of factors including the change in algorithm from using Prometheus (FY18-19) to using Optumas (FY19-20). HCI continues to believe that pregnancy provides an opportunity to impact important care and avoidable expenditures in the Region. The HCI team brought these issues to HCPF and obtained their approval to continue PAC work on the pregnancy episode of care during FY21-22.

Last year's PAC Plan focused on understanding the experience of pregnant Health Colorado members in RAE 4 and the processes in place to identify high-risk women in order to provide targeted care coordination. These efforts set the stage for the FY21-22 PAC Plan. The interventions planned for the pregnancy episode of care in the coming year surround the launch of an enhanced OB Care Coordination program. This program including the Taking Care of Baby and Me® & New Baby, New Life℠ was created by Anthem, Inc. Anthem's program provides Intensive Care Management for high-risk members and self-management support for all enrolled pregnant members, and it rewards members attending important appointments with OB provider. It will utilize clinical guidelines and provide care coordination for women identified as high-risk for adverse pregnancy outcomes. Efforts begin with a thorough feasibility analysis for the program and development of an implementation plan. There will be a marketing component to author both provider-facing and member-centric promotional materials to maximize participation. At the close of FY21-22, it may still be early in the implementation, but outcome measures and intermediate measures of efficacy will be reviewed.

Below is a list of deliverables planned for all PAC interventions in FY22.

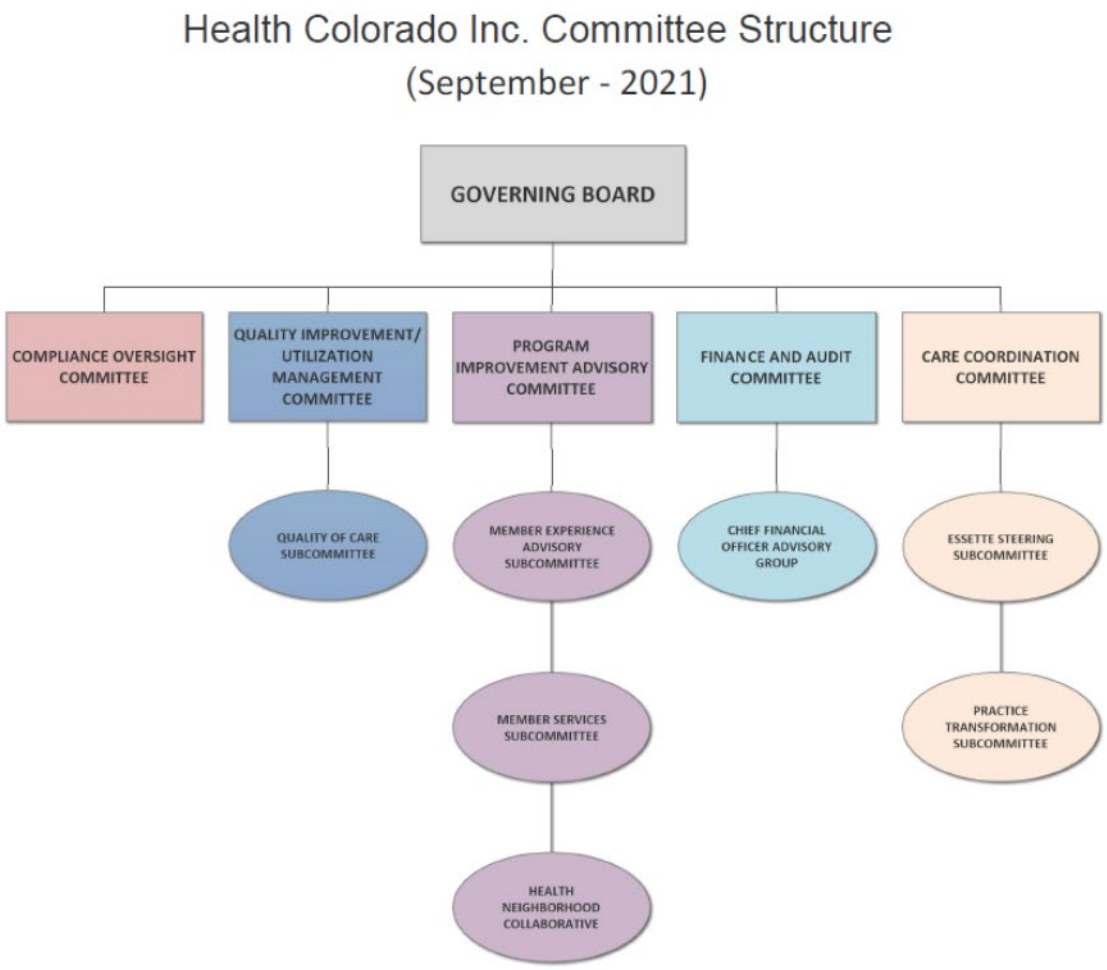
Episode of Care	Milestone #	Intervention	Weight	Projected Due Date
SUD	1	Data Analysis	5	October 15, 2021
SUD	2	Needs Assessment	8	December 15, 2021
SUD	3	Review of Literature/Service Comparison	6	January 31, 2022

