State of Colorado

Department of Health Care Policy and Financing

2004–2005 External Quality Review Technical Report *for* Behavioral Health Organizations

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1. Executive Summary

Introduction

An external quality review (EQR) of the eight behavioral health organizations (BHOs) providing managed behavioral health care services to Colorado Medicaid recipients was conducted by Health Services Advisory Group, Inc. (HSAG), at the request of the Colorado Department of Health Care Policy & Financing (the Department). The Department is the Colorado state agency responsible for purchasing cost-effective health care for qualified low-income residents of Colorado through administration of the state's Medicaid program.

The delivery system for managed behavioral health care services for Medicaid recipients is provided through contracts with BHOs that provide community-based behavioral health services throughout the State of Colorado. During fiscal year (FY) 03-04, the Department contracted with the following eight BHOs:

- Access Behavioral Care-Denver (ABC-Denver)
- Access Behavioral Care-Pikes Peak (ABC-Pikes Peak)
- Behavioral HealthCare, Inc. (BHI)
- Jefferson Center for Mental Health (JCMH)
- Mental Health Center of Boulder County, Inc. (MHCBC)
- Northeast Behavioral Health, L.L.C. (NBH)
- SyCare-Options Colorado Health Networks, L.L.C (SyCare-Options)
- West Slope-Options Colorado Health Networks, L.L.C. (West Slope-Options)

HSAG performed reviews of each BHO regarding the three federally mandated EQR activities—determination of compliance with federal and state standards (compliance monitoring), validation of performance measures, and validation of performance improvement projects (PIPs)—for activities occurring from September 1, 2003, to August 31, 2004. These EQR reviews were conducted by HSAG between September 2004 and June 2005.

This *2004-2005 External Quality Review Technical Report for Behavioral Health Organizations* provides:

- A description of how data from these activities were aggregated and analyzed, and how conclusions were drawn as to the quality, timeliness, and access to care furnished by the BHOs.
- A summary of the findings from the three EQR activities.
- An assessment of each BHO's strengths and weaknesses with respect to provision of behavioral health care services furnished to Medicaid recipients.
- Recommendations for improving the quality of behavioral health care services provided by the BHOs.

This report meets the federal requirement for the preparation of an annual EQR report, as set forth in Balanced Budget Act (BBA) of 1997 and 42 CFR 438.364.

EQR Activities

In conducting the three mandatory EQR activities, HSAG followed the guidelines set forth in the Centers for Medicare & Medicaid Services (CMS) protocols. The three EQR activities were completed for each of the eight BHOs. For each activity the technical methods of data collection and analysis were the same across the BHOs. Common components for these reviews involved the use of standardized data collection monitoring tools, extensive document review and analysis, and a standardized scoring methodology (unique to each activity). On-site reviews involving interviews and additional document and record review were also part of the reviews for compliance monitoring and validation of performance measures. As a result of the review, HSAG issued detailed reports to the Department, which presented findings and recommendations for each EQR activity by BHO (Section 3 of this report provides a summary of the key findings and recommendations by EQR activity and Section 4 provides an assessment of each BHO's overall performance.)

Comparative Analysis

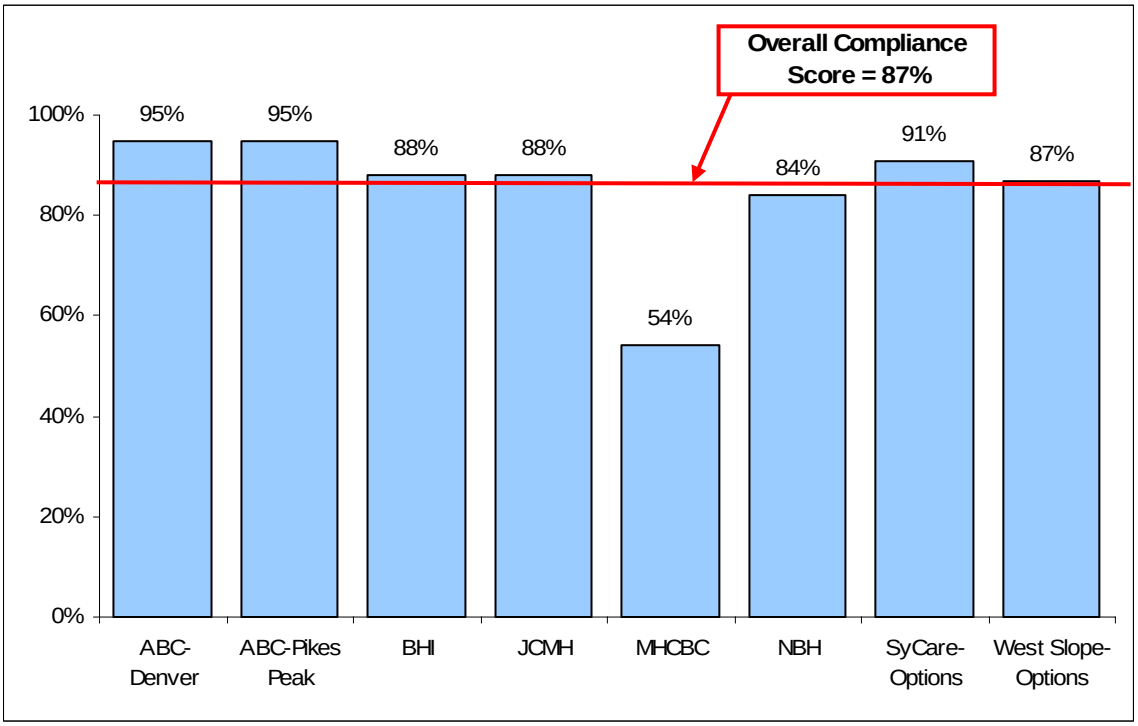
HSAG analyzed the results of the three EQR activities across all eight BHOs. The highlights of this comparative analysis are presented on the following pages (See Section 5 of this report for a more detailed analysis).

Compliance Monitoring

Drawing upon BBA requirements and state contractual requirements, the compliance monitoring review evaluated the following 13 compliance standards: Subcontracts and Delegation (438.230); Provider Issues (438.6, 438.12, 438.214); Marketing (438.104); Advance Directives (438.6, 422.128); Practice Guidelines (438.236); Member Rights and Responsibilities (438.100–.116, 438.10, 438.218); Access and Availability–Service Delivery (438.206); Utilization Review (438.210); Continuity of Care System–Service Delivery (438.208); Quality Assessment and Performance Improvement Documentation (438.240); Quality Assurance Program (438.240); Grievance, Appeals and Fair Hearing (438.228, 438.400–408, 438.414, 438.416); and Credentialing and Recredentialing (438.214). Additionally, implementation of some compliance standards was evaluated through associated record reviews. (Section 5 provides a brief summary of the content for each compliance standard.)

Across the 13 compliance standards and eight record reviews, the overall average score for the eight BHOs was 87 percent, with individual BHO compliance scores ranging from 54 percent to 95 percent (see Figure 1-1). This overall compliance score was calculated based on the total number of applicable elements (compliance monitoring standards and record review) that were *Met*.

Figure 1-1—BHO Overall Compliance Scores for Compliance Monitoring Standards and Record Review Scores



Compliance in the areas of Advance Directives, Access and Availability, Utilization Review, Quality Assurance Program, and Credentialing and Recredentialing of individual practitioners was a strength statewide, with the majority of BHOs receiving scores of 90 percent or higher. Opportunities for improvement were identified in the areas of Subcontracts and Delegation, Provider Issues, Member Rights and Responsibilities, Continuity of Care, Quality Assessment and Performance Improvement (QAPI) Documentation, and Grievances/Appeals/Fair Hearings for at least half of the BHOs.

Validation of Performance Measures

The validation of performance measures activity was designed to ensure the accuracy of the performance measure data that were collected and submitted by the BHOs to the Department and the extent to which the Department and the Division of Mental Health (DMH), or "the State," appropriately performed the calculation of the performance measures. To determine whether the results for each performance measure were valid and accurate, HSAG evaluated the BHOs' systems for processing each type of data used for reporting the performance measures. This involved reviewing the BHOs' processes for data integration, data control, and performance measure documentation.

DMH developed the performance measures and measure definitions. The Department selected which performance measures were to be validated by the EQRO. The calculation of the measures relied on three distinct data sources–claims/encounters, the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey data, and the Colorado Client Assessment Records (CCAR) data.

For FY 03-04, DMH performed all calculations of performance measures, using various sources of data, including encounter data, data derived from the MHSIP survey, and CCAR data. The BHO's role was to collect and submit the encounter and CCAR data to the State for these calculations. The MHSIP survey was conducted by DMH. The BHOs were responsible only for providing correct client contact information to the State. Because the performance measure calculations were performed by one entity, compliance with the measure calculations was the same across all BHOs. Only variances in the processes used by the BHOs to collect and validate performance data prior to submitting it to the State would impact the review findings (resulting in validation findings of *Substantially Compliant*).

Performance Measure Results

For the MHSIP survey, the program as a whole reported an overall average domain score in the 60 percent range for Consumer Perception of Outcome/Positive Change and Consumer Perception of Participation (62 percent and 65 percent, respectively). Overall average domain scores in the 70 percent range were reported for Consumer Perception of Access (71 percent), Quality/ Appropriateness (71 percent), and General Satisfaction (77 percent). Eighty-two percent of members surveyed reported seeing a doctor or nurse outside of the emergency room, a relatively strong finding. While no national benchmark data are available for comparison, these results indicate some room for improvement across all MSHIP measures.

There were five performance measures reported using z-scores, which reflect the performance of BHOs on the various measures relative to a statewide mean. Of the five measures, minimal variation in performance across the BHOs was observed for one measure (Adults Living Independently). Wide variation was observed for Change in Problem Severity in Adults, with various BHOs reporting scores that fell more than three standard deviations above or below the statewide mean. For the remaining three performance measures, most of the BHOs reported scores relatively close to the statewide mean, with only one or two BHOs reporting a score that was greater than one standard deviation above or below the statewide mean. These findings indicate that for most of the five measures, BHO performance is similar.

Table 1-1 shows the overall validation findings for all performance measures reported for the BHOs. A validation finding of *Fully Compliant* indicates that data were collected in a standardized manner and there was no deviation from the measure specifications. A *Substantially Compliant* validation finding indicates that there was some deviation from the performance measure specifications, or the data were not collected using sufficient validation processes to ensure accuracy and completeness. As displayed in Table 1-1, of the 104 performance measures that were reported for the BHOs, 48 were determined to be *Fully Compliant* (or 46 percent), 56 were determined to be *Substantially Compliant* (54 percent), and none was determined to be *Not Valid*. All 46 performance measures that were determined to be *Fully Compliant* were calculated using MHSIP Survey data. The other 56 performance measures, which received a *Substantially Compliant* validation finding, were calculated using encounter data (i.e., penetration rate) or CCAR data. MHSIP survey data were collected in a standardized manner across all BHOs, resulting in a validation finding of *Fully Compliant*. The BHOs collected the encounter and CCAR data; however, validation processes used by the BHOs were determined to be insufficient, resulting in a *Substantially Compliant* validation finding.

Table 1-1—Overall Performance Measure Compliance with Department Specifications Across all BHOs

Validation Findings	Performance Measures	
	Number	Percent
Fully Compliant	48	46%
Substantially Compliant	56	54%
Not Valid	0	0%
Total	**104**	**100%**

For the 48 performance measures that were determined to be *Fully Compliant*, data collection processes were valid, and the measures were calculated in full accordance with measure specifications. For the 56 performance measures that were determined to be *Substantially Compliant*, there was a slight deviation from specifications, or the data collection activities did not have sufficient validation processes in place. There were no measures that received a validation finding of *Not Valid*.

In addition to the validity of the specific performance measures, the review of other aspects of the BHOs' operations crucial to the process for calculating performance measures, showed:

- Acceptable processes were in place as they related to data integration, data control, and documentation.
- The eligibility and claims/encounter data systems for processing the data used for reporting the performance measures were solid, with sufficient processes in place to ensure data quality.
- Sound methods were in place to ensure that all services were entered into the systems in a timely manner.
- Staff were strongly committed to providing quality performance measure data.

Validation of Performance Improvement Projects (PIPs)

The purpose of PIPs is to assess and improve processes and, thereby, outcomes of care. In order for such projects to achieve real improvements in care, and for interested parties to have confidence in the reported improvements, the projects must be designed, conducted, and reported in a methodologically sound manner.

Using the 10 CMS-recommended PIP protocol activities, HSAG validated two PIP studies for each of the eight BHOs. Since the validation of PIPs was combined for SyCare-Options and West Slope-Options, 14 PIPs were validated. The study topics were determined by the individual BHOs and, as such, the PIP study topics were not uniform across the BHOs. Additionally, the PIP studies were at different stages in their implementation, so the number of PIP protocol activities that HSAG reviewed and evaluated varied among the BHOs. Of the 10 CMS-recommended PIP protocol activities, HSAG was able to validate all 14 PIPs for Activities I through VI (study topic through data collection), 13 PIPs for Activities VII and VIII (appropriate improvement strategies and sufficient data analysis and interpretation), 11 PIPs for Activity IX (real improvement achieved), and 4 PIPs for Activity X (sustained improvements achieved).

The 10 PIP protocol activities are further broken down into 13 critical elements. These elements have been designated by HSAG as "critical" for producing valid and reliable results and for demonstrating high confidence in the PIP findings. If one or more critical elements were *Not Met*, the PIP was given a validation score of *Not Met*.

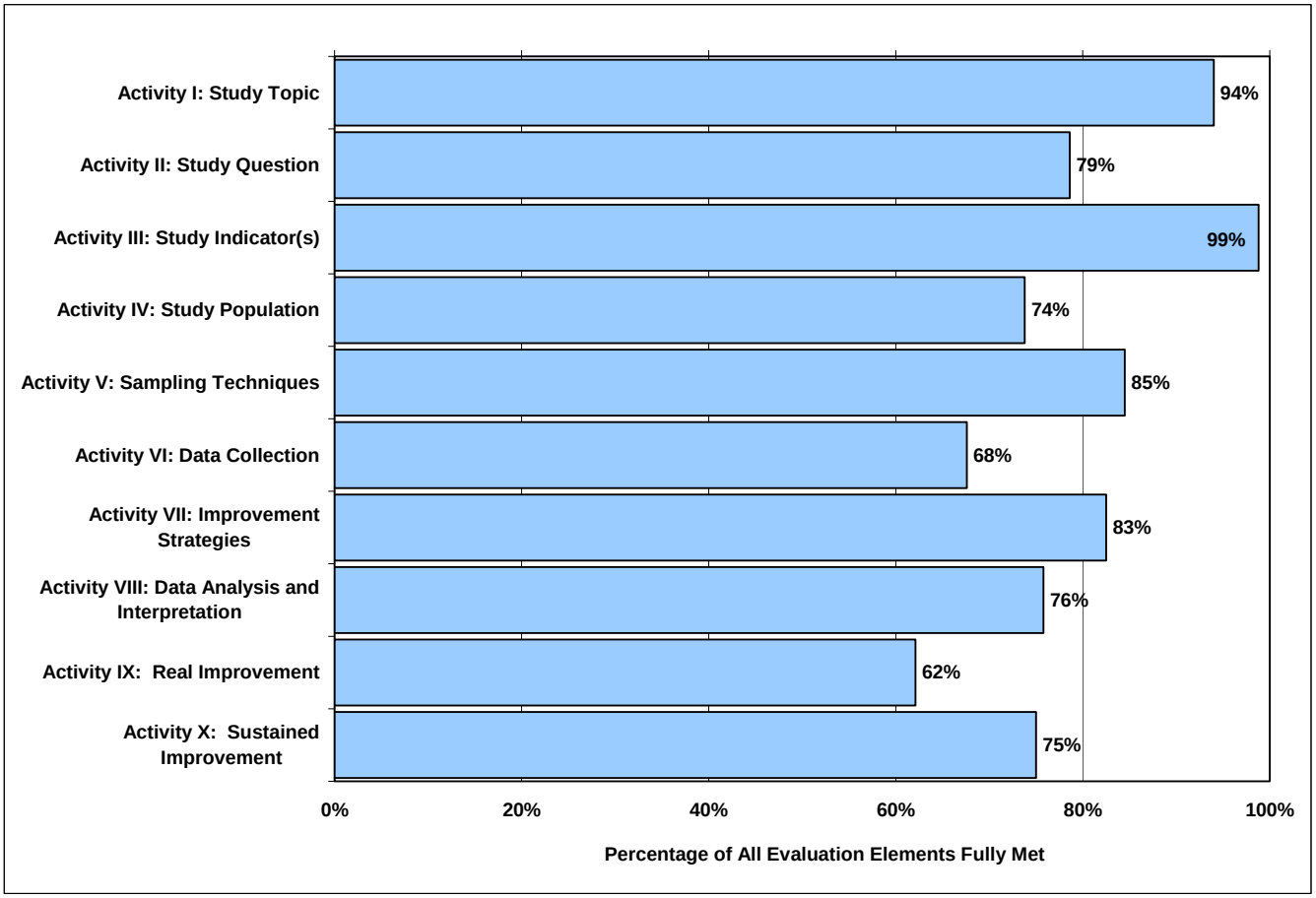
Table 1-2 shows a summary of the PIP validation status for the BHOs. For the eight PIPs given a validation status of *Met*, the overall scores ranged from 86 percent to 98 percent, and for the five PIPs given a validation status of *Partially Met*, the overall scores ranged from 52 percent to 75 percent. Only one of the PIPs with a score of 81 percent received a *Not Met* validation status as a result of not meeting one critical element.

Table 1-2—BHOs' PIP Validation Status

Validation Status	Number of BHOs
Both PIPs were *Met*	3
One PIP was *Met* and one PIP was *Partially Met*	2
Both PIPs were *Partially Met*	2
One PIP was *Partially Met* and One PIP was *Not Met*	1

Figure 1-2 shows the percentages of all evaluation elements that were fully met across all BHOs. Higher performance across all BHOs was observed in the areas of Activity I: Appropriate Study Topic (94 percent); Activity III: Clearly defined Study Indicator (99 percent); Activity V: Valid Sampling Techniques (85 percent); and Activity VII: Appropriate Improvement Strategies (83 percent). Average performance was noted in the areas of Activity II: Clearly Defined, Answerable Study Question (79 percent); Activity IV: Correctly Identified Study Population (74 percent); Activity VIII: Sufficient Data Analysis and Interpretation (75 percent); and Activity X: Sustained Improvement Achieved (75 percent). Below-average performance was observed in the areas of Activity VI: Accurate/Complete Data Collection (68 percent), and Activity IX: Real Improvement Achieved (62 percent).

Figure 1-2—Percentage of Evaluation Elements Fully Met by All BHOs (Both Critical and Noncritical)



Conclusions and Recommendations

A summary of strengths and weaknesses for each BHO is located in Sections 4 and 5. Identification of BHO-specific performance strengths and weaknesses, and related recommendations, were provided in detailed reports to the Department and to each BHO.

Compliance Monitoring

The majority of BHOs were found to be meeting the federal and State requirements with strong showings in the area of Standards: IV—Advance Directives; VI—Access and Availability; VIII—Utilization Review; XI—Quality Assurance Program; and XIII—Credentialing and Recredentialing of individual practitioners.

Recommendations

At the conclusion of its review, HSAG made the following recommendations:

- BHO policies and procedures need to be further enhanced in a number of areas, the key area being policies and procedures related to grievances and appeals. Other policy areas identified for improvement include enrollee rights and responsibilities and subcontracts/delegation.
- The majority of BHOs need to augment material provided to enrollees, ensuring compliance with federal and State requirements related to:
  - Grievance, appeal, and fair hearing procedures and time frames.
  - Obtaining benefits, including access to interpreter services.
  - Enrollee rights and responsibilities.
  - Provider selection and referral processes.
  - Availability of QAPI-related information.

  Additionally, BHOs need to ensure enrollee materials are presented in a manner that is easily understood as well as available in alternative formats.

- All the BHOs should continue to develop effective processes to ensure the accuracy of encounter data submitted to the Department.
- A number of the BHOs need to ensure that staff members are appropriately trained on the denial criteria and process.
- Although many of the BHOs had high compliance scores in the area of credentialing and recredentialing of individual practitioners, additional improvements should be made in their processes related to:
  - Implementation of a tracking system.
  - Credentialing committee procedures.
  - Department notification regarding provider additions and terminations.

For all elements within the standards for which the BHOs received a score of *Partially Met* or *Not Met*, the BHOs were required to submit a corrective action plan for review by HSAG and the Department. The plans were to identify the areas that required correction, the planned interventions, and the timeline for completing the activities. All BHOs submitted their corrective action plans as required and have implemented, or are in the process of implementing, the corrective actions.

Validation of Performance Measures

Overall, the BHOs were successful in reporting accurate and valid performance measures. The BHO information systems captured the necessary data elements to report the Department-required performance measures. In addition, the BHO staff members who collected and reported the performance measures were highly skilled and dedicated to performance improvement.

Recommendations

At the conclusion of its review, HSAG made the following recommendations:

- Follow Department specifications pertaining to data scrubbing of claims and encounter submissions to the Department.
- Improve processes for internally validating CCAR and claims data, including the implementation of a method to perform inter-rater reliability testing and to validate data entry.
- Automate current manual processes related to data validation and submission.
- Implement better tracking processes related to claims and encounters submission.

In reviewing the performance measure reporting process as a whole, the Department should:

- Consider establishing a performance measure work group (which should include representatives from the BHOs, the Department, DMH, and other interested parties) to evaluate the performance measures objectively and determine if they are actionable, meaningful, and valuable, according to the overall program objectives.
- Consider developing other performance measures that assist in evaluating BHO performance in the areas of access, quality, and timeliness of services rendered. BHO contract requirements for timeliness or access could be measured to ensure these requirements are met. Other national performance measures (such as HEDIS®) should be evaluated in terms of the ability to collect performance data that is meaningful to Colorado's behavioral health program.
- Consider establishing minimal standards for performance measures to identify targets for BHO performance, measure improvement over time, and measure overall program performance relative to these standards.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Validation of Performance Improvement Projects

Most BHOs had established a strong framework for conducting PIPs, with five BHOs having at least one PIP achieving a validation score of *Met.* Their strong performance in this area was also reflected in the fact that only one of the BHOs' PIPs was found to have a critical element that was *Not Met*. Above-average performance was observed in the PIP protocol activities related to appropriate study topics, clearly defined study indicators, valid sampling techniques, and appropriate improvement strategies.

For those PIPs in which remeasurement data had been collected and analyzed, the majority of BHOs were able to demonstrate significant improvements in the study indicators, achieving or exceeding benchmark goals.

Recommendations

At the conclusion of its review, HSAG made the following recommendations:

- Immediate steps should be taken by those BHOs for whom corrective actions were identified as a result of the PIP validation process, including the submittal of a corrective action plan to the Department.
- For ongoing phases of current PIPs as well as all future PIPs, the BHOs should ensure that all evaluation elements that were *Partially Met* or *Not Met* are addressed in the documentation submitted. In particular, the BHOs should address the following areas:
  - Providing an estimated degree of automated data completeness for the data collected and analyzed.
  - Providing the automated data collection algorithms that show steps in the production of the study indicators.
  - Discussing any factors that might have threatened the internal or external validity of the study.
  - Clearly describing the method employed to identify the study population, particularly in terms of the length of a member's enrollment in the plan.
  - Presenting the data analysis in a clear and easily understood format.

Findings from the PIP validation were provided to the BHOs in a formal report and follow-up conference calls were held with each BHO. Each BHO was required to develop a corrective action plan to address all evaluation elements that were *Partially Met* or *Not Met*. The BHOs were required to resubmit documentation within 30 days after the conference calls. Each BHO prepared a corrective action plan with supporting descriptions and documentation, which was submitted to HSAG for review and approval. The corrective action plans were determined to sufficiently address all evaluation elements that were not *Fully Met*. The PIPs were not rescored. A corrected final PIP validation report with HSAG re-review comments was prepared and submitted to the Department.

2. Introduction

Purpose

The Balanced Budget Act of 1997 (Public Law 105-33) (BBA) requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The Department opted to meet this requirement (at 42 CFR 438.350) by contracting on February 9, 2004, with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG). By producing and delivering this *2004-2005 External Quality Review Technical Report for Behavioral Health Organizations*, HSAG has complied with 42 CFR 438.364 regarding EQR activities for the Department-contracted BHOs.

Scope

Description of EQR Activities

The 2004-2005 EQR Technical Report focuses on the three federally mandated EQR activities that were performed by HSAG on each BHO. As set forth in 42 CFR 438.352, these mandatory activities included:

- Compliance monitoring evaluation. This evaluation was designed to determine the BHOs' compliance with their contract with the Department, federal regulations, and various compliance monitoring standards, and to review individual records for the areas of credentialing and recredentialing, case management/care coordination, delegation, denials, grievances and appeals, and encounter data verification to evaluate implementation of the standards.
- Validation of performance measures. In addition to validating each of the 13 performance measures identified for validation by the Department in terms of compliance with specifications, three key aspects involved in the calculation of performance measures (data integration, data control and documentation) were assessed.
- Validation of PIPs. For each BHO, two PIPs were reviewed to ensure that the projects were designed, conducted and reported in a methodologically sound manner that would allow real improvements in care to be achieved, and for interested parties to have confidence in the reported improvements.

Description of Colorado's BHOs

The Colorado Medicaid Community Mental Health Services Program provides behavioral health care to Medicaid recipients in Colorado. The program, which is operated under a Section 1915(b) waiver, is a capitated, statewide managed care program administered by the Department. The Department's overall goal in using behavioral health managed care in its Medicaid program is to improve the quality of life for Medicaid beneficiaries by purchasing quality behavioral health services through a coordinated delivery system that promotes and focuses on improved behavioral health outcomes, cost control, accountability, and customer satisfaction. The program is mandatory for all covered Medicaid populations.

Services that BHOs must provide are inpatient hospital, under-21 psychiatric program, 65-and-over psychiatric program, outpatient, physician services, rehabilitation, psychosocial rehabilitation, case management, medication management, emergency, and residential. Other services vary by BHO but may include home-based services for children and adolescents, intensive case management, assertive community treatment for adults with serious mental illnesses, respite care, vocational services, clubhouse and drop-in centers, recovery services, prevention/early intervention, specialized services for addressing adoption issues, and residential services (non-hospital, non-nursing home setting).

During the review period for this report (September 1, 2003, to August 31, 2004), the state had been subdivided into eight service areas. In each of these areas, the program was managed by a Department-contracted BHO (formerly called Mental Health Assessment and Service Agencies, or MHASAs) that was responsible for providing behavioral health services to eligible Medicaid recipients residing in that service area.[1] Table 2-1 identifies the Colorado counties for which each of the eight BHOs was responsible for the delivery of behavioral health services.

[1] Beginning on January 1, 2005, the Department redefined the service areas, subsequently contracting with only five BHOs (Northeast Behavioral Health, Access Behavioral Care, Foothills Behavioral Health, Behavioral HealthCare, Inc., and Colorado Health Partnerships).

Table 2-1—BHOs and Their Service Areas in Colorado	
Colorado BHOs	**Counties in Service Area**
Access Behavioral Care-Denver (ABC-Denver)	Denver
Access Behavioral Care-Pikes Peak (ABC-Pikes Peak)	El Paso, Park, Teller
Behavioral HealthCare, Inc. (BHI)	Adams, Arapahoe, Douglas
Jefferson Center for Mental Health (JCMH)	Clear Creek, Gilpin, Jefferson
Mental Health Center of Boulder County, Inc. (MHCBC)	Boulder and Broomfield
Northeast Behavioral Health, L.L.C. (NBH)	Weld, Larimer, Cheyenne, Elbert, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Yuma
SyCare-Options Colorado Health Networks, L.L.C. (SyCare-Options)	Baca, Bent, Crowley, Kiowa, Otero, Prowers, Huerfano, Las Animas, Pueblo, Chaffee, Custer, Fremont, Lake, Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache
West Slope-Options Colorado Health Networks, L.L.C. (West Slope-Options)	Eagle, Garfield, Grand, Jackson, Mesa, Moffat, Pitkin, Rio Blanco, Routt, Summit, Delta, Gunnison, Hinsdale, Montrose, Ouray, San Miguel, Archuleta, Dolores, La Plata, Montezuma, San Juan

Organization of Report

Section 1 ("Executive Summary") of this report outlines the purpose of the EQR Technical Report; describes, at a high-level, the approach taken by HSAG in conducting EQR activities and drawing conclusions; summarizes the BHO results for each EQR activity; and provides overall recommendations.

Section 2 ("Introduction") provides contextual information about the purpose of the report and the scope of mandatory and optional EQR activities. A brief description of Colorado's behavioral health managed care program and its BHOs is provided, including information on the enrolled managed care recipient population and BHO service areas.

Section 3 ("Description of EQR Activities and BHO-Specific Findings") describes, for each of the three EQR activities, the objectives, data collection and analysis methodology, and type of data obtained. The plan-specific EQR activity results and conclusions drawn are also presented for each BHO.

Section 4 ("Assessment of and Recommendation for BHOs") provides high-level recommendations by BHO, based on an overall assessment of each BHO's results and findings from the EQR activities. Strengths and opportunities for improvement are also discussed.

Section 5 ("Comparative Information") compares the results and findings from the three EQR activities across the eight BHOs, with overall conclusions and recommendations provided for the continued quality improvement in the program.

Section 6 ("Assessment of Prior Recommendations") serves as a placeholder for the 2005–2006 Technical Report, in which an assessment will be provided as to the degree to which the BHOs effectively addressed the recommendations for quality improvement made by HSAG during the previous year's EQR.

3. Description of External Quality Review Activities and BHO-Specific Findings

Introduction

The BBA requires states that contract with MCOs or PIHPs to develop a QAPI strategy to ensure the delivery of quality health care by all MCOs and PIHPs in accordance with the standards established by CMS. At least annually, states must conduct external reviews of each MCO's and PIHP's QAPI program, including its performance on standard measures and the results of PIPs. HSAG, as the EQRO for the Department, performed compliance monitoring, validation of performance measures, and validation of PIPs for each of the BHOs.

This section of the report describes the manner in which the data from the EQR activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and how conclusions were drawn as to the quality, timeliness, and access to the care furnished by the eight Department-contracted Medicaid BHOs. More specifically, for each of the mandatory EQR activities, this section discusses the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data. All EQR activities were performed by HSAG between September 2004 and June 2005, with the review period for all the EQR activities being September 1, 2003, to August 31, 2004. The technical methods of data collection and analysis were the same across the BHOs. More details about the results of the individual EQR activities for each BHO appear in the individual BHO reports prepared by HSAG on each EQR activity (e.g., *2004 Compliance Monitoring Report*).

Compliance Monitoring

Objectives

Private accreditation organizations, state licensing and Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and effective health care. Making sure that the standards are followed is the second step. Per 42 CFR 438.358, the state or its EQRO must conduct a review within a three-year period to determine the MCO's or PIHP's compliance with QAPI program standards. In order to complete this requirement, HSAG, through its EQRO contract with the Department, performed an on-site compliance evaluation of the eight BHOs with which the Department contracts.

