Annual Quality Report

State Fiscal Year 2022-2023

Northeast Health Partners, LLC

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Section 1. Executive Summary

Northeast Health Partners, LLC (NHP) is the Regional Accountable Entity (RAE) for Region 2; the northeast portion of Colorado representing 10 counties spanning more than 20,000 square miles and including more than 100,000 eligible members as of the end of state fiscal year (SFY) 2022/2023 (July 1, 2022 – June 30, 2023). NHP is the only nonprofit RAE with a designated 501(c)(3) status and was founded by four safety-net provider organizations serving the region: Sunrise Community Health, Salud Family Health Centers, North Range Behavioral Health, and Centennial Mental Health Center. NHP also utilizes Carelon Behavioral Health (Carelon, formerly Beacon Health Options) as its contracted Administrative Services Organization (ASO).

The Quality Improvement (QI) program at NHP is responsible for programs and initiatives focusing on improving health outcomes for Health First Colorado (Medicaid) members. The QI program at NHP spans performance tracking, business intelligence, practice transformation, care coordination, and population health initiatives across physical health, behavioral health, and care coordination to ensure programmatic decision-making is data-driven, efficient, strategically aligned, and focused on continual improvement.

This report summarizes the activities, deliverables, accomplishments, barriers, and major programmatic impacts within the NHP QI Program through SFY22/23. Activities around COVID-19 are included where warranted as the Public Health Emergency (PHE) remained in effect throughout most of the fiscal year.

Report Changes

This report has several changes when compared to the reports of previous years. Namely, the Network Adequacy section has been removed. While network adequacy ensures available access to care and the ability to deliver quality care to members, key components of network adequacy including geoanalysis, provider outreach, and contracting and credentialing fall to the Network Management Program. The Network Management Program has its own strategic plan and its own reporting mechanisms including the quarterly Network Adequacy Report where total providers, time and distance standards, service gaps, and provider outreach and credentialing activities are reported. As a result, the activities and results around Network Adequacy have been removed to eliminate duplicative reporting efforts across deliverables.

Previous reports also noted the Potentially Avoidable Complications (PAC) activities. The PAC activities were discontinued after the SFY21/22 year. PAC activities were not included in the SFY22/23 Quality Plan and are not discussed as a program in this report. Additionally, this programmatic removal led to changes in the KPI and Performance Pool metrics. Specifically, the Risk-Adjusted PMPM measure was moved from the Performance Pool measure set to the KPI measure set. This change is noted in this report under these sections. Further, the dental KPI measure changed during the SFY22/23 year to align with core measures, and also includes quarterly goals instead of an annual goal.

Lastly, Monkeypox was previously reported as a potential public health threat at the close of the SFY21/22 year and was included in the previous year's report as an emerging disease with potential impacts on performance measures. However, infection rates remained relatively low, and the Colorado Department of Public Health and Environment (CDPHE) stopped tracking infection rates in March of 2023 after no cases were reported in February of 2023.[1] As a result, Monkeypox is not discussed in this report as its impact on performance measures was likely insignificant.

NHP Quality Improvement Program Overview

The Quality Improvement program creates and oversees regional activities focused on improving service delivery to regional members. In SFY22/23, the QI team at NHP met performance goals, provided contract deliverables on time, and developed regional collaborations to improve healthcare delivery. Administrative support for the QI Program continued under Carelon, with oversight provided by the NHP Director of QI, Dr. Brian Robertson. QI Program activities include the following components:

[1] Colorado Department of Public Health and Environment. Monkeypox. Accessed on July 21, 2023 from https://cdphe.colorado.gov/diseases-a-to-z/monkeypox.

- External Quality Review Organization (EQRO) audits and subsequent post-audit activities
- Overseeing the Encounter Data Validation (411) audit and subsequent post-audit activities
- Managing Performance Improvement Projects (PIPs)
- Chairing/co-chairing committees, including the Quality Management Committee, the Quality Improvement/Pop Health Committee, and the Regional Program Improvement Advisory Committee (PIAC)
- Alignment of activities across population health, condition management, and member engagement
- Performance Measurement Action Plan (PMAP) and independent performance improvement (PI) activities
- Integration with NHP Population Health strategic planning efforts

Pandemic Impact of Quality Indicators

COVID-19 has been a long-standing topic within the healthcare space since its arrival in the United States more than three years ago. With infection rates consistently falling across the United States, the Public Health Emergency (PHE) officially ended during the SFY22/23 year. However, the effects of the PHE (such as increased constraints on physicians, clinical staff, and administrative staff) continue to impact the region.

Previous Quality reports noted COVID-19's direct impact on some performance measures including Well Visits, Dental Visits, and ED Visits. These visits all dropped significantly with the pandemic and have been steadily rising over the past year. In fact, ED visit rates have returned to pre-pandemic levels. These measures will be discussed in more detail in the performance measures section of this report, and NHP will continue to assess performance and trends across all measures.

Department Structure, Committees and Regional Quality Meetings

Quality Management Committee and Quality Improvement/Population Health Committee

NHP developed two quality committees in September of 2020, and holds those committees bi-monthly on alternating months. The Quality Improvement and Population Health Committee is chaired by the Chief Clinical Officer (CCO) Dr. Mark Wallace and co-chaired by the Director of Quality Improvement, and the Quality Management (QM) Committee is chaired by the Director of Quality Improvement and is co-chaired by the CCO.

These two committees offer representation and insight from both physical and behavioral health clinicians and administrators from across the region. Meeting participants continue to represent a myriad of regional partners including hospital systems, local providers, Federally Qualified Health Plans (FQHCs), Community Health Centers (CHCs), Community Mental Health Centers (CMHCs), North Colorado Health Alliance (NCHA), and Carelon Behavioral Health. Topics of discussion in these meetings included reviews of performance measurement, performance improvement opportunities, targeted messaging and public health campaigns, grievances and appeals, population health initiatives, clinical support work such as the Practice Transformation (PT) and the Hospital Transformation Program (HTP), and other topics of interest from Health Care Policy & Financing (HCPF).

Performance Improvement Advisory Committee (PIAC)

The regional Performance Improvement Advisory Committee (PIAC) is an avenue for members' voices and perspectives to be incorporated into regional quality initiatives. Chaired by the Director of Quality Improvement and Co-Chaired by the regional representative at the state PIAC, the regional PIAC met quarterly in SFY22/23. Voting membership is open to active partners and regional Medicaid members. As with the two quality committees, topics of discussion included reviews of performance measurement, performance improvement opportunities, targeted messaging and public health campaigns, grievances and appeals, population health initiatives, clinical support work such as the Practice Transformation (PT) and the Hospital Transformation Program (HTP), and other topics of interest from Health Care Policy & Financing (HCPF).

First Fridays Quality Forum

NHP established a monthly quality forum in May of 2022 and is held on the first Friday of every month from 11:00am-12:00pm. This venue enabled NHP to bring community stakeholders together to discuss relevant quality-based topics in more detail, to answer questions from practices, to showcase successful improvement tactics from clinics, and to help

practices engage with and learn from each other. While most of these topics are covered in regional committee meetings, the topics are not often deeply discussed due to the volume of agenda items covered in the committees. The First Fridays Quality Forum allows for deeper discussion on topics and open dialogue with regional stakeholders. Topics for SFY22/23 Included:

- Care Coordination to Support KPIs (July, 2022)
- Prescriber Tool (August 2022)
- SFY23 Specification Documents (September 2022)
- Well Visit "Best Practices" (October 2022)
- SMART Goals Training (November 2022)
- HCPF APM (December 2022)
- DenTriage (January 2023)
- Healthy Steps (February 2023)
- Care on Location (March 2023)
- Maternity Data Analytics (April 2023)
- SFY24 Performance Measures (May 2023)
- Prescriber Tool (June 2023)

Key Metrics Table

The Key Metrics Table notes the current regional performance for Key Performance Indicators, Behavioral Health Incentive Program measures, and Performance Pool measures with comparisons to the current goal and the previous year's performance. This information is found in Table 1.

Table 1. Key Metrics Table

Key Performance Indicators (KPIs)[2]	Goal[3,4]	SFY22/23[5]	SFY21/22
Behavioral Health (BH) Engagement	15.71%	1.17%	13.88%
Dental Visits	53.92%	48.68%	37.60%
Well Visits (0-15 Months)	60.38%	56.02%	58.02%
Well Visits (15-30 Months)	57.41%	59.24%	54.23%
Well Visits (3-21 Years)	41.48%	35.28%	33.96%
Prenatal Engagement	64.81%	63.18%	64.60%
Risk-Adjusted PMPM[6]	-	-	$385.36
Emergency Department (ED) Visits	477.01	622.03	616.43
Performance Pool	**SFY22/23Goal[7]**	**SFY22/23[8]**	**SFY21/22[9]**
Extended Care Coordination (ECC)	62.70%	-	58.55%
Pre-Mature Birth Rates	9.55%	10.23%	12.17%
BH Engagement for Members Releasing from State Prisons (DOC)	22.08%	-	26.35%
Asthma Medication Ratio	48.96%	46.63%	46.48%
Anti-Depressant Medication Management (A)	67.12%	67.88%	63.56%

[2] KPIs are calculated by Truven and reflect a rolling 12-month methodology.
[3] Goals reflect either the Tier 1 performance targets or the final quarterly target.
[4] Colorado Health Care Policy & Financing. KPI SFY22-23 Baselines and Targets.
[5] Values reflect the most recent calculations in the Data Analytics Portal.
[6] Goals are based on a HCPF average and are not known.
[7] Colorado Health Care Policy & Financing. Regional Accountable Entity Performance Pool Specification Document: SFY 2022-2023. Version 4.
[8] State-calculated fiscal year Performance Pool Measures are expected in December. Rates are reflective of the most recently received data.
[9] Colorado Health Care Policy & Financing. *Performance Pool Workbook FY2122 FINAL PERFORMANCE Revised with DOC.*

Anti-Depressant Medication Management (B)	45.92%	42.82%	41.07%
Contraceptive Care for Postpartum Women	26.56%	22.65%	33.24%
Behavioral Health Incentive Program (BHIP)	**SFY22/23 Goal[10]**	**SFY22/23[11]**	**SFY21/22[12]**
Substance Use Disorder (SUD) Engagement	51.67%	36.82%	54.79%
7-Day Follow-Up After an Inpatient Visit (MH)	52.81%	54.1%	53.59%
7-Day Follow-Up After an ED Visit for SUD	30.69%	34.2%	30.94%
BH Follow-Up After a Positive Depression Screen in Primary Care	87.96%	83.5%	83.99%
Gate measure: Depression Screen Claims Volume	*35.18%*	20.8%	*41.06%*
BH Screen/Assessment for Members in Foster Care	20.38%	10.9%	16.56%

Key Accomplishments in SFY22/23

NHP saw several key accomplishments in SFY22/23 across a number of projects. These accomplishments are outlined below in Table 2.

Table 2. Key Accomplishments from SFY22/23

Project	Accomplishments
Key Performance Indicators	• Maintained the lowest Risk-Adjusted PMPM across all RAEs • Well Visit rates improved across all quarters • Identified a prenatal code that wasn't being calculated in performance rates • ED Visits leveled off • Dental Visits rose over the previous fiscal year • Identified Dental at Your Door and DenTriage as two organizations to potentially improve dental access in the region
Performance Improvement	• Developed Balanced Scorecards for providers • Continued sending DAP chart and action item lists to providers • Targeted and coordinated PI efforts with the region's two largest practices
Practice Transformation	• Implemented the Behavioral Health Practice Transformation Program • Aligned program milestones to KPIs and BHIPs • Continued efforts to support Prescriber Tool implementation
Hospital Transformation	• Began receiving data from the Eastern Plains Healthcare Consortium
Behavioral Health Incentives	• Met 3 out of 5 BHIP measures
Performance Pool	• Maintained strong performance on Extended Care Coordination • Maintained strong performance on BH Engagement after DOC • Preterm birth is below Medicaid, Colorado, and Colorado Medicaid rates • Aggregate preterm birth rates fell below the goal line in March of 2023
411 Audit	• Continued to maintain high inter-rater reliability with HSAG over-reads • Completed the 411 QUIP from the SFY21/22 audit • Passed the SFY22/23 audit without needing to do a formal QUIP
PIP	• Finalized Module 4 with significant increases shown in both measures
Clinical Documentation Audits	• Continued tracking audit performance • Increased the percentage of passing audits by approximately 50%

[10] Regional Accountable Entity Behavioral Health Incentive Specification Document: SFY 2022-2023. Version 3: December 22, 2022.

[11] BH Incentive measures are delayed due to a 90-day claims runout. Data represent estimates based on internal calculations through May of 2023.

[12] BHIP Performance Indicators: SFYs 2018-22. Presented to the state Performance Improvement Advisory Committee on June 21, 2023.

Key Initiatives for SFY23/24

NHP has several key initiatives for SFY23/24 based on previous performance, key successes, and new initiatives. These initiatives are noted in Table 3 and are discussed in more detail in the SFY23/24 Quality Plan.

Table 3. Key Initiatives for SFY23/24[13]

Project	SFY23/24 Goal / Activity
411 Audit	• Continue to maintain high inter-rater reliability with HSAG over-reads • Successfully pass the 411 Audit
All performance measures	• Maintain strong performance in Risk-Adjusted Per Member Per Month (PMPM) measure • Utilize clinic-level Power BI Reports to outreach providers for performance improvement activities • Continue reporting on regional performance across quality committees • Align additional Practice Transformation activities to impact KPIs and BHIP measures • Assess performance across demographic groups in alignment with the Health Equity Strategy • Develop targeted interventions for equity disparity gap closures in partnership with the regional Health Equity Task Force • Develop tip sheets for providers to help with coding practices and to quickly understand performance measures • Pilot and expand Inovalon as a real-time performance measurement and population health data platform to regional providers and administrators
Behavioral Health Incentives Program Measures (BHIP)	• Improve performance on the Depression screening (Gate) measure and Follow-up for Positive Depression Screening measures • Meet the HCPF performance Goals for the three new HEDIS measures • Achieve regional goals for the BH Screen/Assessment for children entering Foster Care • Align the annual and fiscal year HEDIS calculation methodology to the state • Accurately track new HEDIS BHIP measures and refine calculations to meet the state's calculation • Improve performance on the ED SUD measure in alignment with the state PIP • Establish clinic-level performance improvement initiatives for lagging performance • Develop BHIP-specific balanced scorecards
Performance Pool (PP)	• Maintain high performance in Extended Care Coordination • Maintain strong performance in Department of Corrections (DOC) BH Engagement Measure • Meet regional goals for Asthma Medication Ratio • Meet Regional goals for Anti-Depressant Medication Management • Meet Regional Goals for Contraceptive Care Management • Establish clinic-level performance improvement initiatives for lagging performance
Key Performance Indicators	• Meet regional goals for prenatal/post-partum care • Meet regional goals for well visits (all ages) • Maintain strong performance on the Risk-Adjusted PMPM Performance Measure • Improve Dental KPI performance over baseline • Implement a pilot program with DenTriage to increase dental access in the region • Develop reports assessing the acuity (severity) of ED visits • Continue sending DAP charts to practices
Performance Improvement	• Implement Performance Improvement activities to impact the Asthma Medication Ratio measure • Implement Performance Improvement activities to impact the Anti-

[13] This table is included in the Northeast Health Partners' SFY23/24 Quality Improvement Plan.