SUD	4	Pilot Project Development	10	February 15, 2022
SUD	5	Interim Pilot Analysis	6	June 30, 2022
Diabetes	1	Data Analysis	5	October 15, 2021
Diabetes	2	Synthesis of Diabetic PDSA Recommendations	8	February 15, 2022
Diabetes	3	Hospital Transitions of Care Needs Assessment	6	March 15, 2022
Diabetes	4	Condition Management Stakeholder Feedback	6	March 27, 2022
Diabetes	5	Condition Management Deployment Interim Report	6	June 15, 2022
Pregnancy	1	Data Analysis	5	October 15, 2021
Pregnancy	2	Operational Feasibility Assessment	8	October 29, 2021
Pregnancy	3	Implementation Plan	8	November 15, 2021
Pregnancy	4	Orientation/Education	5	January 31, 2022
Pregnancy	5	Interim Pilot Analysis	8	April 15, 2022

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, Performance Pool, and Behavioral Health Incentive measures. These are just a couple of examples of this cross-representation on committees.

As part of ongoing LEAN efforts, HCI's Board of Directors and Program Administrator will collaborate with HCI senior management to further update the HCI Committee Structure in FY21-22. The updated HCI Committee Structure aligns with HCI's Population Health strategic plan and informs HCI's approach to coordinating with stakeholders to meet its contractual obligations and actualizing HCI's goals and objectives in service of HCI members. Please see the below updated HCI Committee Structure as of September 2021.



In addition, ad-hoc meetings with providers have 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 are at the bottom of this Quality Improvement Plan Document

In FY20-21, various stakeholder work groups were held with providers to discuss problem-solving techniques surrounding specific KPI measures, Performance Pool, and Behavioral Health Incentive Program (BHIP) Measures. The HCI Performance Measures Strategy Work Group established the HCI Performance Measures Action Plan (PMAP) Work Group (see PMAP detail above) to address BHIP performance with providers in RAE 4 as a first focus is underway. Specific KPI initiatives have been attempted to address obtaining care compacts and increasing dental services, although Health Neighborhood is being deleted by HCPF. 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 overall. At these meetings and they 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 FY19-20, stakeholder work groups were 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 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, Beacon staff, members, or other concerned parties can all report quality of care issues, typically through an Adverse Incident Report form submitted to the Quality Department or an immediate conversation with their supervisor or Human Resources. All quality of care issues are documented, as are the results of investigations. Corrective actions are tracked and monitored. Reporting, investigation, and tracking of adverse incidents through the Quality Management Department continued during FY20-21 and will continue with reporting to HCPF as required in FY21-22.

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 fifty-six (56) adverse incident reports during FY20-21; a decrease from the seventy-six (76) 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 HCI Quality of Care Committee in FY21-22.

Performance Improvement Goals

Below is an assessment for quality management projects associated with the listed programs. Based upon consultation with HCPF and HCI leadership, it is important to note that recent ‘status’ information is included as HCI deems this information to be useful to inform updates into current quality planning efforts.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2021

Goal	Fiscal Year 21-22 Project/Initiative	Targeted Completion Date	Status
Performance Improvement Projects			
Depression Screening and Follow–up After a Positive Depression Screen. Part One: By June 30, 2022, increase the percentage of depression screens completed during well visits for members attributed to Valley-Wide ages 12 years and older from eleven (11.21%) percent to fifteen (15%) percent. Part Two: By June 30, 2022, increase the percentage of behavioral health follow-ups within thirty (30) days of a positive depression screen completed for members attributed to Valley-Wide ages 12 years and older, from twenty-five (25.15%) percent to thirty (30%) percent.	To improve access to behavioral health care, Health Colorado, Inc. (HCI) will target depression screening in primary care and subsequent behavioral health follow-up as its Performance Improvement Project (PIP) focusing on members who are diagnosed with diabetes. With this focus on members with diabetes, the project will have greater alignment with HCI's condition management efforts and Population Health strategic goals. The effort will aim to increase the rate in which a provider in HCIs' region complete and bill for a depression screen at members' annual well-visit, as well as ensure any positive depression screen has a timely mental health service. This topic was also mandated by the state.	June 30, 2022	Currently, HCI has submitted the Depression screen PIP for approval of module 3. Upon review and approval by HSAG, HCI will begin to implement interventions to increase depression screens at Valley-Wide.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2021

