Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 29, 2023

Health Colorado, Inc.

Quality Improvement Plan FY23-24

1. Purpose/Mission Statement

The mission of Health Colorado, Inc. (HCI) is to advance individual and community health and wellness by creating a system of care that is accessible to every member we serve. We aim to improve members' lives; so, they can live life to the fullest potential. Everything we do is focused on improving the health of people under our care.

Who We Are

HCI is a community health plan that is provider-led and locally driven. We are comprised of local community health organizations including the following three regional Community Mental Health Centers (CMHC): Solvista Health, San Luis Valley Behavioral Health Group, and Health Solutions. HCI is further comprised of a hybrid Federally Qualified Health Center (FQHC) and CMHC, Valley-Wide Health Systems, Inc., and Carelon, an administrative service organization (ASO).

At HCI, we put people at the center of everything we do. Our system is built on a strong support structure of doctors, nurses, therapists, advocates, and mentors who work together to fulfill our members' behavioral, physical, and social health needs.

Our Promise

- We are committed to individual empowerment and whole-person care.
- We promise to support our Providers in quality care delivery.
- We provide health equity to all.

Our Vision

At HCI, we will improve the quality of life for the people we serve by advancing the highest quality, best practices in health care.

Our Values

Innovation: We seek creative ways to solve tough problems, embracing multiple points of view that challenge current ideas of what is possible.

Excellence: We care deeply about what we do, resulting in work that surpasses our stakeholders' expectations and needs. We place high standards of service, support, and compassion at the center of everything we do.

Compassion: We acknowledge, respect, and honor the fundamental value and dignity of all individuals. We demonstrate this in our decision-making and place inclusion as a priority. We acknowledge that diversity makes us better.

Accountability: We feel an obligation to act in the best interests of our community and the people we serve. We accept our responsibilities and believe accountability empowers others to succeed.

Partnership: We believe our ability to build trusted relationships with stakeholders and collaborate across communities breaks down silos and develops innovative strategies that improve the system of care and health and wellness for everyone.

Our Pillars

- Culture of Access
- Performance Driven
- Equity for All
- Members First

2. Yearly Objectives/Top Priorities

The top priorities for FY23-24 are to continue improving on key functional areas that relate to the RAE contract. We will achieve this by following the framework outlined below.

HCI Performance Measures Improvement Strategy:

In 2022, HCI senior leadership established HCI's performance measures improvement strategy in relation to RAE 4 contract-bound performance measures established by the Colorado Department of Health Care Policy and Financing (HCPF). This ongoing strategy effectively guided operational planning and continues to guide decisions through the end of FY 23-24. Considering HCI's mission and population health strategic plan, the following strategic goals serve as a framework for HCI leadership and key stakeholders in FY23-24:

Performance Measure Strategy #1 – Excellent Bi-Directional HCPF Communication Around Performance Measures (HCI Performance Measures Strategy Workgroup)

- *Element #1:* Ensure measure changes communicated to all pertinent parties
- *Element #2:* Provide comprehensive feedback to HCPF on all measures (ex. coding gaps)

Performance Measure Strategy #2 – Improve Timeliness and Accuracy of Internal Performance Measures Data (HCI Performance Measures Data Workgroup)

- *Element #1:* Aggregate level visualization (dashboards) data for each measure (slice by RAE level, care coordination level, provider level - group and practice), attention to equity in data slicing
- *Element #2:* Provider/practice level patient detail per measure (scorecards)

Performance Measure Strategy #3 – Win on all Performance Measures (HCI Performance Measures Strategy Workgroup)

- *Element #1:* Measure improvement prioritization
  - Prioritization Matrix – Strategy workgroup determines criteria (possible examples: how far from target, how many stakeholders required to improve measure, resources available, inter-related measures, finances)
- *Element #2:* Effectively engage key stakeholders for improvement
  - Evaluate top performers (gather best practice) and bottom performers (facilitated improvement) for each measure
- *Element #3:* Process improvement facilitation (dedicated process improvement staff and governance structure)
  - Network/Practice Transformation: primary care and behavioral health –Convene, motivate, and facilitate practices to improve practice level metrics and share best practice
  - RAE/Neighborhood Transformation: Performance Measures Action Plan (PMAP) – Convene, motivate, and facilitate key stakeholders to improve RAE level measures
  - Care Coordination Transformation: value stream – Convene, motivate, and facilitate key stakeholders to improve RAE level measures
- *Element #4:* Effectively incentivize network to perform on key measures
  - Clearly articulate funds flow to provider/key stakeholder for performance
  - Facilitate engagement by providing meaningful/actionable data, improvement tools, and coaching

HCI Performance Measures Action Plan (PMAP):

The purpose of the HCI PMAP process is to serve as a mechanism to further the HCI Performance Measures Strategy Workgroup efforts and to drive performance improvement in collaboration with key RAE 4 stakeholders. Serving as a collaborative to promote continued learning and continued improvement, the HCI Performance Measures Strategy Workgroup meets monthly and reports to the HCI Quality Improvement/Utilization Management (QIUM) Committee.

Key stakeholders involved in the PMAP effort are HCI leadership, partners/providers, Quality Management staff, and members of the HCI QIUM Committee. The PMAP workgroup(s) will be led by a member of the HCI QIUM Committee and/or Quality Management staff. In FY23-24, HCI senior leadership and members of the HCI QIUM Committee will continue to utilize this strategic framework to address performance measurement activity for RAE 4 on the following contract-based measure sets:

- *Key Performance Indicators (KPIs)*
- *Behavioral Health Incentive Plan (BHIP) Measures*
- *Performance Pool Measures (PPMs)*

Reviewing HCI performance in relation to benchmarks/goals/targets, the HCI Performance Strategy Workgroup will periodically rank order measures, determining which measures to focus performance improvement activity within a rapid cycle framework. HCI will utilize the Microsoft Power BI application to analyze and visualize current performance by clinic/provider to identify sites with the greatest

opportunity to impact measure success through process improvement activities. The PMAP workgroup(s) will be comprised of HCI leadership, Quality Management staff, and key RAE 4 partners/providers with opportunities for improvement. The PMAP workgroup(s) may recruit partners/providers identified as strong performers to identify and document best practices as well. The PMAP workgroup(s) will report activities in the monthly HCI QIUM Committee meetings, including review of HCI and provider-level performance data and identification of potential processes and countermeasures to increase overall performance.

Current and Ongoing PMAP Implementation Steps

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

- Perform data analysis of key performance measures to identify intervention targets (KPIs, BHIPs, and PPMs).
- Identify and invite partner/provider representatives to review performance data and make recommendations for interventions.
- Process map transitions of care and workflows to identify gaps and promote standardization of clinical care and work.
- Develop implementation plan for targeted interventions.
- Coordinate with partners/providers to implement interventions and monitor/manage performance, using a pilot project methodology.
- Provide monthly updates on intervention results to the HCI Performance Measures Strategy Workgroup and HCI QIUM Committee.
- Analyze results and make changes to implementation plan/strategy as needed.
- Disseminate generalizable findings to partners and provider organizations in RAE 4.

KPIs, PPMs, and BHIP Measures

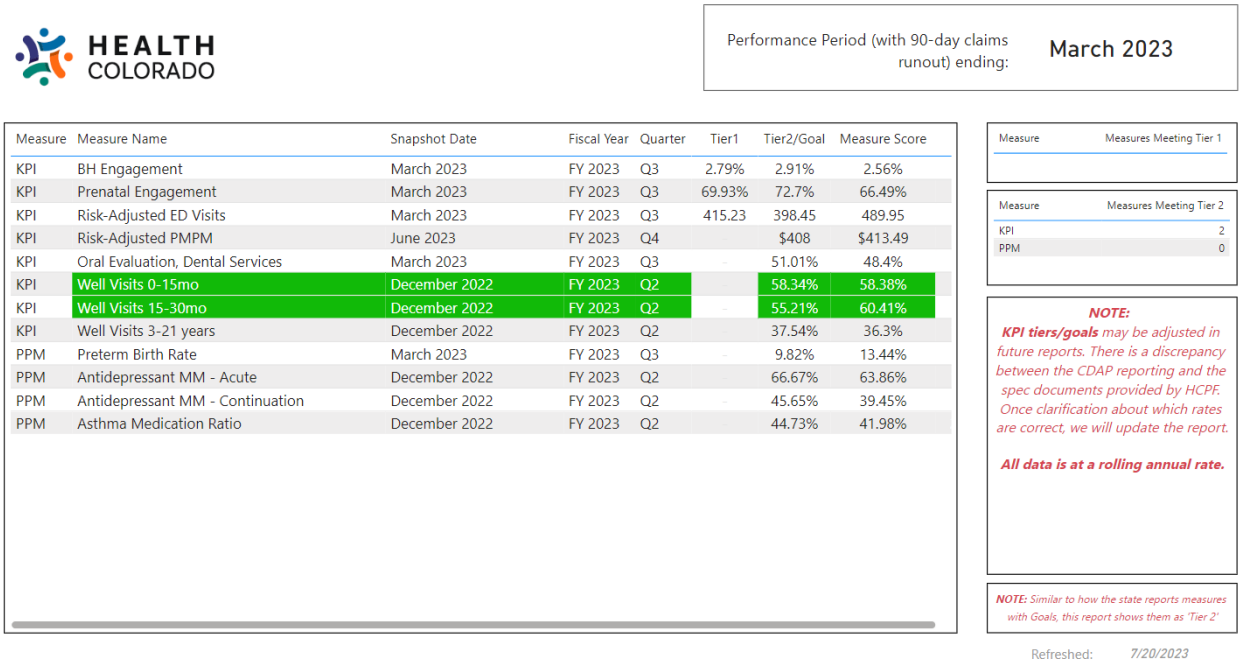
Performance measurement is a core function of HCI's Quality Management program. The primary goal of the Quality Management program is to improve patient care and overall health outcomes, ensuring efficient utilization of services. Through data collection, measurement, and analysis along with visualization of the aspects of care and service that demonstrate opportunities for improvement, HCI will identify and prioritize process improvement and quality improvement activities. Data is collected and used for quality improvement projects and activities that are related to several key indicators of quality. Specifically, the projects primarily focus are on:

- High-volume diagnoses
- High-volume services
- High-risk diagnoses
- High-risk services
- Special populations

HCI strives to monitor provider performance based on the KPIs, BHIP measures, and PPMs established by HCPF for the RAE. Guided by HCI's Performance Measures Improvement Strategy and Goals, we seek 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 our providers, staff, management team, and stakeholders through regular updates at the QIUM Committee, Care Coordination Committee, Health Neighborhood Collaborative, and the regional Program Improvement Advisory Committee (PIAC), as well as workgroups such as the PMAP process and other meetings where applicable.

HCI will utilize the Microsoft Power BI application to visualize data in customized dashboards to inform stakeholders and facilitate decisions on resource utilization. Examples of these dashboards are included below. The first dashboard provides an executive level summary of measure performance; the second depicts providers' monthly trending on individual measures while the third shows provider-level rankings on specific performance.