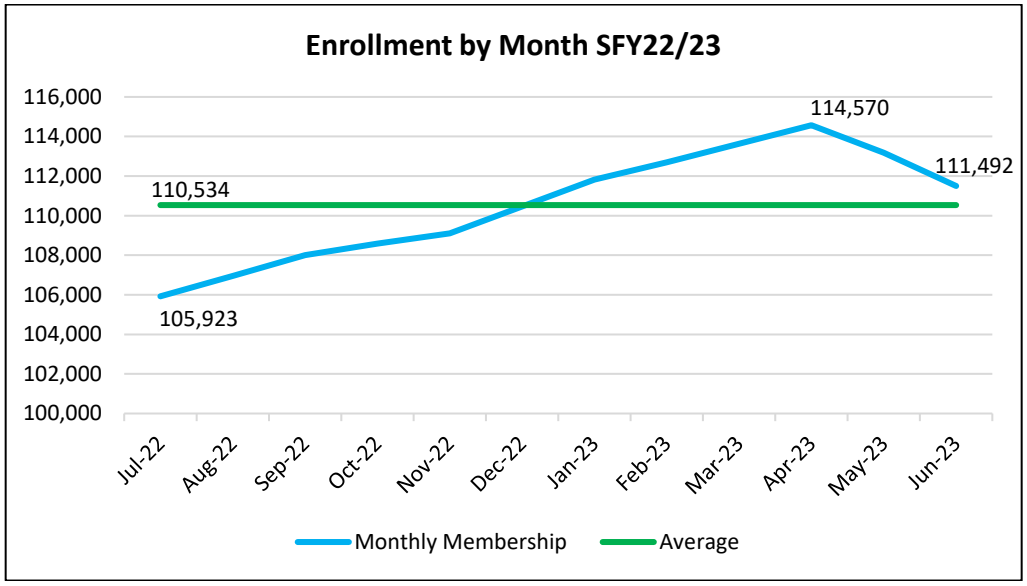
Project	SFY23/24 Goal / Activity
	Depressant Medication Management measure • Implement other targeted Performance Improvement activities to address performance barriers as needed
PIP (Performance Improvement Project)	• Implement the clinical and non-clinical PIPs with regional practices • Assess Clinical PIP performance using HEDIS specifications • Assess baseline performance on the non-clinical PIP (tracking Social Determinants of Health screenings) • Align non-clinical PIP screening questions across sites
Quality of Care	• Incorporate Grievance and Appeals into the Quality of Care review and reporting process • Develop a reporting template for state-level reporting • Increase QOCC meeting frequency to comply with new state requirements for resolution reporting
Practice Transformation Program (PT)	• Build on Practice Transformation work from SFY22/23 • Expand the Behavioral Health Practice Transformation program to include more practices participating in the program • Align milestone activities to performance measures better meet goals
Hospital Transformation Program (HTP)	• Receive test data from Contexture for all connected hospitals • Go live with Contexture for all connected hospitals • Provide training to practices on how to send data to NHP if Contexture is not operational by October 1, 2023. • Refine the current data transmission process with the Eastern Plains Healthcare Consortium (EPHC) to become more automated • Aggregate incoming data from the EPHC with Contexture • Build initial reports for internal analysis

Section 2: NHP Population Characteristics and Penetration Rates

Enrollment Changes

Regional enrollment continued to climb across years, largely due to the Public Health Emergency (PHE) and members maintaining their Medicaid benefits through the PHE. As a result, the average monthly membership increased by almost 10,000 members between SFY21/22 and SFY22/23. However, SFY22/23 also saw the end of the PHE and the need for members to re-enroll to maintain benefits. As a result, membership began declining at the close of the year. June ended with just over 111,000 members, which is down from over 114,000 members in April. This trend is likely to continue in the subsequent months as the PHE unwind continues to reduce regional membership. The monthly enrollment numbers for SFY22/23, captured on the last Monday of every month, are found in Figure 1.

Figure 1. SFY22/23 NHP Total Enrollment, by Month



Demographic Characteristics

Demographic characteristics have been stable across fiscal years. Children under the age of 18 account for over one-third of the region's membership, members aged 18-69 years account for almost 60% of the regional membership, and adults over 70 years old account for less than 5%. Similarly, the region's gender breakdowns have not changed since the past fiscal year with females still accounting for over half of the region's membership (54%) and males accounting for just under half (46%). Regional age and gender breakdowns are found in Table 4.

A vast majority of the regional population identifies as either Hispanic (38%) or white/Caucasian (37%). The next highest race/ethnic group in the region is "unknown/not provided" (12%), multiple/other people of color (7%), black/African American (3%), and Asian (2%). Less than half a percent of the region's Medicaid population identifies as either American or Native Hawaiian/Pacific Islander. English is the most prominent language spoken with 86% of the region's members noting it as their primary language. Spanish is the next most prominent language spoken with 12% of the regional members noting it as their preferred language. All other languages are spoken by less than one percent of the population.[14]

[14] Northeast Health Partners. Language Assistance Services Annual Report.

Table 4. Regional Membership Demographics

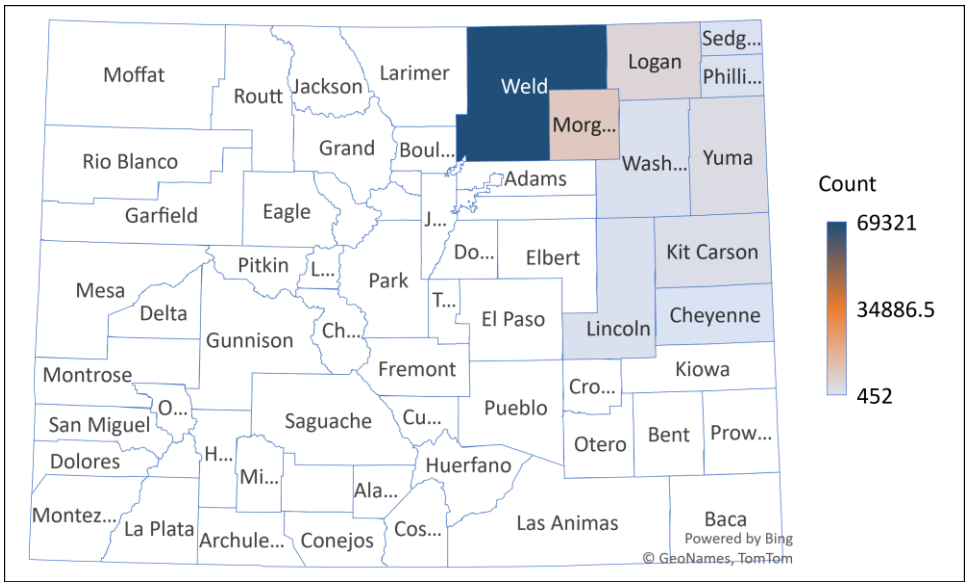
Age	Count of NHP Membership	% of NHP Membership
0-12	27,472	25.98%
13-17	11,550	10.92%
21-69	62,081	58.71%
70+	4,635	4.38%
Gender	**Count of NHP Membership**	**% of NHP Membership**
Male	49,141	46.47%
Female	56,597	53.53%
Other	0	0%
Total Enrollment	**105,738**	

Regional Distribution of Members

The membership distribution across the region has not changed much across fiscal years. In general, membership rose across counties. Weld County, the region's only urban county, has the highest proportion of regional membership. However, due to the rural and frontier nature if the region's counties in addition to the proximity to more densely populated areas, four out-of-region counties have larger membership populations (Adams, Boulder, Arapahoe, and Denver) than the least-populated in-region county (Cheyenne). At the end of SFY22/23, Adams County had 1,849 members, Boulder County had 1,505 members, Arapahoe County had 807 members, and Denver County had 743 members. In contrast, Cheyenne County had only 452 members.

The membership distribution across the regional counties is found in Figure 2.

Figure 2. Regional Membership Distribution, by County



Behavioral Health Penetration Rates

Behavioral health penetration rates remained stable over the past fiscal year with an average penetration rate of 16.3%. NHP did see improvements in monthly performance with a 17.6 % rate in May of 2023, which was the highest monthly rate since August of 2021. Further, penetration rates increased for all aid code categories except for those with an aid code of "other." Rates improved by over 5% for adults, almost 3% for adults with dependent children and foster care members, over 1% for children and expansion members, and almost a full percent for the elderly and disabled.

Members with an aid code of "other" dropped from 23.1% in SFY21/22 to 3.7% in SFY22/23 and was the only aid code group with a penetration rate lower than the previous year. Penetration rates rose for all ethnic groups except those who reported their ethnicity to be Asian (down 3%).

Improvement in penetration rates are due to several factors including increased rates of well visits, integrated behavioral health in primary care clinics, improved screening and referrals, and targeted efforts with underserved demographic groups. Further, the end of the PHE may also impact penetration rates, which should continue climbing in SFY23/24.

Penetration rates by month are found in Figure 3, penetration rates by aid category are found in Figure 4, penetration rates by age are found in Figure 5, penetration rates by ethnicity are found in Figure 6, and penetration rates by regional county are found in Figure 7.