Goal	Fiscal Year 21-22 Project/Initiative	Targeted Completion Date	Status
Performance Measurement Data Driven Projects			
PAC: PAC Plan and associated deliverables will be submitted on time, without any required edits, and receive full allocated point totals.	PAC Plan Final Draft Final PAC Plan SUD Episode of Care Deliverables SUD #1: Data Analysis SUD #2: Needs Assessment SUD #3: Review of Literature/Service Comparison SUD #4: Pilot Project Development SUD #5: Interim Pilot Analysis Diabetes Episode of Care Deliverables DM #1: Data Analysis DM #2: Synthesis of Diabetic PDSA Recommendations DM #3: Hospital Transitions of Care Needs Assessment DM #4: Condition Management Stakeholder Feedback DM #5: Condition Management Deployment Interim Analysis Pregnancy Episode of Care Deliverables:	September 24, 2021 October 22, 2021 **SUD:** October 15, 2021 December 15, 2021 January 31, 2022 February 15, 2022 June 30, 2022 **DM:** October 15, 2021 February 15, 2022 March 15, 2022 May 27, 2022 June 15, 2022	PAC episodes of care have been selected by the leadership team and endorsed by HCPF. Draft proposed deliverables have been presented to HCI leadership. Final deliverables and weights were presented to HCI leadership 9/2. The PAC plan was submitted September 24, 2021,

		Pregnancy: October 15, 2021 October 29, 2021 November 15, 2021 January 31, 2022 April 15, 2022	
Achieve an improvement of 5% (Tier 2) or greater over fiscal year 2021 performance for each KPI. (Tier 1 = 1% improvement). We report our most current results and will work with HCPF on tracking the recent Spec document changes.	**Behavioral Health Engagement** Tier 1 = 2.82% and Tier 2 = 2.94% **Dental Visits** Tier 1 = 33.93% and Tier 2 = 35.31% **Well Visits** Tier 1 = 25.46% and Tier 2 = 26.46% **Prenatal Engagement** Tier 1 = 52.95% and Tier 2 = 55.05% **Emergency Department Visits PKPY** Tier 1 = 543.86 and Tier 2 = 521.89% **Health Neighborhood** Tier 1 = 543.86 and Tier 2 = 521.89%	June 30, 2022	**Behavioral Health Engagement:** HCI rolling annual performance through April 2021 was 2.74% and met Tier 2 for 8 months then Tier 1 in March and no tier in April. We have an outstanding question with the Department on why the revised goal was set so much higher from the previous year for all the RAEs. **Dental Visits:** HCI rolling annual performance through April 2021 was 36.20% and met Tier 1 from July 2020 to March 2021 and Tier 2 in April 2021. **Well-Visits:** HCI rolling annual performance through April 2012 was 21.81%

			and did not meet any tier in any month. Clearly, this measure goal has been impacted by the COVID-19 pandemic national emergency. HCI is on board to work with the Department's change to child and adolescent versus adult well visits but still see the pandemic affecting our ability to meet the goal. **Prenatal Engagement:** HCI rolling annual performance through April 2021 was 68.92% and each month was well above Tier 2. **Emergency Department Visits PKPY:** HCI rolling annual performance through April 2021 was 413.74 visits/PKPY and met Tier 2 each month. **Health Neighborhood:** HCI rolling annual performance through April 2021 was 2.41% and did not meet any tier in any month. This measure will be ceased for FY21-22 per the Department.

Achieve an improvement of 10% over the performance gap for each BH measure by June 30, 2022. We report the most recent here. We will be aligning our efforts with changes in the Spec document.	Baseline, goal, and performance **Engagement in Outpatient Substance Use Disorder (SUD) Treatment** Goal = 40.18% **Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition** Goal = 80.41% **Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder** Goal = 44.27% **Follow-Up after a Positive Depression Screen** Goal = 45.38% **Behavioral Health Screening or Assessment for Children in the Foster Care System** Goal = 28.06%	June 30, 2022	There are challenges with building performance measures codes due to outstanding questions with the state on the Spec Documents in addition to the state cutting off giving the RAEs quarterly data due to resource issues. Rates reported below are subject to change as there is better alignment of internal SQL code with the state code. The depression screen measure has particularly large differences between state and internal reported rates. **Engagement in Outpatient Substance Use Disorder (SUD) Treatment:** HCI monthly performance was above the goal most months (with the exception of March and April 2021) and May 2021 rate was 46.03% **Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition:**