The primary objective of this compliance-monitoring review was to determine Colorado's Medicaid BHOs' compliance with federal regulations, and the Department regulations and contractual requirements, in relation to the following 13 compliance areas:

- Standard I. Subcontracts and Delegation (438.230)
- Standards II. Provider Issues (438.6, 438.12, 438.214)
- Standard III. Marketing (438.104)
- Standard IV. Advance Directives (438.6, 422.128)
- Standard V. Practice Guidelines (438.236)
- Standard VI. Member Rights and Responsibilities (438.100 - .116, 438.10, 438.218)
- Standard VII. Access and Availability–Service Delivery (438.206)
- Standard VIII. Utilization Review (438.210)
- Standard IX. Continuity of Care System–Service Delivery (438.208)
- Standard X. Quality Assessment and Performance Improvement Documentation (438.240)
- Standard XI. Quality Assurance Program (438.240)
- Standard XII. Grievance, Appeals and Fair Hearing (438.228, 438.400–408, 438.414, 438.416)
- Standard XIII. Credentialing and Recredentialing (438.214)

The implementation of a number of these individual compliance standards was also evaluated through associated record reviews. Eight different record reviews were conducted including:

- Delegation Oversight (associated with Standard I)
- Denials (associated with Standard VIII)
- Encounter Data Verification (associated with Standard VIII)
- Case Management/Care Coordination (associated with Standard IX)
- Grievances (associated with Standard XII)
- Appeals (associated with Standard XII)
- Credentialing (associated with Standard XIII)
- Recredentialing (associated with Standard XIII)

The information and findings from these compliance reviews are being used by the Department and the individual BHOs to:

- Evaluate the quality, timeliness, and access to behavioral health care furnished by the BHO.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate the current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Since this was the first year that HSAG performed an on-site evaluation of the BHOs, the results also provided a baseline measure of their performance, informing the Department and the BHOs of strengths and corrective actions needed. Beginning next year, follow-up will be conducted on the findings from the previous year to determine the extent to which any identified deficiencies have been corrected.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance monitoring reviews of the BHOs, HSAG developed nine standardized data collection survey tools for use in all the BHO reviews. One tool was for evaluating the 13 compliance monitoring standards (e.g., practice guidelines, utilization review) and the other eight tools were for conducting the record reviews (e.g., delegation, denials, grievances and appeals). The content of the tools was based on applicable federal and State laws and regulations, and the requirements set forth in the contract agreement between the Department and the BHOs. HSAG also followed the guidelines set forth in the February 11, 2003, *CMS Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans.* Once the compliance monitoring review tools and processes were approved by the Department, HSAG provided technical assistance to all BHOs regarding the tools and the on-site review process.

For each of the BHO compliance reviews, HSAG followed the same basic steps that included:

- **Pre-Review Activities:** Pre-on-site review activities included scheduling the on-site review, developing the on-site review agenda and holding a pre-on-site conference call with the BHO to answer questions and provide any needed information. The detailed agenda as well as the data collection survey tools were provided to the BHO to help facilitate its preparation for the on-site review. One key pre-on-site review activity was the desk review of key documents and other information that HSAG obtained from the Department as well as the BHO. This desk review enabled the HSAG surveyors to understand the BHO's operation better, to identify areas needing clarification, and to begin compiling information before the on-site review.
- **On-Site Review:** The on-site reviews, which lasted three to four days with four or five reviewers, included an opening conference to review the agenda and objectives of the review, document and record review processes, interviews with key BHO staff, and a closing conference at which HSAG summarized preliminary findings and recommendations. All findings were documented on the data collection survey tools, which now serve as a comprehensive record of the assessment activity.

- **Scoring of BHO Performance:** Upon completion of the survey, the following scoring methodology was used by HSAG:
  - For the compliance monitoring standards, the individual elements of each standard were scored *Met*, *Partially Met*, *Not Met* or *Not Applicable.* A summary finding for each compliance monitoring standard was then determined by calculating the percentage of elements *Met* (i.e., total number of compliant elements the BHO received out of the total number of applicable elements).
  - Each record review area was evaluated based on the number of the BHO's compliant elements out of the total number of applicable elements for each individual record reviewed. A summary finding for each record review area was determined by calculating the percentage of compliant elements (i.e., number of compliant elements out of total applicable points).
  - Each BHO was given three overall compliance scores—one for compliance monitoring standards, one for record review, and one for overall compliance. These scores represented the percentage of applicable elements met by the BHO.

  This scoring methodology allowed the Department to identify areas of best practice of the BHO as well as areas where training and technical assistance were needed to improve performance.
- **Compliance Monitoring Report:** After completing the data analysis, HSAG prepared a report of the compliance monitoring review findings and recommendations for the BHO. This report, which complied with 42 CFR 438.364, was then forwarded to the Department and the BHO.
- **Follow-up Activities:** For any standard elements receiving a finding of *Partially Met* or *Not Met*, the BHO was required to submit a corrective action plan for review by HSAG and the Department. The corrective action plan was to identify the areas that required correction, the planned interventions to achieve compliance, the individuals responsible for carrying out the activities, and the timeline for completing the activities. The Department expects each BHO to achieve and maintain full compliance before the next scheduled EQRO review, and will assist the BHOs in improving performance by providing technical assistance and sharing best practices of BHOs found to be performing at a high level.

(See Appendix A in the individual BHO reports for more specific information on the compliance monitoring methodology.)

Description of Data Obtained

In order to assess the BHOs' compliance with federal and State requirements, HSAG obtained information from a wide range of written documents, including committee meeting agendas, minutes and handouts, policies and procedures, QAPI program plan and evaluation work plans, focused study reports, management/monitoring reports (e.g., grievances, utilization), provider agreements and contracts, delegation agreements, clinical review criteria, provider manual and directory, member handbook and enrollment materials, staff training materials and documentation, member satisfaction results, and correspondence.[1]

[1] A complete listing of the documents reviewed is included in the *2004 Compliance Monitoring Report* for each BHO.

For the record reviews, HSAG generated audit samples based on data files provided by the BHO. These files included the following databases: provider credentialing records, recredentialing records, grievance records, appeal records, denial of service records, delegation oversight, and case management/care coordination records. In addition, the Department supplied HSAG with a sample of 15 encounter records for each BHO. All the records were selected from the period under review, September 1, 2003, through August 31, 2004. From each of these databases, a random sample of unduplicated records was selected for on-site review. In general, for each record review, 10 cases were selected for the sample and five additional cases for the over sample. However, for credentialing and recredentialing, 30 cases were selected with 10 additional cases in the over sample.

Finally, information for the compliance monitoring review was also obtained through interaction, discussions, and interviews with key BHO staff (e.g., the BHO leadership, client services staff, medical director).

Conclusions Drawn From the Data

Access Behavioral Care-Denver

ABC-Denver received an overall compliance score of 95 percent, with scores of 95 percent for the compliance monitoring standards and 95 percent for the record review.

Of the 13 compliance standards reviewed, ABC-Denver was found to have *Met* all the individual elements reviewed for five of the standards (i.e., Provider Issues, Advance Directives, Member Rights and Responsibilities, Access and Availability, and Quality Assurance Program). The percentages of elements *Met* for the other standards were 81 percent for Subcontracts and Delegation, 97 percent for Utilization Review, 94 percent for Continuity of Care System, 80 percent for QAPI Documentation, 85 percent for Grievances, Appeals, and Fair Hearings, and 98 percent for Credentialing and Recredentialing. Two of the standards (i.e., Marketing and Practice Guidelines) were *Not Applicable*.

The results of ABC-Denver's record review yielded a compliance score of 100 percent for five out of the eight record review areas (i.e., delegation oversight, grievances record review, appeals record review, credentialing record review and recredentialing record review). For the remaining record review areas, the percentages of compliant elements were 80 percent for denials record review, 80 percent for encounter data verification, and 98 percent for case management/care coordination record review.

Corrective actions included:

- Enhancing or modifying policies related to subcontracts, prohibited affiliations for providers, and grievances and appeal notification processes.
- Revising enrollee materials to comply with federal regulations, in particular as they relate to grievance and appeal policies.
- Continued monitoring of and improving timely access to routine services.

- Developing a review or audit procedure to ensure compliance with service denial requirements.
- Reviewing encounter data code and verification procedures to ensure encounter data submittal accuracy.
- Implementing ongoing monitoring to ensure compliance with care coordination program requirements.

Access Behavioral Care-Pikes Peak

ABC-Pikes Peak received an overall compliance score of 95 percent, with scores of 95 percent for the compliance monitoring standards and 96 percent for the record review.

Of the 13 compliance standards reviewed, ABC-Pikes Peak was found to have *Met* all the individual elements reviewed for five of the standards (i.e., Provider Issues, Advance Directives, Member Rights and Responsibilities, Access and Availability, and Quality Assurance Program). The percentages of elements *Met* for the other standards were 81 percent for Subcontracts and Delegation, 97 percent for Utilization Review, 88 percent for Continuity of Care System, 80 percent for QAPI Documentation, 85 percent for Grievances, Appeals, and Fair Hearings, and 98 percent for Credentialing and Recredentialing. Two of the standards (i.e., Marketing and Practice Guidelines) were *Not Applicable*.

The results of ABC-Pikes Peak's record review yielded a compliance score of 100 percent for four out of the eight record review areas (i.e., delegation oversight, grievances record review, credentialing record review, and recredentialing record review). For the remaining record review areas, the percentages of compliant elements were 77 percent for denials record review, 90 percent for encounter data verification, 94 percent for case management/care coordination record review, and 93 percent for appeals record review.

Corrective actions included:

- Enhancing or modifying policies related to subcontracts, prohibited affiliations for providers, and grievances and appeal notification processes.
- Revising enrollee materials to comply with federal regulations, in particular as it relates to grievance and appeal policies.
- Continued monitoring of and improving timely access to routine services.
- Developing a review or audit procedure to ensure compliance with service denial process.
- Reviewing encounter data code and verification procedures to ensure encounter data submittal accuracy.
- Implementing ongoing monitoring to ensure compliance with care coordination program requirements.

Behavioral HealthCare, Inc.

BHI received an overall compliance score of 88 percent, with scores of 90 percent for the compliance monitoring standards and 86 percent for the record review.

Of the 13 compliance standards reviewed, BHI was found to have *Met* all the individual elements reviewed for three of the standards (i.e., Advance Directives, Practice Guidelines, and Continuity of Care System). The percentages of elements *Met* for the other standards were 75 percent for Subcontracts and Delegation, 94 percent for Provider Issues, 88 percent for Member Rights and Responsibilities, 94 percent for Access and Availability, 97 percent for Utilization Review, 80 percent for QAPI Documentation, 96 percent for Quality Assurance Program, 91 percent for Grievances, Appeals, and Fair Hearings, and 74 percent for Credentialing and Recredentialing. One of the standards (i.e., Marketing) was *Not Applicable*.

The results of BHI's record review yielded a compliance score of 100 percent for three out of the eight record review areas (i.e., denials record review, case management/care coordination record review, and credentialing record review). For the remaining record review areas, the percentages of compliant elements were 92 percent for delegation oversight, 63 percent for encounter data verification, 98 percent for grievance record review, 84 percent for appeals record review, and 77 percent for recredentialing record review.

Corrective actions included:

- Ensuring delegation agreements contain access to records and hold-harmless requirements.
- Revising enrollee materials to comply with federal regulations, in particular as they relate to appeal of service denials, grievance and appeal policies, and enrollee rights and responsibilities.
- Ensuring processes are in place for appropriate service documentation in the clinical record and accurate submittal of encounters.
- Improving service denial processes through staff training on denial criteria and implementation of a database for tracking denials.
- Enhancing or modifying policies related to credentialing and recredentialing, and grievances and appeals.
- Improving the credentialing and recredentialing processes in terms of an effective tracking system, notification of provider additions/deletions, and reporting of complaints and quality of care concerns.

Jefferson Center for Mental Health

JCMH received an overall compliance score of 88 percent, with scores of 83 percent for the compliance monitoring standards and 91 percent for the record review.

Of the 13 compliance standards reviewed, JCMH was found to have *Met* all the individual elements reviewed for two of the standards (Advance Directives and QAPI Documentation). The percentages of elements *Met* for the other standards were 42 percent for Subcontracts and Delegation, 88 percent for Provider Issues, 60 percent for Practice Guidelines, 84 percent for Member Rights and Responsibilities, 95 percent for Access and Availability, 97 percent for Utilization Review, 94 percent for Continuity of Care System, 96 percent for Quality Assurance Program, 59 percent for Grievances, Appeals, and Fair Hearings, and 90 percent for Credentialing and Recredentialing. One of the standards (i.e., Marketing) was *Not Applicable*.

The results of JCMH's record review yielded a compliance score of 100 percent for four out of the eight record review areas (i.e., denials record review, encounter data verification, case management/care coordination record review, and credentialing record review). For the remaining record review areas, the percentages of compliant elements were 81 percent for delegation oversight, 68 percent for grievances record review, 53 percent for appeals record review, and 98 percent for recredentialing record review.

Corrective actions included:

- Amending subcontracts to meet BBA regulations.
- Implementing delegation policies as outlined by the JCMH.
- Providing external provider network with training on corporate compliance, fraud and abuse reporting, and clinical practice guidelines.
- Implementing an internal monitoring process to ensure all employees receive training on corporate compliance and fraud and abuse.
- Implementing a system to track and document practice guideline approvals.
- Revising enrollee materials to comply with federal regulations, in particular as they relate to appeal of program exemption denials, provider selection process, and grievance and appeal policies.
- Conducting a comprehensive evaluation of the utilization management program at least annually.
- Improving service denial processes through staff training on denial criteria.
- Conducting quality-related performance evaluations on all staff and providers, and including quality management findings in the performance reviews of providers.
- Improving record documentation related to grievances and appeals.
- Enhancing or modifying policies related to grievances and appeals, and credentialing and recredentialing.
- Improving credentialing and recredentialing processes as related to tracking timeliness, consistency with policies, use of objective criteria for reviewing information, and communicating provider changes and quality of care concerns to the Department.

Mental Health Center of Boulder County, Inc.

MHCBC received an overall compliance score of 54 percent, with scores of 36 percent for the compliance monitoring standards and 88 percent for the record review.

The review of the 13 standards did not result in a compliance score of 100 percent for any of the standards. The percentages of elements *Met* for the standards were 38 percent for Subcontracts and Delegation, 26 percent for Provider Issues, 0 percent for Advance Directives, 40 percent for Practice Guidelines, 38 percent for Member Rights and Responsibilities, 50 percent for Access and Availability, 67 percent for Utilization Review, 50 percent for Continuity of Care System, 20 percent for QAPI Documentation, 44 percent for Quality Assurance Program, 28 percent for Grievances, Appeals, and Fair Hearings, and 7 percent for Credentialing and Recredentialing. One of the standards (i.e., Marketing) was *Not Applicable*.

The results of MHCBC's record review did not yield a compliance score of 100 percent for any of the four applicable areas reviewed. The percentages of compliant elements for the record reviews were 80 percent for encounter data verification, 96 percent for case management/care coordination record review, 93 percent for grievances record review, and 75 percent for appeals record review. Record reviews on the following were not conducted: delegation oversight, because MHCBC had not delegated any functions; denials, because MHCBC did not have adequate documentation on which to conduct the review; and credentialing and recredentialing, because MHCBC had no providers who had been credentialed/recredentialed during the review period.

Corrective actions included:

- Enhancing or modifying policies related to delegation and subcontracts, provider participation, fraud reporting, advance directives, client rights and responsibilities, provision of member information, referral process, medical necessity, MHCBC's committees, grievances, appeals, denials, and credentialing and recredentialing.
- Revising provider agreements to include all required contract provisions.
- Implementing its corporate compliance plan.
- Providing information about advance directives to providers and adult consumers.
- Revising enrollee materials to comply with federal regulations, in particular as they relate to advance directives, practice guidelines, obtaining benefits, referral process, choosing providers, and grievance and appeal policies.
- Formalizing and documenting the process for the development, implementation and revision of practice guidelines, and clinical review criteria.
- Providing training to staff/providers on client rights and responsibilities, denial process, treatment plan revisions.
- Improving access to care and the system for tracking access to services.
- Enhancing the utilization management program to document service utilization and denials appropriately, and to evaluate program effectiveness.
- Reviewing procedures in place to ensure accurate encounter data are submitted to the Department.

- Expanding and improving the evaluation of utilization and quality improvement performance, and quality improvement program.
- Improving the quality assurance program in terms of committee meetings, monitoring of the quality of clinical care, provider performance evaluations, and integration of quality improvement activities throughout the organization.
- Implementing a tracking system for grievances, appeals, denials, and credentialing/ recredentialing of providers.
- Revising the credentialing and recredentialing process as it relates to the credentialing committee and provider manual description.

Northeast Behavioral Health, L.L.C.

NBH received an overall compliance score of 84 percent, with scores of 81 percent for the compliance monitoring standards and 86 percent for the record review.

Of the 13 compliance standards reviewed, NBH was found to have *Met* all the individual elements reviewed for one of the standards (i.e., Advance Directives). The percentages of elements *Met* for the other standards were 19 percent for Subcontracts and Delegation, 88 percent for Provider Issues, 88 percent for Member Rights and Responsibilities, 96 percent for Access and Availability, 94 percent for Utilization Review, 88 percent for Continuity of Care System, 80 percent for QAPI Documentation, 82 percent for Quality Assurance Program, 85 percent for Grievances, Appeals, and Fair Hearings, and 70 percent for Credentialing and Recredentialing. Two of the standards (i.e., Marketing and Practice Guidelines) were *Not Applicable*.

The results of NBH's record review yielded a compliance score of 100 percent for three out of the seven record review areas (i.e., denials record review, case management/care coordination record review, and grievances record review). For the remaining record review areas, the percentages of compliant elements were 54 percent for subcontracts and delegation oversight record review, 90 percent for encounter data verification, 91 percent for credentialing record review, and 73 percent for recredentialing record review. A review of appeal records was not conducted, as NBH did not have any appeals filed during the review period.

Corrective actions included:

- Revising contracts and procedures to meet standards related to evaluation and monitoring of its delegates.
- Ensuring the Department is notified about terminated contracts.
- Enhancing or modifying policies related to delegation, exemption appeals, continuity and coordination of care, and grievances and appeals.
- Retaining documentation related to disclosure of ownership and control.
- Revising enrollee materials to comply with federal regulations, in particular as they relate to client responsibilities, provider choice, and grievance and appeal policies.
- Reviewing procedures to ensure accurate encounter data are submitted to the Department.

- Improving processes related to corrective action and follow-up of quality program findings, monitoring client outcomes and disseminating medical record standards.
- Improving the credentialing and recredentialing processes related to the credentialing committee, a tracking system for the credentialing process, Department notification of provider additions and deletions, and use of quality findings in provider recredentialing.

SyCare-Options Colorado Health Networks, L.L.C.

SyCare-Options received an overall compliance score of 91 percent, with scores of 88 percent for the compliance monitoring standards and 93 percent for the record review.

Of the 13 compliance standards reviewed, SyCare-Options was found to have *Met* all the individual elements reviewed for four of the standards (i.e., Advance Directives, Practice Guidelines, QAPI Documentation, and Quality Assurance Program). The percentages of elements *Met* for the other standards were 83 percent for Subcontracts and Delegation, 80 percent for Provider Issues, 80 percent for Member Rights and Responsibilities, 85 percent for Access and Availability, 94 percent for Utilization Review, 88 percent for Continuity of Care System, 80 percent for Grievances, Appeals, and Fair Hearings, and 93 percent for Credentialing and Recredentialing. One of the standards (i.e., Marketing) was *Not Applicable*.

The results of SyCare-Options' record review yielded a compliance score of 100 percent for two out of the seven record review areas (i.e., grievances record review and credentialing record review). For the remaining record review areas, the percentages of compliant elements were 98 percent for denials record review, 97 percent for encounter data verification, 86 percent for case management/care coordination record review, 72 percent for appeals record review, and 99 percent for recredentialing record review. Delegation oversight record review was not conducted since SyCare-Options had no delegated activities.

Corrective actions included:

- Amending the provider agreements to include hold-harmless and disclosure of ownership requirements, and to reflect the current operating philosophy of SyCare-Options in the partnership agreement.
- Providing appropriate notification to external providers who are denied inclusion in the network.
- Ensuring periodic compliance committee meetings.
- Revising enrollee materials to be more specific and to comply with federal regulations, as they relate to advance directives, client rights and responsibilities, availability of interpreter and other services, and grievance and appeal notifications.
- Enhancing or modifying policies related to member information distribution, emergency services, right of clients not to be charged a fee, access to care, referral, case management services for "meds only" clients, and grievances and appeals tracking and reporting.
- Developing a corrective action plan to identify action taken when a pattern of complaints is detected or a serious complaint is reported.
- Reviewing procedures to ensure accurate encounter data are submitted to the Department, and recordkeeping is appropriate for denials and appeals.

- Developing an electronic case management system and program for training clinical care managers.
- Conducting ongoing monitoring and oversight of case management records to ensure all requirements are met.
- Improving accountability of community mental health center leadership related to needed corrective actions and follow-up of quality concerns.
- Revising the provider manual related to grievances and appeals.

West Slope-Options Colorado Health Networks, L.L.C.

West Slope-Options received an overall compliance score of 87 percent, with scores of 88 percent for the compliance monitoring standards and 87 percent for the record review.

Of the 13 compliance standards reviewed, West Slope-Options was found to have *Met* all the individual elements reviewed for four of the standards (i.e., Advance Directives, Practice Guidelines, QAPI Documentation and Quality Assurance Program). The percentages of elements *Met* for the other standards were 83 percent for Subcontracts and Delegation, 80 percent for Provider Issues, 80 percent for Member Rights and Responsibilities, 85 percent for Access and Availability, 94 percent for Utilization Review, 88 percent for Continuity of Care System, 78 percent for Grievances, Appeals, and Fair Hearings, and 93 percent for Credentialing and Recredentialing. One of the standards (i.e., Marketing) was *Not Applicable*.

The results of West Slope-Options' record review yielded a compliance score of 100 percent for three out of the seven record review areas (i.e., denials record review, credentialing record review, and recredentialing record review). For the remaining record review areas, the percentages of compliant elements were 72 percent for encounter data verification, 59 percent for case management/care coordination record review, 93 percent for grievances record review, and 74 percent for appeals record review. Delegation oversight record review was not conducted, since West Slope-Options had no delegated activities.

Corrective actions included:

- Amending the provider agreements to include hold-harmless and disclosure of ownership requirements, and to reflect the current operating philosophy of West Slope-Options in the partnership agreement.
- Providing appropriate notification to external providers who are denied inclusion in the network.
- Ensuring periodic compliance committee meetings.
- Revising enrollee materials to be more specific and to comply with federal regulations, as they relate to advance directives, client rights and responsibilities, availability of interpreter and other services, and grievance and appeal notifications.
- Enhancing or modifying policies related to member information distribution, emergency services, right of clients not to be charged a fee, access to care, referral, case management services for "meds only" clients, and grievances and appeals tracking and reporting.
- Developing a corrective action plan to identify action taken when a pattern of complaints is detected or a serious complaint is reported.

- Reviewing procedures to ensure accurate encounter data are submitted to the Department, and record-keeping is appropriate for appeals.
- Developing an electronic case management system and program to train clinical care managers.
- Conducting ongoing monitoring and oversight of case management records to ensure all requirements are met.
- Improving accountability of community mental health center leadership related to needed corrective actions and follow-up of quality concerns.
- Revising the provider manual related to grievances and appeals.

Validation of Performance Measures

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities that the Department contracted with HSAG to conduct. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected by the BHO.
- Determine the extent to which the specific performance measures calculated by the State followed the specifications established to calculate the performance measure(s).
- Identify overall strengths and areas for improvement in the performance measure process.

The Department, along with DMH, calculated 13 performance measures using data submitted by the BHOs. The performance measures themselves were derived from a number of data sources, including claims/encounters data, MHSIP consumer surveys, and CCARs. HSAG conducted a site visit to each BHO to validate the processes used to collect performance data (encounter data and CCAR data) and site visits to the Department and DMH to validate the performance measure calculation process.

Technical Methods of Data Collection and Analysis

HSAG conducted the performance measure validation process in accordance with the CMS guidelines—*Validating Performance Measures, A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002.

The same process was followed for each performance measure validation conducted by HSAG on the BHOs and included the following steps.

- **Pre-Review Activities:** Based on the measure definitions and reporting guidelines, HSAG developed:
  - Measure-specific worksheets that were based on the CMS protocol and were used to improve the efficiency of validation work performed on-site.
  - An Information Systems Capabilities Assessment Tool (ISCAT) that was customized to Colorado's mental health service delivery system and was used to collect the necessary background information on the BHOs' policies, processes, and data needed for the on-site performance validation activities. HSAG added questions to address how encounter data were collected, validated, and submitted to the Department and how CCAR data were initiated, captured in the system, validated, and submitted to the Department.

  Prior to the on-site reviews, the BHOs and Department were asked to complete the ISCAT. HSAG prepared two different versions of the ISCAT, one which was customized for completion by the BHOs, and the other customized for completion by the Department. The BHO version addressed all information system processes and capabilities related to collection of encounter and CCAR data. The Department version addressed all data integration and performance measure calculation activities. In addition to the ISCAT, other requested documents included source code

for performance measure calculation, prior performance measure reports, and supportive documentation. Additionally, other pre-review activities included scheduling the on-site reviews, preparing the agendas for the on-site visits, and conducting conference calls with the BHOs to discuss the on-site visit activities as well as any ISCAT-related questions.

- **On-Site Review:** The on-site reviews, which lasted one to two days, included the following:
  - An opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
  - Assessment of information systems compliance, focusing on the processing of claims and encounters, and recipient and provider data. Additionally, the review evaluated the processes used by the Department to collect and calculate the performance measures, including accurate numerator and denominator identifications and algorithmic compliance to determine if rate calculations were performed correctly.
  - Review of ISCAT and supportive documentation, including a review of processes used for collecting, storing, validating, and reporting the performance measure data. This session, which was designed to be interactive with the key BHO, DMH and Department staff members, allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. Interviews were conducted to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
  - Overview of data integration and control procedures, including discussion and observation of source code logic and a review of how all data sources were combined. The data file was produced for the reporting of the selected performance measures. Primary source verification was performed to further validate the output files. Backup documentation on data integration was reviewed. Data control and security procedures were also addressed during this session.
  - A closing conference to summarize preliminary findings based on the review of the ISCAT and the on-site review, and to revisit the documentation requirements for any post-review activities.
- **Validation Results:** Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS Protocol, a validation finding of *Fully Compliant*, *Substantially Compliant*, *Not Valid* or *Not Applicable* was given for each performance measure. Each validation finding was based on the magnitude of errors detected for the measure evaluation elements, not by the number of elements determined to be "not met." Consequently, it was possible that an error for a single element resulted in a designation of *Not Valid* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it was also possible that several element errors had little impact on the reported rate and the indicator was given a designation of *Substantially Compliant*. In addition to the performance measure findings, a finding of *Acceptable* or *Not Acceptable* was given to the data control and performance measure documentation processes used in the calculation of performance measures.
- **Validation of Performance Measures Report:** After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for each BHO reviewed. These reports, which complied with 42 CFR 438.364, were forwarded to the Department and the appropriate BHO.

(See individual BHO reports for more specific information on the methodology used for validation of performance measures.)

Description of Data Obtained

As identified in the CMS Protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures:

- Information Systems Capabilities Assessment Tool (ISCAT). This was received from each BHO and the Department. The completed ISCATs provided HSAG with background information on the Department and BHOs' policies, processes, and data in preparation for the on-site validation activities.
- Source Code (Programming Language) for Performance Measures. This was obtained from the Department and was used to determine compliance with the performance measure definitions.
- Performance Measure Reports for FY 2003. These were obtained from the Department and reviewed to assess trending patterns and rate reasonability.
- Supportive Documentation. This provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.

Information was also obtained through interaction, discussion, and formal interviews with key BHO and Department staff members as well as through system demonstrations.

Conclusions Drawn From the Data

Access Behavioral Care-Denver

ABC-Denver's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be Acceptable. In addition, no major concerns were identified with the data systems for processing each type of data used for reporting the performance measures (i.e., eligibility and claims/encounter). There were sufficient validation techniques used by ABC-Denver to ensure appropriate Medicaid eligibility. Within the claims and encounter systems, ABC-Denver had internal system edits and validation rules to ensure data quality. A sound method was in place to ensure that all services were entered into the system in a timely manner and a formal audit was conducted to ensure data completeness. Additionally, HSAG recognized ABC-Denver staff's strong commitment to the quality of performance measure data.

Of the 13 performance measures, ABC-Denver was found to be *Fully Compliant* for six performance measures and *Substantially Compliant* for seven performance measures. Corrective actions included:

- Using an automated approach to internal validation of claims data.
- Following Department specifications pertaining to the scrubbing of encounter data prior to submission to the Department, to ensure that data are reliable and accurate.
- Implementing a method to perform inter-rater reliability testing on CCAR data to assess validity and accuracy.

Access Behavioral Care-Pikes Peak

ABC-Pikes Peak's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be Acceptable. In addition, no major concerns were identified with the data systems for processing each type of data used for reporting the performance measures (i.e., eligibility and claims/encounter). There were sufficient validation techniques used by ABC-Pikes Peak to ensure appropriate Medicaid eligibility. Within the claims and encounter systems, ABC-Pikes Peak had internal system edits and validation rules to ensure data quality. A sound method was in place to ensure that all services were entered into the system in a timely manner and a formal audit was conducted to assure data completeness. Additionally, HSAG recognized ABC-Pikes Peak staff's strong commitment to the quality of performance measure data.

Of the 13 performance measures, ABC-Denver was found to be *Fully Compliant* for six performance measures and *Substantially Compliant* for seven performance measures. Corrective actions included:

- Using an automated approach to internal validation of claims data.
- Following Department specifications pertaining to the scrubbing of encounter data prior to submission to the Department, to ensure that data are reliable and accurate.
- Implementing a method to perform inter-rater reliability testing on CCAR data to assess validity and accuracy.

Behavioral HealthCare, Inc.

BHI's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be Acceptable. In addition, no major concerns were identified with the data systems for processing each type of data used for reporting the performance measures (i.e., eligibility and claims/encounter). There were sufficient validation techniques used by BHI to ensure appropriate Medicaid eligibility. Within the claims and encounter systems, BHI had internal system edit checks to ensure data accuracy and reliability. A sound method was in place to ensure that all services were entered into the system in a timely manner. Overall, the processing of claims and encounters was identified as a best practice by HSAG and was easily accessible for primary source verification.

Of the 13 performance measures, BHI was found to be *Fully Compliant* for six performance measures and *Substantially Compliant* for seven performance measures. Corrective actions included:

- Performing additional internal validation of CCAR and claims data pertaining to data entry.
- Compiling supportive documentation of the processes to ensure that data are reliable and accurate for unduplicated counts.
- Moving toward automation and electronic submission (CCAR) for consistency.
- Drafting a study plan to perform inter-rater reliability testing on CCAR data to assess validity and accuracy.

Jefferson Center for Mental Health

JCMH's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be Acceptable. In addition, no major concerns were identified with the data systems for processing each type of data used for reporting the performance measures (i.e., eligibility and claims/encounter). Although JCMH used a manual approach to determine consumer Medicaid eligibility, there were sufficient validation techniques to ensure appropriate eligibility. For its claims/encounter data system, JCMH had built-in systems edit checks to ensure data quality. A sound method was in place to ensure that all services were entered into the system in a timely manner and mechanisms were implemented to ensure data completeness. Additionally, JCMH demonstrated a strong commitment to the quality of performance measurement data by internally evaluating performance and holding itself to a high standard.

Of the 13 performance measures, JCMH was found to be *Fully Compliant* for six performance measures and *Substantially Compliant* for seven performance measures. Corrective actions included:

- Implementing a formal tracking process for manual procedures, including encounter data and CCAR submission.
- Implementing better tracking mechanisms for encounter and CCAR data submitted to the Department.
- Exploring methods to link the appointment/scheduling system with the encounters system, and to combine duplicate records.
- Implementing a method to perform inter-rater reliability on CCAR data to assess validity and accuracy.