Figure 3. SFY22/23 BH Penetration Rates, by Month

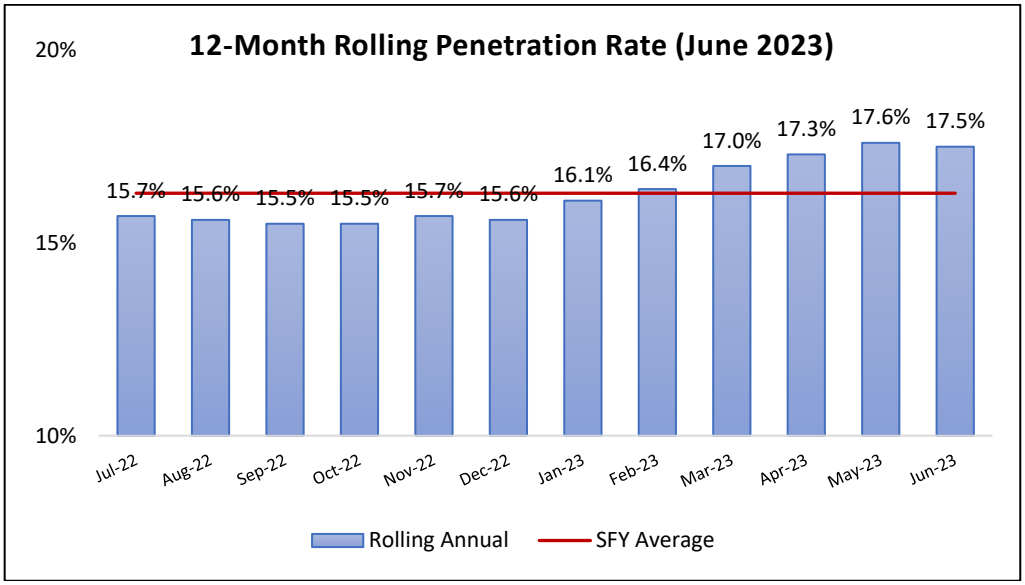


Figure 4: SFY22/23 BH Penetration Rates, by Aid Category

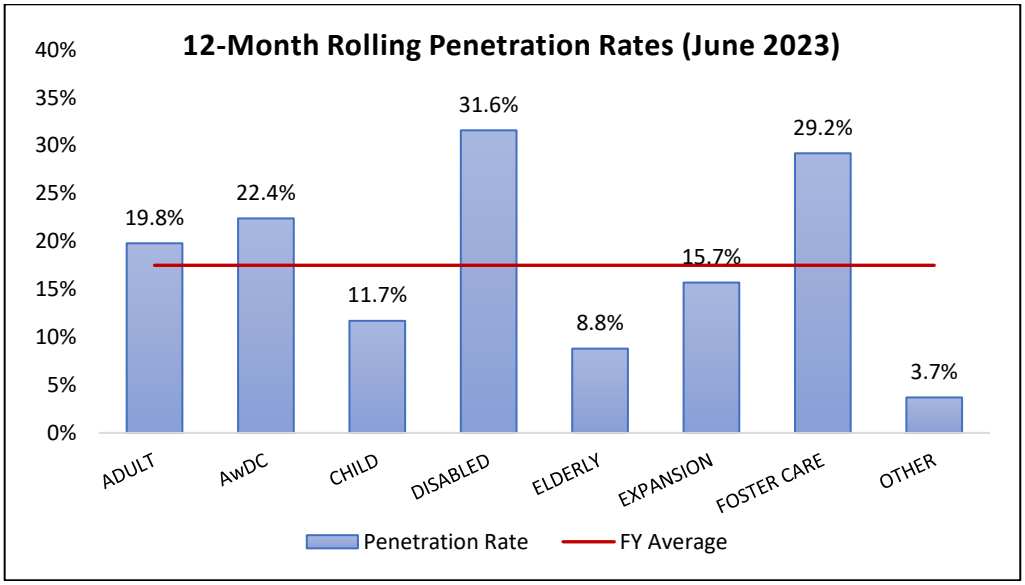


Figure 5: SFY22/23 BH Penetration Rates, by Age

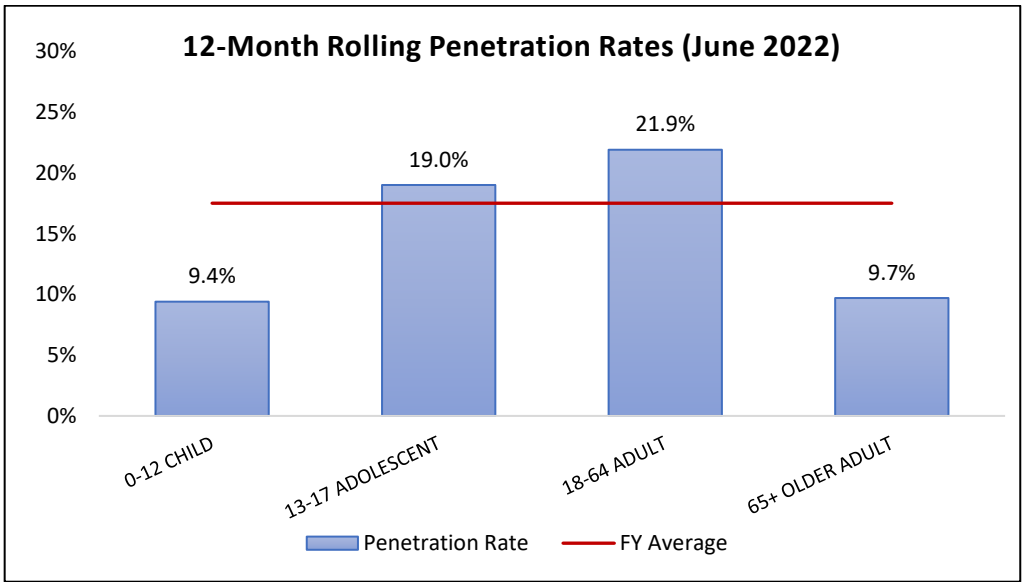


Figure 6: SFY22/23 BH Penetration Rates, by Ethnicity

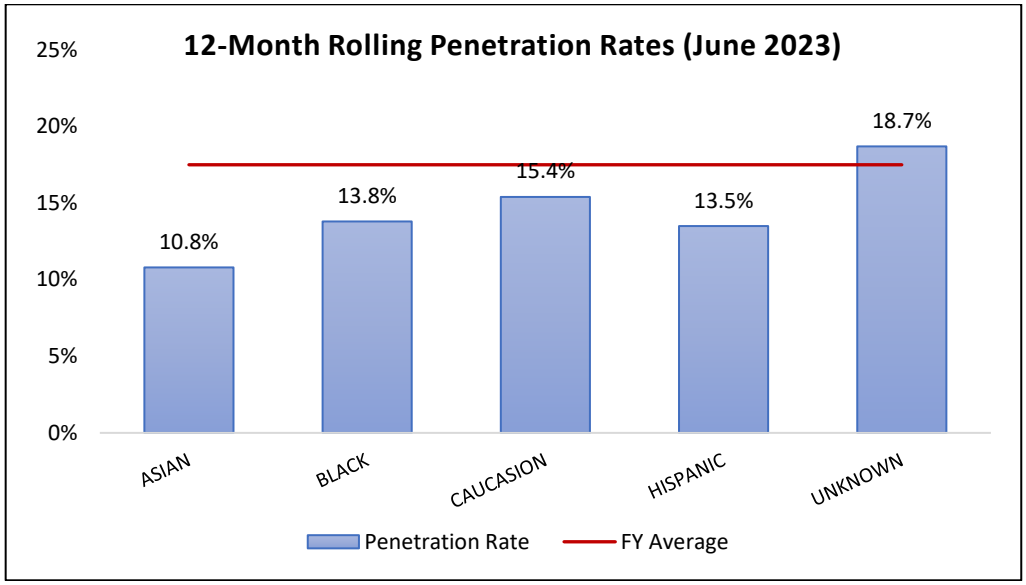
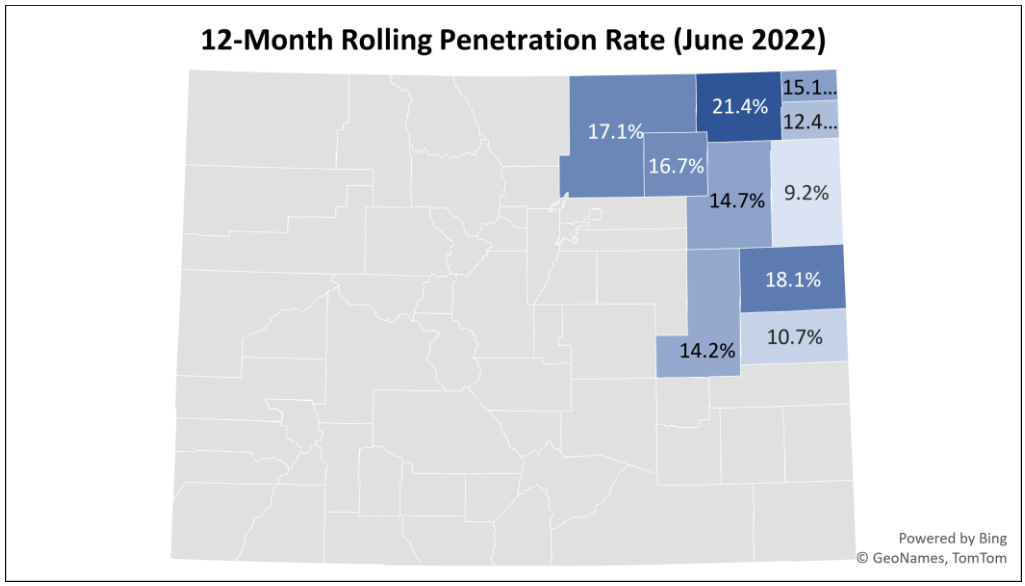


Figure 7: SFY22/23 BH Penetration Rates, by County



Section 3: Compliance Monitoring

Compliance monitoring activities were managed by NHP alongside various departments at Carelon Behavioral Health, including Quality, Care Coordination, Member Services, and Provider Relations. Specific activities related to these efforts are included below.

External Quality Review Organization Audit (EQRO Audit)

The annual SFY22/23 EQRO site review evaluating compliance with NHP and its Health First Colorado contract requirements was completed in April of 2023. The following standards were reviewed as part of the audit:

- 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 Coverage and Authorization of Services, Adequate Capacity and Availability of Services, and the Grievance and Appeal Systems sections all received compliance ratings above 90%. The Enrollment and Disenrollment section met 100% of the required elements. The Coverage and Authorization of Services section and the Grievance and Appeal Systems section sections met 91% of its required elements. The Adequate Capacity and Availability of Services section met 93% of its requirements. These scores resulted in a composite score of 92%. Health Services Advisory Group (HSAG) noted several areas of strength in the SFY22/23 site review report.[15] Table 5 notes regional performance against the state average.[16]

Table 5. EQRO Standards and Regional Performance

Standard	RAE Performance	State Average
Standard I: Coverage and Authorization of Services	91%	93%
Standard II: Adequate Capacity and Availability of Services	93%	95%
Standard VI: Grievance and Appeal Systems	91%	87%
Standard XII: Enrollment and Disenrollment	100%	100%

Summary of Required Actions and CAP Status

NHP initiated improvement activities specific to the areas that resulted in a Corrective Action Plan (CAP) in SFY22/23. The CAP was accepted by HSAG and CAP activities will continue into SFY23/24 with an expected completion before the end of the calendar year (December 2023). Required actions cited in the CAP included:

- NHP must enhance its procedures and monitoring to ensure that all denial decisions are made within time frame requirements. NHP must update its Medical Necessity Determination Timelines policy and any supporting documentation to clarify that the denial decision time frame is based on the date of the service request until the deadline.
- NHP must enhance its procedures and monitoring to ensure that all member notices are sent within time frame requirements. NHP must update its Medical Necessity 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.
- NHP must correct the timely appointment standards in the PCP Practitioner Agreement.
- NHP must enhance monitoring and oversight of delegated entities ensure member letters include the required content.

[15] Colorado Department of Health Care Policy and Financing. *Fiscal Year 2022-2023 Site Review Report for Northeast Health Partners Region 2.* June 2023.

[16] Health Services Advisory Group. *Summary of Fiscal Year (FY) 2022-2023 Compliance Reviews.* Presented to the Integrated Quality Improvement Committee (IQuIC) on August 22, 2023.

- NHP must update the following documents to remove the requirement that the member must follow a verbal appeal request with a written request in any way. NHP must also share updated documentation to other staff to ensure all staff are aware of the requirement.
    - Appeal Job Aid, page 2, remove "appeal must be signed by the member."
    - 305L Appeal Policy, page 12 under section J.2, remove the instruction that the coordinator or specialist must attempt to get a signed appeal request from the member.
    - Appeal Form, which can be found online, remove the statement at the bottom of the page, "Please know that we cannot process this appeal until you sign and return this letter."
- NHP must update 305L Appeals Policy, page 12 of section J.4, to add that the coordinator will make reasonable efforts to notify the member of the delay if the delay is in the member's best interest.

Encounter Data Validation (411) Audit

NHP strives for excellent agreement results in the annual Claims and Encounter Validation Audit, an audit spanning 411 different chart reviews. As demonstrated in past 411 audits, NHP performed very well across the three service categories. NHP observed a high level of accuracy in the psychotherapy section of the audit with an average score of 97%, and also observed a remarkably high level of accuracy in the residential section of the audit. NHP netted an average accuracy score of 99% across all ten of the encounter categories. Finally, NHP observed a high level of accuracy in the inpatient section of the audit. NHP netted accuracy scores averaging 99.8%.

Based upon recent audit results, NHP will tailor trainings specific to the areas in need of improvement found within the audit despite the high level of agreement in the aggregate scores. This year, NHP did not have a single category fall below the targeted 90% threshold.

NHP also reviewed 30 records as part of its interrater reliability (IRR) training and process. Each of these 30 records were reviewed across auditors to ensure consistent scoring. Internally calculated IRR was 86.45%. Any inconsistencies were addressed in training and in some instances, the Health Services Advisory Group (HSAG) was outreached for additional clarification and interpretation. The auditors included:

- Courtney R. Hernandez, MS-HSV
- John Mahalik, Ph.D., MPA (Licensed Psychologist – CO)
- Stephanie Miller-Olsen, LMHC
- Ed Arnold, RN. MSN, BSN, BSE, CPHQ (Overread auditor)

Overall, the average scores for the audit were remarkable. None of the three categories audited fell below the 90% compliance threshold. A summary of performance on the three service categories is presented below in Tables 6, 7, 8, 9, 10, and 11.

Table 6. Summary Indicators for the 411 Audit Inpatient Services

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Primary Diagnosis Code'	R2	Inpatient	136	137	99.2%
'Revenue Code'	R2	Inpatient	137	137	100%
'Discharge Status'	R2	Inpatient	137	137	100%
'Start Date'	R2	Inpatient	137	137	100%
'End Date'	R2	Inpatient	137	137	100%

Table 7. Summary Indicators for the 411 Audit Psychotherapy Services

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Procedure Code'	R2	Psychotherapy	131	137	95.6%
'Diagnosis Code'	R2	Psychotherapy	134	137	97.8%
'Place of Service'	R2	Psychotherapy	130	137	94.8%
'Service Category Modifier' (Procedure Modifier 1)	R2	Psychotherapy	134	137	97.8%
'Unit'	R2	Psychotherapy	134	137	97.8%
'Start Date'	R2	Psychotherapy	134	137	97.8%
'End Date'	R2	Psychotherapy	134	137	97.8%
'Appropriate Population'	R2	Psychotherapy	134	137	97.8%
'Duration'	R2	Psychotherapy	131	137	95.6%
'Staff Requirement'	R2	Psychotherapy	131	137	95.6%

Table 8. Summary Indicators for the 411 Audit Residential Services

Requirement Name	RAE Region Number	Service Category	Numerator	Denominator	%
'Procedure Code'	R2	Residential	136	137	99.2%
'Diagnosis Code'	R2	Residential	133	137	97.0%
'Place of Service'	R2	Residential	136	137	99.2%
'Service Category Modifier' (Procedure Modifier 1)	R2	Residential	136	137	99.2%
'Unit'	R2	Residential	135	137	98.5%
'Start Date'	R2	Residential	136	137	99.2%
'End Date'	R2	Residential	136	137	99.2%
'Appropriate Population'	R2	Residential	136	137	99.2%
'Duration'	R2	Residential	136	137	99.2%
'Staff Requirement'	R2	Residential	136	137	99.2%

Table 9. Interrater Reliability for Inpatient Services

Data Element	Score
Diagnosis Code	100%
Revenue Code	100%
Discharge Status	90%
Service Start Date	100%
Service End Date	100%

Table 10. Interrater Reliability for Psychotherapy Services

Data Element	Score
Procedure Code	100%
Diagnosis Code	100%
Place of Service	80%
Service category Modifier	100%
Unit	100%
Service Start Date	100%
Service End Date	100%
Population	100%
Duration	100%
Staff Requirement	100%

Table 11. Interrater Reliability for Residential Services

Data Element	Score
Procedure Code	100%
Diagnosis Code	100%
Place of Service	100%
Service category Modifier	100%
Unit	100%
Service Start Date	100%
Service End Date	100%
Population	100%
Duration	100%
Staff Requirement	100%

Provider Audits

Carelon Behavioral Health, on behalf of the NHP QI Department, conducts audits across care coordination, physical health, and behavioral health contract compliance. Details about these audits are outlined below. The QI program at NHP collaborated with other Regional Accountable Entities (RAEs) and the Department of Healthcare Policy & Finance (HCPF) to standardize outpatient mental health provider audit tools to provide consistency for provider audits throughout the state.

Care Coordination Audits

The delegated care coordination model at NHP consists of two distinct groups: Accountable and Contributing. Membership attributed to Accountable providers accounts for a sizable portion of regional membership. Accountable providers have the greatest level of capability to impact the complex members and regional KPIs and demonstrate the capacity to provide the full continuum of community care coordination for members. Contributing providers meet minimum Medicaid Per Member Per Month (PMPM) requirements and provide basic services. This provider group has a small medical panel size with limited volume to drive regional performance outcomes. Care coordination for all Contributing PCMPs is delegated to North Colorado Health Alliance (NCHA). NCHA also provides care coordination for members attributed to Sunrise Community Health.

The fiscal year started with the completion of the care coordination audits that were pending final review as of June 30, 2022. Results were summarized to identify strengths and opportunities for improvement within each individual care coordination entity. Aggregate results were presented at the NHP Care Coordination meeting in August 2022. Training on best practices for goal setting, such as the use of SMART Goals (meaning goals that are Specific, Measurable, Appropriate, Realistic, and Time-limited), was conducted for the general care coordination audience. One care coordination entity was placed on a Corrective Action Plan (CAP) due to failure to meet standards of performance.

As the fiscal year progressed, a quality review was done to validate each item on the audit tool and its alignment to the current NHP Care Coordination policy. Minor revisions were made to the audit tool, and the sampling methodology was retained from the previous year's audit to evaluate the delivery of care coordination services in one sample, and compliance with the NHP Opt-Out Policy in a separate sample. Accountable entities and NCHA were audited to evaluate the care coordination activities provided to members using the updated audit tool. These audits utilized a random sample of members identified as needing complex care coordination across the region's four care coordination entities, and subsequent auditing against the following four domains:

- Assessment/Care Plan Elements: All member demographic data is accounted for, as well as meaningful supplemental information that addresses social determinants, cultural specifics, and physical/behavioral health care needs, and appropriate goal-setting.
- Care Coordination Evidence: Evidence displaying that the care plan takes into consideration preferences and goals stated by the member, timely follow-up with members/families, dates in which care coordination activities occurred, identification of medical, behavioral, or social needs that the care coordinator helped identify/connect.
- COUP: Member education on the importance of contacting the Primary Care Provider (PCP) for non-emergent services and/or the Nurse Advice Line, if the member is on the Client Overutilization Program (COUP) list
- Policies and Procedures: All expectations related to the care coordinator's role, including required training, and communication/outreach requirements with members.

The FY22/23 audit was completed in April 2023 in accordance with the above plan. Results were summarized to identify strengths and opportunities for improvement within each individual care coordination entity. Aggregate results were presented at the NHP Care Coordination meeting in May of 2023. All entities voiced challenges with maintaining processes with high rates of staff turnover, but incremental improvement was seen by the entity previously placed on a CAP, and continued assistance was provided by NHP with a planned repeat audit in early FY23/24. A different provider failed to meet the NHP performance threshold, and a CAP was issued with a repeat audit planned in early FY23/24.

Behavioral Health Documentation Audits

NHP conducts random audits on behavioral health practices to evaluate quality of care and compliance with the Health First Colorado (Colorado's Medicaid Program) documentation rules. This includes an audit of the Independent Provider Network (IPN), Substance Abuse Disorder (SUD) Outpatient, Medication Assisted Treatment (MAT), Targeted Case Management (TCM) documentation, Intensive Outpatient (IOP), Residential Treatment (RTF), Inpatient Treatment (IP), SUD Detox providers, SUD Inpatient Treatment, and SUD Residential Treatment. These audits ensure that contracted providers are meeting the guidelines established for service provision and that NHP maintains a high performing network.