			HCI monthly performance was below the goal in each month and May 2021 rate was 68.35%. We had met this measure for FY18-19 until the baseline changed. **Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder:** Data is not provided to HCI to calculate this measure. Data for FY20-21 has not been shared with HCI. **Follow-Up after a Positive Depression Screen:** HCI monthly performance was above the goal for each month and ended March 2021 with a rate of 62.04% **Behavioral Health Screening or Assessment for Children in the Foster Care System** HCI monthly performance was above the goal for each month and ended May 2021 with a rate of 52.38%
Performance Pool	**Preterm Birthrate**	June 30, 2022	There are challenges with building

Achieve an improvement of 10% over the performance gap for each PP measure by 6/30/2022. We demonstrate our current results and are setting up systems with the changes from HCPF for FY21-22.	Goal = 12.06% **DOC Engagement** Goal = 13.39 (All RAEs) **MH Inpatient Admissions (Per 1,000)** Goal = 6.58 **Extended Care Coordination** Goal = 58.65%		performance measures codes due to changing Spec Documents and only recent final version provided. Rates reported below are subject to change as there is better alignment of internal SQL code with state code. **Preterm Birthrate:** HCI rolling annual performance ending in March 2021 was 9.34% and met the goal in each month. **DOC Engagement** HCI rolling annual performance ending in February 2021 was 20.40%, which was above the goal each month. The rate for all RAEs combined was 14.13%, which HCI meets the goal in February 2021. **MH Inpatient Admissions (Per 1,000)** HCI rolling annual performance ending in March 2021 was 6.89 admissions/1,000, which met the goal. HCI met the goal in the most recent 7 out

			of 9 months of the fiscal year. **Extended Care Coordination:** HCI rolling annual performance ending in June 2021 was 73.37% and met the goal in each month.

Goal	Fiscal Year 21-22 Project/Initiative	Targeted Completion Date	Status
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.	Practices were contacted and supplied survey information regarding potential member contact. HCI will continue to support the department in this initiative. CAHPS data shows that Health Colorado, Inc. scored significantly higher in getting timely appointments, care, information, and statistically significantly lower in comprehensiveness than the Colorado RAE aggregate. In addition, the top box scores that fell below the 2021 RAE aggregate are: • Rating of Provider • Rating of Specialist Seen Most Often • Rating of All Health Care • Getting Timely Appointments, Care, and Information • How Well Providers Communicate with Child • How Well Providers Communicate with Parents or Caretakers	June 30, 2022	Survey results have been received and are being evaluated and formatted for presentation and review. Once the results are finalized, HCI will identify interventions that can increase satisfaction scores on future survey results by working directly with one of the facilities included in the survey.

	• Providers' Use of Information to Coordinate Patient Care • Comprehensiveness-Child Development • Comprehensiveness-Child Safety and Healthy Lifestyles • Helpful, Courteous, and Respectful Office Staff • Received Information on Evening, Weekend, or Holiday Care • Reminders about Care from Provider Office • Saw Provider Within 15 Minutes of Appointment		
	Your Opinion Matters is an internal survey that seeks to gain member insight into access related issues and opinions on satisfaction with services rendered.	June 30, 2022	In an effort to increase the response rate for the Your Opinion Matters survey, HCI formed a work group to create a new distribution format for the survey. A poster advertising the survey was created. This poster was translated into Spanish in order to reach our Spanish Speaking population. Based upon member feedback, within the poster, HCI included a QR code. It was determined that this modality made access of the survey easier for our members. The posters will be placed on HCI social media platforms. In addition, a Welltok

			text campaign will be launched. The aim of the campaign was to be another option to reach members and to increase the survey response rates. HCI continues to conduct outreach to members who indicate on the survey that they would like a follow up contact. In FY20-21, [redacted] 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. In addition, if there are downward trends detected in the survey responses, these trends will be reviewed at QIUM, and discussions will be held for possible interventions
	HCI reviewed the ECHO survey results for adults and children based off information received in FY19-20. The Health Services Advisory Group established a benchmark of low performance as responses that fell		As the ECHO was cancelled by the department due to competing priorities stemming from the COVID-19 pandemic,

	below 65%. HCI implemented strategies in FY20-21 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. However, due to COVID-19, the ECHO survey was cancelled by the department in FY20-21; meaning that intervention efforts were not able to be tracked and trended against FY20-21 performance data.		HCI was unable to compare response rates and trend performance data. In the future, as the survey has been transferred to OBH, HCI will revisit the survey and the low performing areas to address continued tracking and trending of member satisfaction.