Mental Health Center of Boulder County, Inc.

MHCBC's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be Acceptable. In addition, no major concerns were identified with the data systems for processing each type of data used for reporting the performance measures (i.e., eligibility and claims/encounter). Although MHCBC used a manual approach to determine consumer Medicaid eligibility, there were sufficient validation techniques to ensure appropriate eligibility. For its claims/encounter data system, MHCBC had built-in systems edit checks to ensure data quality, and a sound method was in place to ensure that all services were entered into the system in a timely manner. MHCBC was found to be lacking in a formal audit process to evaluate the completeness of the claims and encounter data. An issue with the data extraction utility was also identified. However, HSAG found that MHCBC staff had a strong commitment to the quality of performance measurement data, performing internal corrective actions related to the performance measure reporting, and conducting an inter-rater reliability study on CCAR data to ensure provider accuracy.

Of the 13 performance measures, MHCBC was found to be *Fully Compliant* for six performance measures and *Substantially Compliant* for seven performance measures. Corrective actions included:

- Establishing control mechanisms for service activity log data entry.
- Following Department specifications pertaining to the scrubbing of encounter data prior to submission to the Department, to ensure that data are reliable and accurate.
- Focusing efforts on monitoring the submission of encounter data with reason codes being assigned to all encounter data that cannot be extracted in order to identify and address potential submission barriers.
- Implementing better testing protocols for extraction programs for encounter data and CCAR data, in addition to quantifying and tracking extraction issues.
- Implementing better tracking mechanisms for data submitted to the Department, quantifying the number of encounters not resubmitted to the Department after initial rejection from the pre-edit scrubber.

Northeast Behavioral Health, L.L.C.

NBH's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be Acceptable. In addition, no major concerns were identified with the data systems for processing each type of data used for reporting the performance measures (i.e., eligibility and claims/encounter). There were sufficient validation techniques used by NBH to ensure appropriate Medicaid eligibility. Within the claims and encounter systems, NBH had systems edit checks to ensure data accuracy and reliability. A sound method was in place to ensure that all services were entered into the system in a timely manner. However, NBH was found to be lacking in a formal audit process to evaluate the completeness of the claims and encounter data.

Of the 13 performance measures, NBH was found to be *Fully Compliant* for six performance measures and *Substantially Compliant* for seven performance measures. Corrective actions included:

- Formalizing a process to validate manual data entry of encounter data, ensuring consistency across all three of NBH's mental health centers.
- Following Department specifications pertaining to the scrubbing of encounter data prior to submission to the Department, to ensure that data are reliable and accurate.
- Formalizing a process to validate the data entry of CCAR data submitted by external providers.
- Drafting a plan to perform inter-rater reliability testing on CCAR data in order to assess validity and accuracy.

SyCare-Options Colorado Health Networks, L.L.C.

SyCare-Options' data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be Acceptable. In addition, no major concerns were identified with the data systems for processing each type of data used for reporting the performance measures (i.e., eligibility and claims/encounter). There were sufficient validation techniques used by SyCare-Options to ensure appropriate Medicaid eligibility. Within the claims and encounter systems, SyCare-Options had internal system edit checks in place to ensure data accuracy and reliability. A sound method was in place to ensure that all services were entered into the system in a timely manner and a formal audit was conducted to assure data completeness. Additionally, HSAG found that SyCare-Options staff members were cross-trained and knowledgeable regarding performance measure reporting and that excellent validation processes were in place for the data entry of claims.

Of the 13 performance measures, SyCare-Options was found to be *Fully Compliant* for six performance measures and *Substantially Compliant* for seven performance measures. Corrective actions included:

- Performing additional internal validation of CCAR and claims data pertaining to data entry, and compiling supportive documentation of the processes, to ensure that data are reliable and accurate for unduplicated counts.
- Moving toward automation and electronic submission of CCAR data for consistency.
- Drafting a study plan to perform inter-rater reliability testing on CCAR data to assess validity and accuracy.
- Suspending the practice of manually correcting claims without a means to track or document such activity, and instead creating a means to track claims that requires follow-up/correction from providers.
- Continuing to identify additional edits in its system and ensure that each mental health center implements the edits to ensure consistency.

West Slope-Options Colorado Health Networks, L.L.C.

West Slope-Options' data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be Acceptable. In addition, no major concerns were identified with the data systems for processing each type of data used for reporting the performance measures (i.e., eligibility and claims/encounter). There were sufficient validation techniques used by West Slope-Options to ensure appropriate Medicaid eligibility. Within the claims and encounter systems, West Slope-Options had internal system edit checks in place to ensure data accuracy and reliability. A sound method was in place to ensure that all services were entered into the system in a timely manner and a formal audit was conducted to assure data completeness. Additionally, HSAG found that West Slope-Options staff members were cross-trained and knowledgeable regarding performance measure reporting and that excellent validation processes were in place for the data entry of claims.

Of the 13 performance measures, West Slope-Options was found to be *Fully Compliant* for six performance measures and *Substantially Compliant* for seven performance measures. Corrective actions included:

- Performing additional internal validation of CCAR and claims data pertaining to data entry and compiling supportive documentation of the processes to ensure that data are reliable and accurate for unduplicated counts.
- Moving toward automation and electronic submission of CCAR data for consistency.
- Drafting a study plan to perform inter-rater reliability testing on CCAR data to assess validity and accuracy.
- Suspending the practice of manually correcting claims without a means to track or document such activity, and instead creating a means to track claims that require follow-up/correction from providers.
- Continuing to identify additional edits in its system and ensure that each mental health center implements the edits to ensure consistency.

Validation of Performance Improvement Projects

Objectives

As part of its QAPI program, each BHO is required by the Department to conduct PIPs in accordance with 42 CFR 438.240. The purpose of these PIPs is to achieve, through ongoing measurements and intervention, significant improvement that is sustained over time in both clinical care and nonclinical care areas. This structured method of assessing and improving the BHO processes is expected to have a favorable effect on health outcomes and consumer satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the Department is required to validate the PIPs conducted by the BHOs. To meet this validation requirement, the Department contracted with HSAG.

The primary objective of the PIP validation was to determine each BHO's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

For each BHO, HSAG performed the validation activities on two PIPs. Two of the BHOs, (SyCare-Options and West Slope-Options) submitted joint PIPs, upon approval by the Department. Therefore, HSAG validated a total of 14 PIPs (two each for six BHOs and two joint PIPs for Sycare-Options and West Slope-Options).

Technical Methods of Data Collection and Analysis

The methodology used to validate the PIPs was based on CMS guidelines as outlined in the CMS publication *Validating Performance Improvement Projects, A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, which was each BHO completed and submitted to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and assured that all CMS protocol requirements were addressed.

HSAG, with Department input and approval, developed a PIP validation tool to ensure uniform validation of the PIPs. Using this tool, HSAG reviewed each of the BHOs in terms of the following 10 CMS protocol activities for PIPs:

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question

- Activity III. Clearly Defined Study Indicator(s)
- Activity IV. Correctly Identified Study Population
- Activity V. Valid Sampling Techniques
- Activity VI. Accurate/Complete Data Collection
- Activity VII. Appropriate Improvement Strategies
- Activity VIII. Sufficient Data Analysis and Interpretation
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

For several of the PIPs, Activity X was not assessed because the BHO's PIP had not progressed to the phase of collecting data related to sustained improvements at the time of the PIP validation review.

Each activity listed above consisted of evaluation elements necessary to complete a valid PIP successfully. The evaluation elements within each activity were scored by the HSAG review team as *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. To assure a valid and reliable review, some of the elements were designated "critical" elements by HSAG. All of the critical elements had to be *Met* for the PIP to produce accurate and reliable results.

All PIPs were scored as follows:

- *Met*: All critical elements were *Met* **and** 80–100 percent of all elements were *Met.*
- *Partially Met:* All critical elements were *Met* but less than 80 percent of all elements were *Met* **or** one or more critical element(s) were *Partially Met.*
- *Not Met:* One or more critical element(s) were *Not Met.*
- *Not Applicable:* Elements (including critical elements if they were not assessed) were removed from all scoring as not relevant.

In addition to the validation status (e.g., *Met),* each PIP was given an overall percentage score, which was calculated by dividing the total *Met* by the sum of the total *Met, Partially Met* and *Not Met.*

After completing the validation review, HSAG prepared a report of the findings and recommendations for each validated PIP. These reports, which complied with 42 CFR 438.364, were forwarded to the Department and the appropriate BHO.

Depending on the findings for the specific elements and the phase of the PIP, the Department may have required the BHO to submit a corrective action plan. Required corrective actions may have included revising the PIP summary form, submitting additional documentation, and/or modifying or repeating an element of the PIP submitted for validation.

(See Appendix A in the individual BHO reports for a copy of the PIP validation tool used by HSAG in conducting these reviews.)

Description of Data Obtained

The data needed to conduct the PIP validation studies were obtained from the BHOs' PIP summary form. This form provided detailed information about each BHO's PIP as it related to the 10 activities being reviewed, e.g., explanation of study topic, description of study population, study indicator(s) definitions, etc.

Conclusions Drawn From the Data

Access Behavioral Care-Denver

The two PIPs reviewed by HSAG for ABC-Denver were:

- *Readmission Rates*, which sought to decrease the readmission rates among consumers who were discharged from an inpatient setting of an acute care facility for treatment of a primary mental health diagnosis. Incremental reductions in seven- and 30-day hospital readmission rates were demonstrated in every full-calendar measurement dating from 1999.
- *Follow-Up After an Inpatient Stay*, which sought to improve the rates of consumer follow-up treatment within seven and 30 days after an inpatient stay for mental illness. Improvement in seven- and 30-day follow-up rates after an inpatient discharge was achieved in every full-calendar measurement dating from 1999, exceeding the HEDIS 90th percentile on five of six measures for the last three years.

For both of these studies, ABC-Denver presented a well-defined study topic that addressed the broad spectrum of care, which in turn could affect the mental health, functional status, and satisfaction of the BHO's Medicaid consumers. The study indicator selection process was well defined, objective and measurable. The data collection process was completely and thoroughly explained, and data analysis and results were performed and presented in a manner that was easily understood and accurate.

The overall score for both studies was *Met*, and all 10 out of 11 critical elements were *Met* (one critical element was *Not Applicable)*. For the *Readmission Rate* PIP, ABC-Denver received an overall score of 98 percent, with a total of 45 out of 47 applicable elements (including critical elements) being *Met*. For the *Follow-Up After an Inpatient Stay* PIP, ABC-Denver received an overall score of 96 percent, with a total of 45 out of 46 applicable elements (including critical elements) being *Met.*

Although no corrective actions were identified, HSAG recommended that for future PIPs, ABC-Denver provide:

- An estimated degree of automated data completeness for the data collected and analyzed, and a discussion of any factors that might have threatened the internal or external validity of the study

Access Behavioral Care-Pikes Peak

The two PIPs reviewed by HSAG for ABC-Pikes Peak were:

- *Readmission Rates*, which sought to decrease the readmission rates among consumers who were discharged from an inpatient setting of an acute care facility for treatment of a principal covered mental health diagnosis. At the time of the study report, a baseline and one remeasurement had been conducted, showing a nonsignificant decrease in total admissions and readmissions.
- *Follow-Up After an Inpatient Stay*, which sought to improve the rates of consumer follow-up treatment within seven and 30 days after an inpatient stay for mental illness. The rate of follow-up within 30 days improved significantly, surpassing the industry benchmark.

For both of these studies, ABC-Pikes Peak presented a well-defined study topic that addressed the broad spectrum of care, which in turn could affect the mental health, functional status, and satisfaction of the BHO's Medicaid consumers. The study indicator selection process was well defined, objective, and measurable. The data collection process was completely and thoroughly explained, and data analysis and results were performed and presented in a manner that was easily understood and accurate.

The overall score for both studies was *Met*. For the Readmission Rate PIP, ABC-Pikes Peak received an overall percentage score of 95 percent, with all 10 out of 11 critical elements being *Met* (one critical element was *Not Applicable*) and a total of 38 out of 40 applicable elements (including critical elements) being *Met*. For the *Follow-Up After an Inpatient Stay* PIP, ABC-Pikes Peak received an overall percentage score of 98 percent, with all 10 out of 11 critical elements being *Met* (one critical element was *Not Applicable)* and a total of 40 out of 41 applicable elements (including critical elements) being *Met*.

Although no corrective actions were identified, HSAG recommended that for future PIPs, ABC-Pikes Peak provide:

- An estimated degree of automated data completeness for the data collected and analyzed, and a discussion of any factors that might have threatened the internal or external validity of the study.

Behavioral HealthCare, Inc.

The two PIPs reviewed by HSAG for BHI were:

- *Follow-Up Post Hospitalization*, which sought to improve the rates of consumer follow-up after discharge, recidivism at seven and 30 days, and average length of stay per discharge. For most of the measures, the rates exceeded the HEDIS benchmark percentages.
- *Access to Initial Medication Evaluations*, which sought to increase the rates of consumer and clinician satisfaction and access to initial medication evaluation appointments within 14 and 30 days. At the time of the study report, the four study indicators were at different stages of evaluation, with no statistical differences in consumer satisfaction scores and a decreasing satisfaction by clinicians. No analysis had been conducted on the access indicator.

For both of these studies, BHI presented a well-defined study topic that addressed the broad spectrum of care, which in turn could affect the mental health, functional status, and satisfaction of the BHO's Medicaid consumers. The study indicator selection process was well-defined, objective and measurable.

The overall score for the *Follow-Up Post Hospitalization* study was *Met*, with an overall percentage score of 90 percent. All 10 out of 11 critical elements were *Met* (one critical element was *Not Applicable)* and a total of 37 out of 41 applicable elements (including critical elements) were *Met*. The PIP included a well-defined study population, and data collection methods and analyses were presented in a clear and easily understood manner. Although no corrective actions were identified, weaknesses were noted in two of the study questions related to measuring improvements in outcomes. HSAG recommended that for future studies, BHI provide:

- An estimated degree of automated data completeness for the data collected and analyzed, and a discussion of any factors that might have threatened the internal or external validity of the study.

The overall score for the *Access to Initial Medication Evaluation* PIP was *Partially Met* with an overall percentage score of 51 percent. Six out of 11 critical elements were *Met* (one critical element was *Not Applicable* and the others were *Partially Met),* with a total of 23 out of 45 applicable elements (including critical elements) being *Met*. Weaknesses were reported in the areas of the study question, sampling technique, accurate/complete data collection, sufficient data analysis and interpretation, and real improvement achieved. Additionally, corrective actions that were identified involved a complete description of the study population, along with the use of sampling techniques for each indicator that provided a representative sample of the population. Finally, HSAG recommended that BHI:

- Provide detailed information outlining the production of study indicators and results of data completeness.
- Identify factors that threatened the validity of the findings.
- Include at least two additional remeasurement periods to assess sustained improvements.

Jefferson Center for Mental Health

The two PIPs reviewed by HSAG for JCMH were:

- *Access to Routine Offered Intake Appointment,* which sought to increase the percentage of consumers offered a routine intake appointment. The indicator showed intake appointments were offered within seven and 14 days, and the indicator for consumer satisfaction achieved and maintained the benchmark goal.
- *Treatment of Adults with Depression,* which sought to investigate the lack of progress in managing depressive issues among adult consumers with a primary diagnosis of depression. At the time of the study report, JCMH was still in phase one of the PIP and, therefore, no results were available.

For both of these studies, JCMH presented a well-defined study topic that addressed the broad spectrum of care, which in turn could affect the mental health, functional status, and satisfaction of

the BHO's Medicaid consumers. The study indicator selection process was well-defined, objective, and measurable. Weaknesses included a lack of a clearly defined enrollment and eligibility criteria, the data elements that were collected, and the automated data collection process.

The overall score for the *Access to Routine Offered Intake Appointment* study was *Met*, with an overall percentage score of 87 percent. All 10 out of 11 critical elements were *Met* (one critical element was *Not Applicable)* and a total of 41 out of 47 applicable elements (including critical elements) were *Met*. No corrective actions were identified.

The overall score for the *Treatment of Adults with Depression* was *Partially Met*, with an overall percentage score of 73 percent. Eight out of nine critical elements were *Met* (one critical element was *Partially Met)*. A total of 24 out of 33 applicable elements (including critical elements) were *Met*. One corrective action was identified, involving the need to address who would be collecting the data and how JCMH would ensure consistent and accurate collection of the data according to indicator specifications.

Based on the findings from the two PIP validation studies, HSAG recommended that JCMH:

- More thoroughly define the eligibility criteria for the study population—specifically the length of enrollment in the BHO.
- Define all data elements collected.
- Provide algorithms for the automated data process that map out how the indicators were developed.
- Provide an estimated degree of automated data completeness and identify factors that threatened validity of the findings.
- Provide information on the study that will ensure data are collected accurately and consistently.

Mental Health Center of Boulder County, Inc.

The two PIPs reviewed by HSAG for MHCBC were:

- *Solution-Focused Brief Therapy Study*, which sought to reduce the number of services provided to higher-functioning consumers. Study results did not show a decrease in the number of services provided to higher-functioning consumers.
- *Input and Output Study of Individuals with Psychosis*, which sought to address the clinical care and outcomes of Medicaid consumers with chronic, serious mental illness. Results demonstrated that MHCBC provided a broad variety of services to consumers with psychotic disorders as well as effective care, except in the area of employment status.

For both of these studies, MHCBC presented a well-defined study topic that addressed the broad spectrum of care, which in turn could affect the mental health, functional status, and satisfaction of the BHO's Medicaid consumers. The study question was clearly stated and set the focus of the study. The study indicator selection process was well-defined, objective and measurable. Weaknesses noted included a lack of a clearly described study population, data results, and automated data collection process.

The overall score for the *Solution-Focused Brief Therapy* study was *Partially Met*, with an overall percentage score of 63 percent. All 10 out of 11 critical elements were *Met* (one critical element was *Not Applicable)* and a total of 29 out of 46 applicable elements (including critical elements) were *Met*. Although no corrective actions were identified, review activities in which MHCBC scored lower included accurate/complete data collection, appropriate improvement strategies, sufficient data analysis and interpretation, and real improvement achieved.

The overall score for the *Input and Output Study of Individuals with Psychosis* was *Not Met*, with an overall percentage score of 0 percent. Ten out of 11 critical elements were *Met* with one critical element being *Not Met.* A total of 35 out of 43 applicable elements (including critical elements) were *Met*. As a result of not meeting one of the critical elements, a corrective action was identified, involving the need to describe the study population clearly and completely in order to ensure that all consumers to whom the study question applied were included.

Northeast Behavioral Health, L.L.C.

The two PIPs reviewed by HSAG for NBH were:

- *Inpatient Readmission Rates,* which sought to reduce the rate at which consumers were readmitted to an inpatient setting, at seven, 30 and 90 days after discharge from a previous inpatient admission. At the time of the study report, only a partial year's worth of data for the first remeasurement period had been collected; therefore, comparison of results with the baseline data did not show improvement.
- *Follow-Up After an Inpatient Stay*, which sought to improve the rates of follow-up after an inpatient discharge for Medicaid consumers. At the time of the study report, only a partial year's worth of data for the first remeasurement period had been collected; therefore, comparison of results with the baseline data did not show improvement.

For both of these studies, NBH presented a well-defined study topic that could elicit permanent change among providers, which in turn could affect the mental health, functional status, and satisfaction of the BHO's Medicaid consumers. The study indicator selection process was well-defined, objective, and measurable. Weaknesses identified included lack of defined length of enrollment and eligibility criteria for the study population, not providing an assessment of automated data completeness, and not addressing factors that might have affected the internal or external validity of study findings.

The overall score for both studies was *Met*. For the *Inpatient Readmission Rate* PIP, NBH received an overall percentage score of 89 percent, with all 9 out of 11 critical elements being *Met* (two critical elements were *Not Applicable)* and a total of 33 out of 37 applicable elements (including critical elements) being *Met*. For the *Follow-Up After an Inpatient Stay* PIP, NBH received an overall percentage score of 86 percent, with all 11 critical elements being *Met* and a total of 38 out of 44 applicable elements (including critical elements) being *Met*.

Although no corrective actions were identified, HSAG recommended that as NBH moves forward with both studies:

- Statistical significance should be tested between measurement periods to determine if improvements in the follow-up rates are real.
- Factors should be identified that could affect the rates.
- Interventions should be revised or standardized based on their success.

SyCare-Options Colorado Health Networks, L.L.C. and West Slope-Options Colorado Health Networks, L.L.C.

The two PIPs reviewed by HSAG for SyCare/West Slope-Options were:

- *Ambulatory Follow-Up,* which sought to improve the rates of follow-up after hospital discharge for youths and adults. After a baseline and two remeasurement periods, the rate for follow-up fell below the benchmark goal.
- *Diagnosis-Based Treatment Guidelines,* which sought to increase the use of treatment guidelines by standardizing practice among mental health practitioners. The results of the study fell short of the identified performance goal.

For both of these studies, SyCare/West Slope-Options presented a well-defined study topic that could elicit permanent change among providers, which in turn could affect the mental health, functional status, and satisfaction of the BHO's Medicaid consumers. The study indicator selection process was well-defined, objective, and measurable. Weaknesses identified included the study questions, which were not identified; lack of defined enrollment and eligibility criteria; the sampling techniques, which were possibly biased; lack of well-trained qualified staff performing manual data abstractions; lack of completely defined data elements collected; and lack of causal/barrier analysis for the study intervention.

The overall score for both studies was *Partially Met*. For the *Ambulatory Follow-up* PIP, SyCare/West Slope-Options received an overall percentage score of 75 percent, with seven out of 11 critical elements being *Met* (one critical element was *Not Applicable* and three critical elements were *Partially Met).* A total of 35 out of 47 applicable elements (including critical elements) were *Met*. Corrective actions identified included: providing a clearly defined study question and completely describing the study population. For the *Diagnosis-Based Treatment Guidelines* PIP, SyCare/West Slope-Options received an overall percentage score of 52 percent, with eight out of 11 critical elements being *Met* (three critical elements were *Partially Met*). A total of 22 out of 42 applicable elements (including critical elements) were *Met*. Corrective actions identified included providing a clearly defined study question and data analysis plan, and ensuring results can be generalized to the entire study population through the use of statistical significance testing.

Based on the findings from the two PIPs, HSAG recommended that SyCare/West Slope-Options:

- Identify a clearly defined and answerable study topic.
- More thoroughly define eligibility criteria for the study population, qualifications of data collection staff, and the data collection process.

- Perform barrier analysis to determine if interventions were related to improvements.
- Identify factors that threatened validity of the findings.
- Include at least two remeasurement periods to assess sustained improvement.

4. Assessment of and Recommendations for BHOs

Introduction

Drawing upon the results and findings for each of the individual EQR activities described in Section 3, this section provides an assessment of each BHO's overall performance with respect to the quality, timeliness, and access to health care services furnished. For each BHO, summary tables are included showing the BHO's review results for compliance monitoring, the validation of performance measures, and the validation of PIPs. In addition to highlighting the BHO's strengths, this section offers high-level recommendations to enhance and improve performance in the three areas, as applicable.

For the performance measures, the following results are shown:

- **Penetration rates for adults and children** represent the percentage of children or adult Medicaid enrollees who received services from the BHO during the fiscal year.
- **MHSIP survey measures** are provided in several "domains," which are combinations of the scores given on several related questions. Results shown are the percentage of adult BHO Medicaid members who provided positive responses to questions in each domain. The domains displayed are Access, Quality/Appropriateness, Treatment Outcome, Satisfaction With Services, and Participation in Service/Treatment Planning.
- **Consumers Linked to Primary Care** shows the percentage of adult BHO Medicaid members who reported being seen by a doctor or nurse for a health checkup, physical exam, or illness outside of the emergency room. This measure is also collected by the MHSIP survey.
- **Children Living in a Family-Like Setting** measures Medicaid children with serious emotional disturbances who lived in a family-like setting (not in a residential treatment setting, hospital, jail or detention center, or who were homeless). Data were collected from the two most recent CCARs that were administered during the measurement period. Results are shown as z-scores, which reflect the relative performance of the BHOs on the measure, essentially showing how far above or below the statewide mean the BHO scores fell. More specifically, z-scores reflect the number of standard deviations above or below the mean for a given measure.
- **Adults Living Independently** measures Medicaid adults with serious mental illness who lived independently. Data were collected from the two most recent CCARs that were administered during the measurement period. Results are shown as z-scores, which reflect the relative performance of the BHOs on the measure, essentially showing how far above or below the statewide mean the BHO scores fell. The number of standard deviations above or below the mean for the measure is identified.
- **Employment** measures Medicaid adults (aged 18 through 59) who were in the labor force at the time the two most recent CCARs were administered. Employment is defined as full-time, part-time, or active military service. Results are shown as z-scores, which reflect the relative performance of the BHOs on the measure, essentially showing how far above or below the statewide mean the BHO scores fell. The number of standard deviations above or below the mean for the measure is identified.

- **Change in Problem Severity in Children/Adults** are measures of improvement based on the amount of change in problem severity between the CCAR administered at discharge and the most recently administered CCAR prior to discharge. Larger numbers indicate a greater degree of improvement. Negative scores do not mean clients got worse. Rather, negative scores indicate a relatively smaller amount of improvement relative to the rest of the State. A positive score would mean a relatively greater amount of improvement relative to the rest of the State.

Access Behavioral Care – Denver

Table 4-1 through Table 4-3 provide a summary of ABC-Denver's overall performance scores for the three mandatory EQR activities conducted by HSAG for FY 03-04.

Table 4-1—Access Behavioral Care-Denver Overall Scores for Compliance Monitoring	
Compliance Monitoring Review (Overall)	**95%**
Compliance Monitoring Standards (total of 287 applicable elements)	95%
Record Reviews (total of 8 separate reviews)	95%

Table 4-2—Performance Measure Results for Access Behavioral Care-Denver		
Performance Measure	**Reported Rate**	**Audit Designation***
Penetration Rate – Child	6.30%	Substantially Compliant
Penetration Rate – Adult	14.56%	Substantially Compliant
MHSIP – Perception of Access (positive response)	76.6%	Fully Compliant
MHSIP – Perception of Appropriateness (positive response)	69.0%	Fully Compliant
MHSIP – Perception of Outcome (positive response)	60.3%	Fully Compliant
MHSIP – Perception of Satisfaction (positive response)	77.8%	Fully Compliant
MHSIP – Perception of Participation (positive response)	63.3%	Fully Compliant
MHSIP – Consumers Linked to Primary Care	84.7%	Fully Compliant
	Z-Score	
Children Living in a Family-Like Setting	-.67	Substantially Compliant
Adults Living Independently	.47	Substantially Compliant
Employment	-1.42	Substantially Compliant
Change in Problem Severity in Children	.59	Substantially Compliant
Change in Problem Severity in Adults	-2.10	Substantially Compliant

*Audit Designation indicates the degree of compliance with the Department specifications for the measures. If a deviation from the specifications resulted in a +/- bias of greater than 5 percent, the audit designation was determined to be *Not Valid*.

Table 4-3—Overall PIP Scores for Access Behavioral Care-Denver			
PIP Topic	Percentage Score of Critical Elements Met	Percentage Score of All Evaluation Elements Met	Validation Status
Readmission Rates	100%	98%	Met
Follow-Up After an Inpatient Stay	100%	96%	Met

In the area of compliance standards, ABC-Denver achieved a compliance score of 100 percent for five out of 13 compliance standards and five out of eight record reviews. In the area of performance measures, ABC-Denver reported the top domain score among the BHOs for *Consumer Perception of Access*, and exceeded the BHO statewide average for three of the six MHSIP survey measures. Conversely, ABC-Denver reported a z-score that was more than one standard deviation below the mean for *Employment* and a z-score that was more than two standard deviations below the mean for *Change in Problem Severity in Adults*. Finally, ABC-Denver was one of three BHOs for which both PIPs were given a *Met* validation status.

Strengths

ABC-Denver's recognized strengths included the following:

- Operating practices/processes in full compliance with state and federal regulations in the areas of provider issues, advance directives, member rights and responsibilities, access and availability—service delivery, and quality assurance program.
- Solid record documentation in the areas of delegation, grievances and appeals, and credentialing and recredentialing of individual practitioners.
- Strong staff commitment to reporting of performance measure data.
- Sufficient documentation of all data collection processes and useful documents and manuals for the entry of service data.
- Well-defined PIP study topics with effective study indicator selection and data collection processes in place.
- PIP studies that sought to reduce hospital readmission rates and improve rates of consumer follow-up after an inpatient stay.

Improvement Opportunities

The findings from the three EQR-related activities indicated a need for ABC-Denver to implement methods to ensure performance measure data are reliable and accurate, including inter-rater-reliability testing for CCAR data, and ensure encounter data scrubbing techniques follow Department recommendations. Enhancement of policies and processes related to subcontracts, grievance and appeal notifications, service denials, and monitoring access and care coordination were also recommended.

Access Behavioral Care – Pikes Peak

Table 4-4 through Table 4-6 provide a summary of ABC-Pikes Peak's overall performance scores for the three mandatory EQR activities conducted by HSAG for FY 03-04.

Table 4-4—Access Behavioral Care–Pikes Peak Overall Scores for Compliance Monitoring	
Compliance Monitoring Review (Overall)	**95%**
Compliance Monitoring Standards (total of 287 applicable elements)	95%
Record Reviews (total of 8 separate reviews)	96%

Table 4-5—Performance Measure Results for Access Behavioral Care-Pikes Peak		
Performance Measure	**Reported Rate**	**Audit Designation***
Penetration Rate – Child	10.92%	Substantially Compliant
Penetration Rate – Adult	14.46%	Substantially Compliant
MHSIP – Perception of Access (positive response)	65.6%	Fully Compliant
MHSIP – Perception of Appropriateness (positive response)	73.4%	Fully Compliant
MHSIP – Perception of Outcome (positive response)	62.8%	Fully Compliant
MHSIP – Perception of Satisfaction (positive response)	73.0%	Fully Compliant
MHSIP – Perception of Participation (positive response)	59.5%	Fully Compliant
MHSIP – Consumers Linked to Primary Care	81.1%	Fully Compliant
	Z-Score	
Children Living in a Family-Like Setting	-.18	Substantially Compliant
Adults Living Independently	.35	Substantially Compliant
Employment	.68	Substantially Compliant
Change in Problem Severity in Children	2.06	Substantially Compliant
Change in Problem Severity in Adults	-.16	Substantially Compliant

*Audit Designation indicates the degree of compliance with the Department specifications for the measures. If a deviation from the specifications resulted in a +/- bias of greater than 5 percent, the audit designation was determined to be *Not Valid*.

Table 4-6—Overall PIP Scores for Access Behavioral Care-Pikes Peak			
PIP Topic	Percentage Score of Critical Elements Met	Percentage Score of All Evaluation Elements Met	Validation Status
Readmission Rates	100%	95%	Met
Follow-Up After an Inpatient Stay	100%	98%	Met

In the area of compliance standards, ABC-Pikes Peak achieved a compliance score of 100 percent for five out of 13 compliance standards and four out of eight record reviews. In the area of performance measures, ABC-Pikes Peak reported a z-score that was over two standard deviations from the mean for *Change in Problem Severity in Children*. It was one of three BHOs for which both PIPs were given a *Met* validation status.

Strengths

ABC-Pikes Peak's recognized strengths included the following:

- Operating practices/processes in full compliance with state and federal regulations in the areas of provider issues, advance directives, member rights and responsibilities, access and availability—service delivery, and quality assurance program.
- Solid record documentation in the areas of delegation, grievances, and credentialing and recredentialing of individual practitioners.
- Strong staff commitment to quality of performance measure data.
- Well-defined PIP study topics with effective study indicator selection and data collection processes in place.
- PIP studies that sought to decrease hospital readmission rates and improve rates of follow-up treatment after an inpatient stay.