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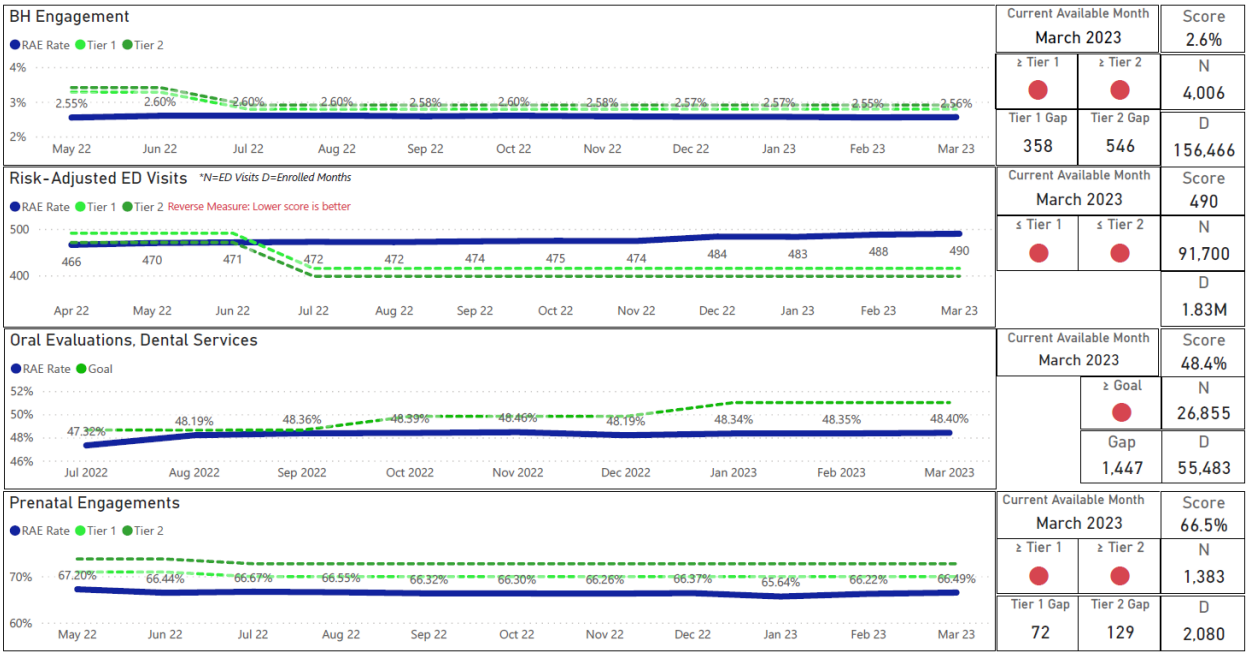
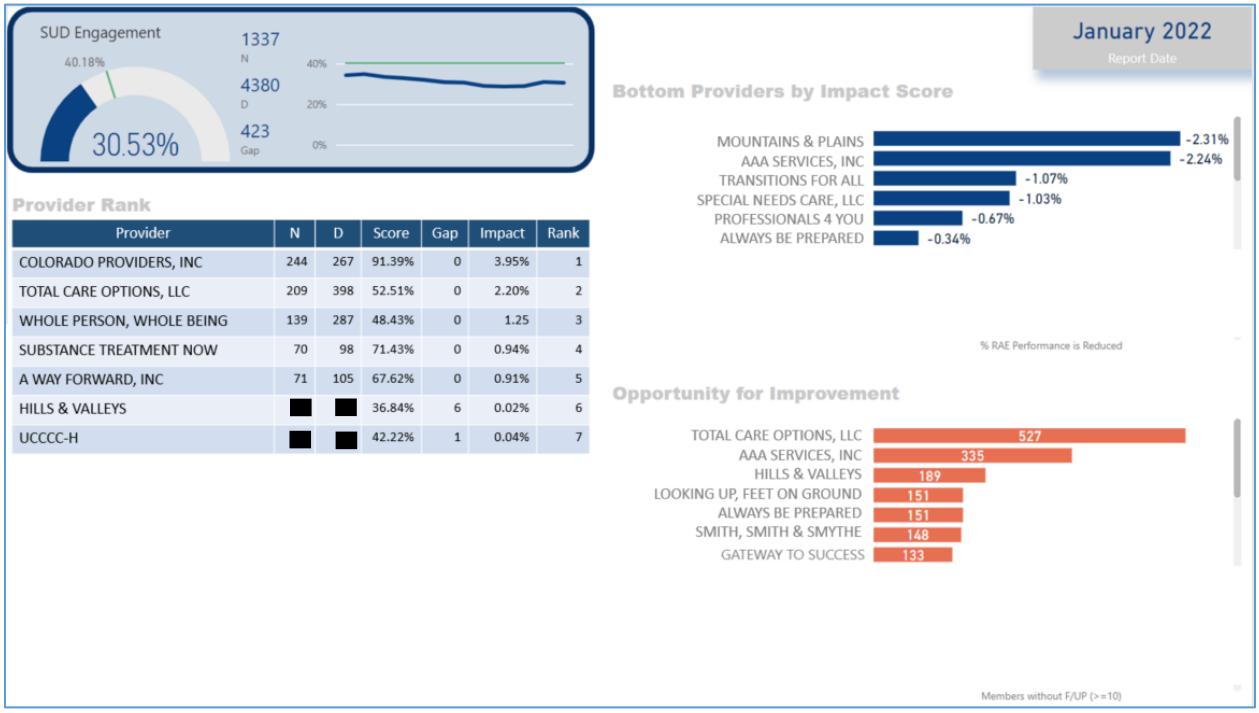
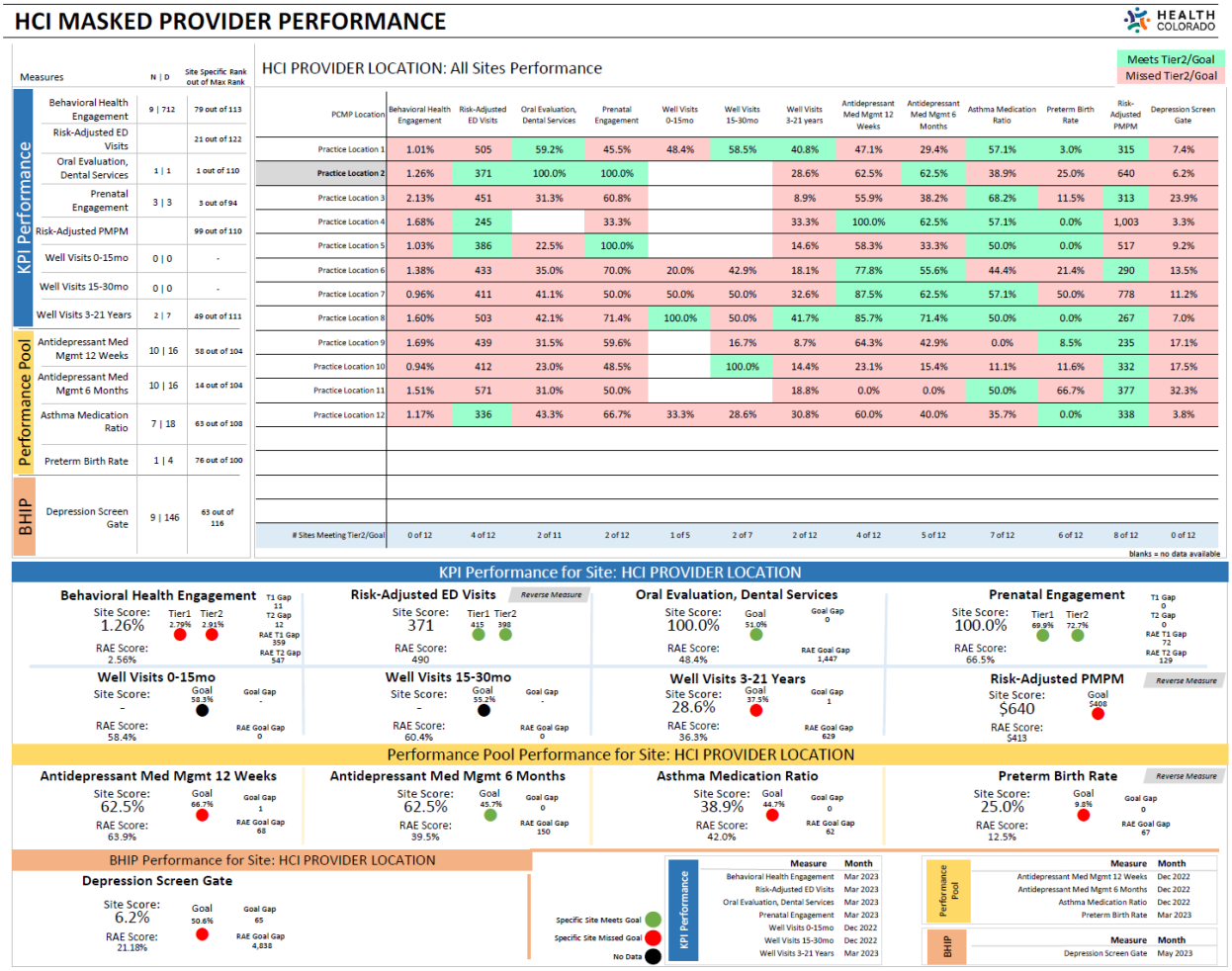




Provider	N	D	Score	Gap	Impact	Rank
COLORADO PROVIDERS, INC	244	267	91.39%	0	3.95%	1
TOTAL CARE OPTIONS, LLC	209	398	52.51%	0	2.20%	2
WHOLE PERSON, WHOLE BEING	139	287	48.43%	0	1.25	3
SUBSTANCE TREATMENT NOW	70	98	71.43%	0	0.94%	4
A WAY FORWARD, INC	71	105	67.62%	0	0.91%	5
HILLS & VALLEYS	[redacted]	[redacted]	36.84%	6	0.02%	6
UCCCC-H	[redacted]	[redacted]	42.22%	1	0.04%	7

Final data-driven visualization tools that HCI developed and now plans to operationalize in FY23-24 are provider-level performance scorecards. These will allow individual clinics to see their performance across all three incentive measure sets in relation to HCI goals as well as in comparison with clinics within their same organization. Assisted by these data visualization tools, HCI will work with practices,

stakeholders, other community organizations, and care coordination entities to evaluate performance and develop strategies to sustain continuous improvement. The table below represents a mock view of a provider-level performance scorecard.



HCI MASKED PROVIDER PERFORMANCE

HEALTH COLORADO

Measures		N | D	Site Specific Rank out of Max Rank
KPI Performance	Behavioral Health Engagement	9 | 712	79 out of 113
	Risk-Adjusted ED Visits		21 out of 122
	Oral Evaluation, Dental Services	1 | 1	1 out of 110
	Prenatal Engagement	3 | 3	3 out of 94
	Risk-Adjusted PMPM		99 out of 110
	Well Visits 0-15mo	0 | 0	-
	Well Visits 15-30mo	0 | 0	-
	Well Visits 3-21 Years	2 | 7	49 out of 111
Performance Pool	Antidepressant Med Mgmt 12 Weeks	10 | 16	58 out of 104
	Antidepressant Med Mgmt 6 Months	10 | 16	14 out of 104
	Asthma Medication Ratio	7 | 18	63 out of 108
	Preterm Birth Rate	1 | 4	76 out of 100
BHIP	Depression Screen Gate	9 | 146	63 out of 116

HCI PROVIDER LOCATION: All Sites Performance

Meets Tier2/Goal
Missed Tier2/Goal

PCMP Location	Behavioral Health Engagement	Risk-Adjusted ED Visits	Oral Evaluation, Dental Services	Prenatal Engagement	Well Visits 0-15mo	Well Visits 15-30mo	Well Visits 3-21 years	Antidepressant Med Mgmt 12 Weeks	Antidepressant Med Mgmt 6 Months	Asthma Medication Ratio	Preterm Birth Rate	Risk-Adjusted PMPM	Depression Screen Gate
Practice Location 1	1.01%	505	59.2%	45.5%	48.4%	58.5%	40.8%	47.1%	29.4%	57.1%	3.0%	315	7.4%
Practice Location 2	1.26%	371	100.0%	100.0%			28.6%	62.5%	62.5%	38.9%	25.0%	640	6.2%
Practice Location 3	2.13%	451	31.3%	60.8%			8.9%	55.9%	38.2%	68.2%	11.5%	313	23.9%
Practice Location 4	1.68%	245		33.3%			33.3%	100.0%	62.5%	57.1%	0.0%	1,003	3.3%
Practice Location 5	1.03%	386	22.5%	100.0%			14.6%	58.3%	33.3%	50.0%	0.0%	517	9.2%
Practice Location 6	1.38%	433	35.0%	70.0%	20.0%	42.9%	18.1%	77.8%	55.6%	44.4%	21.4%	290	13.5%
Practice Location 7	0.96%	411	41.1%	50.0%	50.0%	50.0%	32.6%	87.5%	62.5%	57.1%	50.0%	778	11.2%
Practice Location 8	1.60%	503	42.1%	71.4%	100.0%	50.0%	41.7%	85.7%	71.4%	50.0%	0.0%	267	7.0%
Practice Location 9	1.69%	439	31.5%	59.6%		16.7%	8.7%	64.3%	42.9%	0.0%	8.5%	235	17.1%
Practice Location 10	0.94%	412	23.0%	48.5%		100.0%	14.4%	23.1%	15.4%	11.1%	11.6%	332	17.5%
Practice Location 11	1.51%	571	31.0%	50.0%			18.8%	0.0%	0.0%	50.0%	66.7%	377	32.3%
Practice Location 12	1.17%	336	43.3%	66.7%	33.3%	28.6%	30.8%	60.0%	40.0%	35.7%	0.0%	338	3.8%
# Sites Meeting Tier2/Goal	0 of 12	4 of 12	2 of 11	2 of 12	1 of 5	2 of 7	2 of 12	4 of 12	5 of 12	7 of 12	6 of 12	8 of 12	0 of 12

blanks = no data available

KPI Performance for Site: HCI PROVIDER LOCATION

Behavioral Health Engagement — Site Score: 1.26% (Tier1 2.79%, Tier2 2.91%); RAE Score: 2.56%; T1 Gap 13; T2 Gap 12; RAE T1 Gap 359; RAE T2 Gap 547
Risk-Adjusted ED Visits (Reverse Measure) — Site Score: 371 (Tier1 415, Tier2 398); RAE Score: 490
Oral Evaluation, Dental Services — Site Score: 100.0% (Goal 51.0%, Goal Gap 0); RAE Score: 48.4%; RAE Goal Gap 1,447
Prenatal Engagement — Site Score: 100.0% (Tier1 69.9%, Tier2 72.7%); RAE Score: 66.5%; T1 Gap 0; T2 Gap 0; RAE T1 Gap 72; RAE T2 Gap 129
Well Visits 0-15mo — Site Score: - (Goal 58.3%, Goal Gap -); RAE Score: 58.4%; RAE Goal Gap 0
Well Visits 15-30mo — Site Score: - (Goal 55.2%, Goal Gap -); RAE Score: 60.4%; RAE Goal Gap 0
Well Visits 3-21 Years — Site Score: 28.6% (Goal 37.5%, Goal Gap 1); RAE Score: 36.3%; RAE Goal Gap 629
Risk-Adjusted PMPM (Reverse Measure) — Site Score: $640 (Goal $408); RAE Score: $413

Performance Pool Performance for Site: HCI PROVIDER LOCATION

Antidepressant Med Mgmt 12 Weeks — Site Score: 62.5% (Goal 66.7%, Goal Gap 1); RAE Score: 63.9%; RAE Goal Gap 68
Antidepressant Med Mgmt 6 Months — Site Score: 62.5% (Goal 45.7%, Goal Gap 0); RAE Score: 39.5%; RAE Goal Gap 150
Asthma Medication Ratio — Site Score: 38.9% (Goal 44.7%, Goal Gap 0); RAE Score: 42.0%; RAE Goal Gap 62
Preterm Birth Rate (Reverse Measure) — Site Score: 25.0% (Goal 9.8%, Goal Gap 0); RAE Score: 12.5%; RAE Goal Gap 67

BHIP Performance for Site: HCI PROVIDER LOCATION

Depression Screen Gate — Site Score: 6.2% (Goal 50.6%, Goal Gap 65); RAE Score: 21.18%; RAE Goal Gap 4,838

Specific Site Meets Goal
Specific Site Missed Goal
No Data

KPI Performance

Measure	Month
Behavioral Health Engagement	Mar 2023
Risk-Adjusted ED Visits	Mar 2023
Oral Evaluation, Dental Services	Mar 2023
Prenatal Engagement	Mar 2023
Well Visits 0-15mo	Dec 2022
Well Visits 15-30mo	Dec 2022
Well Visits 3-21 Years	Mar 2023

Performance Pool

Measure	Month
Antidepressant Med Mgmt 12 Weeks	Dec 2022
Antidepressant Med Mgmt 6 Months	Dec 2022
Asthma Medication Ratio	Dec 2022
Preterm Birth Rate	Mar 2023

BHIP

Measure	Month
Depression Screen Gate	May 2023

In FY22-23, HCI senior leadership fully implemented the Performance Measures Improvement Strategy including the charter of PMAP workgroups. By leveraging data visualization tools to understand measure performance, performance gaps, and provider opportunity, HCI monitored these efforts, identified priorities, and enlisted key stakeholders in these PMAP workgroups. For FY23-24, the PMAP workgroups are focused on two BHIP Measures identified by HCI leadership. These are continued efforts on the ED SUD Follow-up and the Behavioral Health Follow-up for Children New to Foster Care measures.