Goal	**Fiscal Year 21-22** **Project/Initiative**	**Targeted Completion Date**	**Status**
Over and Under 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 Lock-in Diversion Program continues to operate in RAE Region 4 for COUP members to address overutilization of services. The COUP program continues to look at the over utilization of services that would make a member appropriate for lock-in services through the RAE. 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, Valley-Wide Health Systems, and San Luis Valley Behavioral Health Group (SLVBHG). If the COUP pilot program is found to be appropriate to extend to other care coordination entities. It will be addressed at that time.	June 30, 2022	The Client Overutilization Program (COUP, also known as "Lock-in") is a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of care or services. See Appendix A for Member Count by Quarters on COUP summary. HCI continues to work with the COUP program to affect those members who are over-utilizing services. HCI outreaches to members who are identified through the COUP list in order to link them to appropriate and

			available services. We will continue to coordinate care and monitor service utilization for these individuals until utilization patterns are stabilized and clinically appropriate. This program provides a post-payment review process allowing for the review of Health First Colorado client utilization profiles. It identifies excessive patterns of utilization in order to rectify over-utilization practices of clients. The Client Over-Utilization Program will restrict clients to one designated pharmacy and primary care physician when there is documented evidence of abuse or over-utilization of allowable medical benefits. In FY20-21, HCI continued to focus on establishing an avenue to determine appropriateness for member lock-in diversion. The focus continued to 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. HCI sees that this particular focus will allow for an additional concentration into emerging costs. It is our intent that members who meet the established criteria will receive six (6) 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 program is to lower total cost of care, to affect better health outcomes, to support HCI's condition management programs, and to aid members in avoiding placement onto the complex member list. We will work with the current HCI Accountable Entities participating in the 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', Valley-Wide, and SLVBHG will continue to serve as the main program collaborators, with other care coordination entities entering the program as warranted.

Monitor and improve underutilization through demonstrated through an improvement of 10% over the performance gap in identified BH measures	BH Incentive Measure 1—Engagement in OP SUD treatment—An initiation encounters plus two (2) or more services within thirty (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 seven (7) day ambulatory follow-up after hospital discharge (BH Incentive Measure 2). Poor performance on this metric will result in QI/Clinical follow-up. Community Mental Health Centers (CMHCs) are provided with daily inpatient census and daily hospital discharge reports.	June 30, 2022	BH utilization trends by member, facility, and service type are monitored monthly 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. HCI will continue to monitor performance on these measures through the tracking and trending of performance data.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 30, 2021

Goal	Fiscal Year 21-22 Project/Initiative	Targeted Completion Date	Status
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 regularly conducted chart audits.	June 30, 2022	Over FY20-21, auditing for EPSDT did occur during regular chart audits. HCI noted scores of 63.64% which is below the target of 80%. HCI will continue to audit for EPSDT during behavioral health treatment record audits and aim for a compliance goal of 80% as well as include this as an area of focus on trainings.

Goal	Fiscal Year 21-22 Project/Initiative	Targeted Completion Date	Status
Quality of Care Monitoring			
Identify and address any and all 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 QIUM Committee. The purpose of this QOCC 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	June 30, 2022	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

	the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Provider treatment record documentation training, audits, 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.		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. All providers are required to report adverse incidents; HCI received 56 adverse incident reports during FY20-21; a decrease from the 76 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 QIUM Committee where trends are analyzed. Training and education on QOCC 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. Providers are reminded and trained on the Quality of Care Concerns and Adverse Incident reporting process at all quarterly documentation training events. We will continue to schedule quarterly trainings throughout FY21-22, the first of which is scheduled for September 30, 2021. The dates of the trainings provided in FY2021 were: • September 23, 2020 • December 10, 2020 • March 18, 2021 • June 21, 2021 Quality of care issues including concerns raised by the Department of Health Care Policy and

			Financing (Department), provider-raised concerns, member concerns, or RAE discovered concerns continue to 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 OCC reporting template.
Goal	**Fiscal Year 21-22** **Project/Initiative**	**Targeted Completion Date**	**Status**
External Quality Review Driven Projects			
HCI will collaborate with Health Services Advisory Group. (HSAG) and the Department on the completion of the annual External Quality Review and complete corrective actions as determined by HSAG	Health Colorado underwent an external quality review organization (EQRO) audit in April of 2021 and will continue to undergo audits annually. Aggregate scores related to the annual FY20-21 EQRO audit for HCI netted an overall score of 94%. The individual scores presented below demonstrate HCI's dedication to excellence. VII. Provider Participation and Program Integrity: 94% VIII. Credentialing and Recredentialing: 94% IX. Sub contractual Relationships and Delegation: 75% X. Quality Assessment and Performance Improvement: 100%	The targeted completion date is determined by HSAG	Stemming from the FY20-21 EQRO audit, three standards were issued a corrective action. These standards are: Standard VII—Provider Participation and Program Integrity Standard VIII—Credentialing and Recredentialing and Standard IX—Sub contractual Relationships and Delegation HCI has submitted the CAP plan for each of the