Improvement Opportunities

The findings from the three EQR-related activities indicated a need for ABC-Denver to implement methods to ensure performance measure data are reliable and accurate, and include testing for inter-rater-reliability for CCAR data, and to ensure encounter data scrubbing techniques follow Department recommendations. Enhancement of policies and processes related to subcontracts, grievance and appeal notifications, service denials, and monitoring access and care coordination were also recommended.

Behavioral HealthCare, Inc.

Table 4-7 through Table 4-9 provide a summary of BHI overall performance scores for the three mandatory EQR activities conducted by HSAG for FY 03-04.

Table 4-7—Behavioral HealthCare, Inc. Overall Scores for Compliance Monitoring	
Compliance Monitoring Review (Overall)	**88%**
Compliance Monitoring Standards (total of 287 applicable elements)	90%
Record Reviews (total of 8 separate reviews)	86%

Table 4-8—Performance Measure Results for Behavioral HealthCare, Inc.		
Performance Measure	**Reported Rate**	**Audit Designation***
Penetration Rate – Child	6.28%	Substantially Compliant
Penetration Rate – Adult	12.59%	Substantially Compliant
MHSIP – Perception of Access (positive response)	69.0%	Fully Compliant
MHSIP – Perception of Appropriateness (positive response)	70.2%	Fully Compliant
MHSIP – Perception of Outcome (positive response)	62.5%	Fully Compliant
MHSIP – Perception of Satisfaction (positive response)	75.4%	Fully Compliant
MHSIP – Perception of Participation (positive response)	56.7%	Fully Compliant
MHSIP – Consumers Linked to Primary Care	80.3%	Fully Compliant
	Z-Score	
Children Living in a Family-Like Setting	-.17	Substantially Compliant
Adults Living Independently	-.05	Substantially Compliant
Employment	.07	Substantially Compliant
Change in Problem Severity in Children	-1.21	Substantially Compliant
Change in Problem Severity in Adults	-1.60	Substantially Compliant

*Audit Designation indicates the degree of compliance with the Department specifications for the measures. If a deviation from the specifications resulted in a +/- bias of greater than 5 percent, the audit designation was determined to be *Not Valid*.

Table 4-9—Overall PIP Scores for Behavioral HealthCare, Inc.			
PIP Topic	Percentage Score of Critical Elements Met	Percentage Score of All Evaluation Elements Met	Validation Status
Follow-Up Post Hospitalization	100%	90%	Met
Access to Initial Medication Evaluation	60%	51%	Partially Met

For the compliance monitoring standards, BHI achieved a compliance score of 100 percent for three out of 13 compliance standards and three out of eight record reviews. For performance measures, BHI reported a z-score that was more than one standard deviation below the mean for *Change in Problem Severity in Children* and reported the lowest domain score for *Consumer Perception of Participation* among the BHOs. All other reported performance measure results for BHI were neither the highest or lowest scores among the BHOs. The validation finding status for BHI's second PIP was *Partially Met*, requiring corrective actions by the BHO to address the areas of noncompliance.

Strengths

BHI's recognized strengths included the following:

- Operating practices/processes in full compliance with state and federal regulations in the areas of advance directives, practice guidelines, and continuity of care system—service delivery.
- Solid record documentation in the areas of denials, case management/care coordination, and credentialing of individual practitioners.
- Best practice recognition for the processing of claims and encounters, which was also easily accessible for primary source verification.
- Well-defined PIP study topics with an effective study indicator selection process.
- PIP studies that sought to improve the rates of consumer follow-up after hospital discharge and improve the rates of satisfaction and access to initial medication evaluation appointments.

Improvement Opportunities

The findings from the three EQR-related activities indicated a need for BHI to ensure compliance with CMS requirements for PIP documentation, specifically in the area of PIP sampling techniques. Internal data validation processes should be implemented for CCAR and claims/encounter data, which are used for performance measure reporting. Enhancement of policies and processes related to credentialing/recredentialing and grievances/appeals, and ensuring required provisions and information are included in member materials and delegation agreements were recommended.

Jefferson Center for Mental Health

Table 4-10 through Table 4-12 provide a summary of JCMH's overall performance scores for the three mandatory EQR activities conducted by HSAG for FY 03-04.

Table 4-10—Jefferson Center for Mental Health Overall Scores for Compliance Monitoring	
Compliance Monitoring Review (Overall)	**88%**
Compliance Monitoring Standards (total of 291 applicable elements)	83%
Record Reviews (total of 8 separate reviews)	91%

Table 4-11—Performance Measure Results for Jefferson Center for Mental Health		
Performance Measure	**Reported Rate**	**Audit Designation***
Penetration Rate – Child	8.49%	Substantially Compliant
Penetration Rate – Adult	14.38%	Substantially Compliant
MHSIP – Perception of Access (positive response)	70.2%	Fully Compliant
MHSIP – Perception of Appropriateness (positive response)	68.1%	Fully Compliant
MHSIP – Perception of Outcome (positive response)	62.0%	Fully Compliant
MHSIP – Perception of Satisfaction (positive response)	75.5%	Fully Compliant
MHSIP – Perception of Participation (positive response)	70.5%	Fully Compliant
MHSIP – Consumers Linked to Primary Care	88.5%	Fully Compliant
	Z-Score	
Children Living in a Family-Like Setting	2.32	Substantially Compliant
Adults Living Independently	-.66	Substantially Compliant
Employment	.53	Substantially Compliant
Change in Problem Severity in Children	.33	Substantially Compliant
Change in Problem Severity in Adults	.53	Substantially Compliant

*Audit Designation indicates the degree of compliance with the Department specifications for the measures. If a deviation from the specifications resulted in a +/- bias of greater than 5 percent, the audit designation was determined to be *Not Valid*.

Table 4-12—Overall PIP Scores for Jefferson Center for Mental Health			
PIP Topic	**Percentage Score of Critical Elements Met**	**Percentage Score of All Evaluation Elements Met**	**Validation Status**
Access to Routine Offered Intake Appointments	100%	87%	Met
Treatment of Adults with Depression	89%	73%	Partially Met

In the area of compliance standards, JCMH achieved a compliance score of 100 percent for two out of the 13 compliance standards and four out of eight record reviews. In the area of performance measures, JCMH reported a z-score for *Children Living in a Family-Like Setting* that was greater than two standard deviations above the mean, and the highest domain score for *Consumers Linked to Primary Care* among the BHOs. In the area of validation of PIPs, the two PIPs received a *Met* and a *Partially Met* status.

Strengths

JCMH's recognized strengths included the following:

- Operating practices/processes in full compliance with State and federal regulations in the areas of advance directives and quality assessment and performance improvement documentation.
- Solid record documentation in the areas of denials, encounter data verification, case management/care coordination, and credentialing of individual practitioners.
- Built-in system edit checks to ensure data quality as well as other sound methods that ensure data completeness.
- Commitment to quality performance measurement data, internally evaluating performance in this area.
- Well-defined PIP study topics with effective study indicator selection process.
- PIP studies that sought to improve the percentage of consumers offered a routine intake appointment and investigate the lack of progress in managing depressive issues among adult consumers with the primary diagnosis of depression.

Improvement Opportunities

The findings from the three EQR-related activities indicated a need for JCMH to implement better tracking systems for encounter and CCAR data submitted to the Department. A method for ensuring inter-rater reliability of CCAR data should be implemented. In the area of PIPs, the study documentation needs to describe enrollment and eligibility criteria and clearly define data elements that were collected. The automated data collection process must be defined and an estimate of the degree of data completeness must be documented. For the *Treatment of Adults with Depression* PIP, a corrective action was required to address the evaluation elements that received either a *Partially Met* or *Not Met* finding. Enhancement of policies and processes in the areas of credentialing/recredentialing, grievances/appeals, service denials, and delegation was recommended. In addition, subcontracts and member materials should be amended to meet requirements, and training for providers should occur in the areas of corporate compliance, fraud and abuse reporting, and clinical practice guidelines.

Mental Health Center of Boulder County, Inc.

Table 4-13 through Table 4-15 provide a summary of MHCBC's overall performance scores for the three mandatory EQR activities conducted by HSAG for FY 03-04.

Table 4-13—Mental Health Center of Boulder County, Inc. Overall Scores for Compliance Monitoring	
Compliance Monitoring Review (Overall)	**54%**
Compliance Monitoring Standards (total of 282 applicable elements)	36%
Record Reviews (total of 4 separate reviews)	88%

Table 4-14—Performance Measure Results for Mental Health Center of Boulder County, Inc.		
Performance Measure	**Reported Rate**	**Audit Designation***
Penetration Rate – Child	8.99%	Substantially Compliant
Penetration Rate – Adult	19.44%	Substantially Compliant
MHSIP – Perception of Access (positive response)	65.2%	Fully Compliant
MHSIP – Perception of Appropriateness (positive response)	68.2%	Fully Compliant
MHSIP – Perception of Outcome (positive response)	61.5%	Fully Compliant
MHSIP – Perception of Satisfaction (positive response)	73.5%	Fully Compliant
MHSIP – Perception of Participation (positive response)	62.9%	Fully Compliant
MHSIP – Consumers Linked to Primary Care	84.3%	Fully Compliant
	Z-Score	
Children Living in a Family-Like Setting	-.08	Substantially Compliant
Adults Living Independently	.35	Substantially Compliant
Employment	-.45	Substantially Compliant
Change in Problem Severity in Children	-.47	Substantially Compliant
Change in Problem Severity in Adults	3.0	Substantially Compliant

*Audit Designation indicates the degree of compliance with the Department specifications for the measures. If a deviation from the specifications resulted in a +/- bias of greater than 5 percent, the audit designation was determined to be *Not Valid*.

Table 4-15—Overall PIP Scores for Mental Health Center of Boulder County, Inc.			
PIP Topic	**Percentage Score of Critical Elements Met**	**Percentage Score of All Evaluation Elements Met**	**Validation Status**
Solution-Focused-Brief Therapy	100%	63%	Partially Met
Input and Output Study of Individuals with Psychosis	91%	0%*	Not Met

*One critical element was not met; therefore, the overall status for the PIP validation was *Not Met* and the percentage score is zero.

The findings from all three mandatory EQR activities indicated a need for MHCBC to continue implementing strategies to assure compliance with federal and State program standards and to improve its methods and documentation for conducting PIPs. MHCBC received an overall compliance score of 36 percent for the 13 standards and 88 percent for the record reviews, for an overall scores of 54 percent. In the area of performance measure reporting, MHCBC reported a z-score for *Change in Problem Severity in Adults* that was three standard deviations above the mean. In the area of PIP validation, one PIP received a *Partially Met* status, and the other received a *Not Met* status. MHCBC received a *Not Met* finding for one of the "Correctly Identified Study Population" critical elements, resulting in an overall validation finding of *Not Met* for the *Input and Output Study of Individuals with Psychosis* PIP. Other areas of weakness in the PIP documentation included a lack of description of the automated data collection process, the algorithms that outline the steps in the production of study indicators, and estimated degree of data completeness.

Strengths

Areas in which MHCBC was commended for its performance included:

- Strong staff commitment to the quality of performance measurement data, performing corrective actions as appropriate and conducting an inter-rater reliability study on CCAR data to ensure provider accuracy.
- Adequate documentation of all data collection processes and manuals for entry of Service Activity Log data used for performance measure reporting.
- Completion of an inter-rater reliability study performed on CCAR data to ensure provider accuracy.
- Well-defined PIP study topics and study questions with effective study indicator selection processes in place.
- PIPs that sought to address the clinical care and outcomes of consumers with chronic, serious mental illness and reduce the number of services provided to higher-functioning consumers.

Improvement Opportunities

The findings from the three EQR-related activities indicated a need for improvement efforts in all three areas (i.e., compliance with contract requirements, performance measures, and PIPs). Development or enhancement of policies and procedures was needed for nearly every area of review. MHCBC should revise enrollee materials and provider agreements to meet requirements. Improvements in training of staff, monitoring and tracking access and service utilization, grievances, appeals and denials, and credentialing/recredentialing of providers were also recommended. For performance measure reporting, MHCBC should focus efforts on monitoring the submission of encounter data, particularly what was not able to be extracted, and to assign reason codes or categories to be able to identify submission barriers. Protocols for better testing for community mental health center extraction programs for encounter data and CCAR data should be implemented. MHCBC should also establish a sound process for the tracking of encounter data that is submitted to the Department. For one of the PIPs, a clearly and completely described study population was required to ensure that the population captured all consumers to whom the study question applied. A corrective action was required to address the area of the PIP that was not in compliance with CMS protocols.

Northeast Behavioral Health, L.L.C.

Table 4-16 through Table 4-18 provide a summary of NBH's overall performance scores for the three mandatory EQR activities conducted by HSAG for FY 03-04.

Table 4-16— Northeast Behavioral Health, L.L.C. Overall Scores for Compliance Monitoring	
Compliance Monitoring Review (Overall)	**84%**
Compliance Monitoring Standards (total of 286 applicable elements)	81%
Record Reviews (total of 7 separate reviews)	86%

Table 4-17—Performance Measure Results for Northeast Behavioral Health, L.L.C.		
Performance Measure	**Reported Rate**	**Audit Designation***
Penetration Rate – Child	8.77%	Substantially Compliant
Penetration Rate – Adult	14.46%	Substantially Compliant
MHSIP – Perception of Access (positive response)	71.0%	Fully Compliant
MHSIP – Perception of Appropriateness (positive response)	68.6%	Fully Compliant
MHSIP – Perception of Outcome (positive response)	60.8%	Fully Compliant
MHSIP – Perception of Satisfaction (positive response)	75.0%	Fully Compliant
MHSIP – Perception of Participation (positive response)	64.8%	Fully Compliant
MHSIP – Consumers Linked to Primary Care	87.8%	Fully Compliant
	Z-Score	
Children Living in a Family-Like Setting	-.98	Substantially Compliant
Adults Living Independently	-.35	Substantially Compliant
Employment	.02	Substantially Compliant
Change in Problem Severity in Children	-.50	Substantially Compliant
Change in Problem Severity in Adults	2.31	Substantially Compliant

*Audit Designation indicates the degree of compliance with the Department specifications for the measures. If a deviation from the specifications resulted in a +/- bias of greater than 5 percent, the audit designation was determined to be *Not Valid*.

Table 4-18—Overall PIP Scores for Northeast Behavioral Health, L.L.C.			
PIP Topic	Percentage Score of Critical Elements Met	Percentage Score of All Evaluation Elements Met	Validation Status
Inpatient Readmission Rate	100%	89%	Met
Follow-Up After an Inpatient Stay	100%	86%	Met

In the area of compliance standards, NBH achieved a compliance score of 100 percent for one of the 13 compliance standards and three out of seven record reviews. In the area of performance measures, NBH reported a z-score that was greater than two standard deviations above the mean for *Change in Problem Severity in Adults*. All other performance measure results reported by NBH were neither the highest or lowest scores among the BHOs. In the area of Validation of PIPs, NBH was one of three BHOs for which both PIPs were given a *Met* status.

Strengths

NBH's recognized strengths included the following:

- Operating practices/processes in full compliance with state and federal regulations in the area of advance directives.
- Solid record documentation in the areas of denials, case management/care coordination, and grievances.
- Well-defined PIP study topics with effective study indicator selection processes in place.
- PIPs that sought to address the need to reduce readmission rates of consumers discharged from the hospital and improve the rates of follow-up after an inpatient discharge for consumers.

Improvement Opportunities

The findings from the three EQR-related activities indicated a need for NBH to focus efforts on ensuring compliance with State and federal regulations in the area of delegation, and credentialing and recredentialing. In addition, enrollee materials and contracts should be revised to meet requirements. To improve performance measure reporting, NBH should formalize a process for validating manual data entry of encounter data, which is consistent across all three mental health centers. In addition, the data entry of CCAR data submitted by external providers should be formally validated.

SyCare-Options Colorado Health Networks, L.L.C.

Table 4-19 through Table 4-21 provide a summary of SyCare-Options' overall performance scores for the three mandatory EQR activities conducted by HSAG for FY 03-04.

Table 4-19—SyCare-Options Colorado Health Networks, L.L.C. Overall Scores for Compliance Monitoring	
Compliance Monitoring Review (Overall)	**91%**
Compliance Monitoring Standards (total of 277 applicable elements)	88%
Record Reviews (total of 7 separate reviews)	93%

Table 4-20—Performance Measure Results for SyCare-Options Colorado Health Networks, L.L.C.		
Performance Measure	**Reported Rate**	**Audit Designation***
Penetration Rate – Child	9.22%	Substantially Compliant
Penetration Rate – Adult	14.60%	Substantially Compliant
MHSIP – Perception of Access (positive response)	76.4%	Fully Compliant
MHSIP – Perception of Appropriateness (positive response)	76.9%	Fully Compliant
MHSIP – Perception of Outcome (positive response)	66.2%	Fully Compliant
MHSIP – Perception of Satisfaction (positive response)	81.7%	Fully Compliant
MHSIP – Perception of Participation (positive response)	72.9%	Fully Compliant
MHSIP – Consumers Linked to Primary Care	79.2%	Fully Compliant
	Z-Score	
Children Living in a Family-Like Setting	-.32	Substantially Compliant
Adults Living Independently	-.12	Substantially Compliant
Employment	-.55	Substantially Compliant
Change in Problem Severity in Children	-.59	Substantially Compliant
Change in Problem Severity in Adults	-2.23	Substantially Compliant

*Audit Designation indicates the degree of compliance with the Department specifications for the measures. If a deviation from the specifications resulted in a +/- bias of greater than 5 percent, the audit designation was determined to be *Not Valid*.

Table 4-21—Overall PIP Scores for SyCare-Options Colorado Health Networks, L.L.C. and West Slope-Options Colorado Health Networks, L.L.C.			
PIP Topic	**Percentage Score of Critical Elements Met**	**Percentage Score of All Evaluation Elements Met**	**Validation Status**
Ambulatory Follow-Up	70%	75%	Partially Met
Diagnosis-Based Treatment Guidelines	73%	52%	Partially Met

Note: SyCare-Options and West Slope-Options submitted two combined PIPs for validation; therefore, PIP findings, strengths, and improvement opportunities are included under SyCare-Options' PIP findings only.

In the area of compliance monitoring, SyCare-Options achieved a compliance score of 100 percent for four out of 13 compliance standards and two out of seven record reviews. SyCare-Options reported the highest rates among BHOs for *Consumer Perception of Appropriateness, Outcome, Satisfaction, and Participation*. However, for the *Change in Problem Severity in Adults* measure, SyCare-Options reported a z-score that was more than two standard deviations below the mean. Neither of SyCare-Options' PIPs received a validation status of *Met*, with study results falling short of the benchmark goals.

Strengths

SyCare-Options' recognized strengths included the following:

- Operating practices/processes in full compliance with State and federal regulations in the areas of advance directives, practice guidelines, quality assessment and performance improvement documentation and quality assurance program.
- Solid record documentation in the areas of grievances and credentialing of individual practitioners.
- Built-in system edit checks to ensure data quality as well as other sound methods that ensure data completeness.
- Staff cross-trained and knowledgeable regarding performance measure reporting.
- Well-defined PIP study topics with effective study indicator selection process.
- PIPs that sought to improve the rates of follow-up after hospital discharge for youth and adults, and increase the use of treatment guidelines by standardizing practice among mental health practitioners.

Improvement Opportunities

The findings from the three EQR-related activities indicated a need for SyCare-Options to focus efforts on improving the performance measure data collection process, which should include performing a formal validation process for the data entry of CCAR and claims data. In the area of validation of PIPs, SyCare-Options should ensure that all submitted PIP documentation addresses the key components of the CMS protocols, including clear identification of the study questions; clearly defined enrollment and eligibility criteria; sound sampling techniques; definitions of data elements to be collected; and causal/barrier analysis for the study interventions. SyCare should enhance policies and processes related to member materials, access to care, and credentialing/recredentialing. Monitoring and tracking processes should be developed or enhanced related to grievances/appeals, case management, and follow-up on quality concerns by mental health centers.

West Slope-Options Colorado Health Networks, L.L.C.

Table 4-22 and Table 4-23 provide a summary of West Slope-Options' overall performance scores for the two mandatory EQR activities conducted by HSAG for FY 03-04.

West Slope-Options' PIP validation findings are shown in Table 4-21 under the SyCare-Options section.

Table 4-22—West Slope-Options Colorado Health Networks, L.L.C. Overall Scores for Compliance Monitoring

Compliance Monitoring Review (Overall)	**87%**
Compliance Monitoring Standards (total of 277 applicable elements)	88%
Record Reviews (total of 7 separate reviews)	87%

Table 4-23—Performance Measure Results for West Slope-Options Colorado Health Networks, L.L.C.

Performance Measure	Reported Rate	Audit Designation*
Penetration Rate – Child	7.60%	Substantially Compliant
Penetration Rate – Adult	15.10%	Substantially Compliant
MHSIP - Perception of Access (positive response)	68.1%	Fully Compliant
MHSIP - Perception of Appropriateness (positive response)	69.3%	Fully Compliant
MHSIP - Perception of Outcome (positive response)	55.7%	Fully Compliant
MHSIP - Perception of Satisfaction (positive response)	75.7%	Fully Compliant
MHSIP - Perception of Participation (positive response)	63.5%	Fully Compliant
MHSIP – Consumers Linked to Primary Care	79.4%	Fully Compliant
	Z-Score	
Children Living in a Family-Like Setting	.08	Substantially Compliant
Adults Living Independently	-.15	Substantially Compliant
Employment	.08	Substantially Compliant
Change in Problem Severity in Children	-.20	Substantially Compliant
Change in Problem Severity in Adults	-3.09	Substantially Compliant

*Audit Designation indicates the degree of compliance with the Department specifications for the measures. If a deviation from the specifications resulted in a +/- bias of greater than 5 percent, the audit designation was determined to be *Not Valid*.

In the area of compliance monitoring, West Slope-Options achieved a compliance score of 100 percent for four out of 13 compliance standards and three out of seven record reviews. In the area of performance measures, West Slope-Options reported a z-score that was more than three standard deviations below the mean for *Change in Problem Severity in Adults*.

Strengths

West Slope-Options' recognized strengths included the following:

- Operating practices/processes in full compliance with State and federal regulations in the areas of advance directives, practice guidelines, quality assessment and performance improvement documentation, and quality assurance program.
- Solid record documentation in the areas of denials and credentialing/recredentialing of individual practitioners.
- Built-in system edit checks to ensure data quality as well as other sound methods to assure data completeness.
- Staff cross-trained and knowledgeable regarding performance measure reporting.

Improvement Opportunities

The findings from the three EQR-related studies indicated a need for West Slope-Options to focus efforts on improving the processes for performance measure reporting and PIP documentation. The performance measure data collection process should include conducting a formal validation process for the data entry of CCAR and claims data. West Slope-Options should enhance policies and processes related to member materials, access to care, and credentialing/recredentialing. Monitoring and tracking processes should be developed or enhanced related to grievances/appeals, case management, and follow-up on quality concerns by mental health centers. In the area of validation of PIPs, West Slope-Options should ensure that all PIP documentation submitted addresses the key components of the CMS protocols, including clear identification of the study questions, clearly defined enrollment and eligibility criteria, sound sampling techniques, definitions of data elements to be collected, and causal/barrier analysis for the study interventions.

5. Comparative Information

Introduction

In this section of the report, the results for all eight BHOs are compared for each of the three mandatory EQR activities—compliance monitoring, validation of performance measures, and validation of PIPs. A comparative analysis of the BHOs' overall performance is presented, as well as an analysis by specific standards and/or evaluation elements. Common areas of strength and areas of improvement among the BHOs are also identified for each EQR activity. Lastly, recommendations are offered to facilitate the continued quality improvement in the program by both the Department and the BHOs.

BHO Comparison

Compliance Monitoring

As discussed in Section 3, the compliance monitoring review evaluated 13 compliance standards and conducted eight separate record reviews. The results from these compliance reviews showed that the majority of the BHOs were meeting 80 percent or more of the applicable compliance elements. The average, overall compliance score for the BHOs was 87 percent, with overall compliance scores ranging from 54 percent to 95 percent (Figure 5-1). For the overall compliance monitoring standards score, the average BHO score was 82 percent—with scores ranging from 36 percent to 95 percent—and for the overall record review score, the average BHO score was 91 percent—with scores ranging from 86 percent to 96 percent (Figure 5-2).

Figure 5-1—BHO Overall Compliance Score

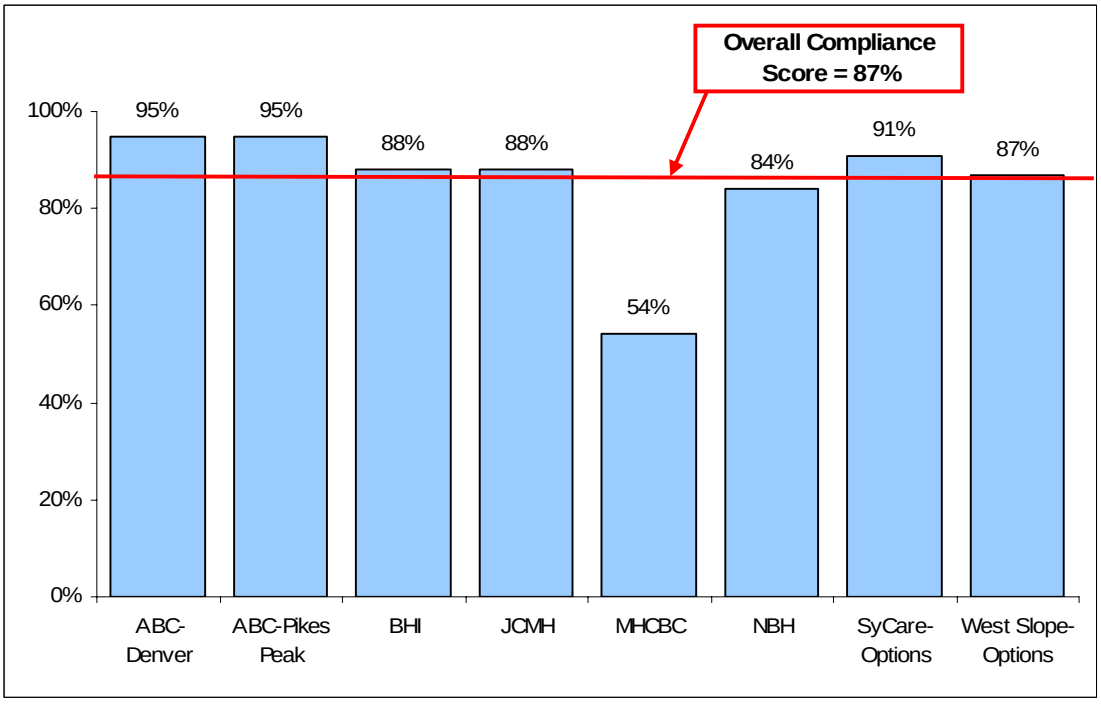
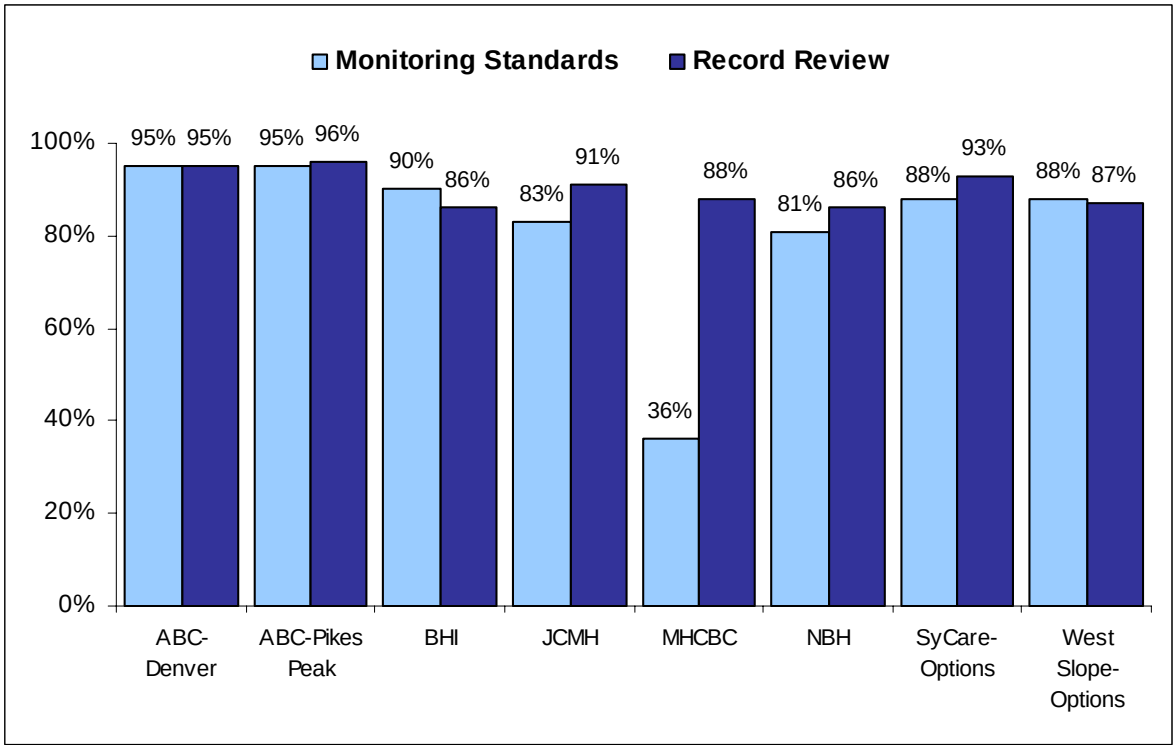


Figure 5-2—BHO Overall Compliance Scores for Compliance Monitoring Standards and for Record Review



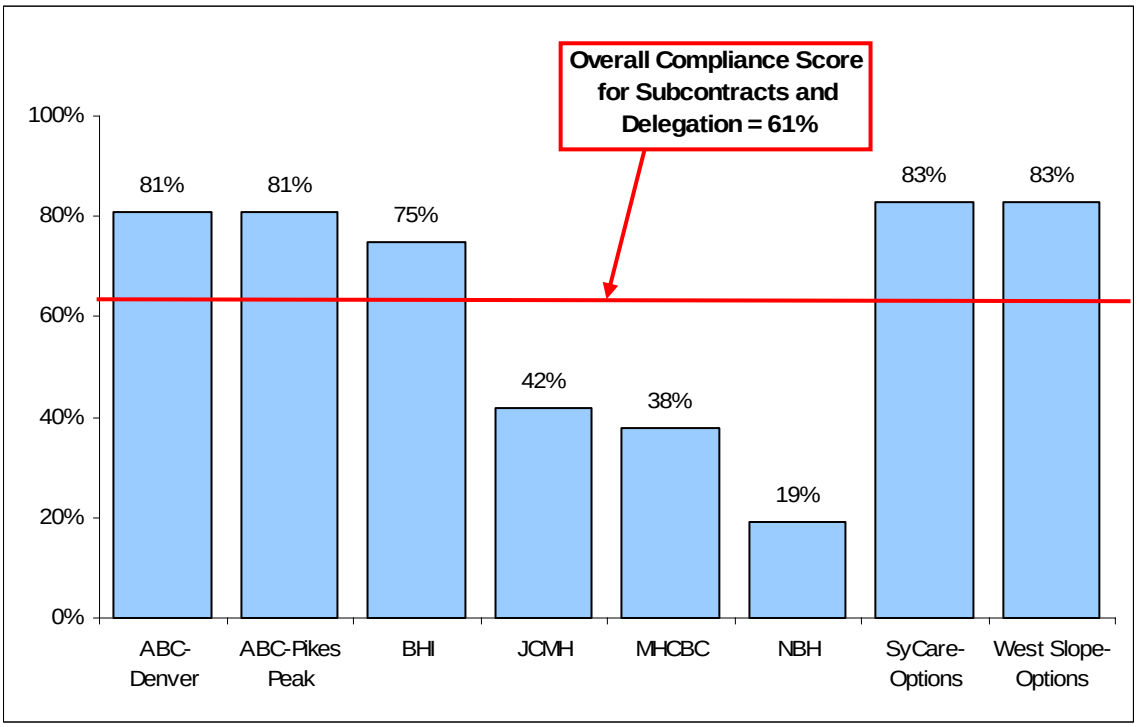
A majority of the BHOs received scores of 90 percent or higher for Standard IV, Advance Directives; Standard VII, Access and Availability—Service Delivery; Standard VIII, Utilization Review; Standard XI, Quality Assurance Program; and Standard XIII, Credentialing and Recredentialing. In contrast, Standard I, Subcontracts and Delegation; Standard II, Provider Issues; Standard VI, Member Rights and Responsibilities; Standard X, Quality Assessment and Performance Improvement (QAPI) Documentation; and Standard XII, Grievances, Appeals, and Fair Hearings, presented improvement opportunities for many BHOs. Standard III, Marketing, was not applicable for any of the eight BHOs.