The group working on ED SUD Follow-up continues to include a multidisciplinary group from Parkview Medical Center and Health Solutions, and their work will align with the HCPF-mandated clinical Performance Improvement Project (PIP). The second PMAP workgroup will re-engage work that began in FY22-23 with Pueblo Department of Human Services related to the Behavioral Health Follow-up for

Children New to Foster Care measure. With the recent clearance of legal signatories to initiate a data-sharing agreement, HCI intends to launch a pilot project to reduce delays in foster care notifications to coordinate appropriate behavioral health engagement for these vulnerable members.

During FY23-24, each of these workgroups will meet at least monthly to develop and implement improvement plans. Updates will be provided on group progress during multiple HCI forums and will not be limited to the QIUM Committee and the PIAC.

Performance Improvement Project (PIP)

FY22-23 brought about the end of a PIP cycle. HCI's work with Valley-Wide Health System on the Depression Screening and Follow-up of Positive Depression Screen measures concluded. HCI submitted Module 4 summarizing the project conclusions, intervention testing conclusions, challenges encountered, and plan for sustainment of successful interventions. Health Services Advisory Group (HSAG) validated the results and confirmed that "significant programmatic improvement was demonstrated for the intervention." For the Follow-up measure, HSAG concluded that the SMART goal was achieved and statistically significant improvement over baseline was achieved. HSAG also concluded that significant programmatic and clinical improvement were demonstrated by the intervention.

HCPF communicated that the next three-year cycle for PIPs will consist of two separate projects. One PIP must focus on a clinical topic while the other will focus on a non-clinical topic. Selecting from the list of potential clinical measures provided by HCPF, HCI elected to pursue performance improvement on the ED SUD Follow-up measure. This measure was chosen due to alignment with the PMAP work that had already commenced with Parkview Medical Center and Health Solutions. The measure specifications for the project will be migrated to the new BHIP measure specification that aligns with the CMS Core Measure: Follow-up After ED Visit for Substance Use (FUA). Baseline data and measure specifications will be submitted to HCPF no later than October 31, 2023. Unlike in the previous cycle, PIP progress updates will only be required once annually.

HCPF directed that the non-clinical PIP must initiate performance improvement to target increased performance of Social Determinants of Health (SDOH) screening among behavioral health utilizers in the region. Following a Technical Assistance (TA) call with HSAG in March 2023, HCI will initiate PIP efforts by understanding current available data streams on SDOH. HCI will develop further interventions based on the information gathered. Potential partners for pilot PIP work will be recruited at the QIUM Committee meeting to refine the process for performing this screening and aggregating this information through impactful and sustainable interventions before RAE-wide implementation is initiated. HCI also plans to incorporate current SDOH screening that is routinely performed by the delegated care coordination entities as part of their intake assessment. As with the clinical PIP, baseline data and measure specifications will be submitted to HCPF no later than October 31, 2023, and PIP progress updates will only be required once annually.

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. HCPF requires HCI 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 (CAP) when warranted, re-audit the provider for continued improvement, and recoup funds if appropriate. These audit activities will continue in FY23-24.

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 CAP 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 through the next fiscal year. The same Quality Improvement staff who conduct the documentation audits facilitated the educational forums. In addition to offering individualized documentation standards training to our providers, there were four large scale multi-provider trainings conducted by the auditors. Many providers had the opportunity to engage in specific discussions and ask clarifying questions about documentation standards. HCI has implemented provider-specific training via Zoom to offer further support and allow for a more personalized, agency-specific training experience for all staff. HCI will continue these educational opportunities into FY23-24.

Examples of some current audits are detailed below. The audit results are illustrated in the corresponding charts associated with each audit.

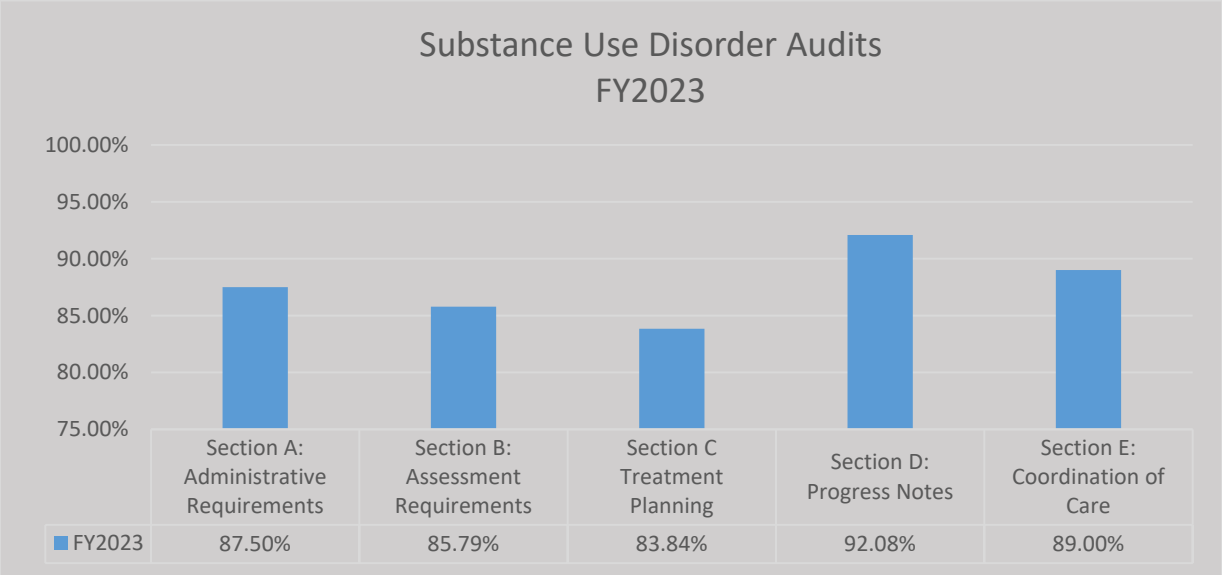
- ### Substance Use Disorder (SUD) Audits

  To date, five SUD outpatient, Medication Assisted Treatment (MAT), and SUD Detox providers completed a SUD audit totaling 26 member charts. Regular and recurring audits and training will continue throughout the year to ensure proper documentation and to support 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). To pass the audit, the member must meet medical necessity, and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below will be audited in six months. In addition to a review of written documentation, a claims review is completed to ensure services are provided in accordance with the requirements of the Uniform

Service Coding Standards (USCS). A failed audit could result in consequences including, but not limited to, required education, recoupment, CAP, and referral to Provider Relations or other licensing agency.

On June 22, 2023, 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

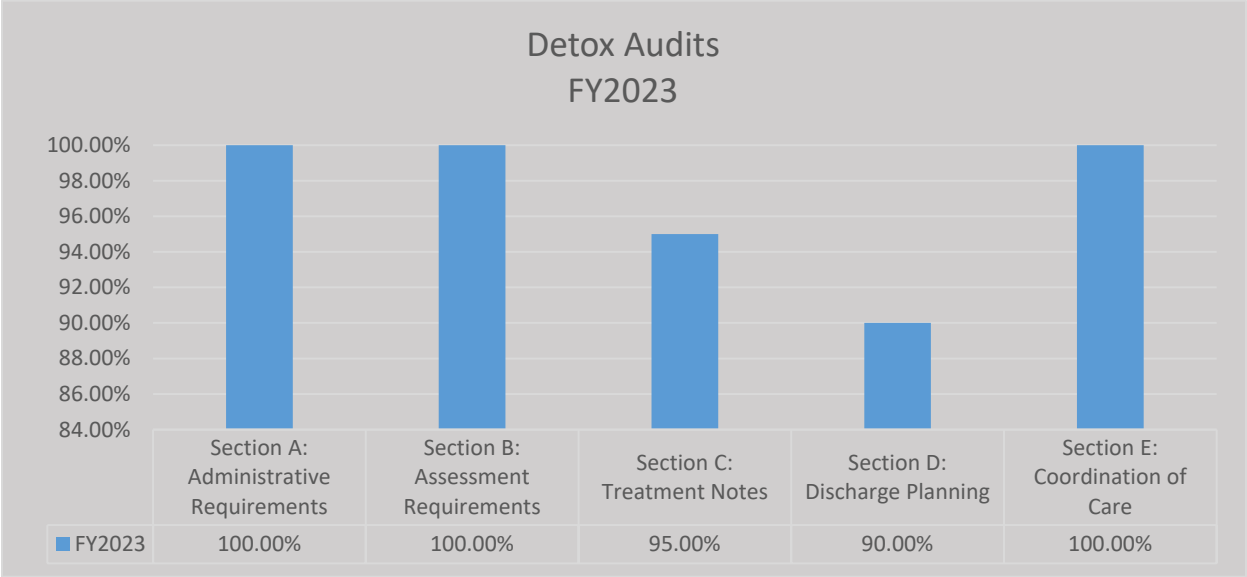
Although the average SUD provider continues to score well above the passing score of 80%, one provider fell below the passing score. This drove the overall average down, so improvement needs to take place. Medical necessity, while not represented in the scoring algorithm, represents the most common weakness in documentation requirements. However, significant improvement has taken place in this area. SUD outpatient providers historically struggle with medical necessity for members who have recently been released from incarceration or who are stepping down from a higher level of care, as these members may not present with current SUD use. Improvements in this area can be attributed to auditors working diligently to give further guidance to providers concerning what is required to meet medical necessity for this population.

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 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.

- 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). To pass the audit, the member must meet medical necessity, and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below will be audited in six months. A failed audit could result in consequences to include, but not limited to, required education, recoupment, 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

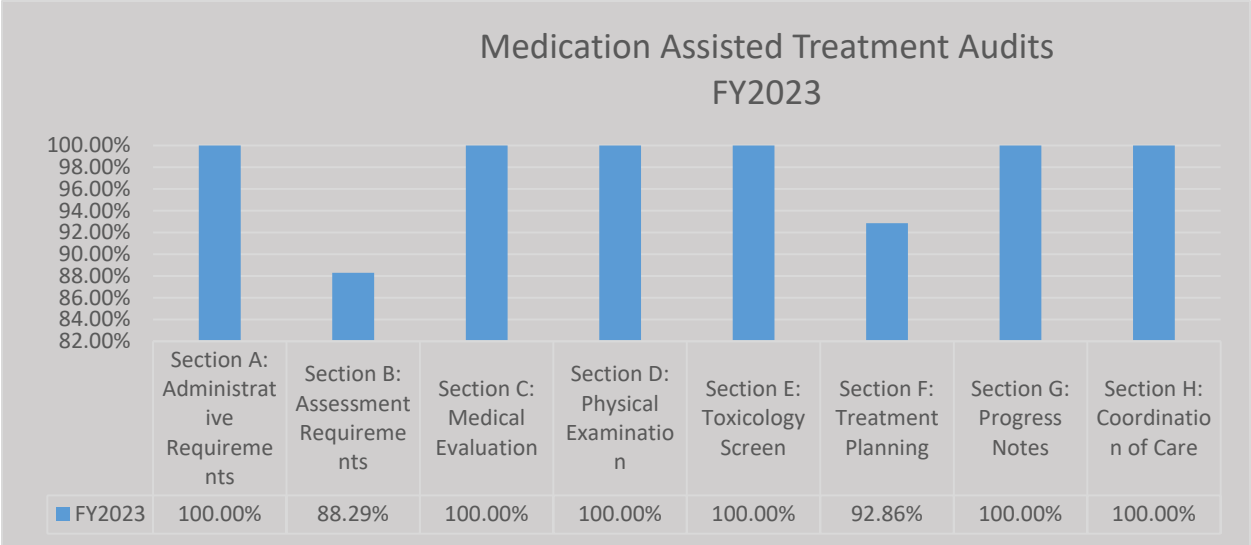
Overall, providers met the documentation standards, showing continued improvement in all areas with the exception of a slight decrease in treatment notes. HCI will maintain efforts to work closely with detox providers to ensure passing scores will continue.

- MAT Audits

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). To pass the audit, the member must meet medical necessity and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below will be audited in six months. A failed audit could result in consequences to include, but not limited to, required education, recoupment, 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.