	As a result of the annual audit, HCI was issued four (4) corrective action plans.		corrective actions levied. Standard VII—Provider Participation and Program Integrity: a CAP was requested for HCI must update informational materials to clarify that, while an individual provider may have objections to services, HCI as an organization does not. Furthermore, HCI should provide additional information stating that, if the provider objects to services, the member should be referred back to HCI to be assigned to a different provider if needed. HCI has planned to add the language to the Behavioral Health Provider Handbook and PCMP Provider Handbook and will be covered in our provider roundtable forum where we cover training material. For Standard VIII—Credentialing and Recredentialing: HCI was issued two (2) corrective actions. The first corrective action identified that HCI's policy, processes, and procedures must ensure representation of denied HCI practitioner

			file applications are selected and reviewed by credentialing management during the annual audit to ensure that no discrimination on behalf of the National Credentialing Committee (NCC) and/or reviewer. HCI submitted the following plan: HCI has made improvements and updates to the Practitioner Credentialing Quality Control - Annual Credentialing Denial and Approval Audit for Potential Discrimination audit tool and process since the 2020 audit was completed to ensure a sample of practitioners from all regions are captured in the blind selection to be audited to also include states and disciplines. Credentialing policy has also been updated May 27, 2021, to reflect these changes and improvements. *CR226.09 Prevention and Monitoring of Non-discriminatory Credentialing and Recredentialing* is reviewed annually against NCQA MBHO standards to assure compliance with standards outlined by

			NCQA. If no changes are identified in contractual or NCQA regulations, no updates to the policy are necessary. *Policy CR 213.09 Practitioner/Provider Appeal Rights, Range of Actions, and Appeal Process* describes the process to formally appeal the decisions of the NCC in accordance with NCQA MBHO Standards. Practitioners have the right to appeal negative committee decisions except for those practitioners/providers who were denied due to not meeting network criteria described in *CR225 Discipline Specific Credentialing Criteria for Practitioners.* Beacon Policy Number *CR 226.09 Prevention and Monitoring of Non-discriminatory Credentialing and Recredentialing* outlines the process to select, credential and recredential practitioners according to a non-discriminatory procedure(s) based on managed behavioral health care industry standards, managed care standards *42 CFR 438.214 and 42 CFR*

			422.204, NCQA, MBHO accreditation standards as well as any other regulatory or state requirements. The National Credentialing Committee (NCC) maintains a multi-disciplinary, heterogeneous members to ensure all specialties related to Behavioral Health are represented. NCC does not base any credentialing decisions based on an applicant's race, ethnicity, national origin, gender, age, religion, disability, and/or sexual orientation. NCC does not base any credentialing decisions solely on the basis of license, registration, or certification. The NCC does not base decisions based on procedure type or patient population including high-risk populations or who specializes in costly treatment. Files submitted to the NCC for review are redacted of any identifying information. (Refer to *CR 203- Practitioner Credentialing Process* and *CR 209-Practitioner Recredentialing Process*).

			On annual basis, three (3%) percent of denied applications are reviewed to ensure no discrimination on behalf of the NCC. If any of the audits result in findings of potential discrimination, the complete credentialing file will be sent back to the NCC under an alias for de novo proceeding. At least annually, the NCC chair will remind the committee of the importance of non-discriminatory discussion and decision making. The annual audits are documented, tracked, and reported to the Corporate Quality Committee (CQC) on annual basis. If HCI has any providers denied participation with Beacon Health Options/Health Colorado, a percentage of the denied files will be chosen for audit. If none of the practitioners are denied participation, they will not be included in the non-discrimination audit. The next corrective action was that HCI must implement a written process for confirming that listings

			in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable), and specialty. HCI submitted the following intervention: *Beacon Network Policy NW 6.27- Provider Database and Provider Directory* details the elements captured and uploaded into the Provider Directory by the Provider Data Department and the process of ensuring this reflects the data entered into the Credentialing system during the Credentialing process. Beacon's provider database is the source for production of its practitioner and provider directories utilizing CAQH data accuracy (based on practitioner attestation) to post to Beacon's web-based provider directory. Changes to provider information within thirty (30) calendar days of receipt of new information, Beacon's online Provider Directory displays the

			date the directory was last updated. Beacon or its vendor audits the accuracy of directory information at least monthly. When it becomes necessary to remove a provider from the network per Beacon's quality and credentialing policies and procedures to be at severity levels that would warrant posting a "no new referrals" notice on the provider's record, Beacon's provider database is updated to reflect this status and the provider is removed from the online directory immediately. (*CR 215 Involuntary Suspension for Quality of Care or Compliance Issue and QM 4- Member Safety Program).* Finally, for Standard IX—Sub contractual Relationships and Delegation, HCI was issued one corrective action. HCI must update its Administrative Services Agreement with Health Colorado contract and delegated agreements to include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement. As a result, HCI has