Following is a brief description of each standard along with a comparison of BHO performance for the standard and results of any associated record review.

Standard I—Subcontracts and Delegation reviewed the BHO's subcontracting process in terms of contract provisions, termination, and access to subcontract records. Additionally and where applicable, the BHO's delegation processes were assessed, especially in terms of evaluating prospective delegates, ongoing and formal monitoring of the delegates for deficiencies, and requiring needed corrective actions.

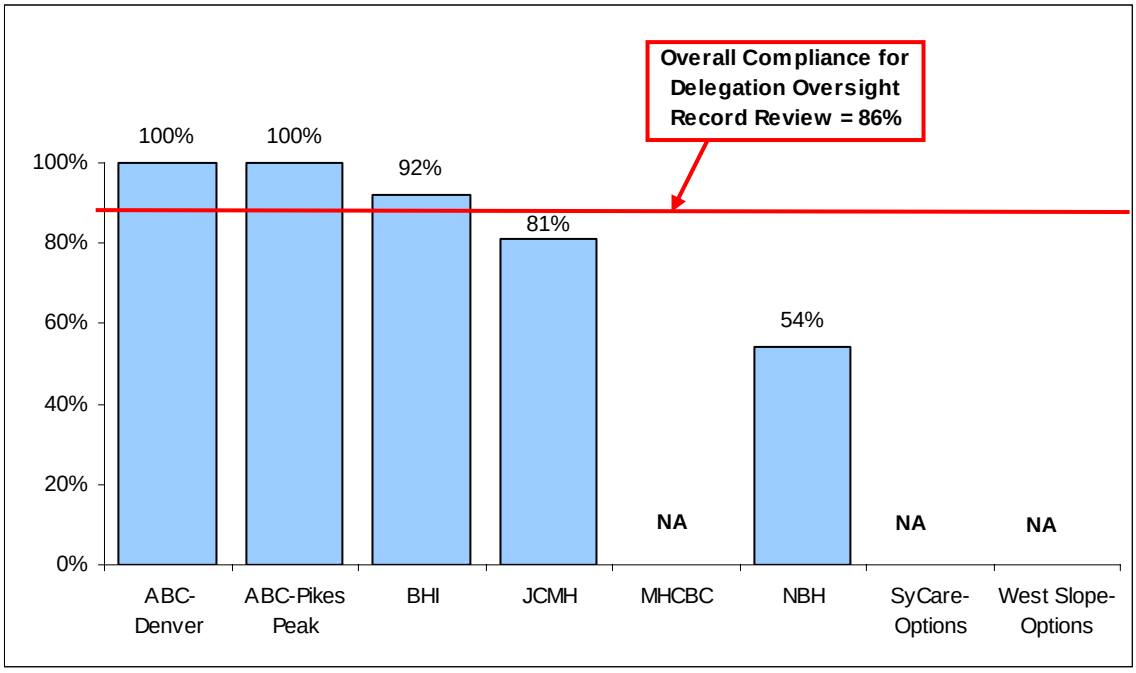
The percentage of applicable elements met for this standard ranged from 19 percent to 83 percent. Common elements requiring corrective action included subcontractor termination process and inclusion of hold-harmless provisions in all subcontracts.

Figure 5-3—BHO Scores for Standard I: Subcontracts and Delegation



Related to this standard, a record review was conducted of delegated services (e.g., delegated entities performing credentialing and recredentialing activities for the BHO). The records were reviewed for evidence of a written agreement or subcontract, presence of reporting and performance expectations, and reporting and follow-up on compliance issues that may exist with the delegated service. The percentage of compliant elements for the Delegation Oversight Record Review ranged from 54 percent to 100 percent.

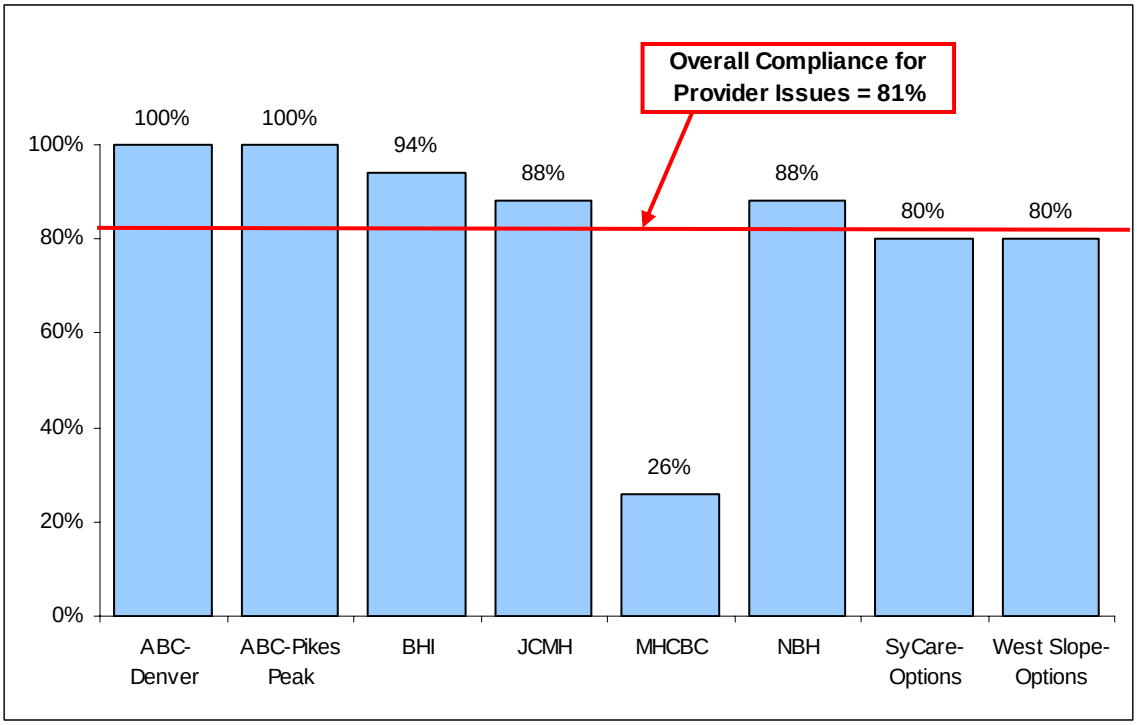
Figure 5-4—BHO Scores for Record Review—Delegation Oversight



Standard II—Provider Issues assessed whether the BHO was in compliance with an array of provider-related requirements such as Clinical Laboratory Improvement Amendments (CLIA) waivers or certification of registration, subcontract provisions addressing access to records, non-discrimination, credentialing, etc., along with a written notification process for providers it declines to include. Additionally, processes related to program integrity and reporting of fraud were evaluated, including the BHO's mandatory compliance plan.

The percentage of applicable elements met for this standard ranged from 26 percent to 100 percent. The most common element requiring corrective action was related to the BHO's compliance plan and procedures designed to guard against fraud and abuse.

Figure 5-5—BHO Scores for Standard II: Provider Issues



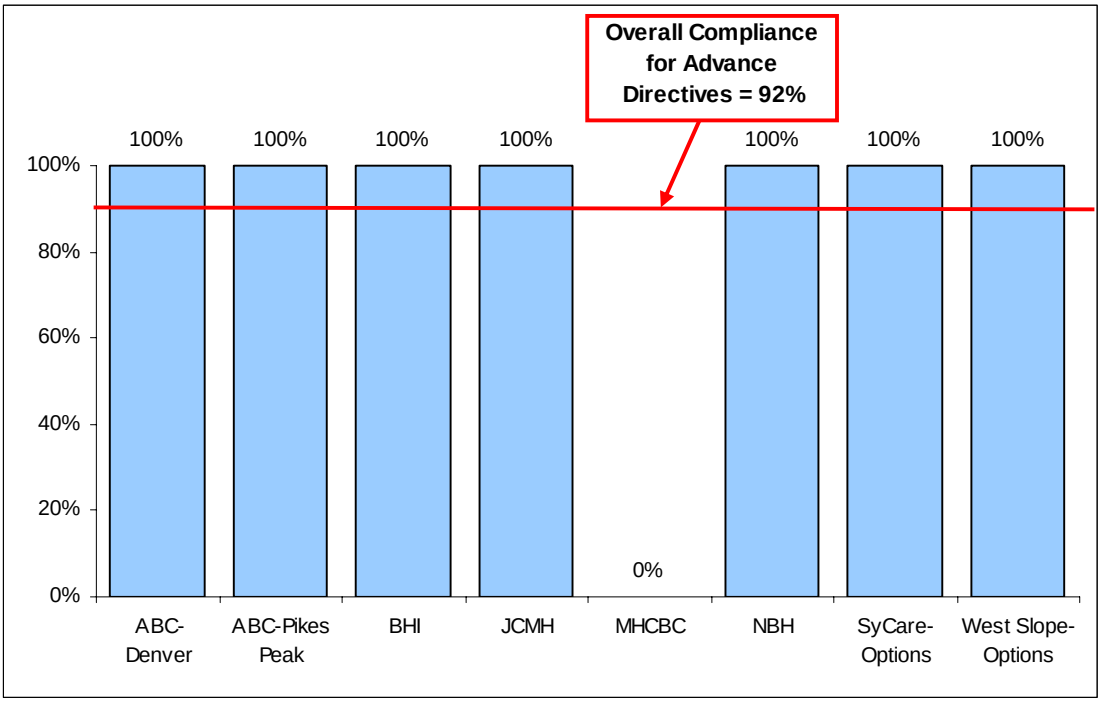
Standard III—Marketing assessed the appropriateness of the BHO's written or oral marketing materials and their distribution to potential members.

Since none of the BHOs marketed Medicaid services, this standard was not applicable and therefore was not evaluated for any of the BHOs.

Standard IV—Advance Directives evaluated the BHO's policies and procedures for advance directives, and reviewed the appropriateness of the written information on advance directives that is distributed to adult members.

The percentage of applicable elements met for this standard ranged from 0 percent to 100 percent, with seven BHOs obtaining scores of 100 percent. The one low-scoring BHO needed to ensure that information about advance directives was provided to adult members.

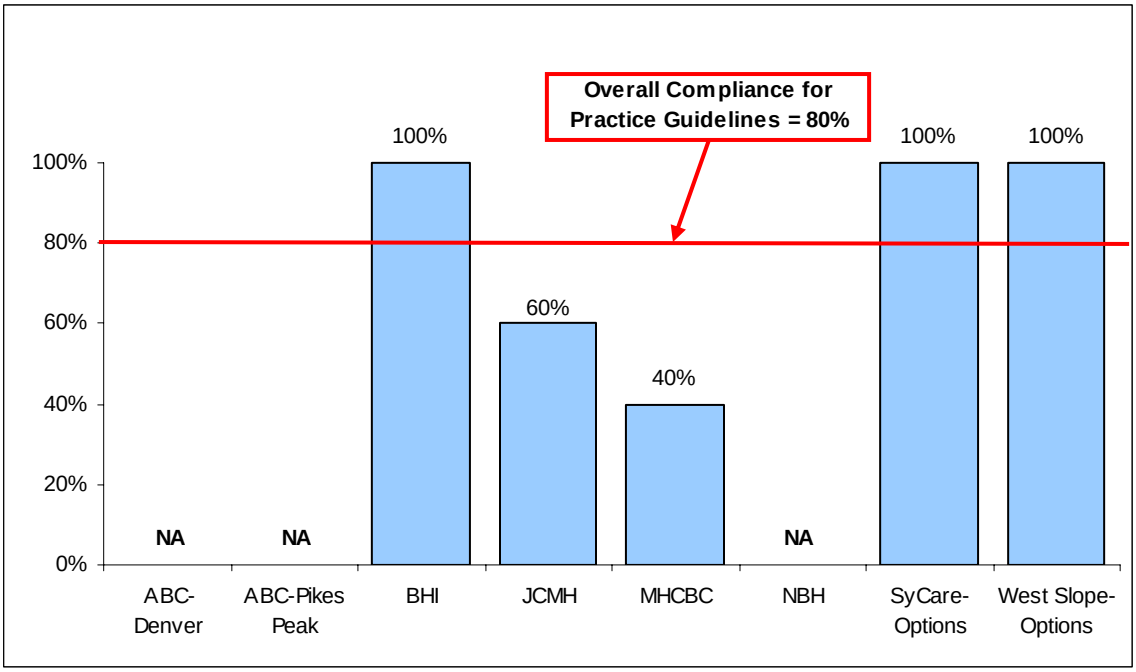
Figure 5-6—BHO Scores for Standard IV: Advance Directives



Standard V—Practice Guidelines reviewed any practice guidelines adopted by the BHO to ensure the guidelines were based on valid and reliable clinical evidence and considered the needs of the BHO's membership. Additionally, the processes for adopting, reviewing, updating, and disseminating the guidelines were evaluated, along with consistency in the application of guidelines in clinical decision-making.

The percentage of applicable elements met for this standard ranged from 40 percent to 100 percent. Common elements requiring corrective action included the need for improvements to the processes used for adopting, reviewing, updating, and disseminating the practice guidelines. For three BHOs, this standard was not applicable because the BHO had not adopted any practice guidelines at the time of the review.

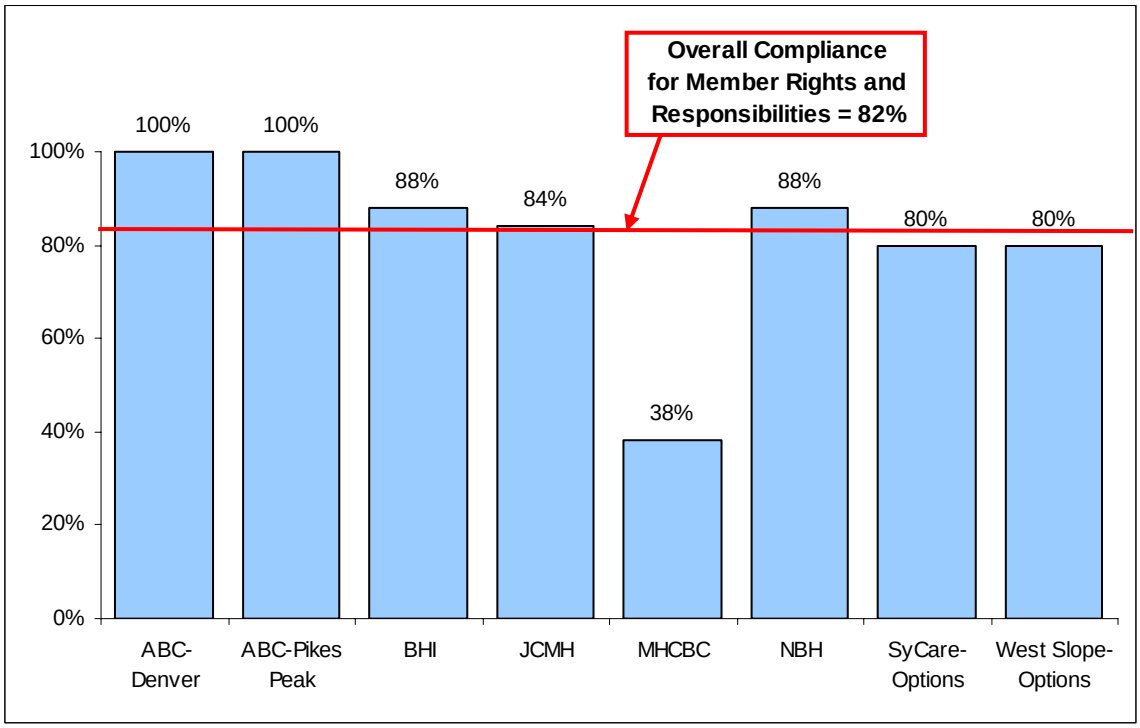
Figure 5-7—BHO Scores for Standard V: Practice Guidelines



Standard VI—Member Rights and Responsibilities evaluated the BHO's policies and procedures related to member rights and responsibilities, ensuring member materials included required information, were easily understood, were available in alternative formats, and were made readily available to members. The provision of information to members regarding emergency coverage and post-stabilization care, and processes associated with evaluating member satisfaction, were also assessed.

The percentage of applicable elements met for this standard ranged from 38 percent to 100 percent. Common elements requiring corrective action included provision of member materials in a format that could be easily understood, inclusion of information on member rights and responsibilities, and development of corrective action plans to address serious member complaints or patterns of dissatisfaction.

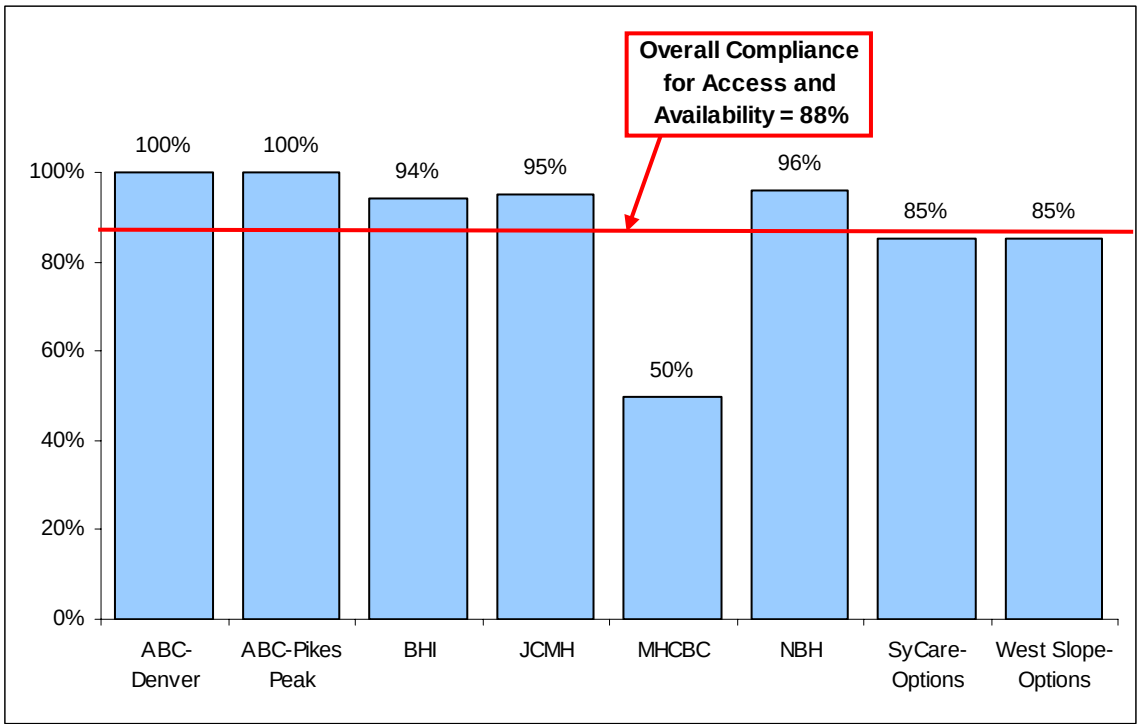
Figure 5-8—BHO Scores for Standard VI: Member Rights and Responsibilities



Standard VII—Access and Availability—Service Delivery evaluated the provision and accessibility of behavioral health services to members residing in nursing homes, and those who were eligible for Medicare and Medicaid. Evidence was examined to demonstrate the BHO's monitoring of access to services and adequate provider capacity. Additionally, processes were assessed that related to meeting the member's request for a particular provider.

The percentage of applicable elements met for this standard ranged from 50 percent to 100 percent. The one element requiring corrective action by a number of the BHOs was related to providing the member with the right to appeal the decision regarding his or her request for a particular provider.

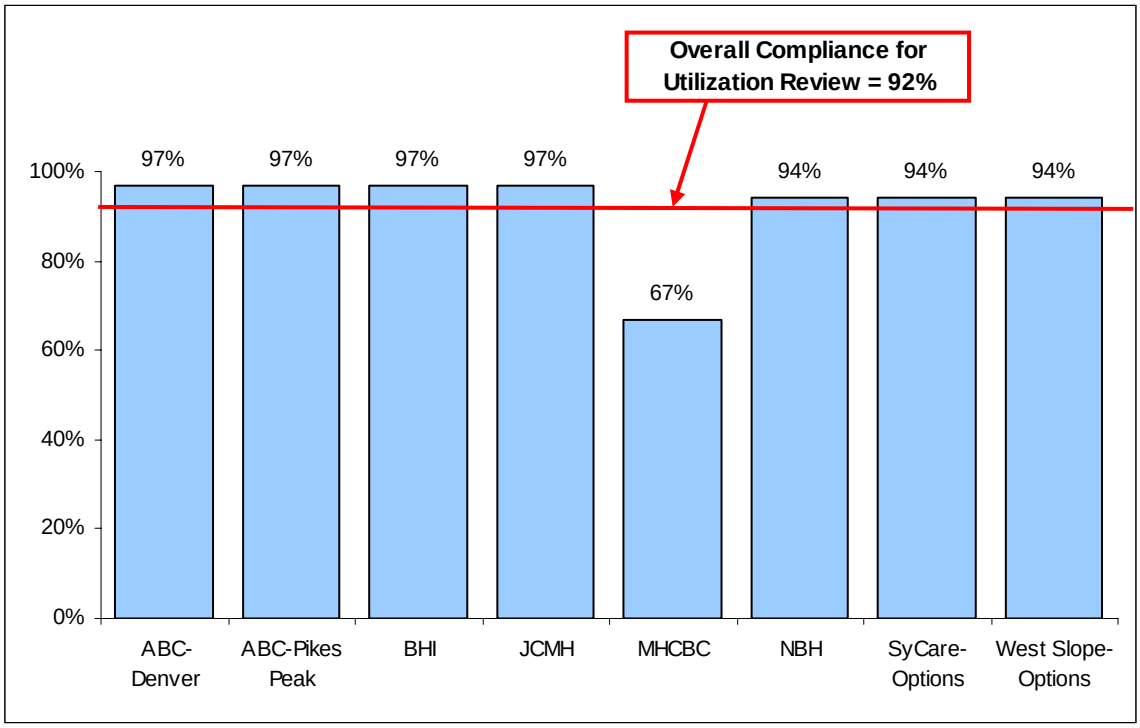
Figure 5-9—BHO Scores for Standard VII: Access and Availability—Service Delivery



Standard VIII—Utilization Review evaluated whether there was an adequate written utilization management program description, if there were processes to identify/correct over- and under-utilization, whether there was evidence that pertinent clinical information was obtained for utilization management decisions, and whether decisions were documented and available to recipients. Additionally, the standard assessed whether there were well-publicized appeals mechanisms, compliance with denial notification standards, whether decisions were rendered within the Department time frames, and whether services submitted as encounters were performed and documented.

The percentage of applicable elements met for this standard ranged from 67 percent to 97 percent. The primary element requiring corrective action by the majority of BHOs was related to the submittal of accurate encounter data, ensuring that services encountered had been documented and performed.

Figure 5-10—BHO Scores for Standard VIII: Utilization Review



Also for this standard, two record reviews were conducted—one was related to service denials and the other to encounter data. The denial records were reviewed for evidence of final decisions by qualified clinicians, consultations with requesting physician, consistent and appropriate application of review criteria and decision standards, and appropriate notification procedures. Encounters were verified in terms of appropriateness of procedure and diagnosis codes, correct date of service documentation, and presence of service documentation. The percentage of compliant elements for the Denials Record Review ranged from 77 percent to 100 percent, and the Encounter Data Verification ranged from 63 percent to 100 percent.

Figure 5-11—BHO Scores for Record Review—Denials

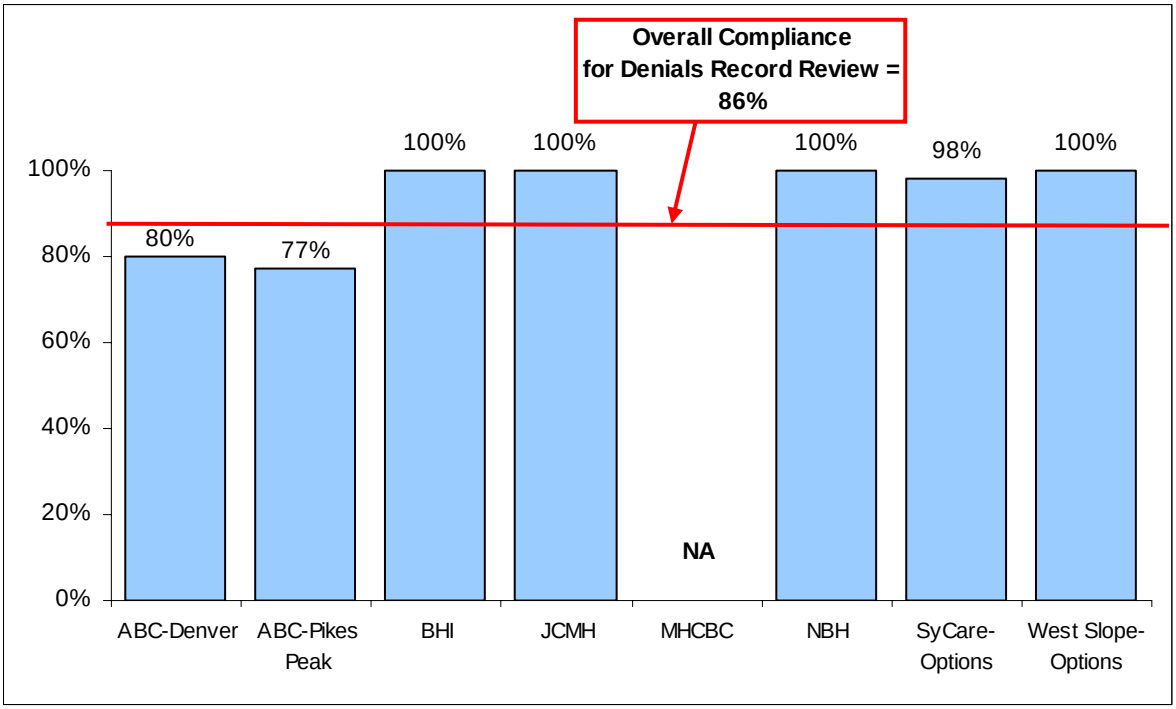
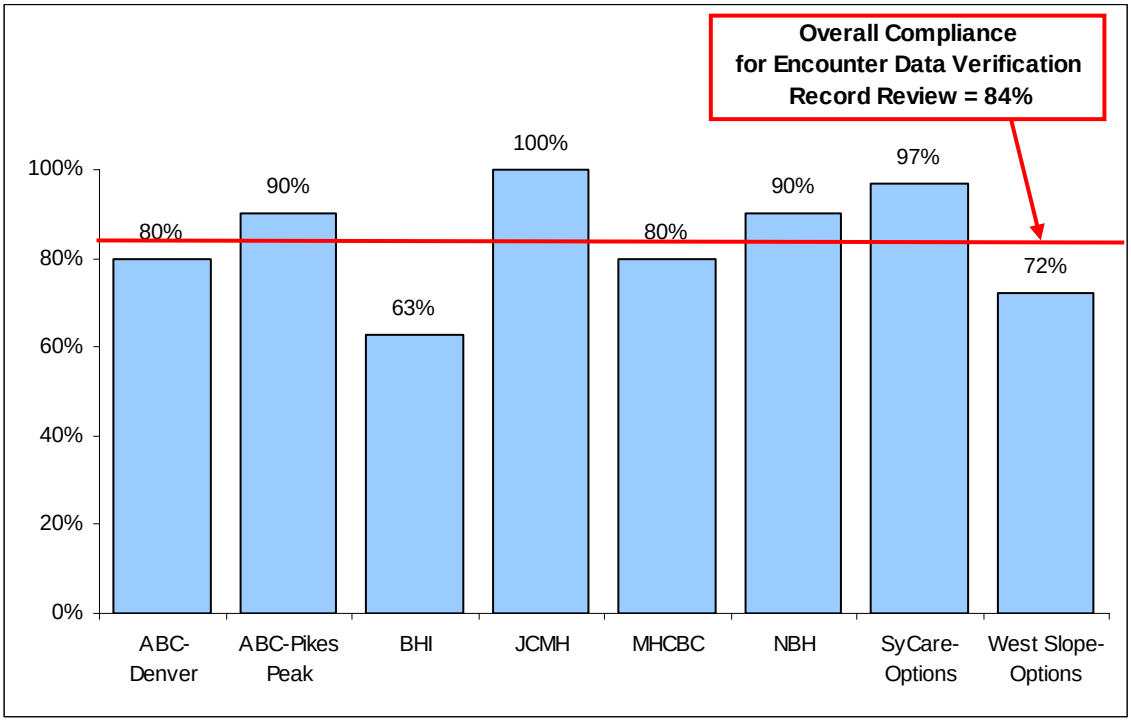


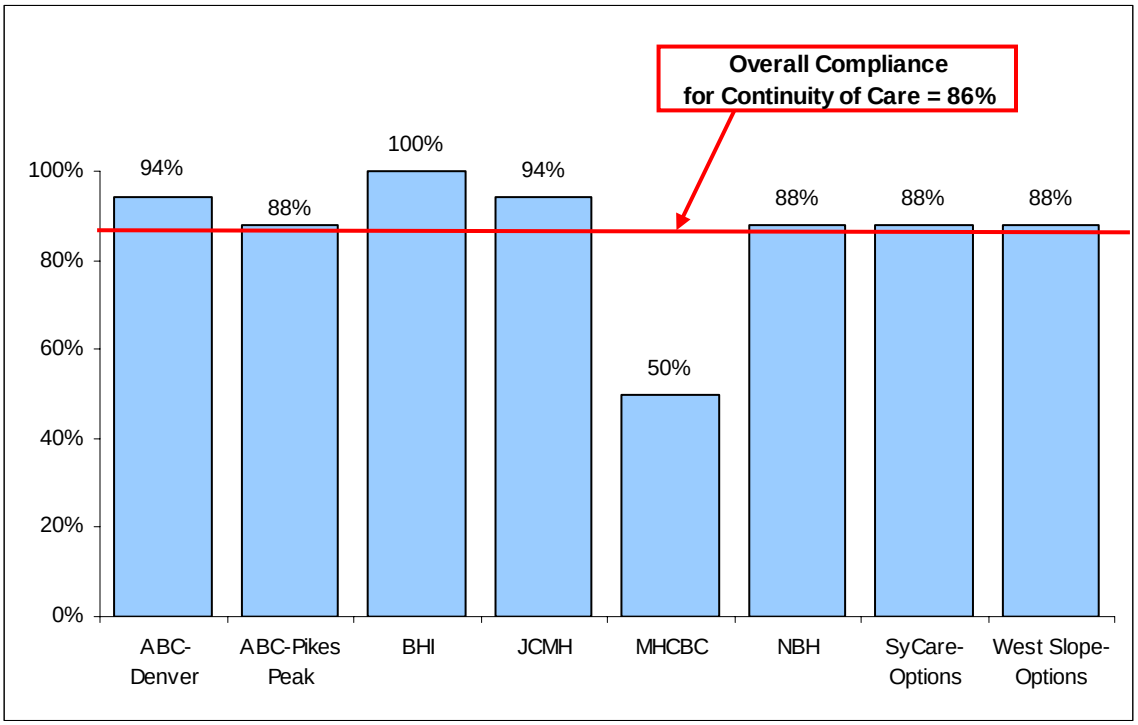
Figure 5-12—BHO Scores for Record Review—Encounter Data Verification



Standard IX—Continuity of Care System—Service Delivery evaluated the BHO's care coordination system, including policies and procedures in place to ensure timely coordination, integration of the member's need for behavioral health and other services, processes for sharing identified needs of members with providers, and assistance in obtaining needed care or support services. Evidence of a demonstrated commitment to the recovery model was also examined.