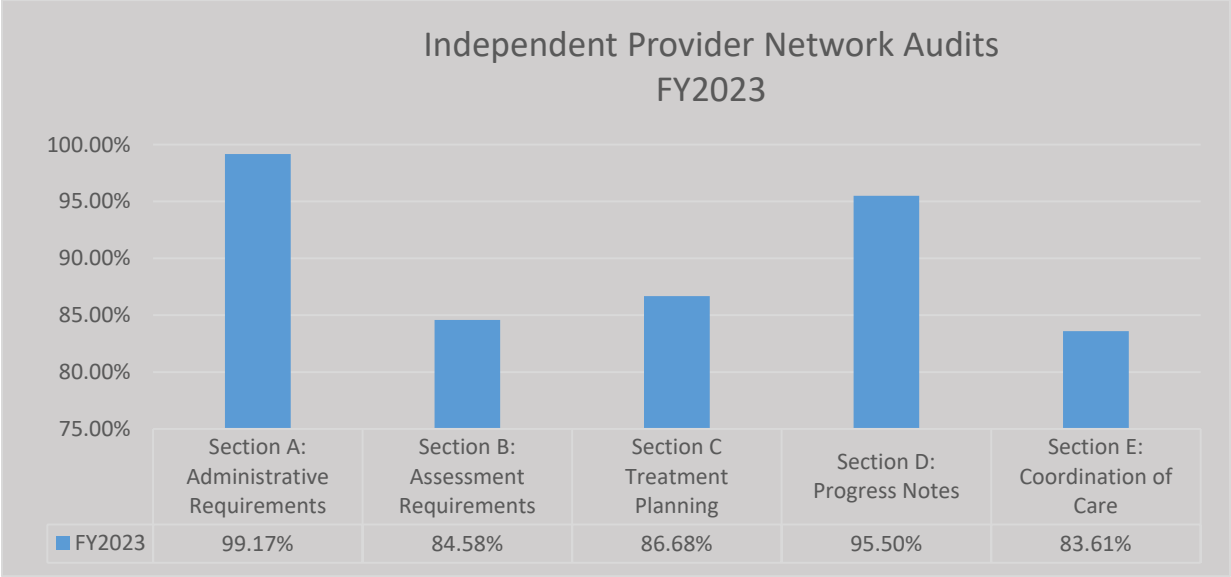
Summary of MAT Performance

MAT providers continue in a positive trajectory and have made improvements in treatment planning. Due to the efficiency of these audits, HCI will continue the same audit procedures.

- ## Mental Health Audits

Routine mental health audits continue to be completed for region 4 Independent Provider Network (IPN) providers. Of the 12 providers who have been audited to date, one failed to meet the minimum passing score of 80% or better and two failed to meet medical necessity. Many providers have also participated in individualized training sessions offered by HCI auditors. Please refer to the audit results in the following charts for an aggregate summary of provider performance. Regular and recurring audits and training will continue throughout the year to ensure proper documentation and to support our provider network.

Mental health outpatient audits consist of reviewing five sections of the member chart (administrative, clinical assessment, treatment planning, progress notes, and coordination of care). To pass the audit, the member must meet medical necessity, and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% or better, the provider will be audited in two years. Providers who fail any category as outlined in the audit tool with 79% or below will be audited in six months. In addition to a review of written documentation, a claims review is completed to ensure services are provided in accordance with the USCS requirements. A failed audit could result in consequences including, but not limited to, required education, recoupment, CAP, and referral to Provider Relations or other licensing agency.



Summary of IPN Performance

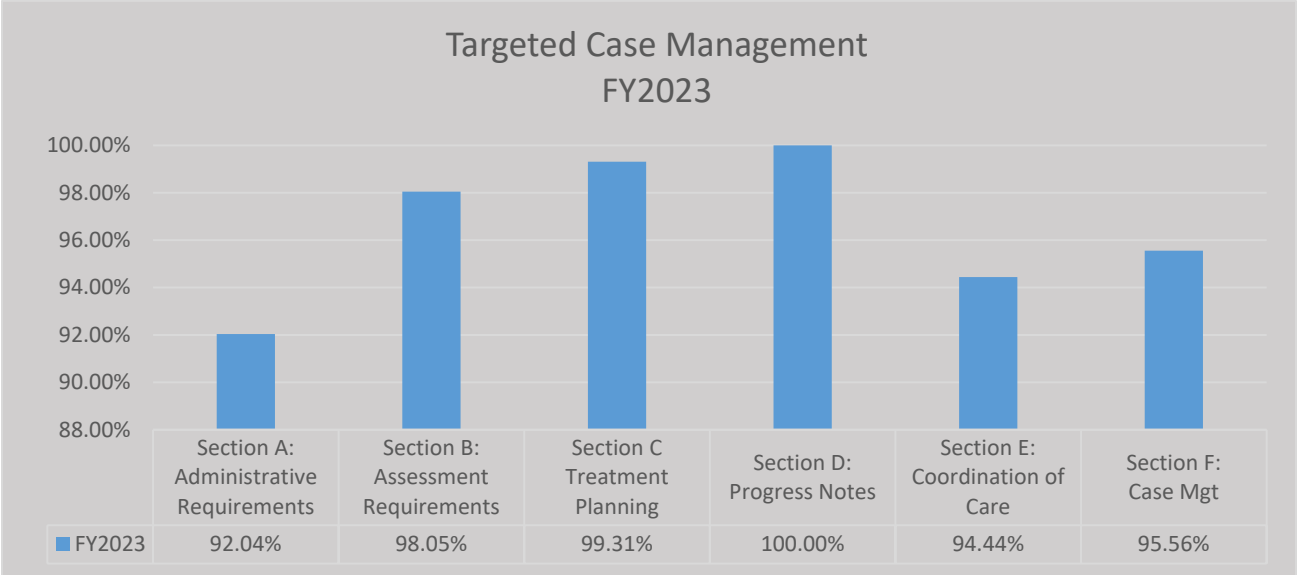
Provider aggregate scores demonstrated a slight decline in three areas. It is not clear what can be attributed to the decrease; however, there will be an increased focus on these elements during provider trainings throughout the new fiscal year.

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

- ## Targeted Case Management (TCM) Audits

TCM audits are similar in nature to SUD and mental health outpatient audits, which consist of reviewing five sections of the member chart (administrative, clinical assessment, treatment planning, progress notes, and coordination of care). TCM audits also include a review of requirements specific to the TCM billing requirement as outlined in the USCS. To pass the audit, the member must meet medical necessity, and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% or better, the provider will be audited in one year.

Providers who fail any category as outlined in the audit tool with 79% or below will be audited in six months. In addition to a review of written documentation, claims review specific to TCM is completed to ensure services are provided in accordance with the requirements of the USCS. A failed audit could result in consequences including, but not limited to, required education, recoupment, CAP, and referral to Provider Relations or other licensing agency.

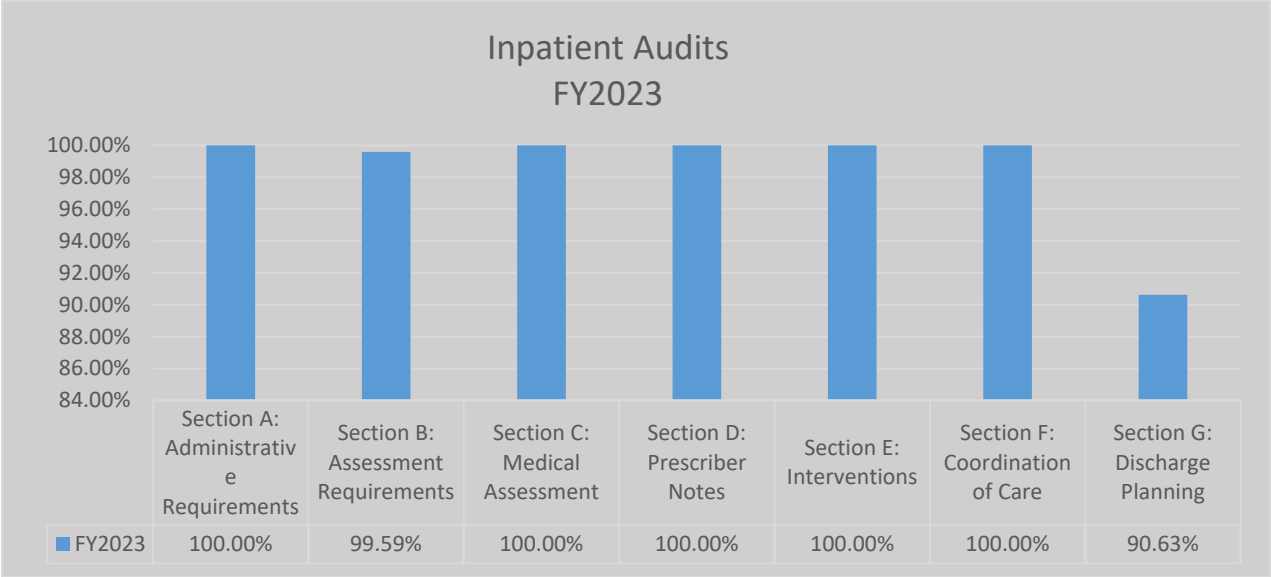


Summary of TCM Performance

There was significant improvement in TCM audit results in fiscal year 2023. No providers fell below the 80% passing score, and one provider passed with a 100% across all domains.

- ## 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). To pass the audit, the member must meet medical necessity and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% 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 80% will be audited in six months. A failed audit could result in consequences including, but not limited to, required education, CAP, and referral to Provider Relations or other licensing agency.



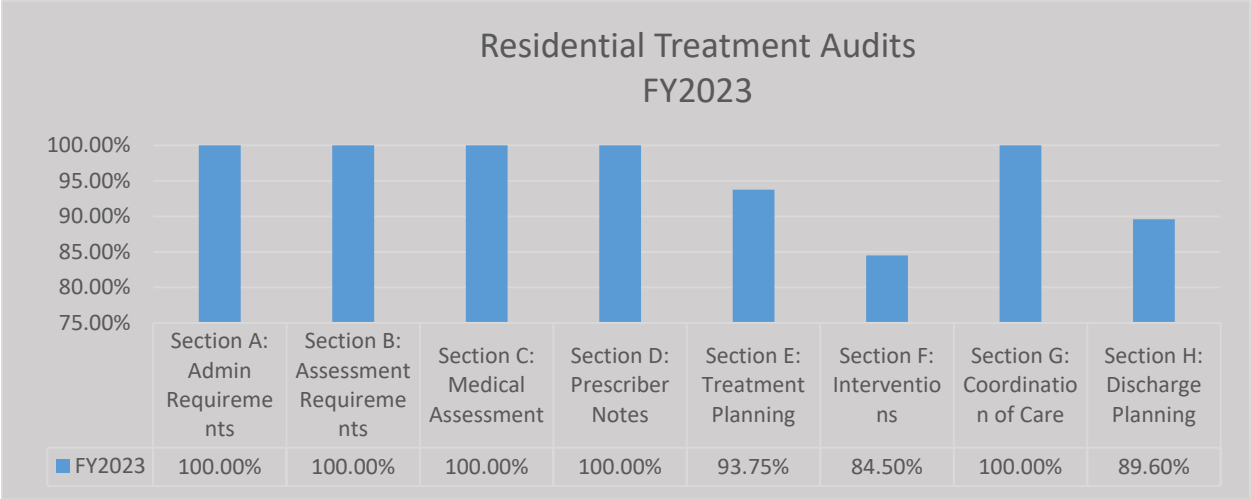
Summary of Inpatient Performance

Inpatient facilities continue to pass all domains required. Previous year scores were all above 90% and inpatient scores continue to improve, with an average of 100% in five domains.

HCI will continue to 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, similar to 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). To pass the audit, the member must meet medical necessity and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below, will be audited in six months. A failed audit could result in consequences including, but not limited to, required education, CAP, and referral to Provider Relations or other licensing agency.



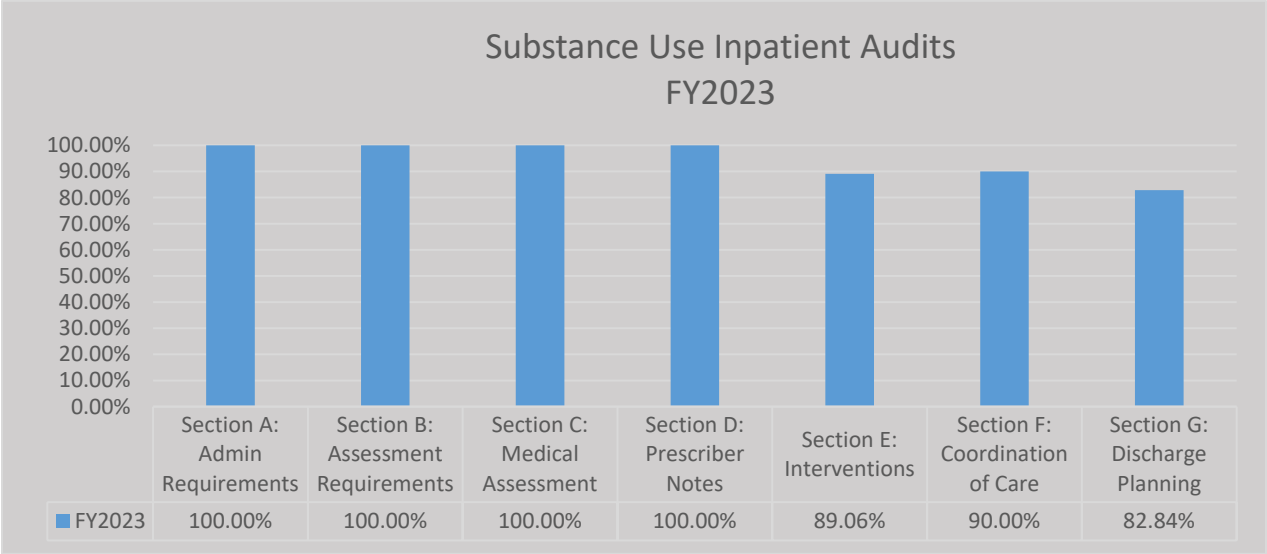
Summary of Residential Treatment Center Performance

Residential treatment showed significant improvement in several domains. No domains fell below the 80% passing score.

HCI will continue to focus on the areas of weakness through provider education, quarterly documentation standards training, and one-on-one trainings.

- ## Substance Use Inpatient Audits

Substance use 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). To pass the audit, the member must meet medical necessity, and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% 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 80% will be audited in six months. A failed audit could result in consequences to include, but not limited to, required education, CAP, and referral to Provider Relations or other licensing agency.