Audits are completed as required by the Colorado Department of Healthcare Policy and Financing (HCPF) to ensure contractual compliance. If audit scores do not meet the minimum required threshold, NHP provides education to the provider about the deficiencies, offers training to the provider, re-audits the provider for continued improvement, potentially requires the provider to create a corrective action plan (CAP) if warranted, and potentially recoups funds. Audits follow Health First Colorado and Office of Behavioral Health (OBH) standards including:

- Administrative Standards
- Assessment Standards

- Treatment Planning
- Progress Note Documentation
- Care Coordination

Medication-Assisted Treatment (MAT) Services are also audited against additional standards including Medication Evaluation, Physical Examination, and Toxicology Screening. To date, no specific trends are emerging in terms of providers scoring consistently low or high on specific standards.

Education on documentation standards was offered throughout the fiscal year and will continue annually. These education sessions are provided by the same staff conducting the audits, and providers have the opportunity to engage with the educators to ask clarifying questions about documentation standards. To provide further support, NHP has provided provider-specific training via Zoom to allow for a more personalized, agency-specific training opportunity.

Substance Use Disorders Audits

In June 2021, the Colorado State Legislature passed Senate Bill 21-137, the "Behavioral Health Recovery Act of 2021." Pursuant to this legislation, Colorado's Department of Health Care Policy and Financing (the Department) is required to arrange for an audit of 33 percent of all denials of authorization for inpatient and residential substance use disorder treatment for each (Medicaid) managed care entity (MCE). In fiscal year 2022-2023, Health Services Advisory Group (HSAG), Colorado's external quality review organization (EQRO), conducted an audit that consisted of an over-read of 33 percent of SUD inpatient and residential service authorization denials for Northeast Health Partners.

Audit Findings

Three denial decisions in the sample were not made within timeliness requirements, and all three were related to SUD residential or inpatient levels of care which are required within 72 hours. Additionally, the Medical Necessity Determination Timelines policy often referred to timelines for Utilization Review Accreditation Commission (URAC) standards, which sometimes conflicted with Colorado regulations. In some instances, the time frames for making the denial decision were based on the date at which additional information was received from the provider, rather than the date of the request. NHP must enhance its procedures and monitoring to ensure that all denial decisions are made within time frame requirements.

Additionally, five out of ten notices of adverse benefit determination (NABDs) reviewed were sent to the member outside of timeliness requirements. All four cases were related to SUD residential and inpatient requests which require 72-hour turnarounds. Additionally, the Medical Necessity Determination Timelines policy referred to timelines for URAC standards, which sometimes conflicted with Colorado regulations. In some instances, the time frames were stated to be based on the date of receipt of additional information from the provider, rather than the date of the request, which is incorrect.

Response to Audit Findings

Based on the results of the HSAG SUD audit, several changes were implemented. Three policies related to medical necessity determinations, content in Notices of Adverse Benefit Determination (NOABDs), and timeliness of NOABDs were reviewed and revised to align with state contract standards. Following these changes, all utilization management staff completed retraining. Additional safeguards were also established to ensure that all member notices are sent within time frame requirements.

EPSDT Audit

Health Services Advisory Group (HSAG) conducted an audit in March of 2023 on Early Periodic Screening Diagnostics and Testing (EPSDT) to determine if policies, procedures, trainings, reports, and relevant documents were aligned with EPSDT federal regulations and specific State requirements, if EPSDT eligible members who were identified as "non-utilizers" were outreached because they had not received any EPSDT services within the 12-month period prior to the annual anniversary date of their enrollment, and if EPSDT considerations were included when making medical necessity determinations prior to denying authorization for services.

Response to Audit Findings

Overall, NHP scored 100% on the Desk Review section, 63% on the Non-Utilizer Score, and 86% on the Post-Denial Score of the audit.[17] Based on the results of the audit, NHP identified the following areas for improvement based on HSAG's findings: Improving desktop procedures, improving documentation, improving onboarding/outreach, and trainings.

Improve Desktop Procedures

NHP will develop a desktop procedure that outlines how NHP works with the Department to obtain EPSDT services for members, when necessary.

Improve Documentation

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

Improve Onboarding/Outreach

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

Trainings

1) NHP will record and post bi-annual EPSDT trainings for providers on the NHP website.
2) NHP will continue to train customer service and UM staff on EPSDT policies, procedures, and documentation requirements annually.

Quality of Care Grievance Audit

Health Services Advisory Group, Inc. (HSAG) conducted a Quality of Care Grievance (QOCG) audit in an effort to understand complaints about potential quality of care issues and to gather information regarding the processes for addressing QOCGs. The Centers for Medicare & Medicaid Services (CMS) definition of a QOCG is:

> A type of grievance that is related to whether the quality of covered services provided by the health plan or provider meets professionally recognized standards of health care including whether appropriate health care services have been provided or have been provided in appropriate settings. Examples of a QOCG include any instances where an enrollee infers or states that they believe they were misdiagnosed, treatment was not appropriate, and/or they received, or did not receive, care that adversely impacted or had the potential to adversely impact their health.

A total of four (4) QOCG cases were reviewed by HSAG during the audit. Based on the review, HSAG determined that NHP adhered to its internal policies and procedures and recommended the following actions to which NHP has implemented or maintained on an ongoing basis:

- Implementation of ongoing staff training on the Colorado-specific QOCG process.

[17] HCPF. FY 2022-2023 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Audit Aggregate Score. June 2023.

- Continue notifying the Department of the QOC issues received. Also, NHP should contact the Department to report ad hoc cases with severity, systematic concerns, and termination of any network provider.
- Continue to work in tandem with the grievance coordinator/OMFA.
- Consider integrating member information such as race, ethnicity, and disability status into the QOC database or merging with available demographic data to monitor for issues or trends.

Section 4: Performance Improvement

Key Performance Indicators (KPIs)

Key performance indicators have steadily risen over the past year as the impact of the PHE lessened on health service utilization. For example, ED visit rates levelled off and returned to pre-COVID-19 rates during SFY22/23, and well visits and dental visits all rose. While the PHE ending has lessened its negative impacts on service utilization, the organizational impacts of the PHE (such as staff retention issues and the continued increase in membership) remained burdensome to the healthcare system. These should become less impactful with the PHE unwind and membership levels declining, but the degree of this impact remains unknown.

Well Visits

Well visit performance continued to climb across almost every quarter for each of the three well visits. This upward trend is related to both the pandemic easing and the alignment to the Practice Transformation milestones. While well visits improved across the quarters, the improvement did not lead to earned incentives. Well Visits for Children Ages 15-30 Months broke the goal line in Q2 of SFY22/23 and continued to climb in Q3, but the Well Visits for Children Ages 0-15 Months did not break the goal threshold as quarterly goals continued to climb just outside of performance levels. Similar improvement yet falling below goal lines were also seen for well visits among those ages 3-21 years. Performance trends for well visits are included in Figures, 8, 9, and 10.

Figure 8. Well Visit Performance, Ages 0-15 Months

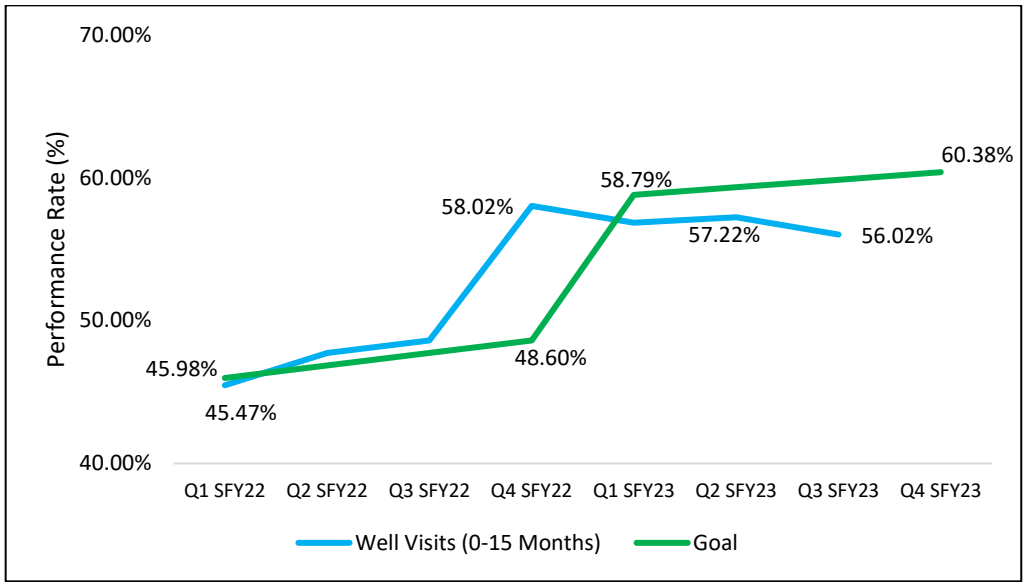


Figure 9. Well Visit Performance, Ages 15-30 Months

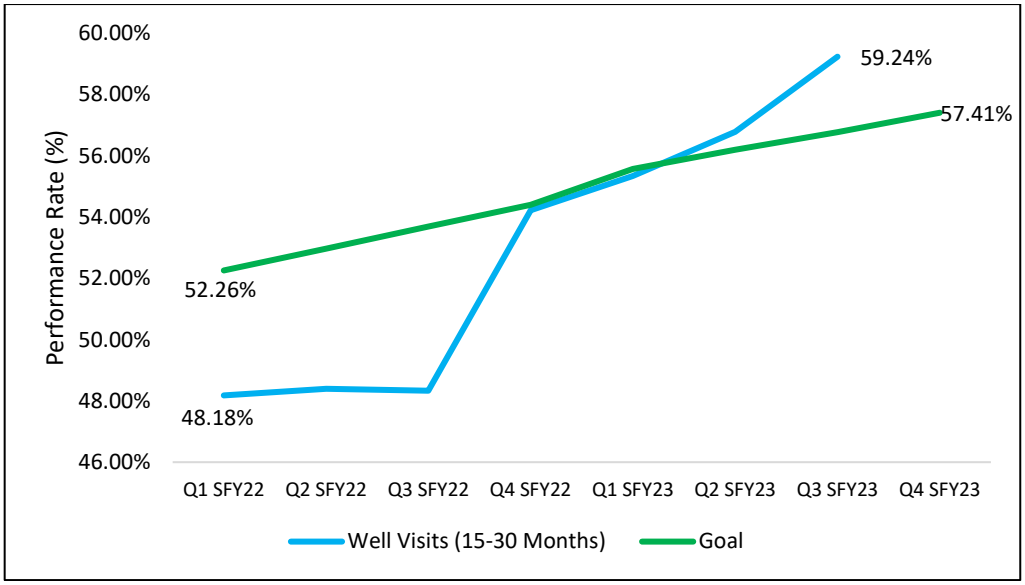
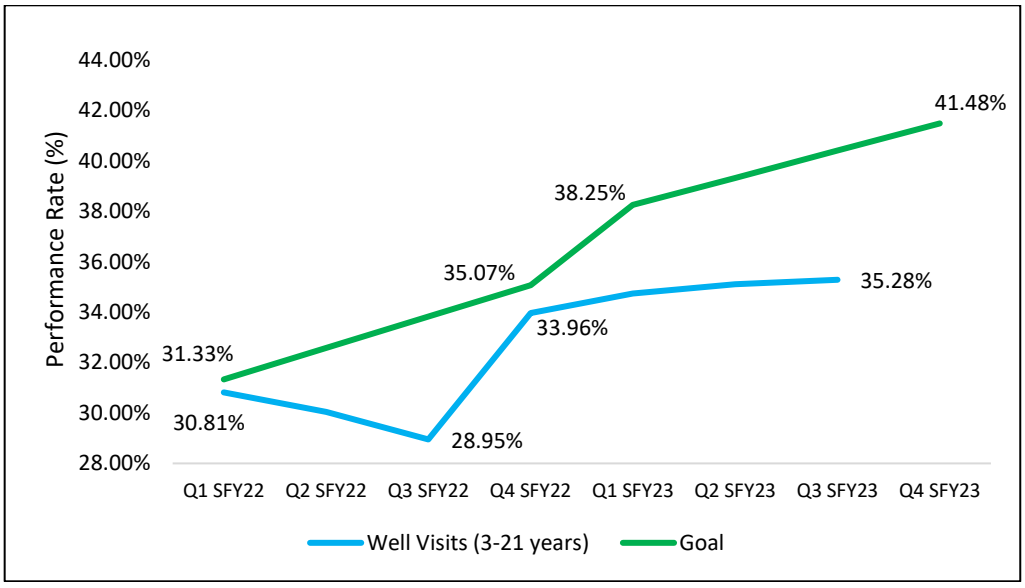


Figure 10. Well Visit Performance, Ages 3-21 Years



ED Visits

ED Visits continued to rise over the previous fiscal year, but abruptly leveled off and stabilized after returning to Pre-COVID-19 rates. Interestingly, the baseline performance period for SFY22/23 spans the time frame when ED rates were at their lowest point during the pandemic. This caused a decrease in the fiscal year goals despite the increase in actual performance rates. As a result, NHP and all the other RAEs consistently performed above the goal line for the fiscal year. Regional performance against the target is captured in Figure 11, and historical rates with the baseline period are noted in Figure 12.

Figure 11. ED Visit Performance

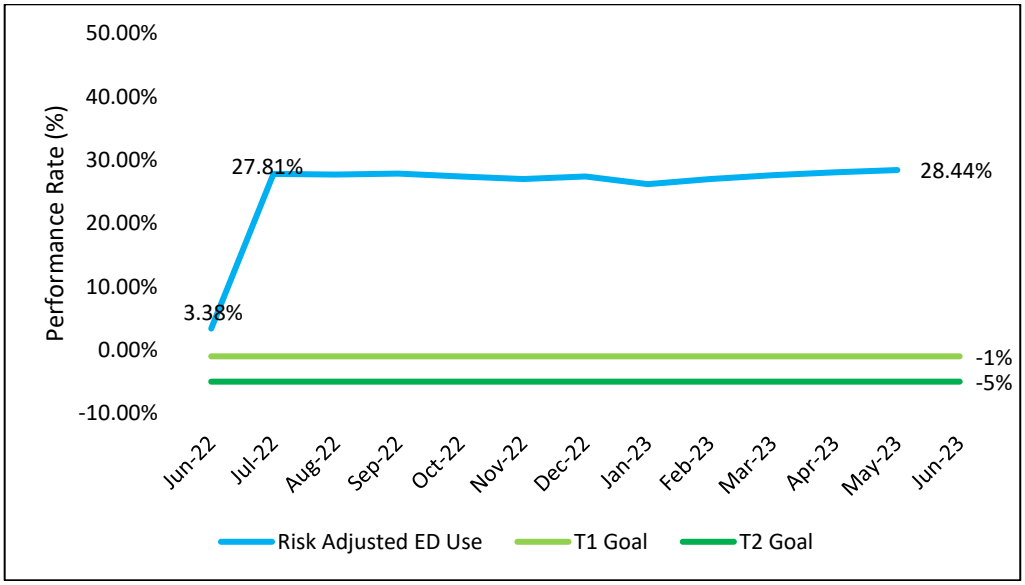
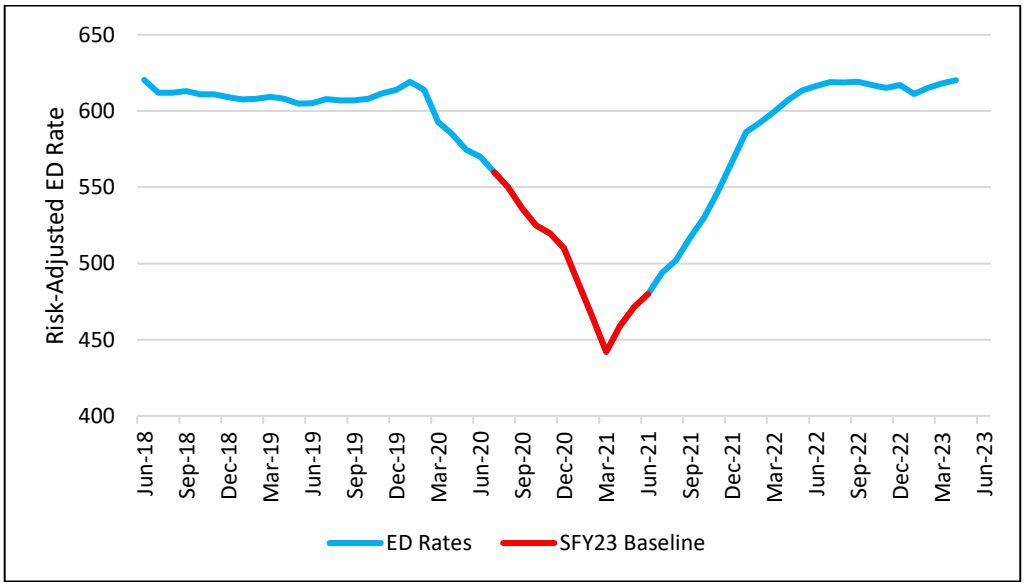