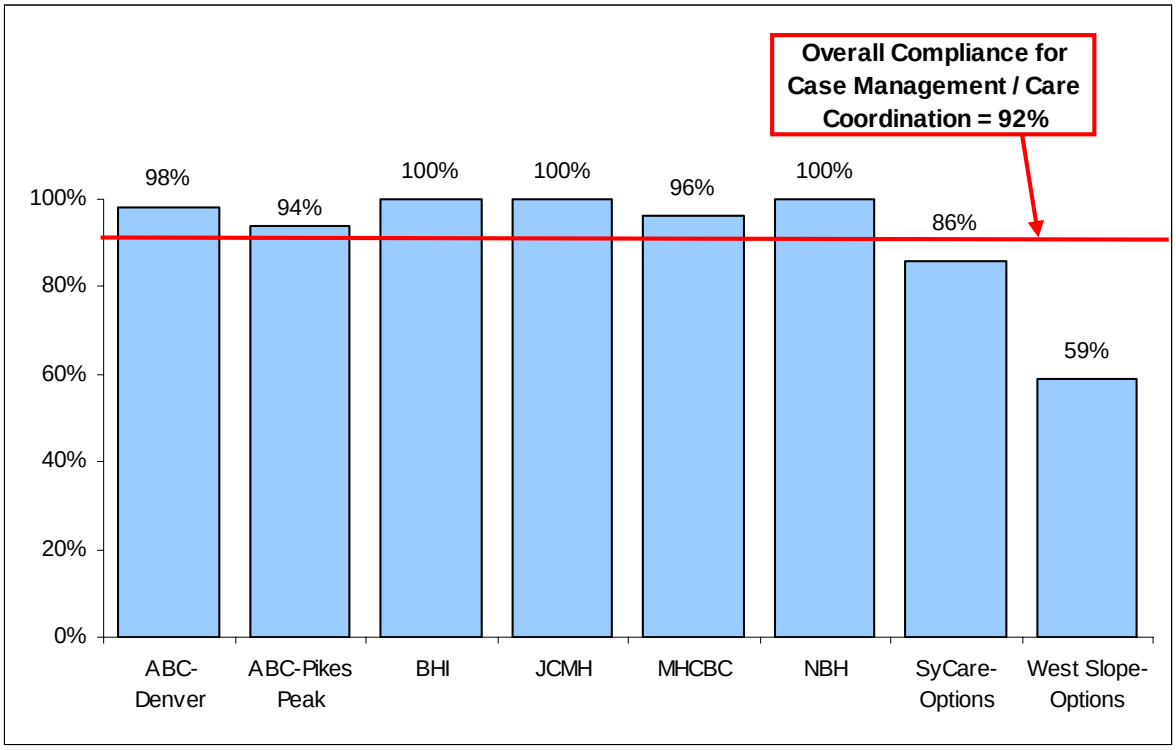
The percentage of applicable elements met for this standard ranged from 50 percent to 100 percent. Common elements requiring corrective action included screening processes to identify special health care needs, arranging for supportive services, and informing new members about their rights to continue receiving ongoing care.

Figure 5-13—BHO Scores for Standard IX: Continuity of Care System—Service Delivery



Related to this standard, a record review was conducted of case management/care coordination. The records were reviewed for evidence of an identified person responsible for coordination, protection of confidentiality, assessment and service plan for special needs, and coordination with other service providers. The percentage of compliant elements for the Case Management/Care Coordination Record Review ranged from 59 percent to 100 percent.

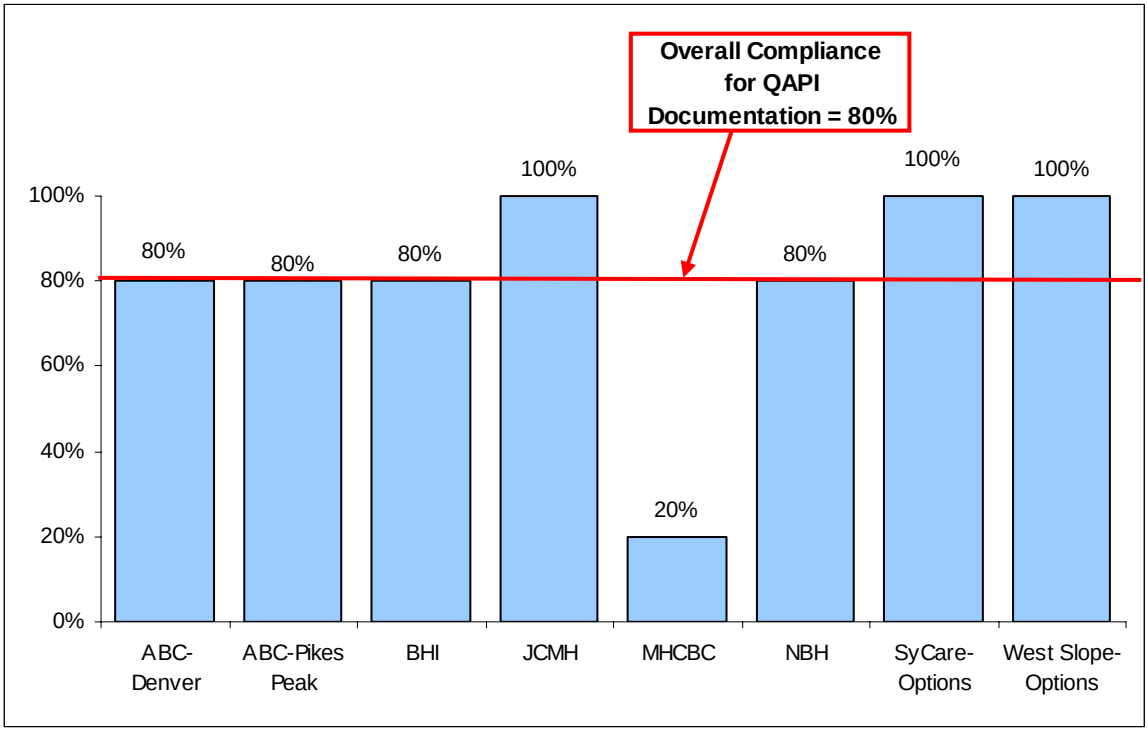
Figure 5-14—BHO Scores for Record Review—Case Management/Care Coordination



Standard X—Quality Assessment and Performance Improvement Documentation assessed the BHO's process for evaluating the impact and effectiveness of its QAPI program, including submittal of an annual report to the Department.

The percentage of applicable elements met for this standard ranged from 20 percent to 100 percent. The one element that required corrective action by a number of the BHOs was informing members and providers that the QAPI-related information was available upon request at no cost.

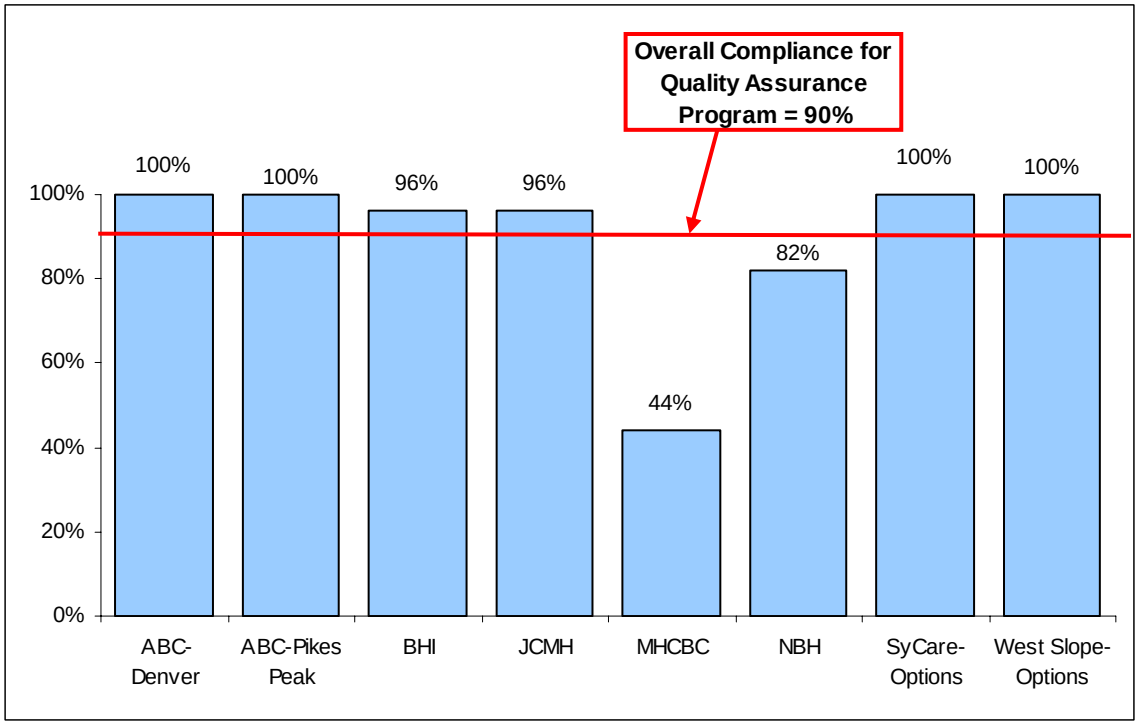
Figure 5-15—BHO Scores for Standard X: Quality Assessment and Performance Improvement Documentation



Standard XI—Quality Assurance Program evaluated the BHO's internal quality assurance program for inclusion of all required components (e.g., health status, outcomes) and for review, analysis, and improvement processes. Additional aspects that were assessed were the use and distribution of quality assurance-related information, medical record standards, quality management coordination, and cooperation with EQR activities.

The percentage of applicable elements met for this standard ranged from 44 percent to 100 percent, with four BHOs receiving scores of 100 percent. The one element that required corrective action by a number of the BHOs was ensuring that the quality management findings were used in recredentialing and recontracting decisions, and annual performance evaluations.

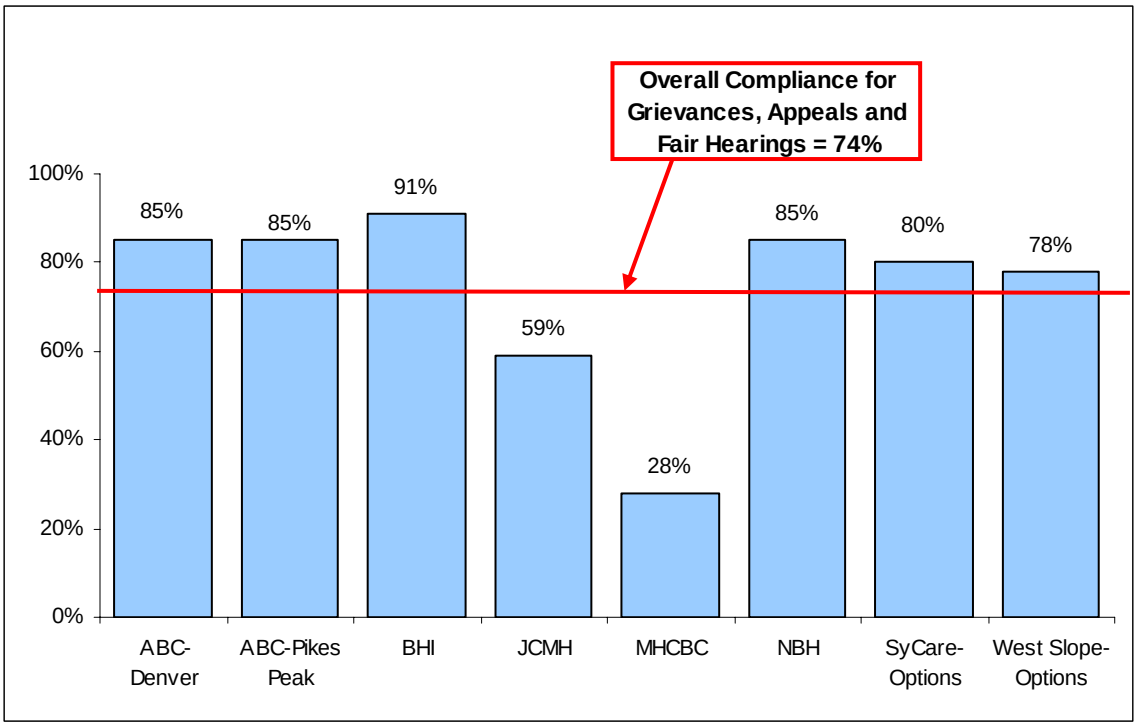
Figure 5-16—BHO Scores for Standard XI: Quality Assurance Program



Standard XII—Grievances, Appeals, and Fair Hearings evaluated compliance with the Department and BBA requirements for both standard and expedited grievances and appeals related to procedures, time frames, and notifications.

The percentage of applicable elements met for this standard ranged from 28 percent to 91 percent. Common elements requiring corrective action included written member appeal notifications related to each action, time frames for mailing appeal notifications, the provision of assistance to members in completing hearing forms, a process for expedited resolution and review, access to review a member's case file, and grievance disposition and notification.

Figure 5-17—BHO Scores for Standard XII: Grievances, Appeals, and Fair Hearings



Also for this standard, two record reviews were conducted—one related to grievances and the other related to appeals. The records were reviewed for evidence of appropriate documentation and notification, and meeting of timeliness standards. The percentage of compliant elements for the Grievances Record Review ranged from 68 percent to 100 percent, and the Appeals Record Review ranged from 53 percent to 100 percent.

Figure 5-18—BHO Scores for Record Review—Grievances

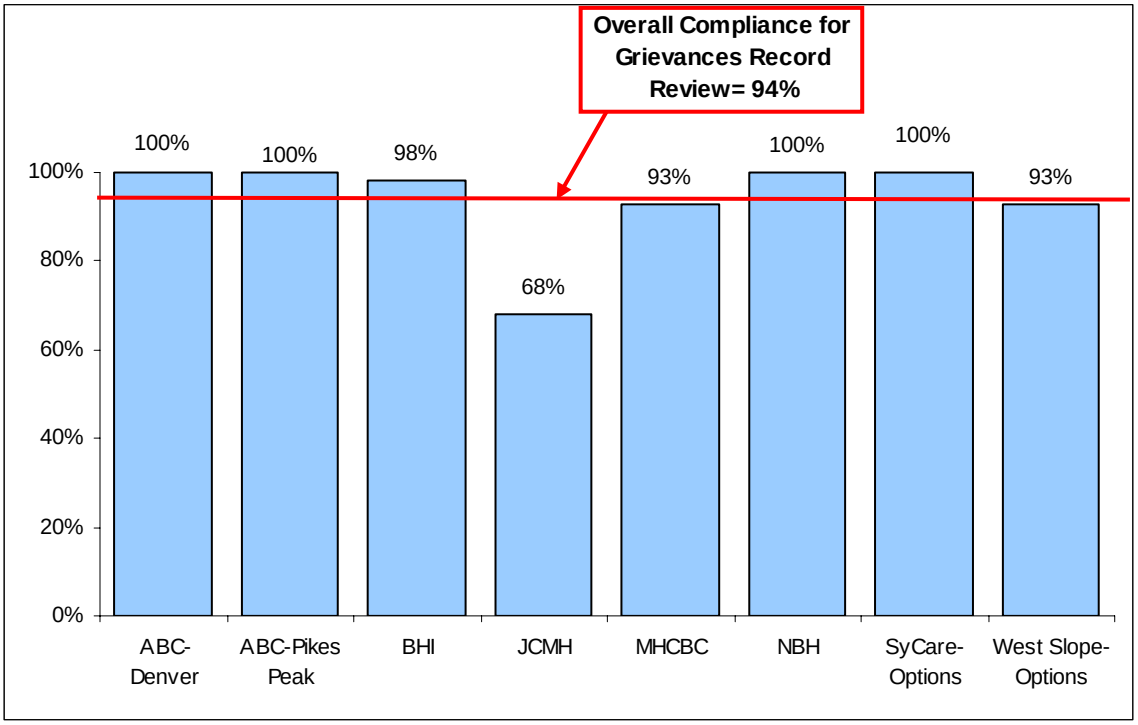
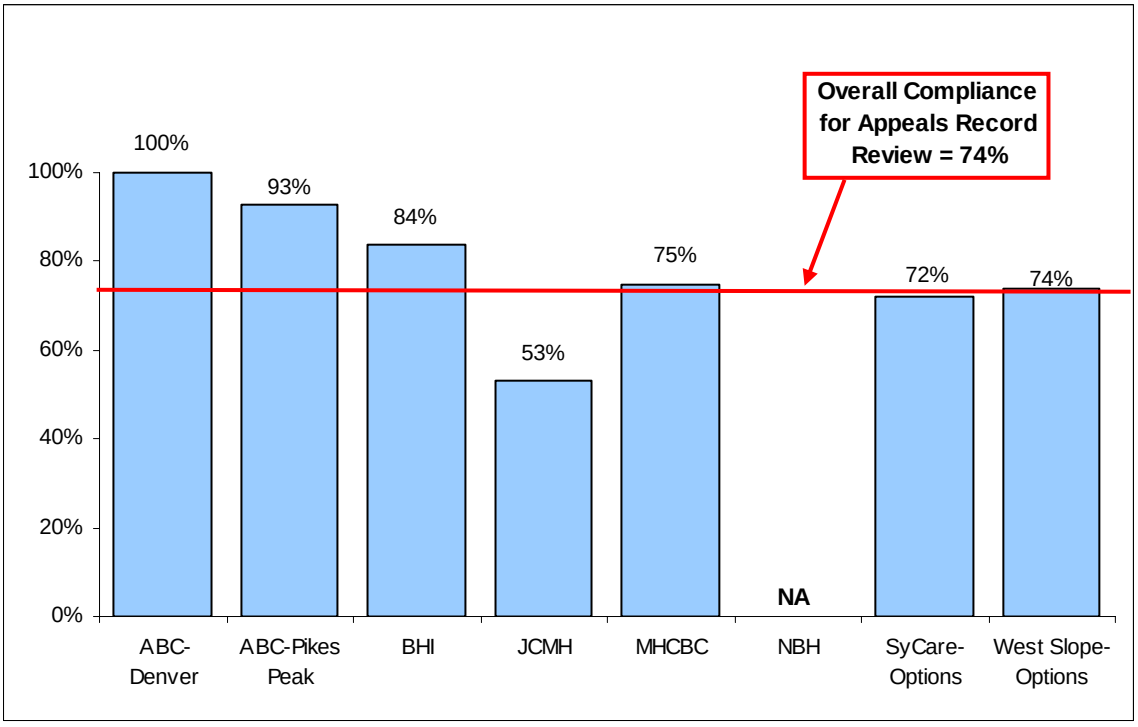


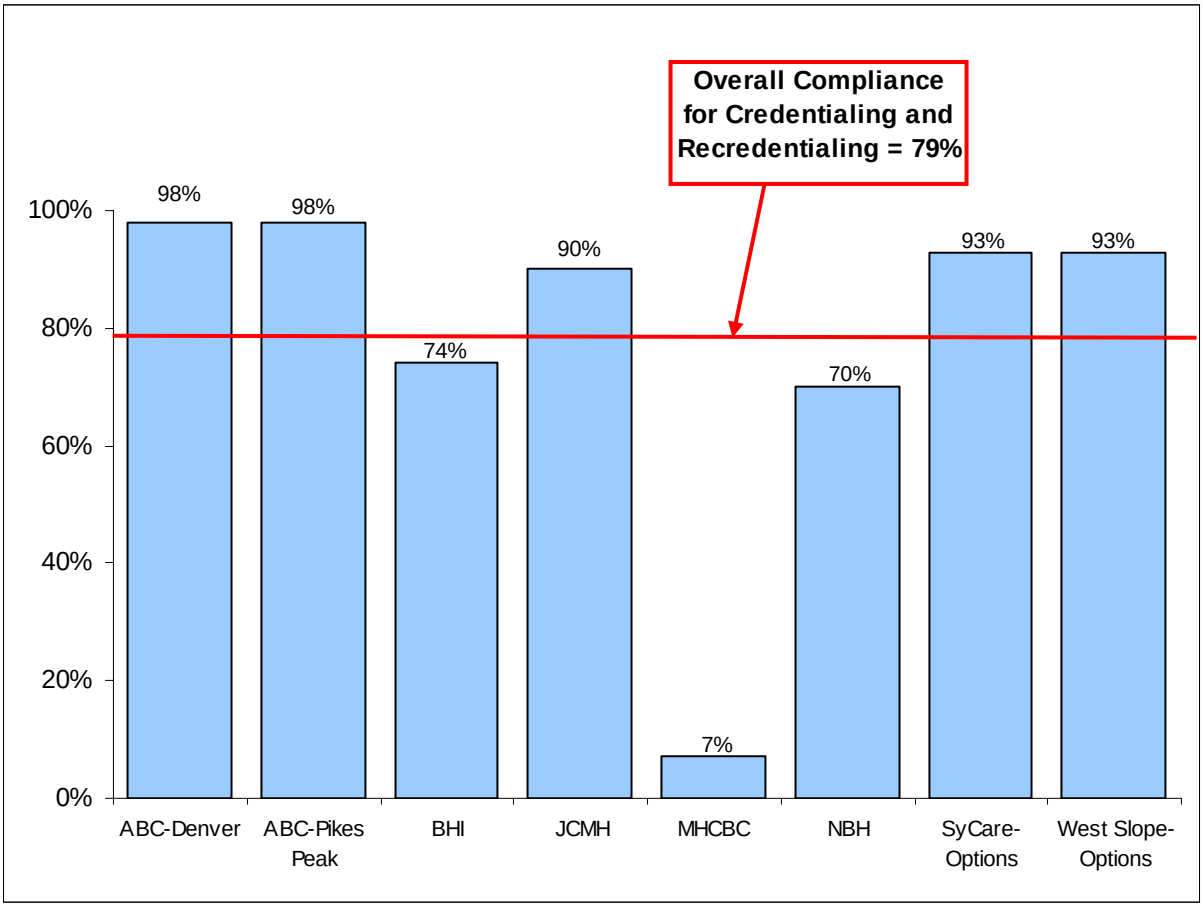
Figure 5-19—BHO Scores for Record Review—Appeals



Standard XIII—Credentialing and Recredentialing evaluated all aspects of the BHO's credentialing and recredentialing program, including use of NCQA standards, written policies and procedures, primary source verification, appeals process, delegated activities, and reporting of quality deficiencies.

The percentage of applicable elements met for this standard ranged from 7 percent to 98 percent. Common elements requiring corrective action included use of NCQA standards, recredentialing of providers every three years, use of objective criteria to identify and evaluate high-volume practitioners, and notification to the Department regarding quality of care concerns and additions/ deletions of network providers.

Figure 5-20—BHO Scores for Standard XIII: Credentialing and Recredentialing



Also for this standard, two record reviews were conducted—one was related to credentialing and the other to recredentialing. The records were reviewed for required elements examined by the BHO for different types of providers and recredentialing time frames. The percentage of compliant elements for the Credentialing Record Review ranged from 91 percent to 100 percent, and for the Recredentialing Record Review from 73 percent to 100 percent.

Figure 5-21—BHO Scores for Record Review—Credentialing

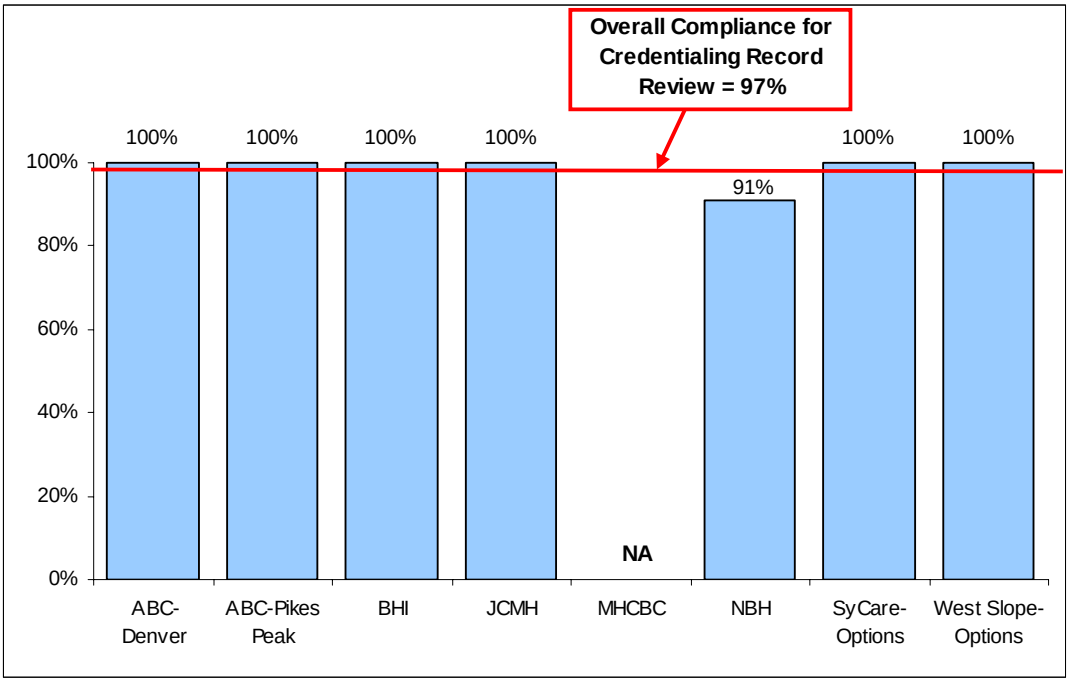
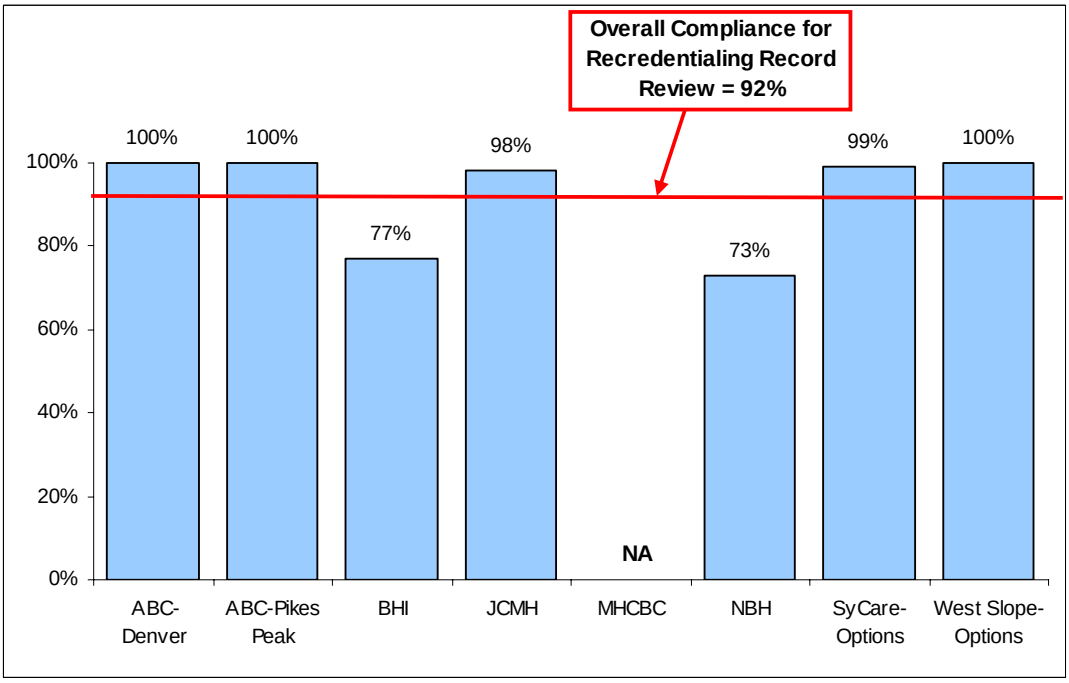


Figure 5-22—BHO Scores for Record Review—Recredentialing



Validation of Performance Measures

Through the performance measure validation process, the review team assigns each reported measure an audit designation status. The CMS Performance Measure Validation Protocol identifies four separate validation findings (audit designations) for each performance measure. These are defined in Table 5-1.

Table 5-1—Audit Designation Definitions

Fully Compliant	Indicates that the performance measure was fully compliant with Department specifications.
Substantially Compliant	Indicates that the performance measure was substantially compliant with Department specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid	Indicates that the performance measure deviated from Department specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
Not Applicable	Indicates that the performance measure was not reported because the BHO did not have any Medicaid consumers who qualified for that denominator.

According to the protocol, the validation finding for each measure is determined by the magnitude of the errors detected for the measure evaluations elements, not by the number of elements determined to be *Not Met*. Consequently, it is possible that an error for a single element may result in a designation of *Not Valid* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several element errors may have little impact on the reported rate, and the measure could be given a designation of *Substantially Compliant.*

For the FY 03-04, DMH performed all calculations of performance measures, using various sources of data, including encounter data, data derived from the MHSIP survey, and CCAR data. The BHO's role was to collect and submit the encounter and CCAR data to the State for these calculations. The MHSIP survey was conducted by DMH. The BHOs were responsible only for providing correct client contact information to the State. Because the performance measure calculations were performed by one entity, compliance with the measure specifications was the same across all BHOs. Only variances in the processes used by the BHOs to collect and validate performance data prior to submitting it to the State would impact the review findings (resulting in validation findings of *Substantially Compliant*).

A total of 104 performance measure results were calculated by the Department and validated by HSAG. A validation finding of *Fully Compliant* indicates that data were collected in a standardized manner and there was no deviation from the measure specifications. A *Substantially Compliant* validation finding indicates that there was some deviation from the performance measure specifications, or the data were not collected using sufficient validation processes to ensure accuracy and completeness. As displayed in Table 5-2, of the 104 performance measures that were reported for the BHOs, 48 were determined to be *Fully Compliant* (or 46 percent), 56 were determined to be *Substantially Compliant* (54 percent), and none were determined to be *Not Valid*. All 46 performance measures that were determined to be *Fully Compliant* were calculated using MHSIP survey data. The other 56 performance measures (which received a *Substantially Compliant* validation finding) were calculated using encounter data (i.e., penetration rate) or CCAR data. MHSIP survey data were collected in a standardized manner across all BHOs, resulting in a validation finding of *Fully Compliant*. The BHOs collected the encounter and CCAR data; however, validation processes used by the BHOs were determined to be insufficient, resulting in a *Substantially Compliant* validation finding.