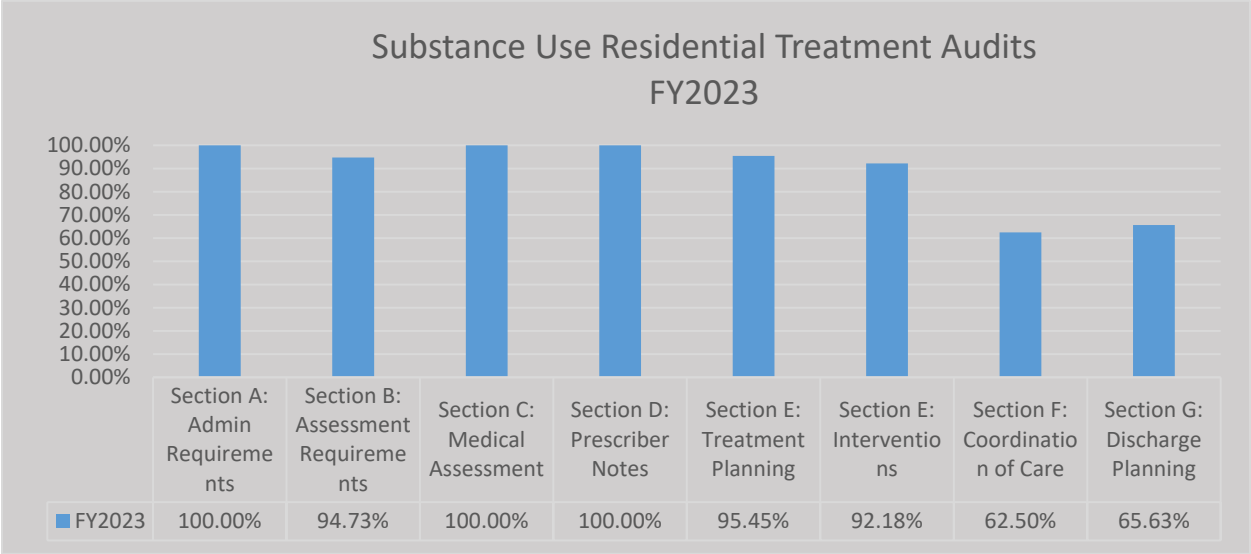
Summary of Substance Use Inpatient Performance

As these audits began in FY 21-22, this was the second year (FY 22-23) that this audit type has been completed. Substance use inpatient facilities continue to pass all domains required.

IN fy23-24, HCI will continue to focus on the areas of underperformance through provider education, quarterly documentation standards training, and one-on-one trainings.

- ## Substance Use Residential Treatment Center Audits

Substance use residential treatment audits, similar to substance use 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). To pass the audit, the member must meet medical necessity and the provider must score 80% or better on each of the aforementioned sections. If the provider passes each section with 80% or better, the provider will be audited in one year. Providers who fail any category as outlined in the audit tool with 79% or below will be audited in six months. A failed audit could result in consequences including, but not limited to, required education, CAP, and referral to Provider Relations or other licensing agency.



Summary of Substance Use Residential Treatment Center Performance

Substance use residential treatment passed all domains with the exception of coordination of care and discharge planning. Substance use residential treatment providers were trained to include care coordination as part of their treatment program to support improvement in FY22-23. Providers have further been trained to include clear aftercare appointment documentation and/or to document when the member refuses follow-up appointments.

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 with complex care needs and chronic conditions and providing them with the care and resources that meet these needs. The HCI care coordination model is sub-divided into care navigation, care management, and low risk care coordination. Care navigation entails removing barriers to accessing care that members may encounter, and connecting members with services and resources that they need. Care management entails supporting members with complex care needs and chronic conditions by ensuring they receive the care they need and engaging them with the care process to improve their health outcomes. Low risk care coordination focuses on members at low risk of poor outcomes, utilization, and unnecessary cost of care. In FY23-24, care coordination entities will explicitly declare which subset(s) of care coordination they intend to deliver. Based on the complex definition that has been in place since January 1, 2022, the assignment of complex members based will factor in the level of service each entity will provide.

In accordance with HCI's Care Coordination Policy, HCI will develop a methodology to randomly sample individual care coordination encounters from Essette, the care coordination documentation

system used by all Care Coordination Entities. These encounters will be audited using the HCI Care Coordination Audit Tool, which will be provided to HCI Care Coordination Entities, and which reflects the contractually identified elements of a care plan and care coordination activities. If the HCI Care Coordination Entity does not achieve the set audit target, the entity will be supported with specialized education/training and a follow-up audit will be performed. If HCI Care Coordination Entities do not pass the second audit, a CAP will be instituted that includes specific criteria and timeline for passing the plan. If the corrective action criteria are not met by the time frame outlined, then further corrective action will be taken up to and including termination of the delegated HCI Community Based Care Coordination contract.

Separate from the clinical documentation reviews described above, HCI Care Coordination leadership will monitor each Care Coordination Entity quarterly for appropriate member outreach and complex member engagement. CAPs will be required for entities failing to achieve improvement in outreach rates and failing to achieve established targets for member outreach or failing to achieve established performance thresholds for complex member engagement. If corrective action criteria are not met by the timelines outlined in the plan, further corrective action will be pursued.

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Chart Audit

HSAG audited HCI in March of 2023 to determine if we:

- Had policies, procedures, trainings, reports, and relevant documents that were aligned with EPSDT federal regulations and specific State requirements.
- Conducted outreach to EPSDT-eligible members who were identified as “non-utilizers” because they had not received any EPSDT services within the 12-month period prior to the annual anniversary date of their enrollment.
- Included EPSDT considerations when making medical necessity determinations prior to denying authorization for services.

HCI identified the following areas as improvement projects for FY23-24 based on HSAG’s findings.

Desktop Procedures
HCI will develop a desktop procedure that outlines how HCI works with HCPF to obtain EPSDT services for members when necessary.

Documentation
- Improve documentation in our electronic health record (EHR) that clearly outlines that the RAE considered medical necessity criteria for EPSDT.
- Expand documentation in our EHR to demonstrate that utilization management (UM) staff consider the member’s needs, environment, and how to assist the member in achieving or maintaining maximum functional capacity.
- Document that a care coordination referral was initiated for members who had a denied capitated behavioral health service.

Onboarding/Outreach

- HCI will begin to send welcome letters to members who do not have valid phone numbers or who opted out of automated calling campaigns.
- HCI will begin to send well visit/dental visit reminder letters to members who have not had had a well visit and/or dental visit in the last year and have opted out of texting, automated calling, or who do not have a valid phone number.

Trainings

- HCI will record and post EPSDT bi-annual trainings for providers on our website.
- HCI will continue to train customer service and UM staff on EPSDT on an annual basis.

- External Quality Review Organization (EQRO) Audit

In April of 2023, HCI underwent an external audit conducted by HSAG, which is the EQRO contracted with HCPF. The following four standards were reviewed:

- Standard I—Coverage and Authorization of Services
- Standard II- Adequate Capacity and Availability of Services
- Standard VI-Grievance and Appeal Systems
- Standard XII- Enrollment and Disenrollment

The Enrollment and Disenrollment section earned perfect score of 100%. The Coverage and Authorization of Services section earned a score of 94%. The Grievance and Appeals section earned a score of 91%. Finally, the Adequate Capacity and Availability of Services section earned a score of 86%.

Please note that Beacon Health Options (Beacon) is now operating as Carelon Behavioral Health (Carelon). For this section, Beacon will be used as this was how Carelon was presented in the reporting of results by HSAG. HSAG noted several areas of strong performance for HCI across the four standards audited. For the Coverage and Authorization of Services section, HSAG noted that, *"Beacon UM staff members described innovations since the last review period which included adding automation solutions to the Provider Connect system to improve providers' experience in requesting services; reducing barriers for prior authorization requests where appropriate; and working to educate providers about frequently requested services such as methadone, medication assisted treatment, and other substance use disorder (SUD) services which have continued to increase since the implementation of the SUD benefit. Beacon drafted additional policies such as the RAE Authorization of Inpatient and Residential SUD Services to further describe SUD authorization procedures, which accurately included all applicable time frames. Staff members on the UM team participated in annual interrater reliability assessments and met the 80 percent passing rate during the review period. Due to staff exceeding the 80 percent scores during the July 2022 testing, Beacon stated that leadership decided to raise the passing threshold to 90 percent."*

For the Adequate Capacity and Availability of Services section, HSAG noted that, *"Policies, procedures, network adequacy quarterly reports, and GeoAccess reports all demonstrated that HCI made efforts to contract with each specialty type required by the contract and expand its provider network quarter*

over quarter. Region 4 spans the South and Southeast regions of Colorado and comprises 19 counties, only one of which is urban. Staff members described that in recent years, providers showed an increased interest in working with the Medicaid population; however, much of the network growth occurred in the urban counties. Telehealth services declined from one third during the coronavirus disease 2019 pandemic down to one fifth of utilization in the first quarter of FY 2022–2023, with members being more and more likely to request in-person services during the review period. Both internal documentation and provider- and member-facing educational materials showed how HCI would provide access to family planning services and offer second opinions, at no cost to the member. And according to the Network Adequacy Quarterly Report for FY 2022–2023, just over 30 percent of HCI's physical and behavioral health providers offered after-hours appointments. Provider relations staff members described a focus on responding to provider questions, tracking metrics such as inquiry response time which is monitored and reported to the Department monthly. Beacon monitored one quarter of the provider network each quarter to assess adherence to timely appointment standards. While adherence to the timely appointment standards fell below 50 percent for primary care medical providers (PCMPs), behavioral health adherence during the quarter ranged from 60 percent to almost 90 percent. Beacon implemented corrective action plans (CAPs) for providers not meeting the standards and worked to resolve these deficiencies through scheduling system updates or reassigning members; providers were reassessed within 90 days. HCI ensured physical and mental health accommodations for members by collecting provider data during the contracting process and posting the specialty accommodations in its online provider directory. Filters included languages offered, gender preference, provider's race and ethnicity, whether the office is wheelchair accessible, and proximity to public transportation."

For the Grievance and Appeal Systems section, Beacon employs community outreach managers to receive and process appeals, and delegates to four CMHCs and one FQHC that employ member advocates to receive and process grievance requests from members. All staff involved in grievance and appeal procedures were trained during onboarding, annually, and during routine one-on-one meetings. Additionally, Beacon submitted an Appeal and Complaint Training Microsoft PowerPoint Presentation and Complaint Job Aid that were used in conjunction with routine training. Appeals can be requested by a member orally or in writing. Community outreach managers are trained to educate members about their rights to appeal and to request a State fair hearing as well as to communicate to the member the limited time frame to receive additional evidence to support the member's appeal request.

If clinical expertise is needed, Beacon maintains a panel of peer advisors with clinical expertise to review appeals and make decisions regarding the information collected during the request. Of the ten appeal sample records, one was expedited, and Beacon staff members made a reasonable effort to contact the member about the resolution within the 72-hour time frame. Beacon submitted documentation such as the 305L Appeal Policy, Appeal Guide, Appeal Job Aid, and State Fair Hearing Guide that accurately defined "appeal" and "adverse benefit determination." HCI submitted a full appeal record sample and overall met 97% compliance for ten appeal sample records. Member advocates and Beacon staff members are to follow the same policies and procedures when a member files a complaint and enters the grievance into the Feedback database for tracking. All staff members demonstrated full understanding of the definition of "grievance" and accepted grievances verbally or

in writing. Staff also demonstrated understanding through submitted documentation which included the 303L Grievance Policy, Complaint Delegation Procedures, Call Center Training, and the Complaint Flow Chart. HCI submitted a full grievance record sample and overall met 100% compliance for ten grievance sample records. Member letters were written in an easy-to-understand language and met the sixth grade reading level requirement.

Finally, in the Enrollment and Disenrollment section HSAG noted that *"HCI partners with Beacon who receives Electronic Data Interchange (EDI) 834 files from the State five days a week, Tuesday through Saturday, and accepts members into the Beacon data system in the order in which they are enrolled. Evidence submitted for review included the Non-Discrimination Policy, Enrollment and Disenrollment of Medicaid Members policy and procedure, Disenrollment Rights, Enrollment Workflow, and Member Services Presentation. Beacon described the process of completing edits and reconciliations routinely. Policies, procedures, and training that were submitted supported efforts and awareness around member nondiscrimination and staff members described how members are not to be discriminated against. During the interview, staff members stated that if a member did make a complaint regarding discrimination, the complaint would be documented and sent through the proper channels for investigation and resolved within the grievance resolution time frame. EXECUTIVE SUMMARY Health Colorado, Inc. FY 2022–2023 Compliance Review Report Page 1-8 State of Colorado HCI-R4_CO2022-23_RAE_CR_Report_F1_0623 Regarding disenrollment, Beacon staff members did not report any requests for disenrollment for this review period. However, staff members described a process wherein they would work with the member and provide resources that are necessary to assist the member. If the member moved out of the region, Beacon described the process used to complete a warm hand off to the new region and help the member through the transition. Members could also request disenrollment, and Beacon described how staff would work with members to assist in a smooth transition. However, Beacon reported that the only instances of disenrollment during the review period were due to the member moving out of the region."*

With the findings presented by HSAG, HCI considers the annual EQRO audit to be a success. With that said, HSAG did provide CAPs to HCI for the sections where scores were below 100%. HCI will work alongside HSAG in order to meet all corrective action deadlines and requirements.

- 411 Audits

In FY22-23, HCI conducted its annual Claims and Encounter Validation audit (411 audit). For the third year in a row, the audited services categories were psychotherapy services, residential services, and inpatient services. Results from each of these separate categories are detailed below.

Psychotherapy Services

As presented in the table below, HCI observed a high level of accuracy in the psychotherapy section of the audit. HCI achieved accuracy scores between 90.5% and 95.6%, with an average percentage of accuracy of 94%. HCI's strongest categories of performance, which all achieved accuracy scores of 99%, were:

- Service Category Modifier

- Unit
- Start Date
- End Date
- Appropriate Population

No encounter categories fell below the 90% accuracy threshold.

The table below presents the audit-scoring summary for HCI's response data file for Psychotherapy encounter lines.