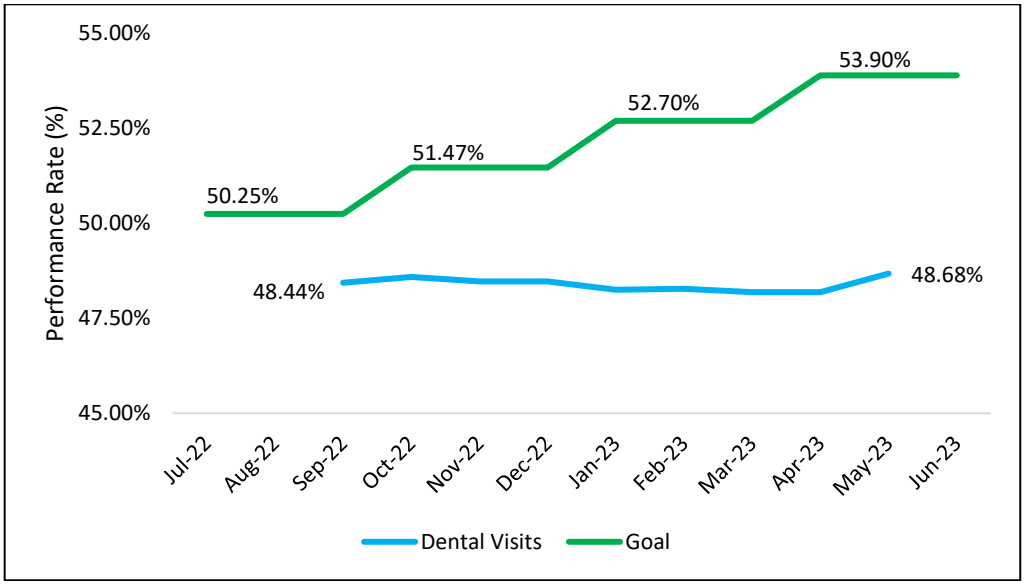
Figure 12. Historical ED Rates and the SFY22/23 Baseline Period



Dental Visits

The dental visit measure changed in SFY22/23 to align to HEDIS measures and resulted in an improvement in performance (from 37.33% in Q2 SFY22 to 48.19% in Q3 SFY23). Along with a new metric, performance goals also shifted from a static annual goal to a continually increasing quarterly goal. Further, NHP explored the dental network and found a potential discrepancy in the number of dentists in the region versus the available network of providers. This generated questions about whether the dental network was adequate for the region, which may help explain the flatline performance versus an increasingly-distant stair-stepped goal. NHP does not contract directly with dental providers, but found opportunities to increase dental access through mobile dentistry. The impacts of these efforts should be seen in SFY23/24.

Figure 13. Dental Visit Performance



Prenatal Engagement

Prenatal Engagement rates remained stable, but with a slight downward trend in SFY22/23. However, performance rates have not fluctuated beyond two percentage points since May of 2021, with a low rate of 63.07% in May of 2021 and a high rate of 65.25% in May of 2022. In fact, the rate has not fallen below a 61% threshold since January of 2020, representing a ceiling effect spanning a three-and-a-half-year period.

NHP conducted a data analysis on CPT codes and found a universal billing code listed in the specification document as a usable and viable code (CPT Code 59400), but was not calculated in the overall baseline or performance rate. Because this code was not captured in the baseline calculation, its impact on NHP reaching the Tier 1 or Tier 2 goal levels is unknown. However, because this code is not included in the calculation, the actual performance rate for prenatal engagement is almost 15 percentage points higher than the reported rate.

Interestingly, the rate of CPT Code 59400 use has increased during the fiscal year while overall performance rates have decreased. NHP has done a significant amount of work communicating KPI results to practices including disseminating specification documents and codes. The results of this work may have resulted in adversely impacting rates among viable, but uncalculated CPT codes. Also, the population growth may also impact performance rates through the past year. In July, NHP saw 1,051 members served from 1,627 members (performance rate of 64.5%). In May of 2023, NHP saw 1,143 members served from 1,809 members (performance rate or 63.2%). This represents an increase of almost 100 members served across a population of almost 200 additional members. The prenatal engagement rate is captured in Figure 14 and the prenatal engagement rate with code 59400 is captured in Figure 15.

Figure 14. Prenatal Engagement

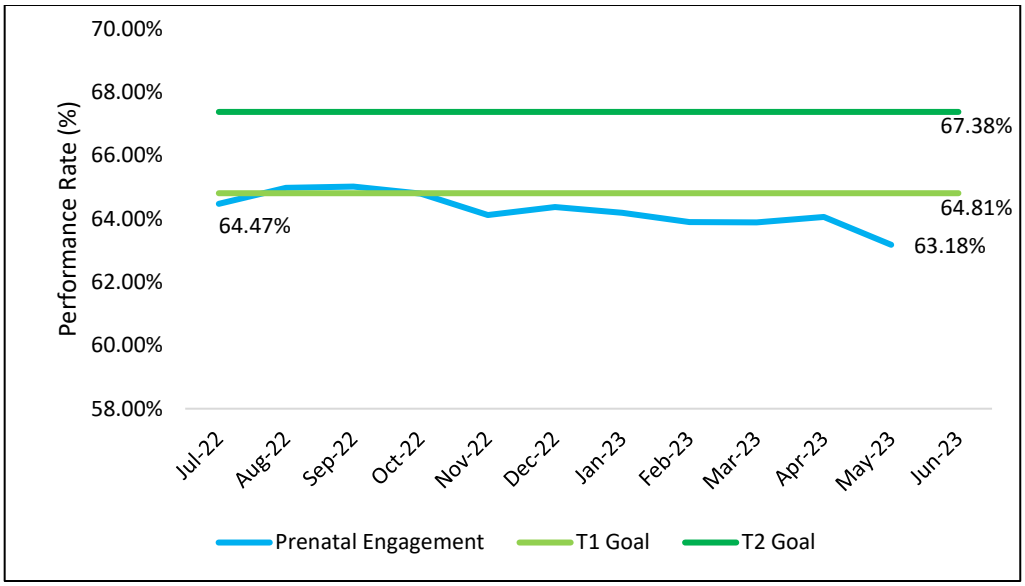
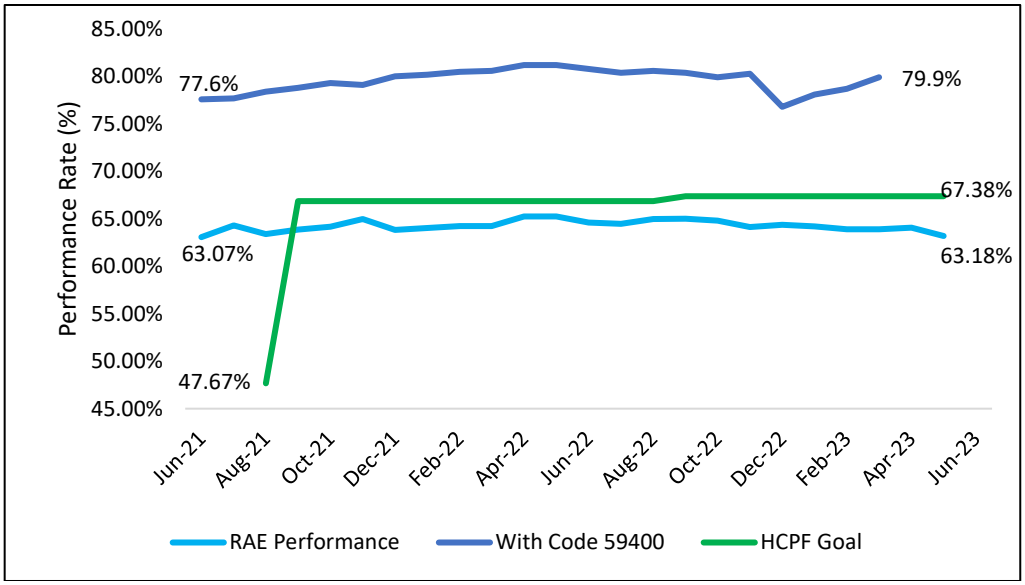


Figure 15. Prenatal Engagement with Code 59400

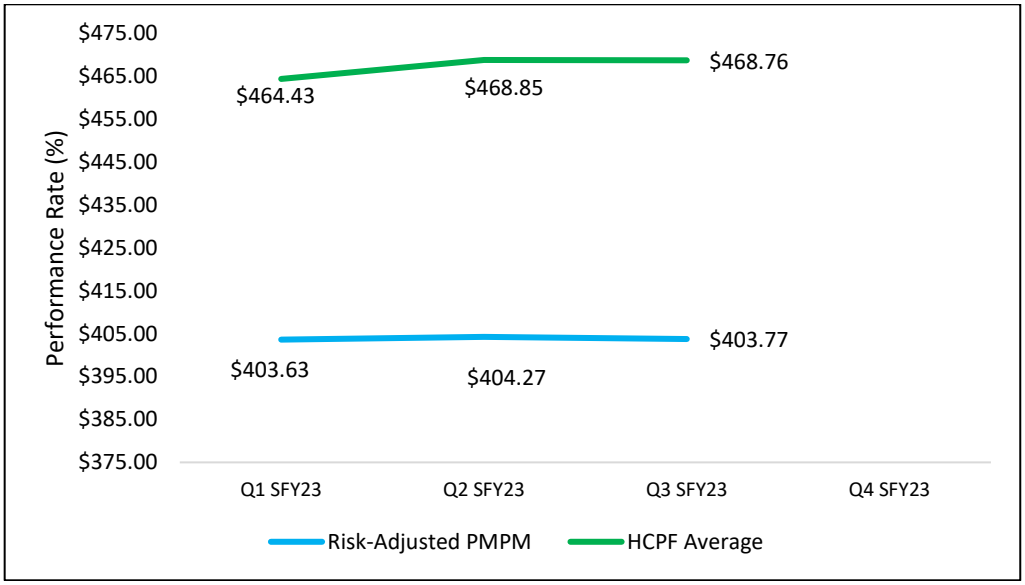


Risk-Adjusted PMPM

Risk-Adjusted PMPM is a new KPI measure for SFY22/23, but was a Performance Pool Measure in SFY21/22. NHP consistently had the lowest Risk-Adjusted PMPM rate across all RAEs during the SFY21/22 year and this trend continued in the SFY22/23 year. This measure was calculated internally on a monthly with an annual calculation provided by HCPF in SFY21/22. As a KPI measure for SFY22/23, it is still calculated internally monthly but now calculated quarterly by the state. This allows for better performance insight and better validation with internal calculations. Quarterly rates for SFY22/23 are shown below in Figure 16.[18]

[18] Rates are calculated by HCPF on a quarterly basis. Q4 results have not been provided at the time of this report.

Figure 16. Risk-Adjusted PMPM



Performance Pool

Performance Pool measures have changed little across fiscal years with the exception of removing the Risk-Adjusted PMPM Measure for SFY22/23. The Performance Pool consisted of Extended Care Coordination, Premature Birth Rates, Behavioral Health Engagement with members releasing from Department of Corrections facilities, and medication adherence measures for Asthma Medication Ratio, Anti-Depressant Medication Management, and Contraceptive Care.

NHP has and continues to perform well on the Extended Care Coordination measure. Because this measure is offset from the fiscal year to account for care plan development, performance visualizations are not included in this report.

Medication Adherence

Medication adherence rates have been slightly inconsistent over the past fiscal year. Asthma Medication Ratio has been steadily declining over the year but saw a significant uptick in Quarter 3 over Quarter 2. Additionally, the 12-Week Anti-Depressant Medication Management is represented in a near-parabolic curve with a significant drop and a significant increase that broke the goal line in Quarter 3. This same increase was also seen in the 6-Month Anti-Depressant Medication Management measure, but to a much lesser extent that also still lags behind the goal line. In fact, Contraceptive Care has been the only measure that Has not sharply improved. Performance rates for Asthma Medication Ratio, Anti-Depressant Medication Management for 12 Weeks and 6 Months, and Contraceptive Care are found in Figures 17, 18, 19, and 20, respectively.