Table 5-2—Overall Performance Measure Compliance with Department Specifications Across all BHOs

Validation Findings	Performance Measures	
	Number	Percent
Fully Compliant	48	46%
Substantially Compliant	56	54%
Not Valid	0	0%
Total	**104**	**100%**

For the 48 performance measures that were determined to be *Fully Compliant*, data collection processes were valid and the measures were calculated in full accordance with measure specifications. For the 56 performance measures that were determined to be *Substantially Compliant*, there was a slight deviation from specifications, or the data collection activities did not have sufficient validation processes in place. There were no measures that received a validation finding of *Not Valid*.

For the performance measures determined to be *Substantially Compliant*, key recommendations were made by HSAG to ensure the reliability, accuracy, and validity of the data used to calculate these measures. These included:

- Following Department specifications pertaining to data scrubbing of claims and encounter submissions to the Department.
- Improving processes for internally validating CCAR and claims data, including the implementation of a method to perform inter-rater reliability testing and validation of data entry.
- Automating current manual processes related to data validation and submission.
- Implementing better tracking processes related to claims and encounters submission.

In addition to analyzing the validity of the specific performance measures, HSAG also conducted a review of other aspects of the BHO's operation that were considered crucial to the process for calculating performance measures, as any deficiencies in these areas could potentially impact the validity of the measure. These other areas included data integration, data control, performance measure documentation, eligibility data processing, and claims/encounter data processing. The results showed that for all BHOs:

- Acceptable processes were in place as they related to data integration, data control, and documentation across the BHOs.
- The eligibility and claims/encounter data systems were reliable, with sufficient processes in place to ensure accurate and complete data.
- Sound methods were in place to ensure that all services were entered into the system in a timely manner.
- Staff members were strongly committed to producing performance measure data.

Performance Measure Results

Although not included in the individual EQR activity reports for performance measures, for this report, data were also analyzed in terms of the actual performance measure results for the BHOs. For the purposes of analysis, the results for the 13 performance measures are displayed and discussed. Figure 5-23 through Figure 5-34 show the reported rates by BHO, as well as the Colorado BHO average, for the performance measures.

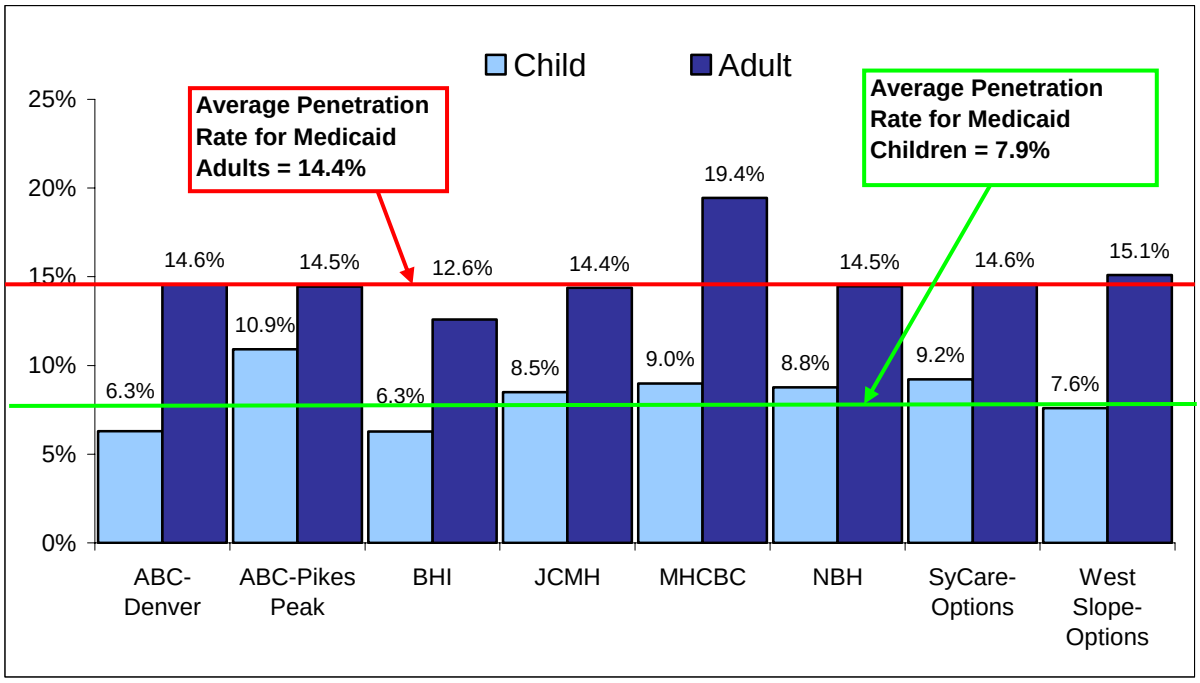
BHO Penetration Rates

Two Department performance measures that were calculated using encounter data pertained to penetration rates:

- Percentage of area Medicaid adults having received BHO-managed services.
- Percentage of area Medicaid children having received BHO-managed services.

Figure 5-23 shows the child and adult penetration rates for each BHO.

Figure 5-23—Penetration Rate for Medicaid Children and Adults, by BHO



The penetration rates for:

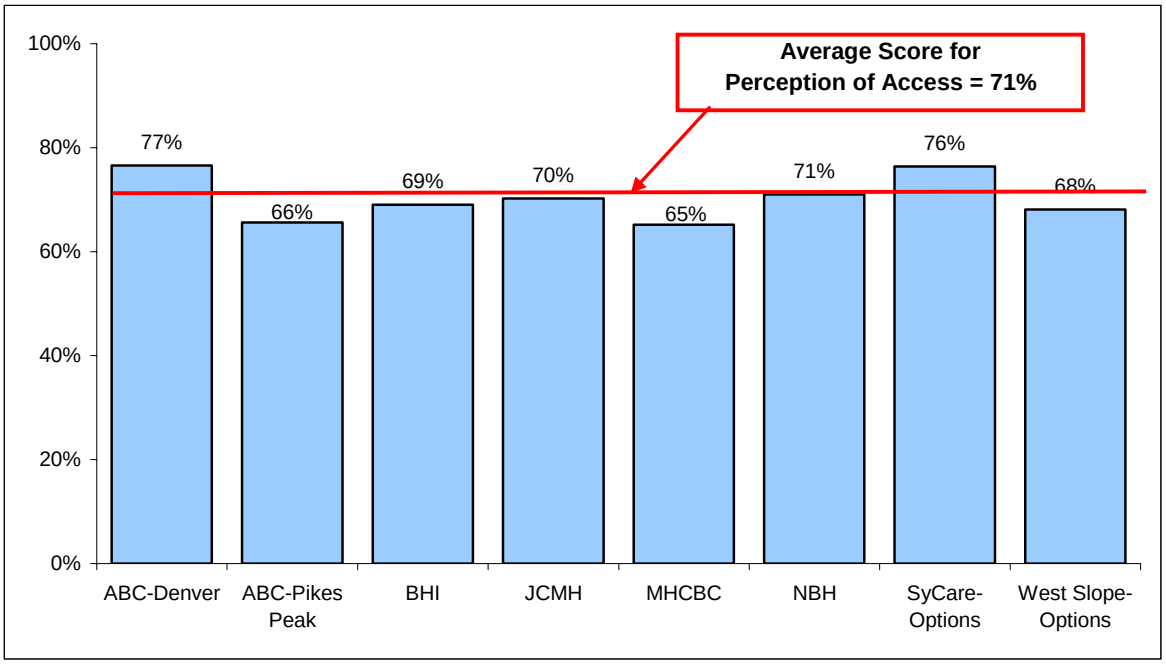
- Children ranged from a high of 10.9 percent for ABC-Pikes Peak to a low of 6.3 percent for BHI and ABC-Denver. The overall Colorado Medicaid average was 7.9 percent, with a range of rates of 4.6 percentage points.
- Adults ranged from a high of 19.4 percent for MHCBC to a low of 12.6 percent for BHI. The overall Colorado Medicaid average was 14.4 percent, with a range of rates of 6.8 percentage points.

Penetration rates are impacted by many factors, including geographic differences, demographics of the community, ease of access to services, and individual behavior. The penetration rates are displayed here for information purposes only and are not intended to be used as a comparison of BHO performance.

Consumer Perception of Access

Using MHSIP survey data, this performance measure domain reflects the percentage of Medicaid adults surveyed who agree or disagree with the ease and convenience of accessing services (consumer perception of access). MSHIP survey responses are collected using a 5-point Likert scale, with one equal to strong agreement, and five equal to strong disagreement. For the purposes of this report, only agreement results are displayed. Agreement is defined as a mean that is less than 2.5 on a scale of 1–5. Disagreement is defined as a mean that is greater than 2.5. The reported rates of agreement ranged from a high of 77 percent (reported by ABC-Denver) to a low of 65 percent (reported by MHCBC). The BHO average was 71 percent, with a range of rates of approximately 11 percentage points.

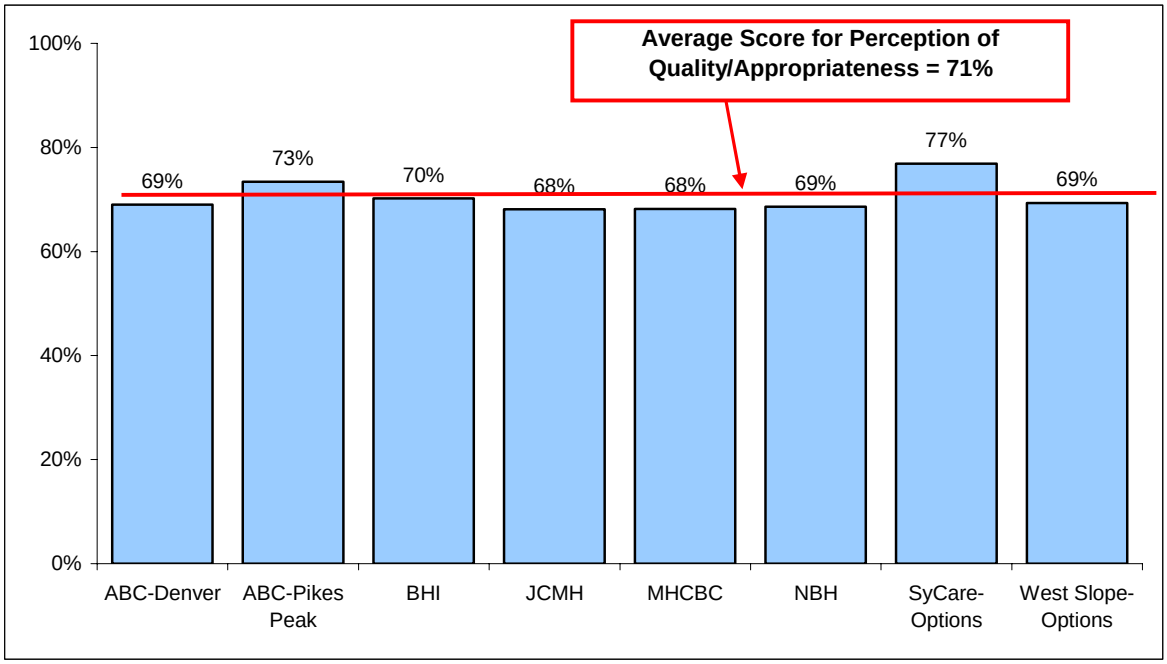
Figure 5-24—Percentage of Adults Agreeing with Domain Score for Consumer Perception of Access, by BHO



Consumer Perceptions of Quality/Appropriateness

Using MHSIP survey data, this performance measure domain reflects the percentage of Medicaid adults surveyed who agree or disagree with the level of quality of care provided (consumer perception of quality/appropriateness). Agreement is defined as a mean that is less than 2.5 on a scale of 1–5. The reported agreement rates ranged from a high of 77 percent (reported by SyCare-Options) to a low of 68 percent (reported by JCMH and MHCBC). The BHO average was 71 percent, with a range of rates of approximately 9 percentage points.

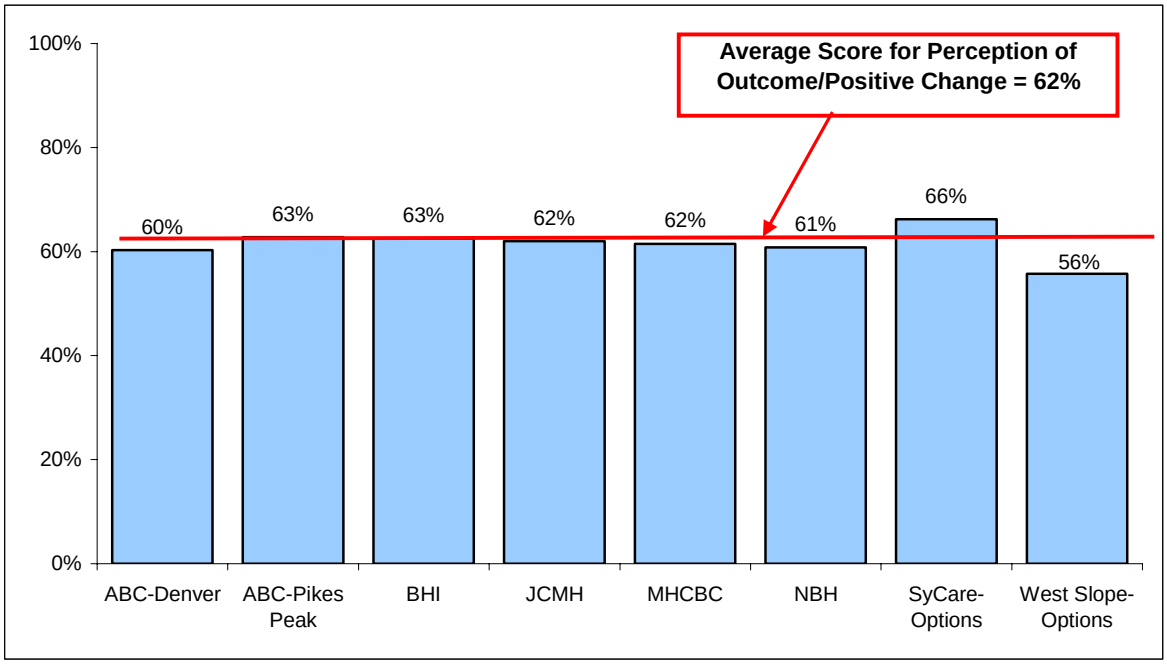
Figure 5-25—Percentage of Adults Agreeing with Domain Score for Consumer Perception of Quality/Appropriateness, by BHO



Consumer Perception of Outcome/Positive Change

Using MHSIP survey data, this performance measure domain reflects the percentage of Medicaid adults surveyed who agree or disagree that care received brought about good results (consumer perception of outcome/positive change). Agreement is defined as a mean that is less than 2.5 on a scale of 1–5. The reported agreement rates ranged from a high of 66 percent (reported by SyCare-Options) to a low of 56 percent (reported by West Slope-Options). The BHO average was 62 percent, with a range of rates of approximately 11 percentage points.

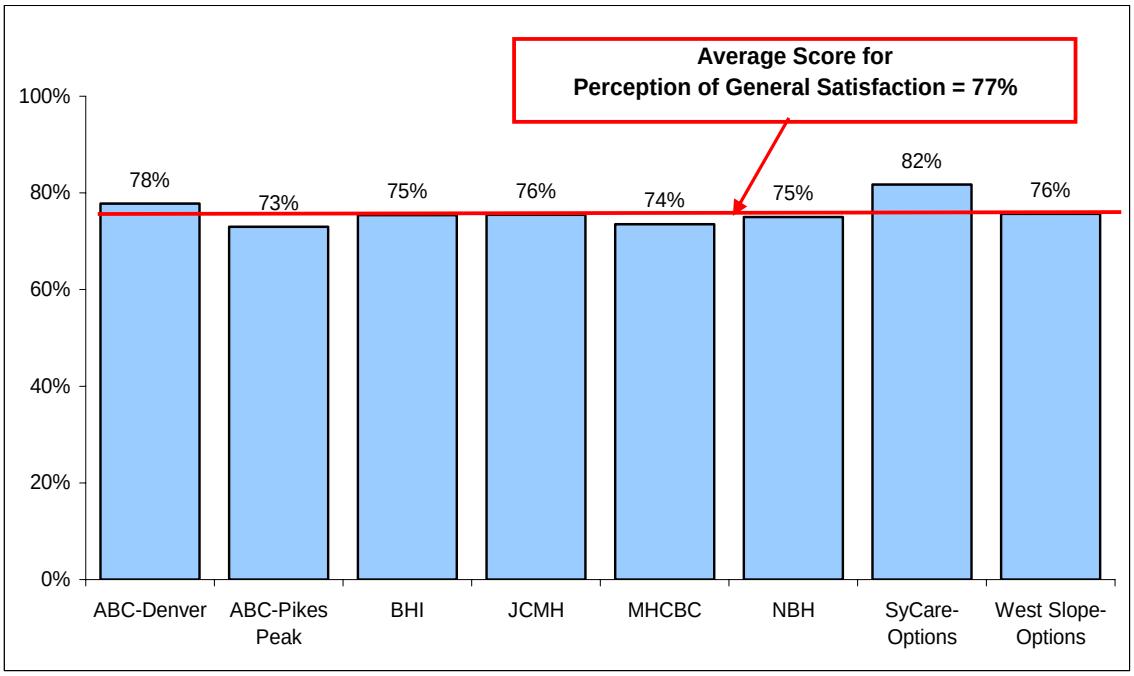
Figure 5-26—Percentage of Adults Agreeing with Domain Score for Consumer Perceptions of Outcome/Positive Change, by BHO



Consumer Perception of General Satisfaction

Using MHSIP survey data, this performance measure domain reflects the percentage of Medicaid adults surveyed who agree or disagree that they are generally satisfied with services provided (consumer perceptions of general satisfaction). Agreement is defined as a mean that is less than 2.5 on a scale of 1–5. The reported agreement rates ranged from a high of 82 percent (reported by SyCare-Options) to a low of 73 percent (reported by ABC-Pikes Peak). The BHO average was 77 percent, with a range of rates of approximately 9 percentage points.

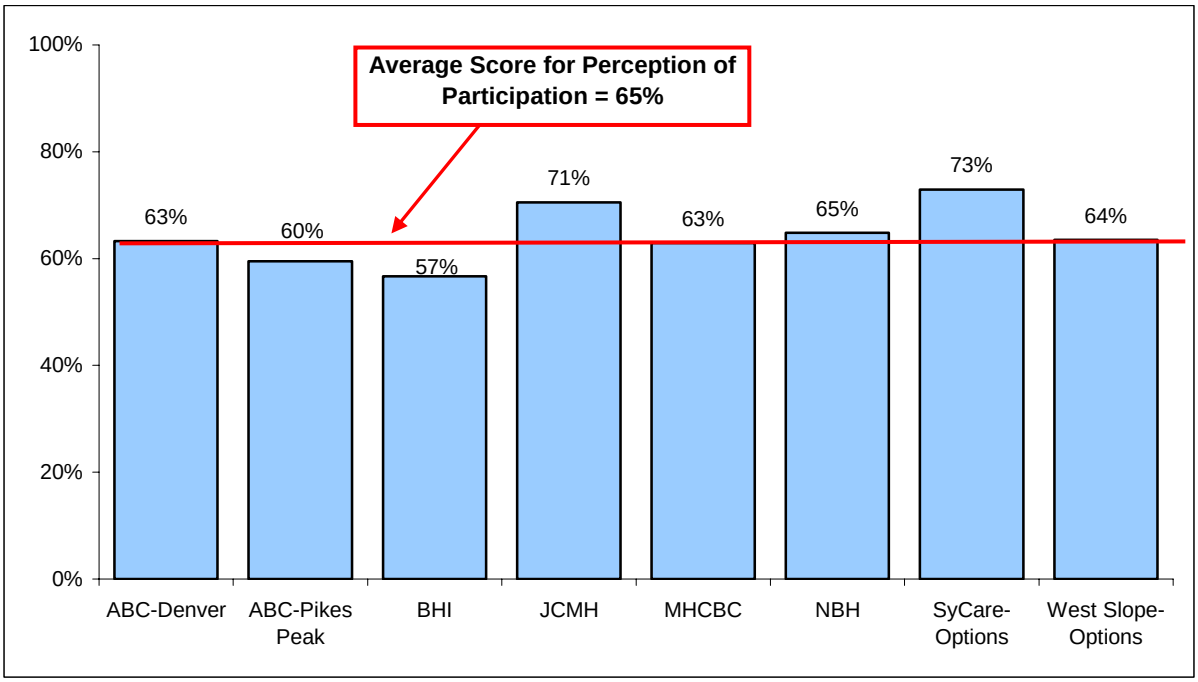
Figure 5-27—Percentage of Adults Agreeing with Domain Score for Consumer Perceptions of General Satisfaction, by BHO



Consumer Participation in Treatment

Using MHSIP survey data, this performance measure domain reflects the percentage of Medicaid adults surveyed who agree or disagree that they are involved in their own treatment (consumer participation in treatment). Agreement is defined as a mean that is less than 2.5 on a scale of 1–5. The reported agreement rates ranged from a high of 73 percent (reported by SyCare-Options) to a low of 57 percent (reported by BHI). The BHO average was 65 percent, with a range of rates of approximately 16 percentage points.

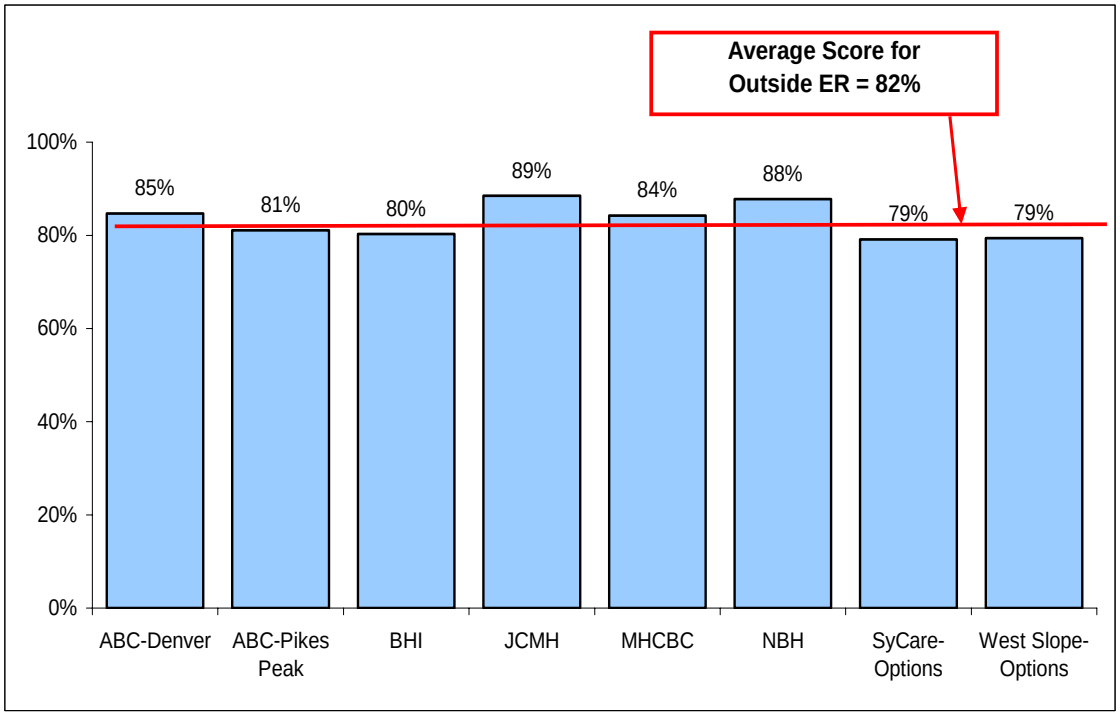
Figure 5-28—Percentage of Adults Agreeing with Domain Score for Participation in Treatment Planning, by BHO



Consumers Linked to Primary Care

Using MHSIP survey data, this performance measure reflects the percentage of Medicaid adults surveyed who reported seeing a doctor or nurse face-to-face other than in the emergency room. The reported rates ranged from a high of 89 percent (reported by JCMH) to a low of 79 percent (reported by SyCare-Options and West Slope-Options). The BHO average was 82 percent, with a range of rates of approximately 9 percentage points.

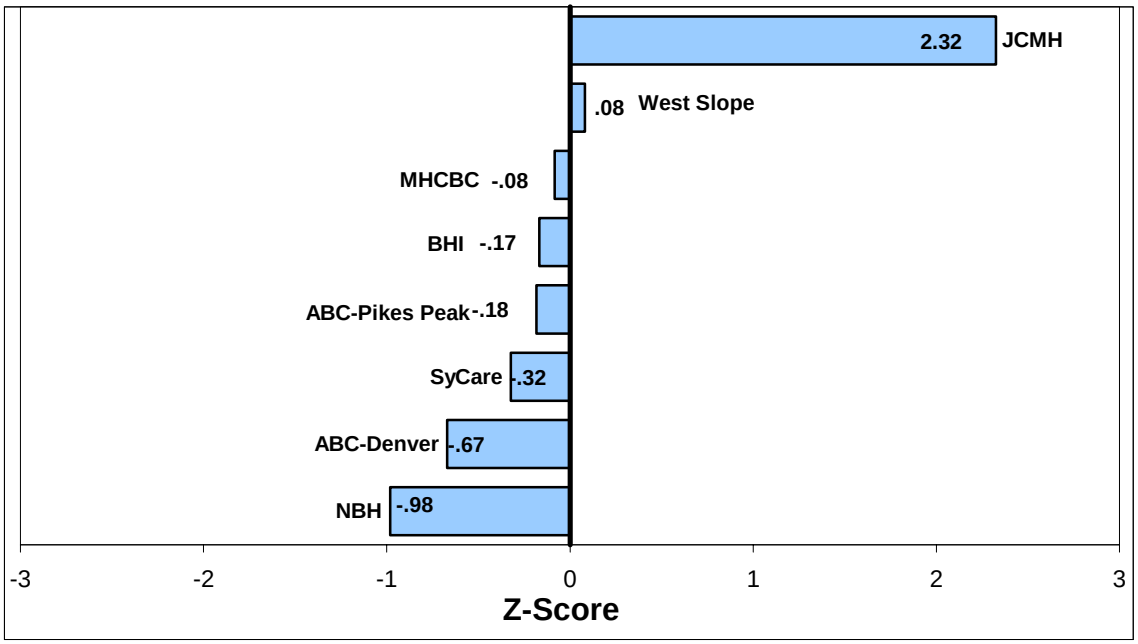
Figure 5-29—Percentage of Adults Reporting Seeing a Doctor/Nurse in Other Than an Emergency Room, by BHO



Children Living in a Family-Like Setting

Using CCAR data, this performance measure reflects Medicaid children with serious emotional disturbances (SED) living in a family-like setting at Time 1 and Time 2 during the reporting period. For this measure, raw scores were transformed to z-scores. Positive z-scores indicate that the raw score was above the mean; negative z-scores indicate that the raw score was below the mean. As shown in Figure 5-30, the z-scores for *Children Living in a Family-Like Setting* ranged from a high of 2.32 (or greater than two standard deviations above the mean), reported by JCMH, to a low of -0.98, reported by NBH. Overall, two BHOs had positive z-scores while six BHOs had negative z-scores. Generally, the distribution of the z-scores was less than one standard deviation from the mean, with the exception of JCMH.

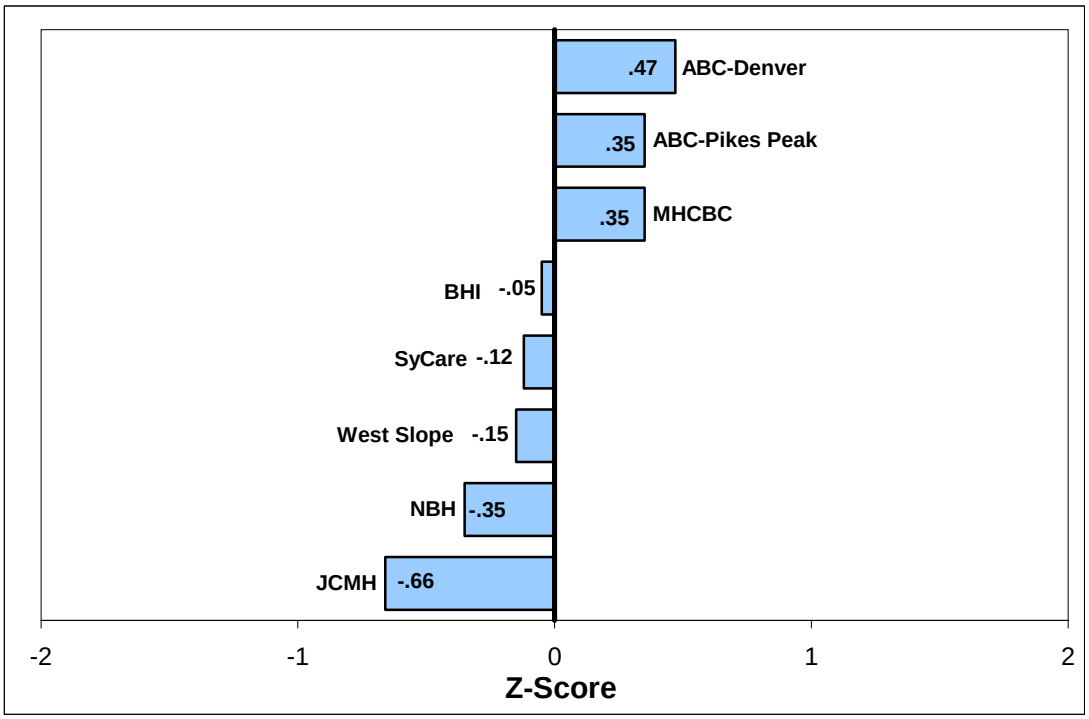
Figure 5-30—Z-Score Distribution for Children Living in a Family Like-Setting, by BHO



Adults Living Independently

Using CCAR data, this performance measure reflects Medicaid adults with serious mental illness (SMI) living independently at any time during the reporting period. For this measure, raw scores were transformed to z-scores. Positive z-scores indicate that the raw score was above the mean; negative z-scores indicate that the raw score was below the mean. The z-scores for *Adults Living Independently* ranged from a high of 0.47 (reported by ABC-Denver) to a low of -0.66 (reported by JCMH). Overall, three BHOs had positive z-scores, while five BHOs had negative z-scores. The range of scores was relatively narrow, with none of the BHOs reporting a z-score that was more or less than one standard deviation from the mean.