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Procedure Code'	R4	Psychotherapy	126	137	92.0%
'Diagnosis Code'	R4	Psychotherapy	127	137	92.7%
'Place of Service'	R4	Psychotherapy	124	137	90.5%
'Service Category Modifier' (Procedure Modifier 1)	R4	Psychotherapy	131	137	95.6%
'Unit'	R4	Psychotherapy	131	137	95.6%
'Start Date'	R4	Psychotherapy	131	137	95.6%
'End Date'	R4	Psychotherapy	131	137	95.6%
'Appropriate Population'	R4	Psychotherapy	131	137	95.6%
'Duration'	R4	Psychotherapy	128	137	93.4%
'Staff Requirement'	R4	Psychotherapy	131	137	95.6%

Residential Services

As presented in the table below, HCI achieved accuracy scores between 97.8% and 99.3%, with an average percentage of accuracy of 99%. HCI's strongest categories of performance, which all achieved accuracy scores of 99%, were:

- Procedure Code
- Place of Service
- Service Category Modifier
- Unit
- Start Date
- End Date
- Appropriate Population
- Duration and
- Staff requirement

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	99.3%
'Diagnosis Code'	R4	Residential	134	137	97.8%
'Place of Service'	R4	Residential	136	137	99.3%
'Service Category Modifier' (Procedure Modifier 1)	R4	Residential	136	137	99.3%
'Unit'	R4	Residential	136	137	99.3%
'Start Date'	R4	Residential	136	137	99.3%
'End Date'	R4	Residential	136	137	99.3%
'Appropriate Population'	R4	Residential	136	137	99.3%
'Duration'	R4	Residential	136	137	99.3%
'Staff Requirement'	R4	Residential	136	137	99.3%

Inpatient Services

As presented in the table below, HCI observed a very high level of accuracy in the inpatient section of the audit. HCI achieved accuracy scores between 92.0% and 99.3%, with an average score of 97%. HCI's strongest categories of performance, which all achieved accuracy scores of 99%, were:

- Revenue Code
- Start Date
- End date

The table below presents the audit-scoring summary for HCI's response data file for Inpatient encounter lines.

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Primary Diagnosis Code'	R4	Inpatient	126	137	92.0%
'Revenue Code'	R4	Inpatient	136	137	99.3%
'Discharge Status'	R4	Inpatient	134	137	97.8%
'Start Date'	R4	Inpatient	136	137	99.3%
'End Date'	R4	Inpatient	135	137	98.5%

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, 2021 through September 2022. In an attempt to create a positive impact on the next 411 audit conducted in FY24, HCI will send out training to providers on the 411 audits, service categories, and common areas of concern. Further,

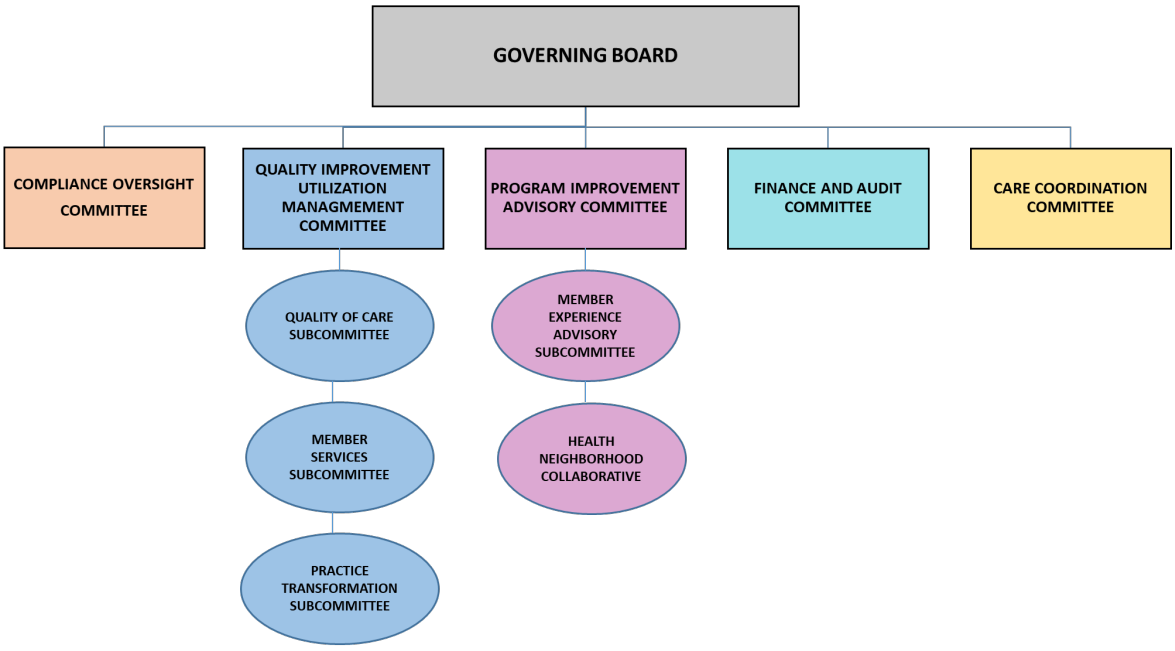
HCI has created additional checks and balances to ensure the accuracy of data received. HCI plans to conduct this activity in FY23-24 as well.

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. For example, the Quality Director serves as a member of the Coordination of Care Subcommittee. This has provided insight into challenges as well as improved clarity around the KPIs, PPMs, and BHIP measures.

As part of ongoing strategic planning efforts, HCI's Board of Directors and Program Officer will collaborate with HCI senior management to review and update the HCI Committee Structure in FY23-24 if necessary. The updated HCI Committee Structure aligns with HCI's Population Health strategic plan and informs HCI's approach to coordinating with stakeholders to meet contractual obligations and actualizing HCI's goals and objectives in service of HCI members. Please refer to the following updated HCI Committee Structure.

Health Colorado, Inc. Committee Structure



In addition, ad-hoc meetings with providers to obtain input from a point of care perspective have begun and will continue. HCI has created a work plan for continued process improvement, which is reviewed quarterly at the HCI QIUM Committee meeting. The details of the work plan are on the final page of this Quality Improvement Plan Document.

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, Carelon staff, members, or other concerned parties can all report quality of care issues. This is typically done 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 FY22-23 and will continue with reporting to HCPF as required in FY23-24. In FY22-23, all founded quality of care complaints have been reported to the State quarterly in preparation for the upcoming contractual changes for the Quality of Care Grievance (QOCG) process.

HCPF recently informed HCI of an upcoming change to Quality of Care investigation and reporting requirements. The Department of Healthcare Policy and Finance (HCPF) has notified the RAE of changes in the investigation and reporting requirements for the Quality of Care and Grievance processes. HCPF has determined that quality of care concerns and grievances are to be combined wherein, the definition will include both grievances and potentially significant patient issues to be known as Quality of Care Grievances.

Carelon, has begun the process to update workflows, policy and procedures, and reporting forms to include notifying the Department of all reported Quality of Care Grievances, utilizing Department required reporting form, and increase number of Quality of Care Committee (QOCC) meetings to meet the shortened investigatory timelines. Carelon will continue to review updated Department requirements and contractual changes to remain compliant with Department requirements. Upon receipt of this information, planning has begun in conjunction with Quality, Office Member and Family Affairs, and Clinical Department staff along with the Medical Director to develop improved workflows, updated Policies and Procedures, and best practices for reporting and investigation. As further guidance is received, adjustments will be made to ensure continued compliance with HSAG contractual requirements.

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 71 adverse incident reports during FY22-23, which was an increase from the 61 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. They will continue to be maintained by the HCI QOCC in FY23-24.

3. Quality Program Leadership

John Mahalik , Ph.D., MPA Director of Quality Assurance [redacted]	**Jeremy White, MA** Manager of BH Clinical Quality [redacted]
Stephanie Miller-Olsen BH Clinical Quality Audit Analyst, Senior [redacted]	**Courtney Hernandez, MS-HSV** BH Clinical Quality Audit Analyst, Senior [redacted]
Edward Arnold, MSN, BSN, BSE, CPHQ Performance Improvement Analyst [redacted]	**Andrea Zasowski** BH Clinical Quality Audit Analyst, Senior [redacted]
Melissa Schuchman, MA Business Info Analyst II [redacted]	**Anna Pittar-Moreno** BH Clinical Quality Audit Analyst [redacted]
Mikaela Smyth BH Clinical Quality Audit Analyst, Senior [redacted]	**Lori Roberts** Chief Executive Officer/Program Officer [redacted]
Sarah Nelson Director of Operations [redacted]	

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 29, 2023

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.

Goal	Fiscal Year 23-24 Project/Initiative	Targeted Completion Date	Status
Performance Improvement Projects			
ED SUD Follow-up By June 30, 2023, increase the percentage of members ages 13 and older with an emergency department (ED) visit with a principal diagnosis of SUD or any diagnosis of drug overdose who receive a follow-up within seven days of the ED discharge to achieve a statistically significant improvement rate of 30.04%. NOTE: Goal listed above is based on baseline period CY22 data. Official statistically significant goal will be established using baseline period FY22-23 once full baseline calculation is available with October 31, 2023, submission.	To increase clinically appropriate follow-up after ED encounters related to SUD &/or drug overdose, HCI will develop evidence-based interventions, test intervention effectiveness, disseminate impactful interventions throughout the region, and implement sustainability plans for those interventions. This work will start with a focus on the ED provider with the largest qualifying member encounters in the region and a significant opportunity for improvement, Parkview Medical Center.	Clinical PIP Measure Selection Form was submitted on July 31, 2023. Initial PIP submission form due: October 31, 2023. PIP Intervention worksheet due: June 30, 2024.	Upon approval of the Clinical PIP Measure Selection Form from HCPF, next steps will be initiated.

SDOH Screening By June 30, 2023, increase the percentage of HCI members who utilize a behavioral health (BH) service and receive a SDOH screening to achieve a rate of 5.0%. NOTE: Goal listed above is based on baseline period CY22 data. Official statistically significant goal will be established using baseline period FY22-23 once full baseline calculation is available with October 31, 2023 submission.	To increase HCI awareness of SDOH screening data across the region with a focus on members who utilize BH services, initial efforts will focus on systematic collection and reporting of SDOH screening data currently being performed. Follow-up efforts will be developed based on information obtained during initial phases. Potential partners will be recruited at QIUM in September 2023 to initiate pilot PIP work on performing SDOH screening, transmitting screening results to HCI, and aggregation of screening data. Data collection on SDOH screening included as part of care coordination intake will be integrated with other SDOH results.	Initial PIP submission form due: October 31, 2023. PIP Intervention worksheet due: June 30, 2024.	Upon approval from HCPF of initial PIP submission form, next steps will be initiated.

Quality Improvement Plan
Name: Health Colorado, Inc.
RAE: 4
Date: September 29, 2023

Goal	Fiscal Year 23-24 Project/Initiative	Targeted Completion Date	Status
Performance Measurement Data Driven Projects			
Achieve incremental improvement for each KPI based on goal-setting methodology by HCPF. Most KPI measures have quarterly goals that increase incrementally through the year. Measures without quarterly goals are reflected accordingly.	**Depression Screening and Follow-up (Screening)** Quarter 1 = 18.84%, Quarter 2 = 20.31%, Quarter 3 = 22.14%, Quarter 4 = 23.96% **Depression Screening and Follow-up (Follow-up Plan)** Quarter 1 = 16.54%, Quarter 2 = 18.23%, Quarter 3 = 19.92%, Quarter 4 = 21.62% **Oral Evaluation/Dental Services** Quarter 1 = 48.30%, Quarter 2 = 49.12%, Quarter 3 = 49.93%, Quarter 4 = 50.74% **Well Visits Part 1 (0-15 months)** Quarter 1 = 43.2%, Quarter 2 = 44.1%, Quarter 3 = 45.1%, Quarter 4 = 46.0% **Well Visits Part 1 (15-30 months)** Quarter 1 = 59.03%, Quarter 2 = 59.51%, Quarter 3 = 60.00%, Quarter 4 = 60.49% **Well Visits Part 2 (3-21 years)** Quarter 1 = 37.14%, Quarter 2 = 37.81%, Quarter 3 = 38.47%, Quarter 4 = 39.13% **Prenatal Engagement and Post-Partum Care (Prenatal)** Quarter 1 = 64.71%, Quarter 2 = 65.41%, Quarter 3 = 66.11%, Quarter 4 = 66.81% **Prenatal Engagement and Post-Partum Care (Post-Partum)** Quarter 1 = 50.85%, Quarter 2 = 51.70%, Quarter 3 = 52.55%, Quarter 4 = 53.40% **Emergency Department Visits PKPY** *Note: Reverse measure*	June 30, 2024	**Depression Screening and Follow-up Plan:** Practice Transformation (PT) coaching and clinical guidelines, pre-visit planning, team-based care, and/or outreach. **Oral Evaluation/ Dental Services:** Ad hoc text campaigns for all members to be screened at least yearly. Members ages 20 and under receive an IVR call. Collaboration with DentaQuest will continue into the next fiscal year. It is here that we will continue to leverage our partnership to attempt to increase dental services to our members. **Well Visits Part 1 (0-15 months):** PT coaching and clinical guidelines, pre-visit planning, team-based care, and/or outreach. IVR and text campaigns to members who have not had a well visit. **Well Visits Part 1 (15-30 months):** Activities for FY 23-24 include:

	Tier 1 is a 1% improvement from baseline, Tier 2 is greater than a 5% improvement from baseline. Tier 1 = 466.64 and Tier 2 = 447.78 **Risk-Adjusted PMPM** *Note: Reverse measure* Two payment tiers are available. 100% payment is awarded for performance less than the ACC average risk adjusted PMPM. 50% payment is awarded for any improvement in risk adjusted PMPM from RAE baseline. Baseline: $400.15		PT coaching and clinical guidelines, pre-visit planning, team-based care, and/or outreach. IVR and text campaigns to members who have not had a well visit. **Well Visits Part 2 (3-21 years):** PT coaching and clinical guidelines, pre-visit planning, team-based care, and/or outreach. IVR and text campaigns to members who have not had a well visit. **Prenatal and Post-Partum Care:** HCI (Elevance) Maternity Care Program **ED Visits PKPY:** Care Coordination transitions of care workflows. PT coaching on access to care. **Risk-Adjusted PMPM:** PT coaching and clinical guidelines, pre-visit planning, team-based care, and/or outreach, Care Coordination/Care Navigation/Condition Management programs; patient engagement outreach.
Achieve an improvement of 10% over the performance gap for each BH measure by June 30, 2024.	**Initiation and Engagement of SUD Treatment (Engagement)** Goal = 12.84%	June 30, 2024	**Initiation and Engagement of SUD Treatment (Engagement):**

	Follow-Up after Hospitalization for Mental Illness Goal = 80.41% **Follow-Up after ED Visit for Substance Use** Goal = 28.45% **Part 1: Depression Screening** Goal = 48.61% **Follow-Up after a Positive Depression Screen** Goal = 53.37% **BH Screening or Assessment for Children in the Foster Care System** Goal = 27.53%		This measure continues to be the measure focus for the BH PT program. Practices are incentivized to implement Plan-Do-Study-Act (PDSA) cycles to target performance on this measure. **Follow-Up after Hospitalization for Mental Illness** A new measure specification has been initiated this FY in line with the CMS core measure. HCI will continue to monitor performance on this measure and may reengage with the PMAP workgroup currently on hiatus with Peakview Hospital should performance decline. **Follow-Up after ED Visit for Substance Use** The group working on ED SUD Follow-up continues to include a multidisciplinary group from Parkview Medical Center and Health Solutions and their work will align with the HCPF-mandated clinical PIP. **Part 1: Depression Screening** The PT team will be focusing this FY on

			improving performance on this measure and the similar KPI measure (Depression Screening & Follow-up Plan) through workflow optimization and education on G-code use. **Follow-Up after a Positive Depression Screen** Goal = 53.37% This measure will continue to be followed through Power BI dashboards with awareness on the potential impact of increased depression screening performed due to focused efforts on KPI and BHIP measures. **BH Screening or Assessment for Children in the Foster Care System** Weekly lists of youth with Aid Code change sent to CMHCs for follow up. PMAP workgroup revived in September of 2023 with Pueblo DHS data-sharing agreement signed. A PMAP workgroup for FY23-24 will reengage with work that began in FY22-23 with Pueblo DHS related to the BH Follow-up for Children New to Foster

			Care measure. With the recent clearance of legal signatories to initiate a data-sharing agreement, HCI intends to initiate a pilot project to reduce delays in foster care notifications in order to coordinate appropriate BH engagement for these vulnerable members.
Performance Pool Achieve an improvement of 10% over the performance gap for each PPM by June 30, 2024.	**Extended Care Coordination** Goal = 23.47% **Preterm Birthrate** Goal = 8.57% **DOC Engagement** Goal = 24.70 (All RAEs) **Asthma Medication Ratio** Goal = 44.36% **Antidepressant Medication Management – Acute** Goal = 65.46% **Antidepressant Medication Management– Continuation** Goal = 42.37% **Contraceptive Care for Postpartum Women** Goal = 43.10%	June 30, 2024	**Extended Care Coordination (ECC)** HCI Care Coordination Policy has been updated to include quarterly expectations and audits of ECC performance for each care coordination entity. CAPs will be required for failure to improve performance in FY 23-24Q1/Q2 or achieve RAE targets in FY 23-24Q3/Q4. Workflow and data management coaching will be provided as needed. **Preterm Birthrate** The Elevance Maternity Care program continues to be implemented across the region to target women with high-risk pregnancies. Risk-stratification tools are used to identify this population and provide them with targeted care coordination using

			evidence-based intervention demonstrated to decrease neonatal intensive care admissions and pregnancy complications. The MyAdvocate program supports women identified as low or medium risk. The Healthy Rewards Program also provides incentives to all women to complete key milestone care elements (e.g., first prenatal check.) **DOC Engagement** HCI's Care Coordination model continues to focus on multisystem involved groups that include Justice System and Department of Corrections (DOC) involved members. Team meetings and training for care coordinators on Complex Solutions facilitate coordination of care for this vulnerable population and should facilitate improved performance on this BH engagement. **Asthma Medication Ratio** The asthma condition management program is

			available to all care coordination entities to utilize as appropriate for members receiving care coordination. Focus populations include the Care Management cohort with medical complexity complicated by asthma, and the Care Navigation cohort with gaps in care related to asthma management. **Antidepressant Medication Management – Acute** The depression condition management program is available to all care coordination entities to utilize as appropriate for members receiving care coordination. Focus populations include the Care Management cohort with medical complexity complicated by depression, and the Care Navigation cohort with gaps in care related to depression management. **Antidepressant Medication Management– Continuation** The depression condition management program is available to all care coordination entities to utilize as

			appropriate for members receiving care coordination. Focus populations include the Care Management cohort with medical complexity complicated by depression, and the Care Navigation cohort with gaps in care related to depression management. **Contraceptive Care for Postpartum Women** The Elevance Maternity Care program continues to be implemented across the region to support women during their pregnancy and through the post-partum period. Targeted outreach continues through the post-partum period.

Goal	Fiscal Year 23-24 Project/Initiative	Targeted Completion Date	Status
Member Experience of Care Improvement Driven Projects			
HCI will work with HCPF to support survey initiatives, evaluate responses, and formulate interventions to address areas of low satisfaction.	HCI will continue to support HCPF in this initiative. CAHPS data will be tabulated and performance scores across categories will be aggregated. Based upon the survey results, HCI will identify areas of low performance and implement appropriate interventions in FY23-24.	June 30, 2024	When survey results are received, they will be 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. HCI will take the results of the CAHPS data received in FY24 and implement targeted interventions where low satisfaction scores are reported.
	Your Opinion Matters (YOM) is an internal survey that seeks to gain member insight into access-related issues and opinions on satisfaction with services rendered.	June 30, 2024	HCI will begin to advertise the survey as a pop-up icon on its web page. The intent is to have an accessible icon that members can easily see, thus increasing accessibility to the member survey. In addition, HCI will begin to utilize its social media platforms to advertise the survey. In conjunction with the YOM survey, HCI will begin to look at shareholder member survey data and compare the outcomes against the CAHPS and the YOM data where applicable. HCI continues to conduct outreach to members who indicate on the survey that they would like a follow up contact. In FY22-23, 71 members have taken the survey and [redacted] members 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. Any downward trends detected in the survey responses will be reviewed at QIUM, and discussions will be held for possible interventions
			ECHO surveys were not conducted during FY22-23 but may be incorporated in FY23-24. HCI will present results regionally and will look to work with clinical sites to improve performance as necessary.

Goal	Fiscal Year 23-24 Project/Initiative	Targeted Completion Date	Status
Over and Under Utilization of Services Projects			
Improve overutilization through implementation of The Client Overutilization Program (COUP), also known as "Lock-in." Evaluate the effectiveness of the COUP pilot programs by analyzing both quantitative and qualitative member level data for members recommended for lock-in status.	The COUP lock-in diversion program continues to operate in Region 4 for COUP members to address overutilization of services. The COUP program continues to look at the over utilization of pharmacy and ED services that would make a member appropriate for lock-in services through the RAE. Collaborative efforts with care coordination entities to monitor utilization continue to occur region wide. Care coordinators continue to focus on an integrated, robust, whole-person care plan development and improvement to support COUP members on lock-in and the COUP list. In alignment with best practices, HCI	June 30, 2024	HCI will continue efforts to monitor the utilization of services by members through the COUP outreach and lock-in diversion and lock-in programs. COUP lists are distributed to care coordinators to outreach and engage in care coordination quarterly. Care coordination entities have the option to enroll members in the lock-in program quarterly. HCI audits the performance of our

	care coordinators continue to focus our COUP lock-in intervention on members who have been on the COUP list for two consecutive quarters and have qualified for COUP Diversion by using six or more high-risk prescriptions, having filled prescriptions from three or more different pharmacies, or from three or more different prescribers. Literature on lock-in programs and best practices from around the country indicates that lock-in interventions provide the most cost savings and outcome improvement if used as part of a broader drug utilization review strategy for members who overuse or misuse certain medications, primarily controlled substances. HCI hopes to demonstrate that this focus will direct limited intensive resources to clients needing this level of support and decrease emerging costs for the complex population.		delegated care coordination entities annually. HCI has also initiated quarterly COUP meetings with all of our delegated entities to share regional best practices, lessons learned, successes, challenges, and plans for improvement.
Monitor and improve underutilization demonstrated through an improvement of 10% over the performance gap in identified BH measures.	**Initiation and Engagement of SUD Treatment (Engagement)** Goal = 12.84% **Follow-Up after Hospitalization for Mental Illness** Goal = 80.41% **Follow-Up after ED Visit for Substance Use** Goal = 28.45% **Part 1: Depression Screening** Goal = 48.61% **Follow-Up after a Positive Depression Screen** Goal = 53.37% **BH Screening or Assessment for Children in the Foster Care System**	June 30, 2024	BH utilization trends by member, facility, and service type will continue to be monitored monthly and reviewed at the monthly QIUM committee meeting. Chart audits are regularly conducted over a wide variety of service modalities. HCI audits mental health providers, substance use outpatient providers, detox, mental health and SUD residential treatment facilities, mental health and SUD inpatient facilities, mental health and SUD intensive outpatient facilities,

	Goal = 27.53%		targeted case management, and medication assisted therapy (MAT). All audits focus on the appropriateness of services provided in order to ensure proper utilization. Fraud, Waste, and Abuse are also areas that these audits can address. HCI will continue to monitor performance on these measures through the tracking and trending of performance data. **Initiation and Engagement of SUD Treatment (Engagement):** This measure continues to be the measure focus for the BH PT program. Practices are incentivized to implement PDSA cycles to target performance on this measure. **Follow-Up after Hospitalization for Mental Illness** A new measure specification has been initiated during FY 23-24 in line with the CMS core measure. HCI will continue to monitor performance on this measure and may reengage with the PMAP

			workgroup currently on hiatus with Peakview Hospital should performance decline. **Follow-Up after ED Visit for Substance Use** The group working on ED SUD follow-up continues to include a multidisciplinary group from Parkview Medical Center and Health Solutions. Their work will align with the HCPF-mandated clinical PIP. **Part 1: Depression Screening** The PT team will be focusing FY 23-24 on improving performance on this measure and the similar KPI measure (Depression Screening & Follow-up Plan) through workflow optimization and education on G-code use. **Follow-Up after a Positive Depression Screen** Goal = 53.37% This measure will continue to be followed through Power BI dashboards with awareness on the potential impact of increased depression screening performed due

			to focused efforts on KPI and BHIP measures. **BH Screening or Assessment for Children in the Foster Care System** Weekly lists of youth with Aid Code change sent to CMHCs for follow up. PMAP workgroup revived in September of 23 with Pueblo DHS data-sharing agreement signed. A PMAP workgroup for FY23-24 will reengage with work that began in FY22-23 with Pueblo DHS related to the BH Follow-up for Children New to Foster Care measure. With the recent clearance of legal signatories to initiate a data-sharing agreement, HCI intends to initiate a pilot project to reduce delays in foster care notifications to coordinate appropriate BH engagement for these vulnerable members.

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs Projects			
Increase performance on the DOC Engagement PPM Goal = 24.70 (all RAEs)	**DOC Engagement** HCI's Care Coordination model continues to focus on multisystem-involved groups that include Justice System and DOC involved members.	June 30, 2024	Efforts are underway to coordinate with Carelon's Clinical Department and PMAP team to identify strategies to positively

	Team meetings and training for care coordinators on Complex Solutions facilitate coordination of care for this vulnerable population and should facilitate improved performance on this BH engagement measure.		affect performance for this special population. One such activity is a training taking place on September 6, 2023. This training will be provided to all care coordination entities in the HCI region. The focus of the training will address education regarding timely outreach and assistance with scheduling follow-up appointments for the DOC population.

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
Quality of Care Monitoring			
Identify and address 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 subcommittee of the QIUM Committee. The purpose of the 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 the Quality Management Department, and findings are evaluated for appropriate follow-up, corrective action, and monitoring. Provider treatment record documentation audits, and provider education are ongoing and occur individually in areas where scores indicate problems are evident. If	June 30, 2024	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, and other concerned parties can report quality of care issues through an Adverse Incident reporting form submitted to the Quality Department. All Quality of Care issues are documented, as are results of investigations. Corrective actions are tracked and monitored.

	improvement is not seen, the corrective action process is initiated. Audits include a review of encounters/claims against the chart documentation.		Reporting, investigation, and tracking of adverse incidents through the Quality Management Department continued during the previous 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 71 adverse incident reports during FY22-23, which was an increase from 61 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 monthly or as needed. Overall, there has been a gradual increase in adverse incidents and a decrease in 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, and reminders with reporting tip sheets are sent out biannually. HCI will continue to schedule quarterly trainings throughout FY23-24, the first of which is scheduled for September 28, 2023. The dates of the trainings provided in FY2023 were: • September 29, 2022 • December 13, 2022 • March 30, 2023 • June 22, 2023 Quality of Care issues including concerns raised by HCPF, 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. HCI has finalized a process for Quality of Care reporting to HCPF; however, recent information regarding change to Quality of Care investigation and reporting requirements (PA06 QOCG) has prompted process and implementation planning in conjunction with the

			Quality Department, Office of Member and Family Affairs, and Clinical Department teams along with the Medical Director. Initial steps to develop updated workflows, policies and procedures, reporting, and investigatory best practices have begun. The Quality of Care Grievance (QOCG) process will integrate the former Complaint/Grievance process with the quality of care investigation process. HCI will take action to address all QOCGs within the region and will process and respond to all QOCGs by reporting the issue to HCPF, completing investigations as needed, and reporting the outcomes back to HCPF as required. As further guidance is received, adjustments will be made to ensure continued compliance of HSAG contractual requirements.