Figure 17. Asthma Medication Ratio

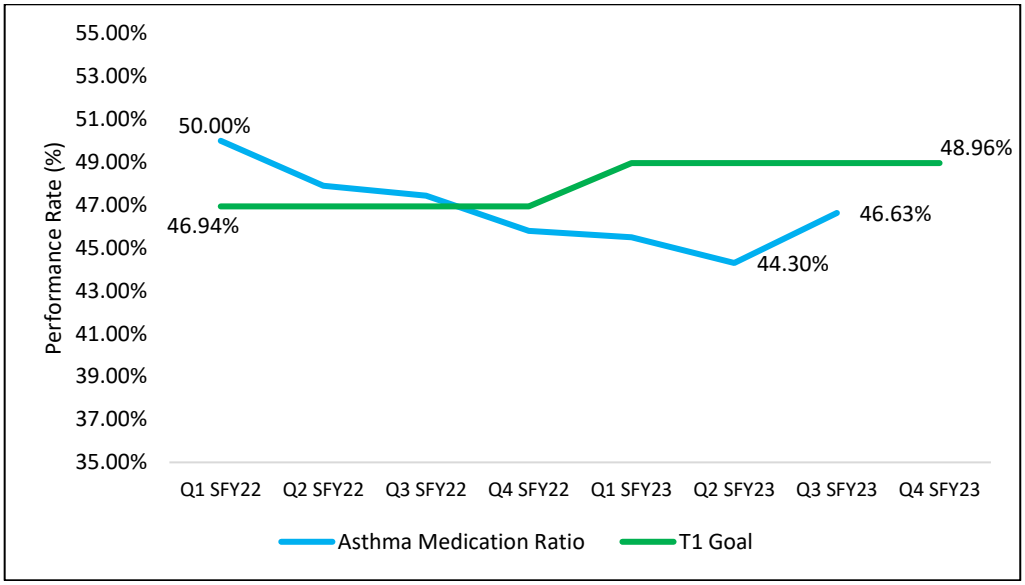


Figure 18. Anti-Depressant Medication Management (12 Weeks)

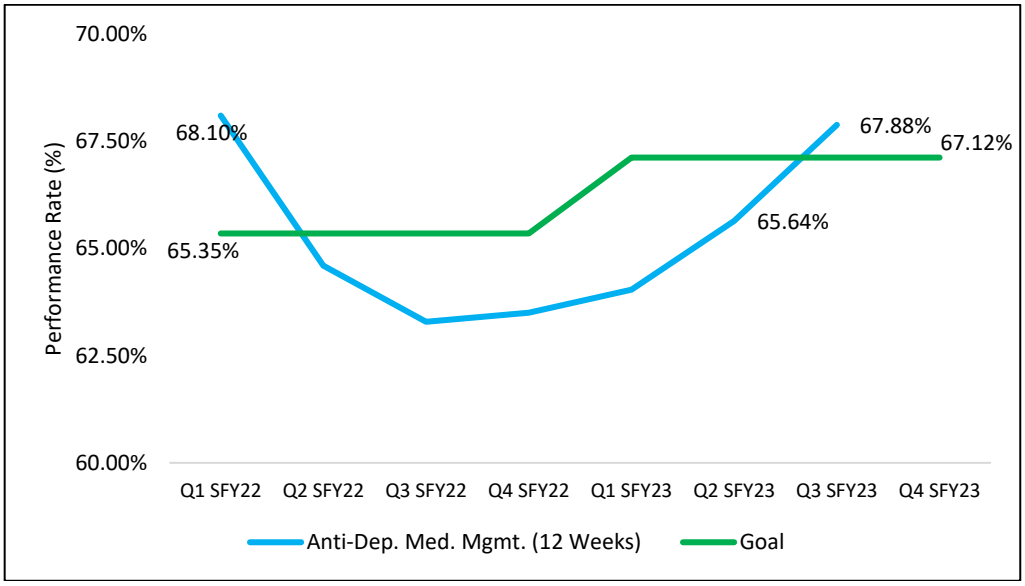


Figure 19. Anti-Depressant Medication Management (6 Months)

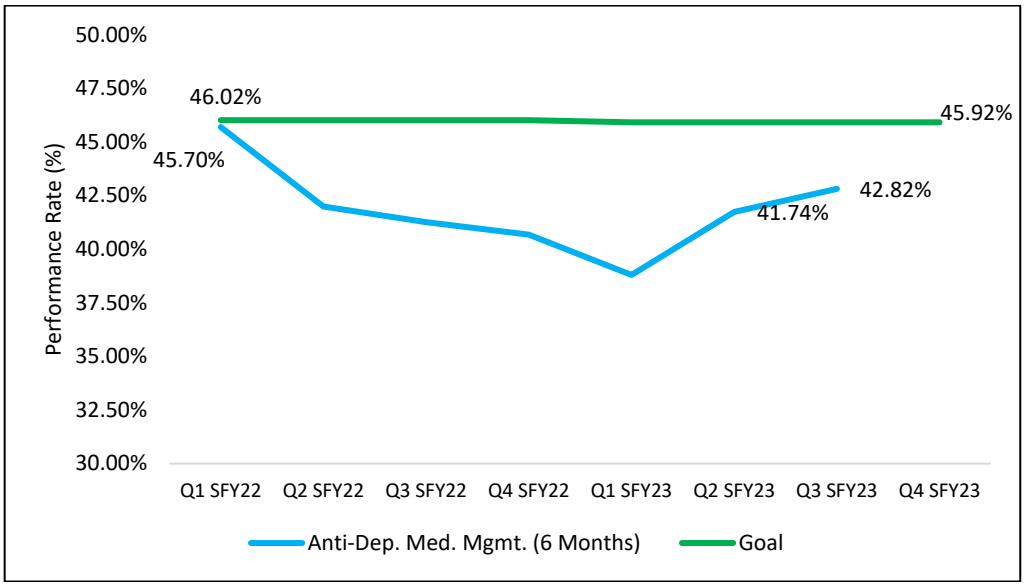
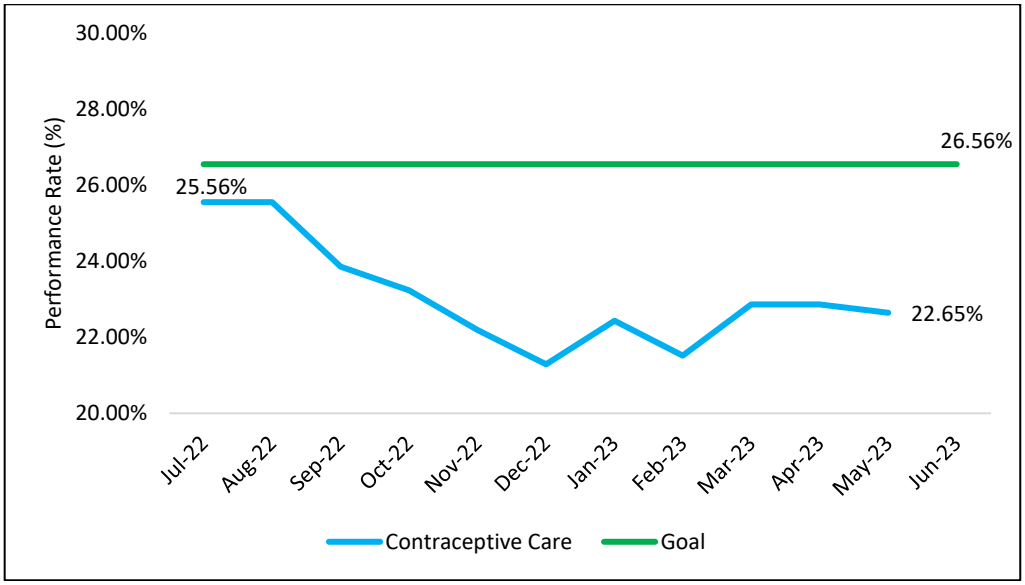


Figure 20. Contraceptive Care

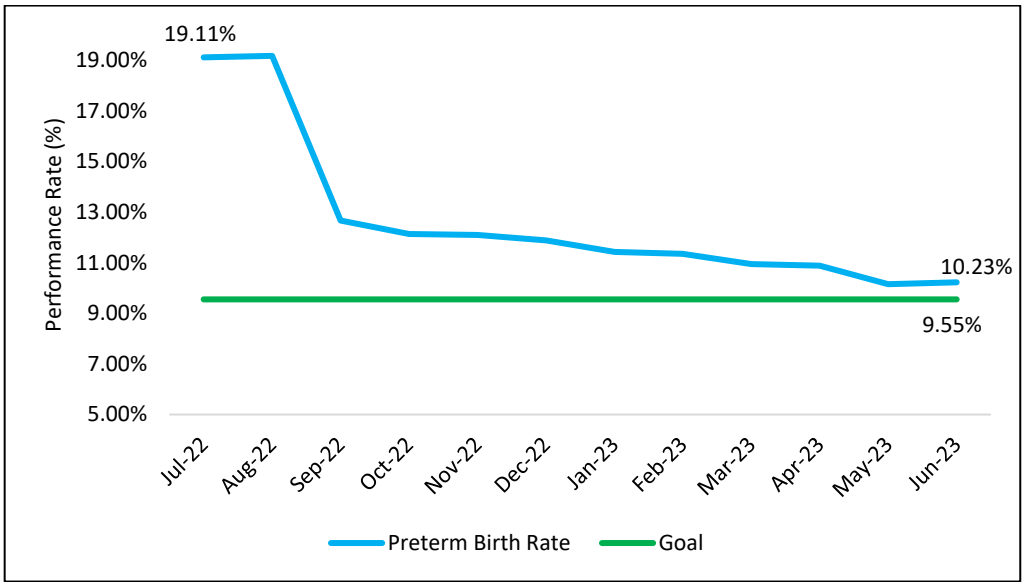


Preterm Birth Rate

The preterm birth rate for NHP has been declining steadily over the past several fiscal years. The most recent data supplied by the state in August of 2022 showed overall regional performance at 8.33% spanning a time frame between April of 2022 and March of 2023. This rate is not only below the SFY23 goal of 10% but is also lower than the Colorado Medicaid Average (approximately 12%), the US Average (approximately 10%), and the Colorado Average (approximately 9%).[19] Performance rates for premature birth rate are found in Figure 21 and are reflective of a 12-month rolling average calculated internally.

[19] Health Care Policy & Financing. *RAE2 KPI Performance Pool Premature Birth Rate 040122_033123.* Sent via e-mail on August 22, 2023.

Figure 21. Preterm Birth Rate



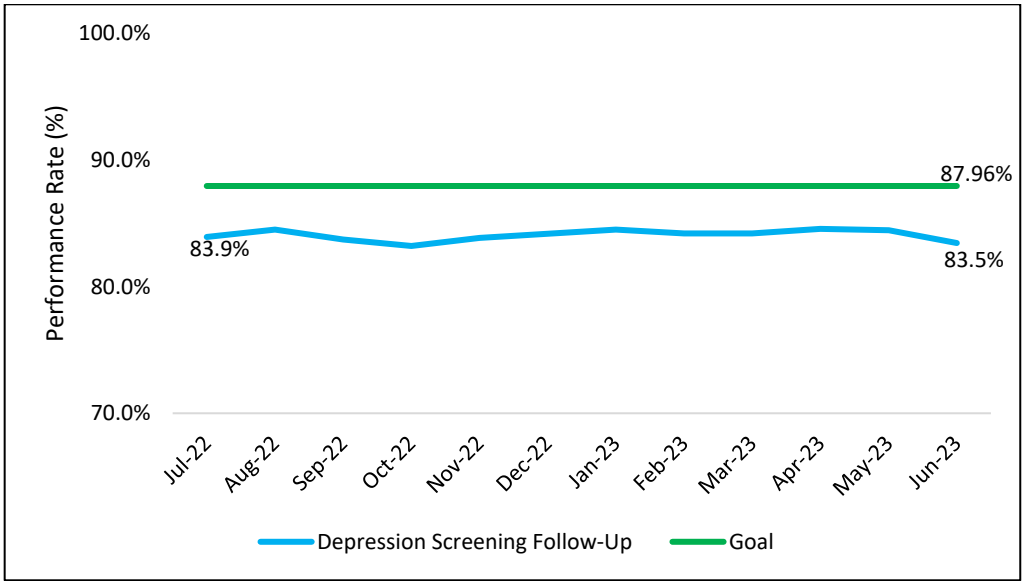
Behavioral Health Incentive Program (BHIP)

NHP continues to perform well in the BHIP program. NHP historically reached two out of the five performance measures, but met three of the five measures for SFY22/23, and would have hit four measures had it met the depression screening gate measure. Rates for follow-up appointments after positive depression screens have remained relatively stable over time. While NHP did not reach the goal level for follow-up visits after a positive depression screen, its performance rate has been leading all RAEs in recent years.

Follow-Up after a Positive Depression Screen in Primary Care

Depression screening and follow-up rates both improved sharply during SFY20/21 which may be directly related to the state Performance Improvement Project (PIP) focusing on depression screening and follow-up rates. In fact, the follow-up rate for positive depression screenings for SFY21/22 was the highest rate among all RAEs. This rate leveled off at the 83% rate for SFY22/23 and remained slightly under the goal level.

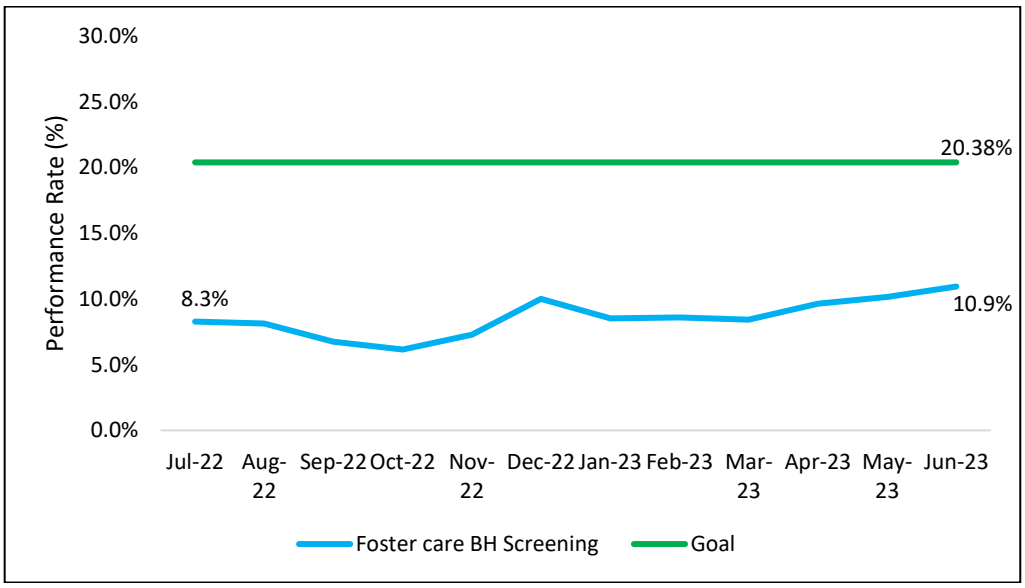
Figure 22. Follow-Up After Positive Depression Screen in Primary Care



BH Screen/Assessment for Members in Foster Care

The behavioral health screening measures for members in foster care is a focus of data exploration for NHP. While the total population of members who qualify for this measure remains low, the ability to impact this measure is high. However, data explorations have not yielded fruitful insights. NHP has processes in place with Weld County Department of Human Services to receive data weekly about members new to the foster care system in Weld County. These members are then outreached by care coordination teams for physical and behavioral health assessments. The integrated system of care between the two largest physical and mental health providers in the region allows for an efficient process for screenings across both physical and behavioral health. NHP believes the efficiency of screenings and the complex timestamps of when aid codes are applied and/or when Medicaid coverage begins contributing to low performance on this measure and is actively exploring a new dataset to identify dates along the process of care. Figure 23 shows performance on the Behavioral Health Assessment for Members in Foster Care.

Figure 23. BH Assessment for Members in Foster Care



SUD Engagement and 7-Day Follow-Up After an ED Visit for SUD

Substance Use Disorder (SUD) rates remained stable across both BHIP measures for SFY22/23. The 7-Day Follow-Up rate after an ED Visit for Substance Use Disorder (SUD) stayed at 34% throughout the year but exceeded the goal threshold. This may be related to enhanced care coordination efforts with the region's largest hospital. Conversely, the SUD Engagement Rate dipped slightly from the beginning of the fiscal year but did not meet the goal threshold based on internal calculations. Rates for the 7-Day Follow-Up after an ED Visit for SUD and SUD Engagement rates are found in Figures 24 and 25.