			submitted the following plan: Amended the Administrative Services Agreement to include the detailed language specified in 42 CFR 438.230(c)(3).
Annual Claims and Encounter Audit (411 Audit)	In order to assess the accuracy of submitted claims and encounters, each year HCI undergoes an annual claims and encounter validation audit. The purpose of this audit is to assess service coding accuracy in submitted claims and encounters. Three services categories were audited in FY20-21. Those categories were residential services, psychotherapy services, and inpatient services.	June 30, 2022	As in past 411 audits, HCI performed very well across the three service categories audits. Aggregate scores reflected a high level of confidence in accuracy of the submitted claims and encounters. HCI observed a high level of accuracy in the psychotherapy section of the audit. HCI achieved accuracy scores between 94% and 99% percent, with an average percentage of accuracy of 98%. HCI's strongest categories of performance, which all achieved accuracy scores of 99% were: • Unit • Start Date • End Date • Appropriate Population • Duration • Staff Requirement HCI observed a very high level of accuracy in the residential section of the audit. HCI achieved accuracy sores of 99% percent across all ten

			(10) encounter categories. HCI observed a very high level of accuracy in the inpatient section of the audit. HCI achieved accuracy scores between 99% and 100% percent. HCIs strongest categories of performance, which all achieved accuracy scores of 100% were: • Principal Surgical Procedure Code • Revenue Code • Start Date • End Date In order to continue to see a high confidence in the accuracy of submitted claims and encounters, HCI created and disseminated training on the 411 audits to its provider network. It is believed that this training, when administered to the provider network, will generate continued high performance in future 411 audits.

Goal	Fiscal Year 21-22 Project/Initiative	Targeted Completion Date	Status
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 Performance and Improvement Advisory Committee (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, 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	June 30, 2022	In FY20-21, HCI participated in State PIAC meetings and held Regional PIAC meetings/learning collaboratives to further goals of communicating best practices and sharing/receiving feedback from stakeholders to improve healthcare delivery in region 4. In the August 2020 HCI PIAC meeting, group members received information about Nursing and Therapy Services of Colorado (NTSOC), which is a non-profit organization serving children with special needs. State PIAC updates were provided noting the State's intent to connect members with providers, promote health equity, ensure members receive specific communication, and evaluate the success of these efforts. The group received information about the Non-Emergency Medical Transportation Survey (NEMT), including web

	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.		links to English and Spanish survey versions. Lastly, a RAE 4 member spoke to the group about his challenges with MedRide, noting request for transportation need to be made 48 hours in advance versus the day of service. In the September 2020 HCI PIAC meeting, a presenter with Triple Aim presented on the Directing Others to Services (D.O.T.S.) program, including discussion on 72-hour response to post-overdoses impacting ED utilization. The group also learned about suicide awareness/QPR training (Question, Persuade, and Refer) and received community resources. Lastly, the group learned more about changes to adult dental benefits from DentaQuest. In the October 2021 HCI PIAC meeting, the group learned about telehealth to complement existing local care services as well as expanding access points in both traditional and non-traditional locations. The group also received Colorado Crisis System

			resources and information with an emphasis on the youth-teen campaign. In the November 2021 HCI PIAC meeting, a CDPHE representative spoke to the Diabetes Self-Management Education and Support (DSMES) program, including the sharing of resources and information for members and providers in RAE 4. Relatedly, the group received an update on the Potentially Avoidable Costs/Complications (PAC) diabetes episode of care with an emphasis on regional statistics and listing of top PCMP providers for members with diabetes. The group received State PIAC updates, noting the ongoing focus on COVID-19 (access to care and economic impacts). Lastly, the group learned about Beneficent, which offers wealth preservation and planning for long-term care (Medicaid or VA aid and attendance). In the January 2021 HCI PIAC meeting, the RAE 4 KPIs were reviewed in detail, noting their importance to assess

			the functioning of the overall system in coordination with HCPF. The group discussed performance on the Behavioral Health Engagement, ED Visits, Health Neighborhood, Dental Visits, Prenatal Engagement, and Well Visits KPIs and also identified opportunities to improve. In order to meet RAE 4 members' needs, the HCI PIAC group decided to have the first monthly meeting in each quarter be 'Pueblo-centric', the second monthly meeting in each quarter be 'rural-focused', and the third monthly meeting in each quarter be 'health neighborhood-focused.' The group also discussed how to access COVID-19 vaccinations in RAE 4 with feedback from regional providers and care coordination entities. In the February 2021 HCI PIAC meeting, the group learned about oral health and dental benefits via a presentation by DentaQuest. In addition, the group received information about the Child Abuse Response and Evaluation (CARE) network, as well as the