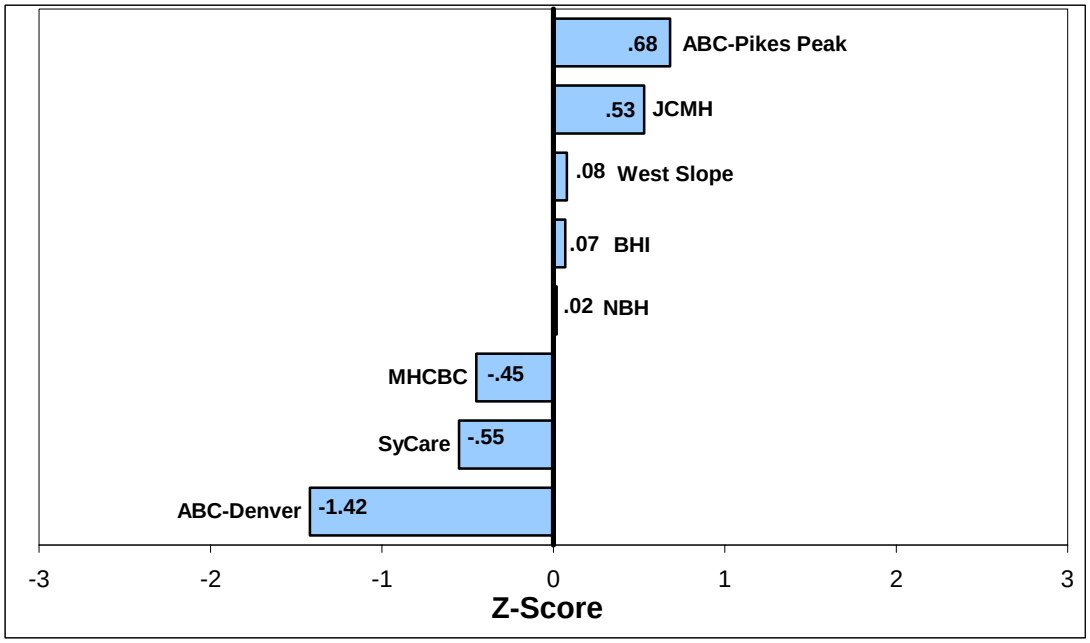
Figure 5-31—Z-Score Distribution for Adults Living Independently, by BHO



Employment

Using CCAR data, this performance measure reflects Medicaid adults with SMI in the labor force. For this measure, raw scores were transformed to z-scores. Positive z-scores indicate that the raw score was above the mean; negative z-scores indicate that the raw score was below the mean. Employment z-scores ranged from a high 0.68 (reported by ABC-Pikes Peak) to a low of -1.42 (reported by ABC-Denver). Overall, five BHOs had positive z-scores, while three BHOs had negative z-scores. Generally, the distribution of the z-scores was less than one standard deviation from the mean, with the exception of ABC-Denver.

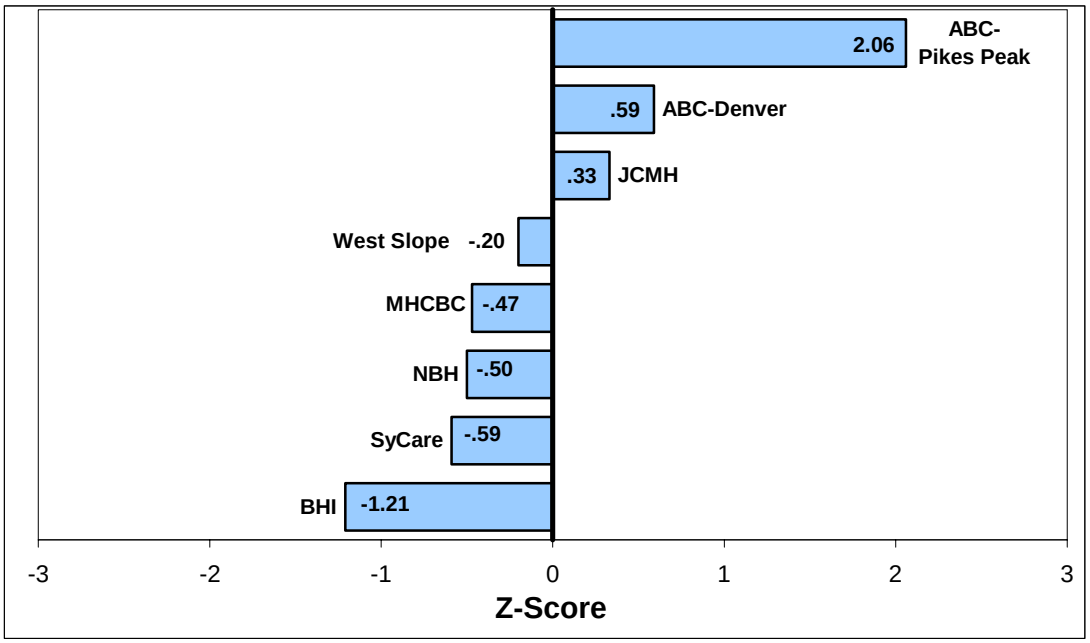
Figure 5-32— Z-Score Distribution for Employment, by BHO



Change in Problem Severity in Children

Using CCAR data, this performance measure reflects the change in problem severity for child Medicaid discharges. For this measure, raw scores were transformed to z-scores. Positive z-scores indicate that the raw score was above the mean; negative z-scores indicate that the raw score was below the mean. The scores ranged from a high of 2.06 (or greater than two standard deviations above the mean) for ABC-Pikes Peak, to a low of -1.21 (or greater than one standard deviation below the mean) for BHI. Overall, three BHOs had positive z-scores, while five BHOs had negative z-scores. The range of scores is somewhat wider for this measure, particularly emphasizing the difference in results between the top score and the bottom score.

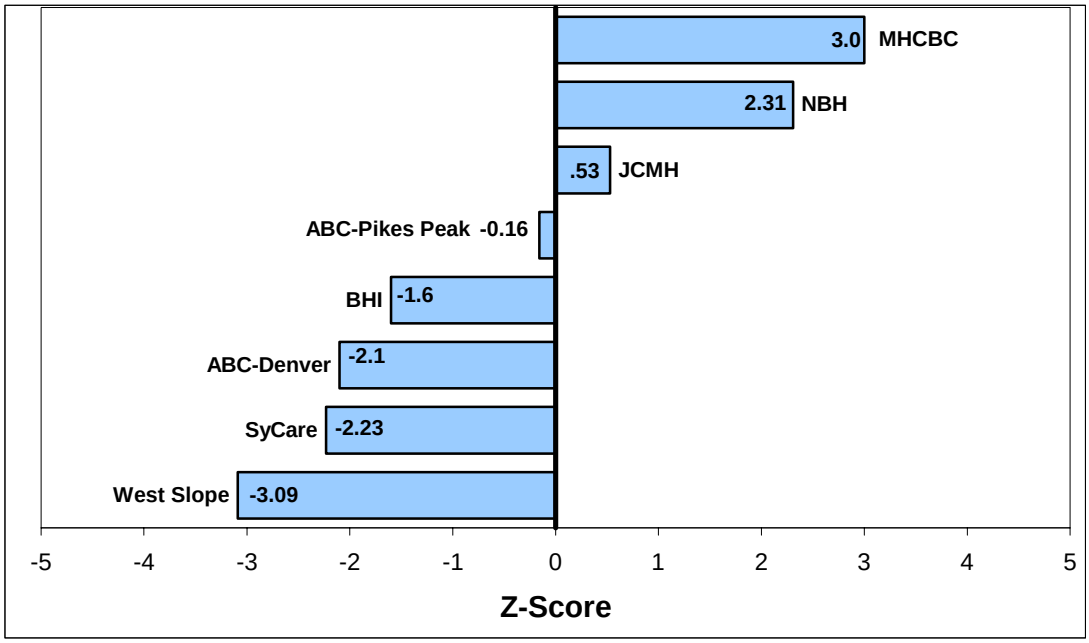
Figure 5-33—Z-Score Distribution for Change in Problem Severity in Children, by BHO



Change in Problem Severity in Adults

Using CCAR data, this performance measure reflects the change in problem severity for adult Medicaid discharges. For this measure, raw scores were transformed to z-scores. Positive z-scores indicate that the raw score was above the mean; negative z-scores indicate that the raw score was below the mean. The scores ranged from a high of 3.00 (or three standard deviations above the mean) for MHCBC, to a low of -3.09 (or more than three standard deviations below the mean) for West-Slope Options. Overall, three BHOs had positive z-scores, while five BHOs had negative z-scores. The range of scores is even wider for this measure, indicating more distinct differences in scores.

Figure 5-34—Z-Score Distribution for Change in Problem Severity in Adults, by BHO



The following tables are summary tables showing all performance measure scores for all BHOs. The first table (Table 5-3) shows the performance measure results that are reported as percentages. The second table (Table 5-4) shows the performance measure results that are reported as z-scores.

Table 5-3—Percentage Results for Performance Measures, by BHO

Performance Measures	ABC-Denver	ABC-Pikes Peak	BHI	JCMH	MHCBC	NBH	SyCare-Options	West Slope-Options	BHO Average
Penetration Rate – Child	6.30%	10.92%	6.28%	8.49%	8.99%	8.77%	9.22%	7.60%	**7.90%**
Penetration Rate – Adult	14.56%	14.46%	12.59%	14.38%	19.44%	14.46%	14.60%	15.10%	**14.40%**
MHSIP – Perception of Access (positive response)	76.6%	65.6%	69.0%	70.2%	65.2%	71.0%	76.4%	68.1%	**71%**
MHSIP – Perception of Appropriateness (positive response)	69.0%	73.4%	70.2%	68.1%	68.2%	68.6%	76.9%	69.3%	**71%**
MHSIP – Perception of Outcome (positive response)	60.3%	62.8%	62.5%	62.0%	61.5%	60.8%	66.2%	55.7%	**62%**
MHSIP – Perception of Satisfaction (positive response)	77.8%	73.0%	75.4%	75.5%	73.5%	75.0%	81.7%	75.7%	**77%**
MHSIP – Perception of Participation (positive response)	63.3%	59.5%	56.7%	70.5%	62.9%	64.8%	72.9%	63.5%	**65%**
MHSIP – Consumers Linked to Primary Care	84.7%	81.1%	80.3%	88.5%	84.3%	87.8%	79.2%	79.4%	**82%**

Table 5-4—Z-Score Results for Performance Measures, by BHO

Performance Measures	ABC-Denver	ABC-Pikes Peak	BHI	JCMH	MHCBC	NBH	SyCare-Options	West Slope-Options
Children Living in a Family-Like Setting	-.67	-.18	-.17	2.32	-.08	-.98	-.32	.08
Adults Living Independently	.47	.35	-.05	-.66	.35	-.35	-.12	-.15
Employment	-1.42	.68	.07	.53	-.45	.02	-.55	.08
Change in Problem Severity in Children	.59	2.06	-1.21	.33	-.47	-.50	-.59	-.20
Change in Problem Severity in Adults	-2.10	-.16	-1.60	.53	3.00	2.31	-2.23	-3.09

Validation of Performance Improvement Projects

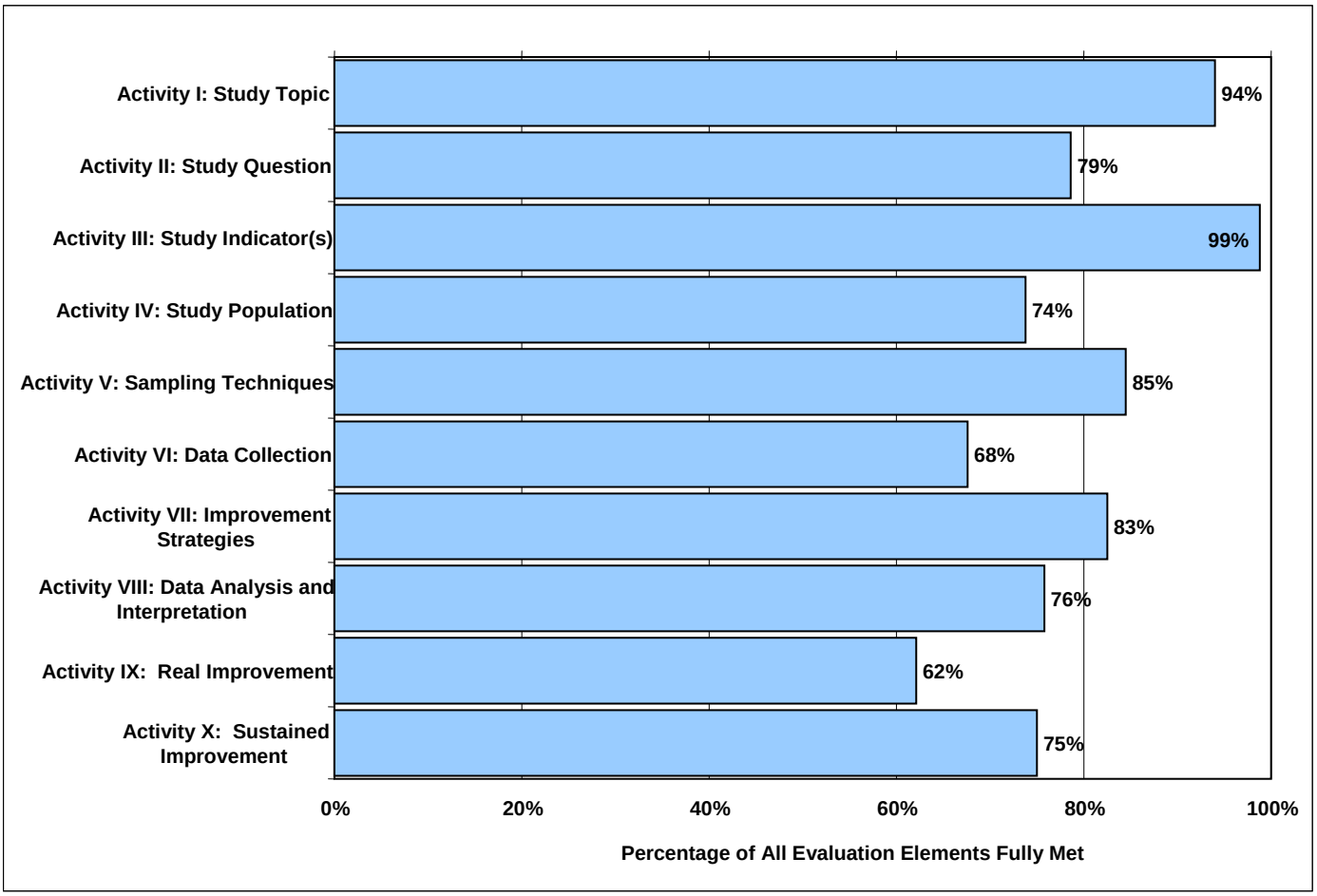
Using the 10 CMS-recommended PIP protocol activities, HSAG validated two PIP studies for each of the eight BHOs. Since the validation of PIPs was combined for SyCare-Options and Slope West-Options, 14 PIPs were validated. The study topics were determined by the individual BHOs and, as such, the PIP study topics were not uniform across the BHOs. Additionally, the PIP studies were at different stages in their implementation, therefore the number of PIP protocol activities that HSAG reviewed and evaluated varied across the BHOs. Of the 10 CMS-recommended PIP protocol activities, HSAG was able to validate all 14 PIPs for Activities I through VI (Study Topic through Data Collection), 13 PIPs for Activities VII and VIII (Appropriate Improvement Strategies and sufficient Data Analysis and Interpretation), 11 PIPs for Activity IX (Real Improvement Achieved), and 4 PIPs for Activity X (Sustained Improvements Achieved).

Each PIP was given an overall validation finding of *Met*, *Partially Met* or *Not Met*. As detailed in Section 3, this overall score was based on the total percentage of elements that were *Met* and whether all applicable critical elements were *Met.* The 11 elements designated by HSAG as "critical" had to be *Met* for the PIP to produce accurate and reliable results, and to be considered in full compliance. In terms of the overall PIP scores:

- For PIPs with overall scores of *Met:* Three BHOs (ABC-Denver, ABC-Pikes Peak, NBH) were given a *Met* PIP validation status for both of their PIPs and two BHOs (BHI and JCMH) for one of their PIPs, with the overall scores of these *Met* PIPs ranging from 86 percent to 98 percent.
- For PIPs with overall scores of *Partially Met*: SyCare/West Slope-Options was given a validation status of *Partially Met* for both of their PIPs and three BHOs (BHI, JCMH, and MHCBC) for one of their PIPs, with overall scores for these *Partially Met* PIPs ranging from 52 percent to 75 percent.
- For PIPs with overall scores of *Not Met*: MHCBC was the only BHO to have a PIP given a *Not Met* validation status. While this PIP had a validation score of 81 percent, it did not meet a critical element related to Activity IV: Correctly Identified Study Population (i.e., capturing all members to whom the study questions applies).

Figure 5-35 displays the percentage of all evaluation elements that were fully *Met* across all BHOs. Higher performance across all BHOs was observed in the areas of Activity I: Appropriate Study Topic (94 percent); Activity III: Clearly Defined Study Indicator (99 percent); Activity V: Valid Sampling Techniques (85 percent); and Activity VII: Appropriate Improvement Strategies (83 percent). Average performance was noted in the areas of Activity II: Clearly Defined, Answerable Study Question (79 percent); Activity IV: Correctly Identified Study Population (74 percent); Activity VIII: Sufficient Data Analysis and Interpretation (75 percent); and Activity X: Sustained Improvement Achieved (75 percent). Below-average performance was observed in the areas of Activity VI: Accurate/Complete Data Collection (68 percent); and Activity IX: Real Improvement Achieved (62 percent).

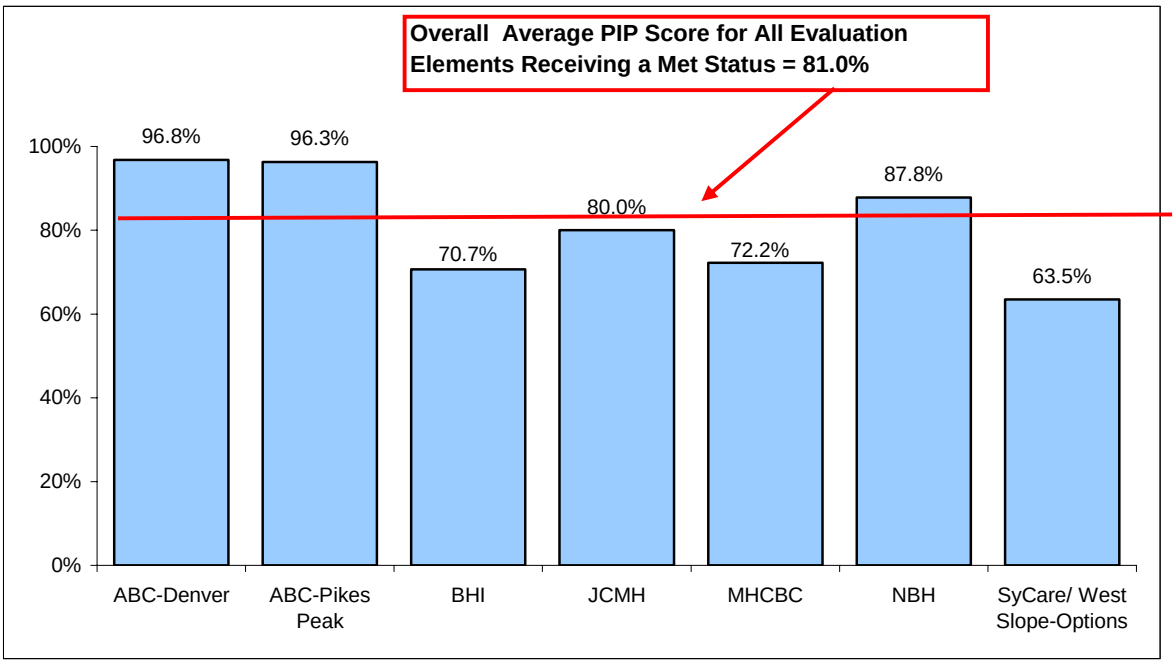
Figure 5-35—Percentage of All PIP Evaluation Elements Fully Met



For Figure 5-36, HSAG calculated the BHO-average percentage score from the two PIPs that were validated. Using this average percentage score provides a more accurate reflection of the BHO's ability to conduct a PIP. The percentage score includes evaluation of critical and noncritical elements. Low percentage scores indicate difficulty with specific activities, while high percentage scores indicate the BHO was able to understand, document, and perform the required activities. Percentage scores that fall between the high and low scores may indicate the BHO had difficulty with just one of the two PIPs, and may need assistance in producing a valid PIP.

Figure 5-36 provides a comparison of each BHO's average percentage score of all evaluation elements (both critical and noncritical) that were *Met* across all activities for the two PIPs that were validated. ABC-Denver and ABC-Pikes Peak received the highest average scores (96.8 percent and 96.3 percent, respectively), followed by NBH and JCMH (with an average score of 87.8 percent and 80 percent, respectively). SyCare /West Slope-Options, BHI, and MHCBC received scores that were below average, indicating a need for improvement to the PIP process and documentation to ensure compliance with CMS requirements.

Figure 5-36—Average PIP Scores Across All Evaluation Elements, by BHO (Includes Critical and Noncritical Elements)



The 10 PIP protocol activities are further broken down into 13 critical elements. These elements have been designated by HSAG as "critical" for producing valid and reliable results and for demonstrating high confidence in the PIP findings. If one or more critical elements were *Not Met*, the PIP was given a validation score of *Not Met*. Table 5-5 provides a summary of the number of PIPs that *Met* the critical elements. Ten PIPs associated with six BHOs received a *Met* status for all critical elements, and four PIPs associated with four BHOs received a *Partially Met* status for one to four critical elements. Only one of the PIPs received a *Not Met* status for one of the critical elements (method for capturing all members to whom the study question applies).

Table 5-5—Numbers of PIPs That *Met* All Critical Elements

Activity	Critical Elements	# PIPs*	Percentage
Activity I: Appropriate Study Topic	Has the potential to affect member health, functional status, or satisfaction.	14/14	100%
Activity II: Clearly Defined, Answerable Study Question	Is answerable/provable.	12/14	86%
Activity III: Clearly Defined Study Indicators	Are well defined, objective, and measurable.	14/14	100%
	Allow for the study questions or hypothesis to be answered or proven.	14/14	100%
	Have available data that can be collected on each indicator.	14/14	100%
Activity IV: Correctly Identified Study Population	Is accurately and completely defined.	12/14	86%
	Captures all members to whom the study question applies.	11/14	79%
Activity V: Valid Sampling Techniques	Ensure a representative sample of the eligible population.	13/14	93%
Activity VI: Accurate/Complete Data Collection	A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	3/4	75%
Activity VIII: Sufficient Data Analysis and Interpretation	Is conducted according to the data analysis plan in the study design.	10/11	91%
	Allows for generalization of the results to the study population if a sample was selected.	11/13	85%

* The number of PIPs that *Met* the critical elements over the total number of PIPs that were assessed on the element.

With respect to critical elements, three BHOs (ABC-Denver, ABC-Pikes Peak, and NBH) received a *Met* status for all critical elements for both PIPs that were validated. Only one BHO (MHCBC) received a *Not Met* status for a critical element, which resulted in the PIP finding of *Not Valid*. The remaining BHOs received a *Partially Met* status for at least one critical element across the two validated PIPs.

The one critical element that was *Not Met* by MHCBC was under PIP Activity IV: Correctly Identified Study Population—*Captures all members to whom the study question applies.*

Below are the critical elements that received a finding of *Partially Met* for some of the BHOs:

- The one critical element under Activity II: Clearly Defined Answerable Study Question—*The written study question or hypothesis is answerable/provable.*
- The two critical elements under Activity IV: Correctly Identified Study Population—(1) *Is accurately and completely defined* and (2) *Captures all members to whom the study question applies.*
- The one critical element under Activity V: Valid Sampling Techniques—*Ensure a representative sample of the eligible population.*
- The one critical element under Activity VI: Accurate/Complete Data Collection—*A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.*
- The two critical elements under Activity VIII: Sufficient Data Analysis and Interpretation—(1) *Is conducted according to the data analysis plan in the study design,* and (2) *Allows for generalization of the results to the study population if a sample was selected.*

Table 5-6 provides the numerical percentage scores for critical elements *Met*, all elements *Met* (both critical and noncritical elements), and overall PIP validation status for each BHO.

Table 5-6—Summary of Each BHO's Compliance Ratings for All PIP Evaluation Elements

BHO and PIP Study	% Critical Elements Met	% All Elements Met	Validation Status
ABC-Denver: Readmission Rate	100	98	Met
ABC-Pikes Peak: Follow-Up After an Inpatient Stay	100	98	Met
ABC-Denver: Follow-Up After an Inpatient Stay	100	96	Met
ABC-Pikes Peak: Readmission Rate	100	95	Met
BHI: Follow-Up Post Hospitalization	100	90	Met
NBH: Inpatient Readmission Rate	100	89	Met
JCMH: Access to Routine Offered Intake Appointment	100	87	Met
NBH: Follow-Up After an Inpatient Stay	100	86	Met
SyCare/West Slope: Ambulatory Follow-Up	70	75	Partially Met
JCMH: Treatment of Adults with Depression	89	73	Partially Met
MHCBC: Solution-Focused Brief Therapy Study	100	63	Partially Met
SyCare/West Slope: Use of Diagnostic-Based Treatment Guidelines	73	52	Partially Met
BHI: Access to Initial Medication Evaluations	60	51	Partially Met
MHCBC: Input/Output Study of Individuals with Psychosis	91	81	Not Met

Conclusions and Recommendations

BHO-specific recommendations were listed in the Compliance Monitoring, Performance Measure Validation, and Performance Improvement Project reports provided to the Department and each BHO. The following recommendations were those noted to be systemwide areas in need of performance improvement.

Compliance Monitoring

The majority of BHOs were found to be meeting the federal and State requirements with strong showings in the area of Standards IV—Advance Directives; VI—Access and Availability; VIII—Utilization Review; XI—Quality Assurance Program; and XIII—Credentialing and Recredentialing.

Recommendations

- BHOs' policies and procedures need to be further enhanced in a number of areas, the key area being policies and procedures related to grievances and appeals. Other policy areas identified for improvement include enrollee rights and responsibilities and subcontracts/delegation.
- The majority of BHOs need to augment material provided to enrollees, ensuring compliance with federal and State requirements related to:
  - Grievance, appeal, and fair hearing procedures and time frames.
  - Obtaining benefits, including access to interpreter services.
  - Enrollee rights and responsibilities.
  - Provider selection and referral processes.
  - Advance directives.
  - Availability of QAPI-related information.

Additionally, BHOs need to ensure enrollee materials are presented in a manner that is easily understood as well as available in alternative formats.

- All the BHOs should continue to develop effective processes to ensure the accuracy of encounter data submitted to the Department.
- A number of the BHOs need to ensure that their staff members are appropriately trained on the denial criteria and process.
- Subcontract/delegation agreements should be reviewed and amended by the BHOs to address all BBA requirements, such as hold-harmless and disclosure of ownership.
- Although many of the BHOs had high compliance scores in the area of credentialing and recredentialing, additional improvements should be made in their processes related to:
  - Implementation of a tracking system.
  - Credential committee procedures.
  - Notification of the Department regarding provider additions and terminations.

Validation of Performance Measures

Overall, the BHOs were successful in reporting accurate and valid performance measures. The BHO information systems captured the necessary data elements to report the Department performance measures. None of the performance measures was scored as *Not Valid*. The BHOs have some room for improvement in the area of ensuring accurate and complete data collection processes in order to further strengthen the accuracy of the performance measure results.

In the area of actual performance, a trend in BHO-specific performance was noted. High performance was observed by SyCare-Options in the MHSIP domains of consumer perception of services, with the BHO reporting the highest scores for four of the five measures.

Overall, BHO performance measure scores were mixed. For the MHSIP survey, the program as a whole reported an overall average domain score in the 60 percent range for Consumer Perception of Outcome/Positive Change and Consumer Perception of Participation (62 percent and 65 percent, respectively). Overall average domain scores in the 70 percent range were reported for Consumer Perception of Access (71 percent), Quality/Appropriateness (71 percent), and General Satisfaction (77 percent). Eighty-two percent of members surveyed reported seeing a doctor or nurse outside of the emergency room, a relatively strong finding. While no national benchmark data are available for comparison, these results indicate some room for improvement across all MSHIP measures.

With respect to the CCAR measures reported with z-scores, there was minimal variation in performance across the BHOs for the *Adults Living Independently* measure. All BHO's z-scores were within less than one standard deviation from the mean. For two other measures, z-scores that were greater than two standard deviations from the mean were reported by a single BHO (JCMH reported a z-score of 2.32 for *Children Living in a Family-Like Setting*, and ABC-Pikes Peak reported a z-score of 2.06 for *Change in Problem Severity in Children.* The widest variation in z-scores was observed in the *Change in Problem Severity in Adults*, with z-scores that ranged from 3.0 for MHCBC to -3.09 for West-Slope Options, indicating a more distinct variation in performance for this measure.

Recommendations

While none of the performance measures was found to be *Not Valid*, the BHOs should make additional improvements to their performance measure processes ensure the reliability, accuracy and validity of the data used to calculate these performance measures. These improvements included:

- Following Department specifications pertaining to data scrubbing of claims and encounter submissions to the Department.
- Improving processes for internally validating CCAR and claims data, including the implementation of a method to perform inter-rater reliability testing and to validate data entry.
- Automating current manual processes related to data validation and submission.
- Implementing better tracking processes related to claims and encounters submission.

In reviewing the performance measure reporting process as a whole, the Department should:

- Consider establishing a performance measure work group (which should include representatives from the BHOs, the Department, DMH, and other interested parties) to evaluate performance measures objectively and determine if they are actionable, meaningful, and valuable, according to the overall program objectives.
- Consider developing other performance measures that assist in evaluating BHO performance in the areas of access, quality, and timeliness of services rendered. BHO contract requirements for timeliness or access could be measured to ensure these requirements are met. Other national performance measures (such as HEDIS) should be evaluated in terms of the ability to collect performance data that is meaningful to Colorado's mental health program.
- Consider establishing minimal performance standards for performance measures to identify targets for BHO performance, measure improvement over time, and measure overall program performance relative to these standards.

Validation of Performance Improvement Projects

Most BHOs had established a strong framework for conducting PIPs, with five BHOs having at least one PIP given a validation score of *Met*. Their strong performance in this area was also reflected in the fact that only one of the BHOs' PIPs was found to have a critical element that was *Not Met*. Above-average performance was observed in the PIP protocol activities related to appropriate study topics, clearly defined study indicators, valid sampling techniques, and appropriate improvement strategies.

For those PIPs in which remeasurement data had been collected and analyzed, the majority of BHOs were able to demonstrate significant improvements in the study indicators, achieving or exceeding benchmark goals.

Recommendations

- Immediate steps were to be taken by those BHOs for whom corrective actions were identified as a result of the PIP validation process. Findings from the PIP validation were provided to the BHOs in a formal report and follow-up conference calls were held with each BHO. Each BHO was required to develop a corrective action plan to address all evaluation elements that were *Partially Met* or *Not Met*. The BHOs were required to resubmit documentation within 30 days after the conference calls. Each BHO prepared a corrective action plan with supporting descriptions and documentation, which was submitted to HSAG for review and approval. The corrective action plans sufficiently addressed all evaluation elements that were not fully *Met*. The PIPs were not rescored. A corrected final PIP validation report with HSAG re-review comments was prepared and submitted to the Department.
- For ongoing phases of current PIPs as well as all future PIPs, the BHO should ensure that all evaluation elements that were *Partially Met* or *Not Met* are addressed in the documentation submitted. In particular, the BHOs should address the following areas:

- Providing an estimated degree of automated data completeness for the data collected and analyzed.
- Providing the automated data collection algorithms that show steps in the production of the study indicators.
- Discussing any factors that might have threatened the internal or external validity of the study.
- Clearly describing the method employed to identify the study population, particularly in terms of the length of a member's enrollment in the plan.
- Presenting the data analysis in a clearly and easily understood format.

6. Assessment of Prior Recommendations

Since this *2004–2005 External Quality Review Technical Report for Behavioral Health Organizations* is the first of such reports and is serving as a baseline in terms of EQR activity findings, an assessment of prior recommendations is not included. Beginning next year, an assessment will be provided as to the degree to which the BHOs effectively addressed the recommendations for quality improvement made by HSAG as a result of the FY 04-05 EQR activities.