Figure 24. 7-Day Follow-Up After an ED Visit for SUD

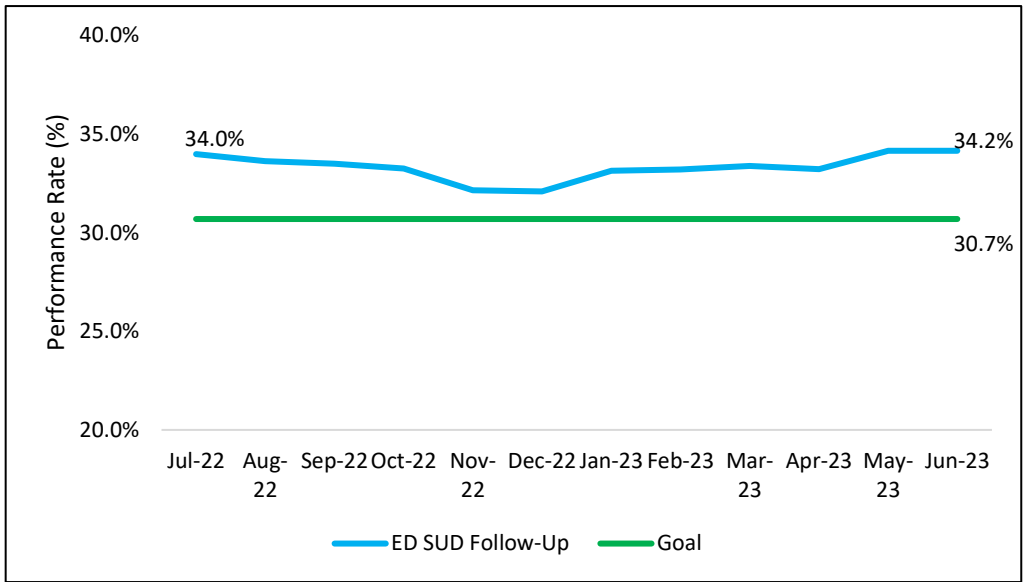
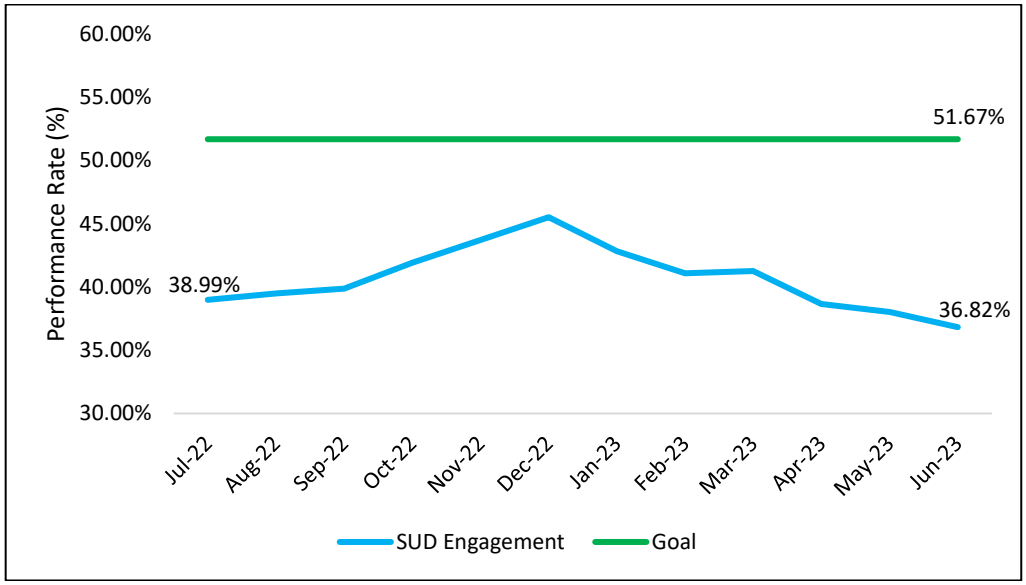


Figure 25. SUD Engagement



Performance Improvement Projects (PIPs)

State PIP (Increasing Depression Screening and Follow-Up)

In coordination with the Colorado Department of Health Care Policy and Financing (the Department), NHP was directed to continue the work on a single performance improvement project (PIP). In FY22-23, the PIP's focus was again to increase depression screening rates and the completion of subsequent behavioral health follow-up services after a positive depression screening. The focus of NHP and the SMART AIM provider was to analyze PIP related data, identify opportunities and barriers to improvement, examine the successes and challenges of interventions, and work toward continued and sustained improvement. The single PIP focused on the depression screen and follow up and is described below.

NHP continued to partner with the Monfort Clinic at Sunrise Community Health Center as the SMART AIM provider in coordination with North Range Behavioral Health working to improve performance on the two (2) measures. The depression screening measure assesses depression screening utilizing a validated tool within primary care encounters for members twelve (12) years and older. The second measure is follow-up after positive depression screening that evaluates the rate that members twelve (12) years and older receive a follow-up encounter with a behavioral health provider within thirty (30) days of a positive depression screening. The statistically significant goals established in Module 1 in FY20-21 remained in place.

In FY22-23, NHP and Sunrise continued intervention testing for each of these measures. For the Depression Screening measure, testing on the “Staff Education and Feedback on Depression Screening Procedures” intervention focused on the utilization of the pre-visit planning tool by Medical Assistants (MAs) and targeted the failure mode of “MA skips PHQ-4 during check-in process without medical rationale.” This achieved the SMART Aim goal as performance was elevated at the time of the intervention. This is due to the prolonged period between the baseline calculation and the implementation of the intervention that was forced by the Public Health Emergency (PHE). The strength of this intervention was demonstrated by the sustained performance gains in the face of MA staffing issues and increased COVID volume between November 2021 and February 2022. The intervention's efficacy is also supported by the ability to be adopted so quickly as Sunrise initiated an MA training program in response to the work force challenges. The results of the PIP for the Depression Screening measure are found in Figure 26.

For the Follow-up After a Positive Depression Screen measure, the intervention “Provider Education on Integrated Care Delivery Following Positive Depression Screening” targeted the failure mode of “Provider addresses issue with plan &/or psychopharmacology and no Behavioral Health involvement.” A major focus for this intervention included methods used to notify BH providers in the event of a positive depression screen such as flags in the electronic health record (EHR) or pagers. Performance on this measure improved and exceeded the SMART Aim goal in June 2022. The results of the PIP for the Follow-up After Positive Depression Screening measure are found in Figure 27.

Early in FY22-23, NHP identified a challenge to the final timetable for completion of the PIP and submission of Module 4 due to processes to allow full 90-day claim lag to be included in submission. A Technical Assistant (TA) call was conducted with HCPF and the Health Services Advisory Group (HSAG). The processes involved and timelines were reconciled such that NHP would be able to submit Module 4 by the suspense date with an amended submission with full data shortly after the suspense date.

NHP submitted the Module 4 summarizing the project conclusions, intervention testing conclusions, challenges encountered, and plan for sustainment of successful interventions. Per the direction from the TA Call, this included data through May 2022. HSAG validated the results for the Depression Screening measure and confirmed that “significant clinical and programmatic improvement was demonstrated for the intervention.” The initial submission for the Follow-up of a Positive Depression Screen measure was not validated as HSAG determined that statistically significant improvement from baseline was not demonstrated, though significant clinical improvement and programmatic improvement were demonstrated. HCPF authorized one resubmission of Module 4 and the resubmission included the results from June 2022.

Upon subsequent review, HSAG concluded that the Follow-up measure achieved the SMART Aim goal and statistically significant improvement over baseline.

Figure 26. Depression Screens Completed for Members Ages 12 and Up at Monfort Family Clinic

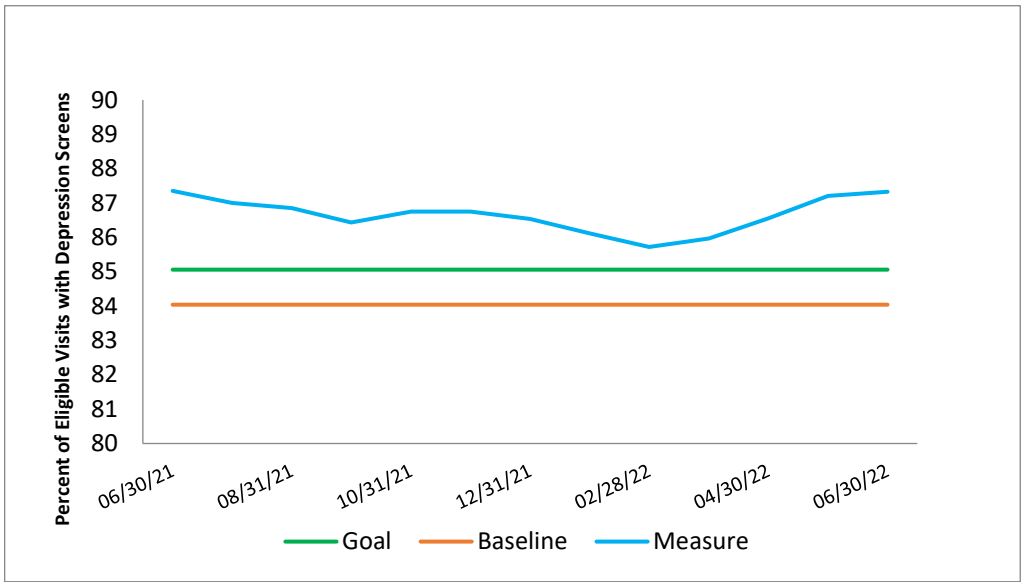
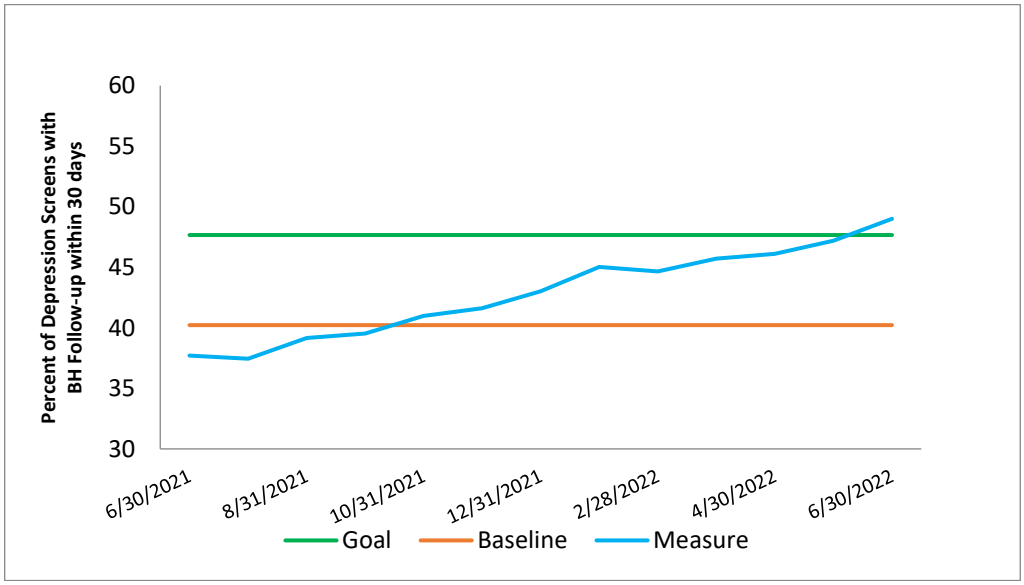


Figure 27: BH Follow-up within 30 days of a Positive Depression Screen for Members Ages 12 and Up at Monfort Family Clinic



Other Performance Improvement Projects

DAP Project

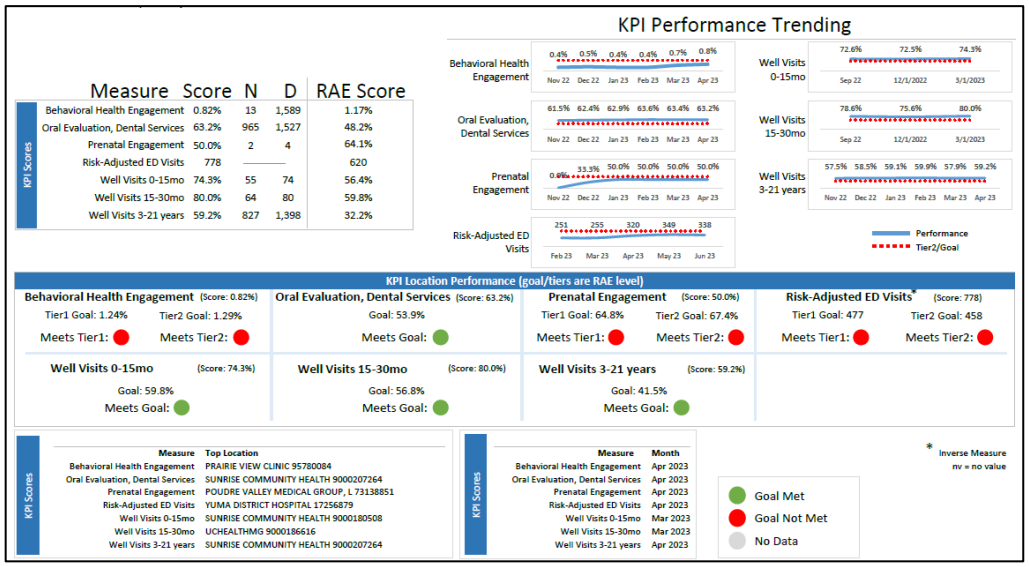
NHP began sending charts and action lists from the Colorado Data Analytics Portal (DAP) during the previous fiscal year and continued that process through SFY22/23. This enabled practices to receive performance data and action lists directly from

a secured inbox instead of logging into the DAP to extract the information. This gave providers direct insight into performance, and enabled clinics to outreach attributed members who did not have completed visits for those measures.

Balanced Scorecards

NHP developed balanced scorecards in SFY22/23 to create better visibility with clinic and regional performance for both KPIs and Performance Pool Measures. These scorecards are sent directly to providers monthly, specifically noting performance, performance trends, and utilize color-coded visuals to clearly see the measures that are either met or not met. The scorecards also note the top-performing practice across each measure to foster both competition and collaboration among regional practices. Figure 28 is an excerpt of one of the scorecards specifically noting performance related to KPIs. NHP will expand the scorecards to behavioral health providers with BHIP performance in SFY23/24.

Figure 28. Balanced Scorecard KPI Example



2022-2023 411 QuIP Results

In SFY22/23, NHP engaged North Range Behavioral Health in the 411 Quality Improvement Project (QuIP) as a result of the SFY21/22 411 audit. As noted below in Table 12, results improved for the provider in the one encounter category required for the QuIP. At the beginning of the QuIP, NHP implemented a training to improve documentation performance within the service category. The training was delivered to the practice's Administrative Director who then trained and educated clinical providers on documentation standards for the sole encounter category that fell below 90% on the audit. NHP considers this a successfully completed performance project due to the overall increase in scores within the project.

This intervention will be adopted and can be used for further improvement going forward. For example, the training conducted on USCM requirements and best practice documentation for these encounter categories are transferable to the current encounter categories for the 411 audit for all facilities and providers. The auditing and monitoring encounter categories will continue through the efforts set forth in the annual 411 claims and encounter audit. New areas of improvement can be incorporated into future documentation training with regional behavioral health providers after the results of the next 411 audit are tabulated.