Goal	Fiscal Year 22-23 Project/Initiative	Targeted Completion Date	Status
External Quality Review Driven Projects			
HCI will collaborate with HSAG and HCPF on the completion of the annual External Quality Review, and complete corrective actions as determined by HSAG.	HCI underwent an EQRO audit in April of 2023 and will continue to undergo audits annually. Aggregate scores related to the annual FY22-23 EQRO audit for HCI netted an overall score of 92%. The individual scores presented below demonstrate HCI's dedication to excellence. I. Coverage and Authorization of Services: 94% II. Adequate Capacity and Availability of Services: 86% VI. Grievance and Appeal Systems: 91% XII. Enrollment and Disenrollment: 100% As a result of the annual audit, HCI was issued five CAPs.	The targeted completion date is determined by HSAG.	Stemming from the FY22-23 EQRO audit, three standards were issued a corrective action. HCI has submitted the CAP plan for each of the corrective actions levied to HSAG. HSAG has approved the CAP plans and HCI will be submitting the supportive documents in October 2023. HCI was issued five corrective actions related to partially met requirements. The Corrective Action Plans are as follows: <u>Standard I</u>-Coverage and Authorization of Services: • HCI must enhance its procedures and monitoring to ensure that all member notices are sent within time frame requirements. • HCI must update its Medical Necessity Determination Timelines policy and any supporting documentation to clarify that the notification time frame is based on the date of

			the service request until the deadline. <u>Standard II</u>-Adequate Capacity and Availability of Services: • HCI must correct the timely appointment standards in the PCP Practitioner Agreement. • HCI must develop a way to identify its Region 4 membership and gain an understanding of the membership's cultural norms and practices and how they may affect access to healthcare. HSAG suggests a review of current data, utilization trends, cultural subgroups, and community partners as sources of information to explore. HCI has an opportunity to come into compliance through upcoming work that will be part of the Health Equity Plan. <u>Standard VI</u>-Grievance and Appeal Systems: • HCI must update the following documents

			to remove language that the member must follow a verbal appeal request with a written request. Additionally, HCI must share updated documentation with other staff members to ensure awareness of the updated requirement. ○ Appeal Job Aid, page 2, stated the "appeal must be signed by the member." ○ Appeal Guide, page 4, in the section "What is the Difference between a Quick Appeal and Standard Appeal?" point 2 stated that "You do need to follow up a verbal standard appeal request in writing," which is incorrect. ○ 305L Appeal Policy, page 12, section J.2, inaccurately stated that the coordinator or specialist must attempt to get a signed appeal request from the member. ○ Appeal Form, which can be found online, inaccurately stated at the bottom of the page, "Please know that we cannot process this appeal

			until you sign and return this letter. We have provided a self-addressed stamped envelope." ● HCI must make reasonable efforts to notify the member of an extension and must enhance documentation of such attempted communications between the member and staff member. HCI must update the Appeals Policy to include that the coordinator will make reasonable efforts to notify the member of an extension. In FY24, HCI will be submitting evidence of compliance with the following standards: Member Information Requirements, Provider Selection & Program Integrity, Sub-contractual Relationships & Delegation, and Quality Assessment & Performance Improvement.
Annual Claims and Encounter Audit (411 Audit)	To assess the accuracy of submitted claims and encounters, HCI undergoes an annual claims and encounter validation audit each year. The purpose of this audit is to assess service coding accuracy in submitted claims and	March 2024	As in past 411 audits, HCI performed very well across the three service categories audits. Aggregate scores reflected a high level of

	encounters. The following three services categories were audited in FY22-23: residential services, psychotherapy services, and inpatient services.		confidence in accuracy of the submitted claims and encounters. HCI observed a high level of accuracy in all three sections of the audit. HCI achieved accuracy scores between 90% and 99% spanning all encounter service categories. HCI observed a high level of accuracy in the psychotherapy section of the audit. HCI achieved accuracy scores between 90.5% and 95.6%, with an average percentage of accuracy of 94%. HCI's strongest categories of performance, which all achieved accuracy scores of 99% were: • Service Category Modifier • Unit • Start Date • End Date • Appropriate Population No encounter categories fell below the 90% accuracy threshold. HCI achieved accuracy scores between 97.8% and 99.3%, with an average percentage of accuracy of 99%. HCIs strongest categories of performance, which all

			achieved accuracy scores of 99% were: • Procedure Code • Place of Service • Service Category Modifier • Unit • Start Date • End Date • Appropriate Population • Duration • Staff requirement HCI observed a very high level of accuracy in the inpatient section of the audit. HCI achieved accuracy scores between 92.0% and 99.3%, with an average score of 97%. HCI's strongest categories of performance, which all achieved accuracy scores of 99% were: • Revenue Code • Start Date • End Date To maintain high confidence in the accuracy of submitted claims and encounters, HCI created and disseminated training on the 411 audits to its provider network. This training, when administered to the provider network, will generate continued high

			performance in future 411 audits. In addition, HCI will work with providers if and when they fall below the 90% threshold in a quality improvement project as directed by HCPF.

Goal	Fiscal Year 23-24 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 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	June 30, 2024	HCI hosted four regional PIAC meetings via Zoom/MS Teams in July 2022, October 2022, January 2023, and April 2023. PIAC meeting minutes and documentation are posted on the HCI website for members, providers, and stakeholders. Access 2 Sign Language provides interpretation for deaf and hard of hearing attendees. Each meeting includes State PIAC updates, regional MEAC updates, Health Neighborhood Forum updates, and community and provider updates. Further, guest speakers present at these meetings on topics such as RAE 4 Hospital Transformation Program (HTP) efforts and the HCI Performance Measures Improvement Strategy. This approach allows attendees to learn about programs and initiatives in our region and to hear information directly from the subject matter experts. HCI

	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, HCI will participate in multi-disciplinary statewide advisory committees and learning collaboratives for the purposes of monitoring the quality of the program overall and guiding the improvement of program performance. HCI 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.		regional PIAC topics included the following: • The Public Health Emergency (PHE) • Connect for Health Colorado • Cultural competency • Health Equity, Diversity, Inclusion & Accommodation (HEDIA) roundtable • HTP presentations • Performance Measures Improvement Strategy The meetings also allowed time for discussion of other relevant topics. During the July 2022 meeting, Southeast Colorado Hospital and Weisbrod Community Hospital leaders spoke to their RAE 4 HTP efforts. This presentation sought to promote a better understanding of HTP, including the HTP timeline. The presentation also sought to provide an understanding of community engagement strategies and to provide feedback on SDOH. The HTP presenters referenced their process for selecting performance measures, implementation strategy, and potential impact on HCI members. The HTP presenters also spoke about social needs screening and notification, including screening for utility assistance, food, transportation, and housing.

			The HCI PIAC responded to several discussion questions facilitated by the HTP presenters to further inform HTP efforts in Region 4. During the October 2022 meeting, HCI's Quality Management Performance Improvement Specialist presented and revisited the HCI Performance Measures Improvement Strategy, specifically focusing on the following three strategic goals and activities: • Performance Measure Strategy 1: Excellent bi-directional HCPF communication around performance measures (HCI Performance Measures Strategy Workgroup) • Performance Measure Strategy 2: Improve timeliness and accuracy of internal performance measures data (HCI Performance Measures Data Workgroup) • Performance Measure Strategy 3: Win all performance measures (HCI Performance Measures Strategy Workgroup) During the January 2023 meeting, the Colorado Health Institute (CHI) presented and facilitated discussion to gather feedback on ACC 3.0. CHI discussed the intent of the Accountable Care Collaborative (ACC):

			• Delivers cost effective, quality health care services to Health First Colorado members to improve the health of Coloradans. • Coordinates regional physical and BH care services to ensure member access to appropriate care. CHI also noted the ACC 3.0 timeline and goals. <u>ACC Timeline:</u> • Spring/summer 2023 – concept papers • November 2023 – draft request for proposal • April 2024 – request for proposal • September 2024 – vendor awards • July 1, 2025 – go live <u>ACC Goals:</u> • Improve quality care for members • Close health disparities and promote health equity • Improve care access • Improve the member and provider service experience • Manage costs to protect member coverage and benefits as well as provider reimbursements CHI facilitated a JamBoard exercise posing the following questions and responses: • What is currently working well with RAE performance indicators focused on quality, access, and customer

			service? What is not working well? What opportunities exist to promote greater equity? • *There is a focus on integrated care and measures that pull in both primary care and BH care. KPIS and other metrics reflect this.* • *Appreciate HCPF is working to provide advance specifications for performance measurement versus months after it has been implemented.* • *Appreciate discussion about incorporating health equity into every measure we use. HCI has specific performance strategy to incentivize providers to improve.* • *The number of metrics can be a challenge. They must be meaningful and measurable.* • *Measures changing rapidly can be a challenge.* • *Metrics are not very well aligned from the practice level up through the HCPF level. BH metrics are very limited and non-standardized.* • How can Phase III promote team-based care and non-traditional health workers like doulas, peer support services, and community health workers? • *Reviewing provider reimbursement and capacity to better align role expectations to avoid creating additional work,*

			including duplicative reporting on measures. • *Next HCI meeting will have a presenter from CO Home Visiting Coalition to speak to best practices.* • *Grant funding may be able to incentivize this if it is not already available.* • HCPF is seeking feedback on current PCMP requirements. What is and is not working? What changes would promote greater accountability? • *Workforce challenges are constantly an issue.* • *Suggest HCPF require and pay for Patient Centered Medical Home recognition/ certification. Example: https://www.health.ny.gov/technology/nys_pcmh/* • *"Require" may not be the right term. "Incentivize through payment increases" might be better for incentivizing PCMH.* • *RAEs only pay PMPM and incentives, which makes it difficult to look at PCMPs and assess what requirements they are and are not following.* • *Practices vary greatly within the region in regard to the implementation of an equitable payment model that pays all providers for serving all members, regardless of practice size.* • How can HCPF and RAEs ensure care coordinators are addressing the unique needs

			of various populations and leveraging the right partners? • *Region 4 is unique and has a large landscape.* • *The definition of complex care really targets members so we can provide appropriate level of care coordination.* • *Case Management Agencies (CMAs) such as Community Centered Boards (CCBs) and Single Entry Points (SEPs) work with members with some of the highest needs--and costs--in the system. RAEs are not incentivized to offer these entities the resources and information the RAEs have that these organizations need.* • *Collaboration happens with the member in every practice. When they leave a practice, what happens? How to ensure that services continue?* • What should HCPF consider as it works to standardize data collection and reporting on care coordination across the RAEs? • *A standardized referral process for all RAEs* In the April 2023 meeting, Dr. Laura Knudtson, Director of the Colorado Home Visiting Coalition, presented on the Colorado Home Visiting Program to provide a basic understanding of what is meant by home visiting, share

			the models operating in Colorado, and introduce a tool for finding home visiting programs operating in a given area. Dr. Knudston noted that home visiting is an ongoing relationship, and home visitors partner with parents to provide tools, supply information, and connect them to resources so infants and young children are healthy with the following program outcomes: • Better pregnancy outcomes • Improved school readiness • Reduced child welfare involvement • Economic self-sufficiency • Better health outcomes • Stronger parent-child bonding • Connection to resources • Reduced parental isolation • Increase in positive parenting practices • Healthier child development • Reduced child maltreatment • Reduced foster care placement During the April 2023 meeting, the Southeast Colorado Hospital District presented on the RAE 4 HTP, noting Southeast Colorado Hospital is in the furthest southeast corner of Colorado with a population of 3,514. It is the only hospital in the county, and services 2,557 square miles. Southeast Colorado Hospital District provided the following

			HTP updates, challenges, and next steps: <u>Updates:</u> • Patient Information to the RAEs • Ensuring Patient Follow-Up from an Inpatient Stay • Patient Follow-Up Compliance • Data Collection Analysis and Dashboard Development • Bridging Social and Clinical Patient Needs • CHA ALTOS Program <u>Challenges:</u> • Small work staff doing multiple projects • Staff lack skills to do some projects • RAEs and Case Managers for patients not on same page • Not acknowledged due to small population base • Lack of IT resources • Lack of communication <u>Next Steps:</u> • Hitting the milestones • Keeping the community engaged • Keeping communications open

Fiscal Year 2023-2024 Quality Management Work Plan Goals/Quality Monitoring and Compliance Activities

The goals for the FY23-24 work plan have also been created and approved by the QIUM. The performance goals for FY23-24 are as follows:

GOAL #1: Further develop the continued monitoring of KPIs, BHIPs, and PPMs. Implement targeted interventions where applicable.
GOAL #1A: Invite stakeholders to HCI Performance Measures workgroup, establish learning collaborative via HCI QIUM Committee and workgroup, target low performing measures.
GOAL #1B: Target low performing measures, identify countermeasures, monitor performance.
GOAL #2: Quarterly or when applicable, monitor results of performance improvement project.
GOAL #3: Conduct regularly scheduled documentation audits and offer education based upon audit results.
GOAL #4: Complete QM program documents annually.
GOAL #4A: Complete an evaluation on the progress on the previous year's goals and use it to determine goals for the upcoming year.
GOAL #4B: Monitor progress on new goals over the course of the fiscal year and adjust goals as needed.
GOAL #5: As part of the Population Health team along with RAE leadership, identify opportunities to expand upon the existing PT framework and provide support to population health initiatives.
GOAL #6: Ensure monitoring of member surveys. Implement targeted interventions where applicable.
GOAL #7: Semiannually or when applicable, monitor the average turnaround time for complaints and grievances.
GOAL #8: Ongoing monitoring of EQRO activities. Implement targeted interventions where applicable.
GOAL #9: Ongoing monitoring of quality of care concerns and related activities. Implement targeted interventions where applicable.
GOAL #9A: Conduct regular quality of care and grievance monitoring
GOAL #10: Quarterly or when applicable, monitor the results of the Access to Care provider audits.