			Colorado Crisis Services network. Lastly, the group discussed COVID-19 vaccination access and challenges for RAE 4 members and providers. In the HCI PIAC meeting in April 2021, there was a presentation on the Potentially Avoidable Costs/Complications (PAC) SUD episode of care in order to inform Committee members and receive feedback on their experiences with the recent SUD benefit expansion. Moreover, the group received information about RAE 4's vaccination outreaches to members, including COVID-19 vaccine text campaign, an interactive voice recording (IVR) outreach campaign, and live calls to potentially homebound members. The group was notified that FEMA has taken over administration of the COVID-19 community vaccination site at State Fairgrounds in Pueblo. In the May 2021 HCI PIAC meeting, there was a presentation on the Potentially Avoidable Costs/Complications (PAC) maternity/pregnancy

			episode of care in order to inform Committee members about maternity services available in the region and receive feedback on their experiences with accessing maternal care services in the region. Group members also received information on Unite Colorado, including discussion of the coordination care network structure and Unite Colorado website.

Fiscal Year 2021-2022 Quality Management Work Plan Goals

The goals for the FY21-22 work plan have also been created and approved by the QIUM. The performance goals for FY21-22 are as follows.

GOAL #1: Further develop the continued monitoring of Key Performance Indicators (KPIs), Behavioral Health Incentive Program (BHIP) measures, and Performance Pool measures (PPs). Implement targeted interventions where applicable.

GOAL #1A: Invite stakeholders to HCI Performance Measures workgroup, establish learning collaborative via HCI QIUM Committee and workgroup, targeting low performing measures.

GOAL #1B: Target low performing measures, identify countermeasures, monitor performance.

GOAL #2: Quarterly or when applicable, monitor results of the performance improvement project.

GOAL #3: Quarterly or when applicable, monitor results of PAC program initiatives and deliverables.

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

GOAL #5: Complete QM program documents monthly and identify trends for program improvement.

GOAL #6: Monitor progress on new goals over the course of FY21-22, and adjust goals, as needed with the QIUM Committee in addition to planning FY22-23 work plan goals.

GOAL #7: In collaboration with the Population Health team, Finance, and HCI leadership, identify opportunities to expand upon the existing and future practice transformation framework and provide support to population health initiatives.

GOAL #8: Ensure monitoring of Member Surveys. Implement targeted interventions where applicable.

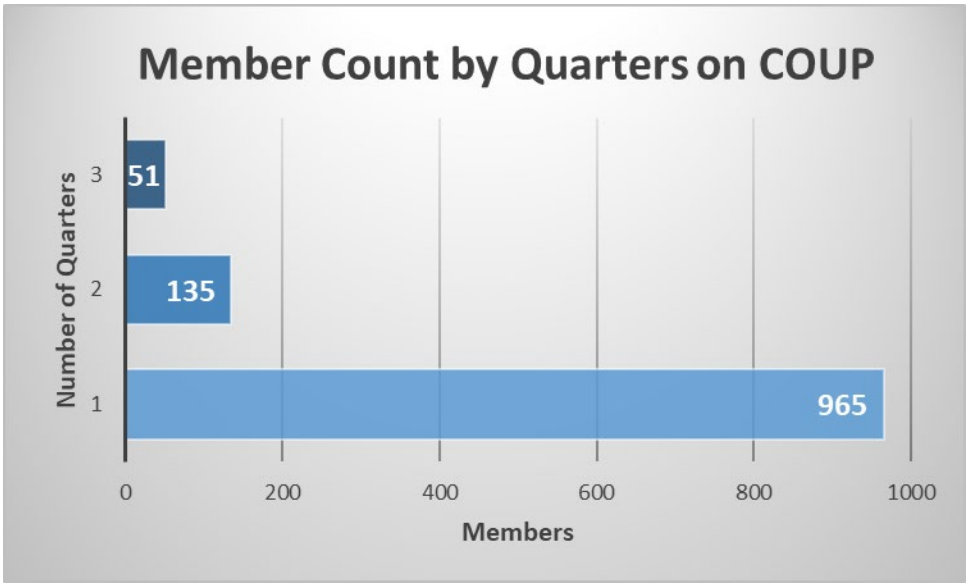
GOAL #9: Quarterly, monitor the average turnaround time for complaints and grievances and any needs for improvement to be implemented.

GOAL #10: Ongoing monitoring of External Quality Review Organization (EQRO) or HCPF contract activities. Implement targeted interventions where applicable.

GOAL #11: Ongoing monitoring of Quality of Care concerns and activities. Implement targeted interventions where applicable.

Appendix A

COUP Program List of Unique Members



There were a total of 1151 unique members on the COUP list in FY19-20 quarters one (1) through three (3); There were 965 members (83.84%) on the COUP list for only one (1) quarter, 135 members (11.73%) on the COUP list for two (2) quarters, 51 members (4.43%) on the COUP list for three (3) quarters.