Table 12. Psychotherapy Encounters Outcomes

Encounter Data Type Below 90%	Baseline Rate	After Intervention September 2022	After Intervention October 2022	After Intervention November 2022
Place of Service	67.9%	100%	100%	100%

Section 5: Member & Family Experience

Member Satisfaction

CAHPS Survey

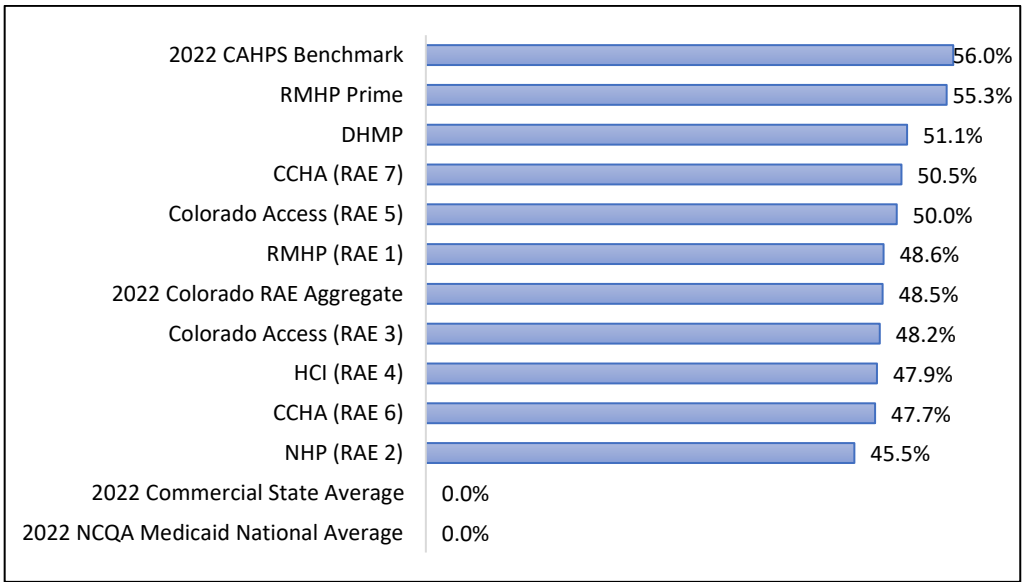
NHP participates in the annual Consumer Assessment of Healthcare Professionals and Systems (CAHPS) survey. The results for SFY21/22 showed a low response rate for both the child and adult surveys. As a result, NHP began disseminating information across the region about the SFY22/23 CAHPS survey. Information was presented at the Member Engagement Advisory Committee (MEAC), the Quality Improvement/Population Health Committee, the Quality Management Committee, and the regional PIAC. NHP also disseminated information to practices through the Practice Transformation Program during individual meetings with practices to help improve response rates for more accurate results.

NHP saw an increase in response rates for adults of almost 33% (from 6.59% to 8.74%) and in children of almost 10% (from 9.52% to 10.46%) from SFY21/22. In general, NHP saw stable rates in adults for the Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Getting Care Quickly, and How Well Doctor's Communicate. Customer Service saw a statistically significant increase in rates (from 82.7% to 94.8%), and Coordination of Care fell but had less than 100 responses.

The childhood responses saw stable rates in Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and How Well Doctor's Communicate. Increases were seen in Getting Needed Care, Getting Care Quickly, and Customer Service. As with the adult respondents, Customer Service saw a statistically significant increase in rates (from 82.1% to 96.3%), in addition to Getting Needed Care (from 76.5% to 89.9%). No categories dropped between years for child respondents.

Because of the expansive nature of the results spanning both children and adults, the "Rating of All Healthcare" measure is reported for both adults and children in Figures 29 and 30, respectively. Complete results can be found in the full report.[20,21]

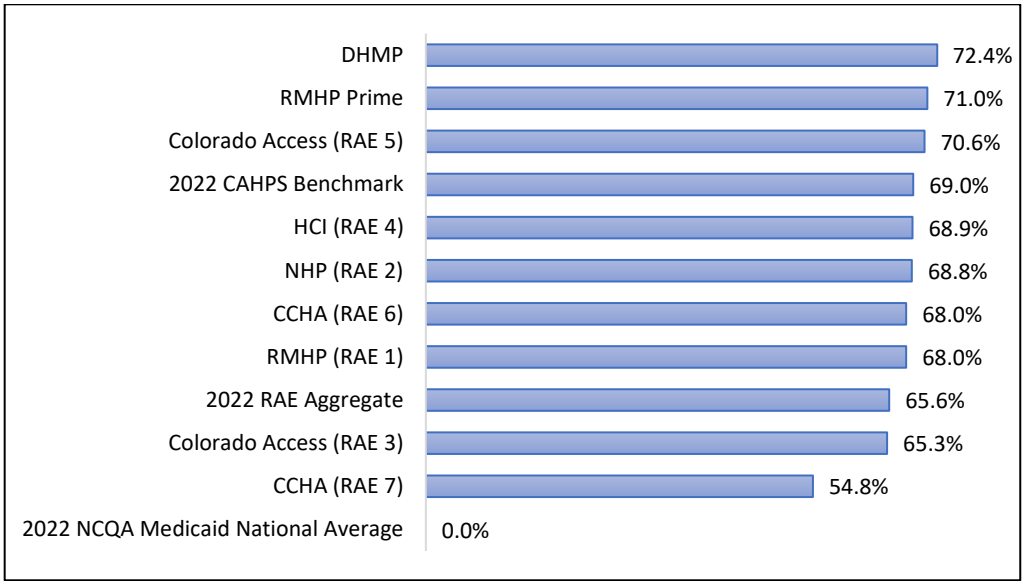
Figure 29. Regional Adult CAHPS Survey Summary: Rating of All Healthcare



[20] Health Care Policy and Financing. 2023 Colorado Adult Regional Accountable Entity (RAE) Member Experience Report. September 2023.

[21] Health Care Policy and Financing. 2023 Colorado Child Regional Accountable Entity (RAE) Member Experience Report. September 2023.

Figure 30. Regional Child CAHPS Survey Summary: Rating of All Healthcare

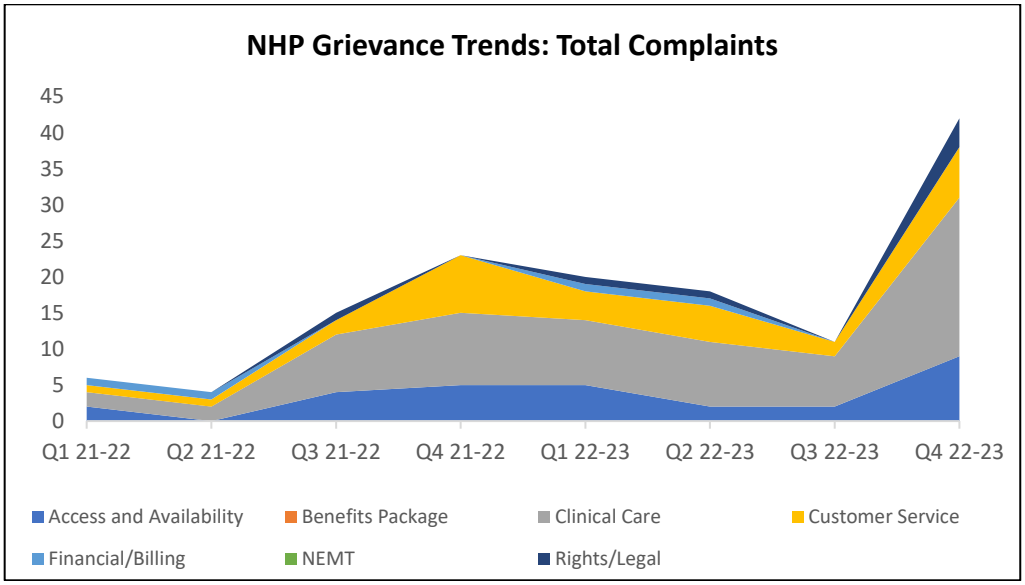


Grievances and Appeals

Carelon, on behalf of NHP, processes and completes any grievances and appeals received. Data specific to both are tracked by Carelon and any identified trends are monitored and presented at regional committees on a quarterly basis. NHP educated members, families, and health care professionals on members' rights regarding how to make grievances during SFY22/23. NHP processed 91 grievances during SFY22/23 which was an increase of 93% from SFY21/22. NHP attributes the significant increase in grievances to the ongoing education to members, families, and health care professionals. Seventy-three percent (73%) of the members who filed grievances during SFY22/23 were satisfied with the resolution of the grievance and the remaining 27% disagreed with the resolution. The complainants who disagreed with the resolution were given information on a second level review. The average turnaround time to resolve a complaint was 10.5 days.

NHP received 38 requests for appeals during SFY22/23. Fourteen appeal requests were not processed because they were either received after the sixty-day deadline or did not include a signed Designated Client Representative (DCR) form. One appeal request was not processed because the denied services had been previously appealed. For the 23 processed appeals, 11 were expedited and were resolved within the 72-hour time frame and 12 were standard appeals that were resolved within 10 working days. Two appeals received extended time frames at the request of the parents to allow more time to collect documentation. The 12 denials were upheld (meaning services remained denied) and 11 denials were overturned (meaning services were subsequently authorized). NHP continued to chart grievances to better surface trends as seen below in Figure 31.

Figure 31. Grievance Trends from SFY20/21 through SFY22/23



Quality of Care Concerns

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

NHP received five quality of care concerns in SFY22-23, none of which resulted in a Corrective Action Plan (CAP) being imposed on the provider. These care-monitoring initiatives, along with treatment record reviews and training, are conducted with the goal of ensuring members receive the best care possible and will continue to be maintained by the Quality Management Department in SFY23/24. Further in SFY23/24, NHP will update all workflows, Policies and Procedures, and investigatory processes to comply with HCPF QOCG contract amendments.

Section 6: Hospital and Practice Transformation

Hospital Transformation Program[22]

The Hospital Transformation Program (HTP) is a multi-year collaboration with regional hospitals to send data to the RAEs on selected hospital performance measures. Contexture, the state's Health Information Exchange, is the entity responsible for gathering HTP data to send to the RAEs. However, several hospitals within the region are not connected to Contexture for data transmission, specifically along the Eastern Plains. NHP developed a data collection tool for hospitals to securely send data to NHP, which is then parsed out to care coordination groups for follow-up. NHP is receiving data, revising the data collection tool for automation, and is starting to receive test data from Contexture from the other hospitals.

Practice Transformation[222]

The Practice Transformation program continued its alignment to support Quality initiatives with several milestones focused on KPIs, BHIPs, and Performance Pool measures. NHP also launched the Behavioral Health Practice Transformation program in SFY22/23 with two six-month phases of implementation. Overall, five practices completed programmatic milestones and NHP will expand the program to include more practices in SFY23/24. Milestones focused on being data-driven, supported performance improvement projects, and integrating behavioral and physical health.

The Physical Health Practice Transformation programs saw collective improvement in well visit rates, which may have had a direct impact on the increased rates of regional well visits. Additionally, eight clinics saw improvement in diabetes management rates, two clinics saw improvement in controlled blood pressure rates, and all three clinics who focused on dental performance saw increases in dental rates. Behavioral Health practices participating in the program all saw increases in BHIP scores, developed quality-specific initiatives within their practices, and reported high levels of satisfaction with the practice transformation programs. Programmatic milestones for physical and behavioral health programs are found below in Tables 13, 14, and 15.

Table 13. Physical Health Practice Transformation Milestones

Milestone	Description	Requirements
1. Data-Driven Improvement	A. Wellness Visits Rate	1. Using either EMR or DAP data, determine baseline (CY 2021), and then improve by 12% from 2021 baseline. Submit performance data by June 30, 2023.
	B. Choose one of these state defined measures: -Diabetes, CMS 122 -High Blood Pressure, CMS 165 -Depression Screening and Follow-up, CMS 2 -Dental visits, KPI -Immunizations, CMS 117	1. Can use either EMR or DAP, determine baseline (CY 2021), and improve by 10% from baseline to the target goal or meet the target goal. -Diabetes: Target 19% (less than 19%) -Depression Screening and Follow-up: Target 93% -High Blood Pressure: Target 82% -Dental visits: Target 39.55% -Childhood Immunizations: Target 57%
2. Population Management	A. Wellness Registry/Report	1. Utilize a Registry/reports to identify patient-level gaps in care including: a. Well Visits AND b. At least one other care gap from Milestone 1.B
		2. Using a PDSA process create a workflow to outreach identified patients with gaps in care identified in the Registry

[22] Detailed information on this program is captured in the Health Neighborhood Plan and the Health Neighborhood report.

3. Team Based Care	A. Pre-visit Plan	1. Build a pre-visit planning tool for wellness visits to identify any gaps in care including: -Preventative Screenings -Immunizations -Condition-specific lab work, assessments, and/or diagnostics
		2. Provide 2 de-identified examples from 2 different quarters of a completed pre-visit planning tool.
	B. Standing Orders	1. Develop and utilize a documented standing order that streamlines teamwork for the measure chosen in 1.B.
		2. Provide a documented workflow describing your clinic's process for using standing orders.
		3. Provide 2 de-identified patient examples from 2 different quarters of how a standing order has been implemented. (For a total of 4 examples).
4. BH Integration and Engagement	A. BH Integration	1. Complete IPAT for baseline assessment
		2. Complete a PDSA to implement next steps for next level of BH integration
		3. Complete post improvement IPAT assessment and do one at least of the following: a. Advance integration by one IPAT level b. Maintain level 6 of IPAT OR c. attain >3% on Behavioral Health Engagement on KPI

Table 14. Phase I Behavioral Health Milestones (July – December, 2022)

Milestone	Description	Requirements
Milestone 1	BH PT Kick-off event	Attend June 29th, 2022 kick-off event in person 10:00 am- 12:00 pm
Milestone 2	Practice Assessment	Practice Assessment to be completed with your coach
Milestone 3	Quality Improvement	Develop Written QI Plan/Strategy for 2022 with your coach.
Milestone 4	Learning Collaborative	Practice to attend BH Learning Collaboratives
Milestone 5	Indicator #1 SUD Engagement Metric Performance	Complete one PDSA cycle with PT coach with a focus on SUD Engagement

Table 15. Phase II Behavioral Health Practice Transformation Milestones (January-June, 2023)

Milestone	Description	Requirements
1. BHIP Performance/Data-Driven Improvement	Choose one of the following: SUD Engagement Inpatient MH F/UP Depression Screen Follow -up	Using either EMR, or PowerBI Data determine baseline and then improve by 10% of 2022 baseline. Submit performance data by June 2024 Tier 1: Complete at least one PDSA cycle Tier 2: Close the gap by 10% Tier 3: Meet or exceed RAE target
2. Population Management	Wellness/Registry Report	Develop a registry/report to identify clients in specified population ie SUD, Major Depression AND identify needs/gaps of care. Utilize a PDSA process to create a workflow to outreach identified clients, treatment plan person-centered, incorporating values, lifestyle and social contexts of clients. Utilize evidenced based practice
3. Performance Visualization Tool	Practice develops dashboard for tracking performance (SUD Engagement/Depression Screen Follow -up, measure-based care tools, access, no show, retention) and develops process for sharing with clinical staff at least quarterly	Develop a performance visualization tool with your coach OR Provide a copy of the tool that you use to review performance data with clinical staff AND Provide a list of quarterly scheduled meetings where data will be reviewed with staff
4. Learning Collaboratives	Attend all 4 Learning collaboratives in FY 23-24	At least one practice representative attends each learning collaborative but does not have to be the same person each time. Learning Collaboratives are held each quarter during the fiscal year. Representatives must complete the post LC survey including their name and practice name.
5. Practice Assessment	Complete the annual Practice Transformation assessment	Generally completed between July 1, 2023, and September 30, 2023