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Colorado Medicaid Community
Mental Health Program

2006-2007 External Quality Review Technical Report

for

Behavioral Health Organizations

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CONTENTS

Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with 42 Code of Federal Regulations (CFR) 438.358 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which any previous recommendations were addressed by the MCOs and PIHPs. To meet this requirement, the State of Colorado Department of Health Care Policy & Financing (the Department) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare a report describing the external quality review (EQR) activities performed for the State's contracted behavioral health organizations (BHOs), which are behavioral health PIHPs, and the findings derived from the activities. The State contracts with five BHOs: Access Behavioral Care (ABC); Behavioral HealthCare, Inc. (BHI); Colorado Health Partnerships, LLC (CHP), Foothills Behavioral Health, LLC (FBH); and Northeast Behavioral Health, LLC (NBH).

Scope of EQR Activities Conducted

This EQR technical report focuses on the three federally mandated EQR activities that were conducted. As set forth in 42 CFR 438.352, these mandatory activities were:

- **Compliance monitoring evaluation.** This evaluation was designed to determine the BHOs' compliance with their contract and with State and federal regulations through review of performance in 10 compliance areas (i.e., standards) and through review of individual records to evaluate implementation of the requirements.
- **Validation of performance measures.** HSAG validated each of the performance measures identified by the Department to evaluate the accuracy of the performance measures reported by or on behalf of the BHOs. The validation also determined the extent to which Medicaid-specific performance measures calculated by the BHOs followed specifications established by the Department.
- **Validation of performance improvement projects (PIPs).** For each BHO, two PIPs were reviewed to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

The results of these three EQR activities performed by HSAG were reported to the Department and the BHOs in individual activity reports for each BHO. Performance scores and validation findings from the activities for all BHOs are detailed in Section 3 and summarized in tables in Appendix D of this report.

Definitions

The BBA states that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible."[1-1] The domains of quality, access, and timeliness have been chosen by the Centers for Medicare & Medicaid Services (CMS) as keys to evaluating the performance of MCOs and PIHPs. The following definitions were used by HSAG to evaluate and draw conclusions about the performance of the BHOs in each of these domains.

Quality

CMS defines quality in the final rule at 42 CFR 438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-2]

Timeliness

Timeliness is defined by the National Committee for Quality Assurance (NCQA) relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-3] It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO or PIHP, e.g., processing expedited appeals and providing timely follow-up care.

Access

In the preamble to the BBA Rules and Regulations,[1-4] CMS discusses access and availability of services to Medicaid enrollees as the degree to which MCOs and PIHPs implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO or PIHP.

[1-1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

[1-2] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 3, October 1, 2005.

[1-3] National Committee on Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

[1-4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Overall Conclusions and Recommendations

To draw conclusions and make recommendations about the quality and timeliness of, and access to, care provided by the BHOs, HSAG assigned each of the components (standards, performance measures, PIPs) reviewed for each activity to one or more of these three domains as described in Section 3 of this report.

The following is a high-level statewide summary of the conclusions drawn from the findings of the activities regarding the BHOs' strengths and HSAG's recommendations with respect to quality, timeliness, and access. BHO-specific findings, strengths, and recommendations are described in detail in Section 3 of this report.

Quality

Overall, statewide BHO performance in the domain of quality was strong, increasing the likelihood that the BHOs would experience desired health outcomes for their members. In particular, the BHOs' study findings and scores related to quality showed that there were substantial improvements from the previous year in the areas of performance measures and PIPs. This year, the validation of performance measures gave all the BHOs *Acceptable* scores for data integration, data control processes, and performance measure documentation, and found all of their performance measures to be valid. Also, the majority of BHOs received a score of *Fully Compliant* for all the measures. Additionally, 10 of the 13 statewide averages for the quality-related performance measures increased between assessment years. In the area of PIPs, all 10 of the PIPs reviewed this year were given a validation status of *Met* (as opposed to 7 last year), with 100 percent of all critical elements *Met*. The BHOs had successfully addressed recommendations identified the previous year, for example, in areas related to staff qualifications, study description, and inconsistencies in the data analysis. There was also a marked increase in the statewide average score for three of the quality-related compliance standards (i.e., practice guidelines, continuity-of-care system, and credentialing) and for the review of records for documentation of services.

The BHOs' eligibility and claims/encounter data systems for processing the data used for reporting the performance measures were solid this year, with sufficient processes in place to ensure data quality. Many of the BHOs had improved data integrity and oversight processes this year through the implementation of a variety of quality improvement strategies (e.g., special initiatives, new committees or task forces, additional staffing). All the BHOs showed strong performance in the compliance areas of practice guidelines, continuity-of-care system, and the quality assessment and performance improvement (QAPI) program. Each BHO had put in place a number of practice guidelines that were based upon clinician and consumer input, and each BHO had implemented a wide array of collaborative partnerships and initiatives such as colocation of mental health services in provider offices. The BHOs also had comprehensive and compliant QAPI programs in which they routinely analyzed and integrated data from multiple sources as part of their quality improvement process. Lastly, in addition to overall solid and compliant PIP projects, six of the BHOs' PIPs were successful in achieving improved outcomes, ranging from increased rates in follow-up after an inpatient discharge to increased use of evidence-based practices in guiding treatment decisions.

In the domain of quality, HSAG recommends for certain BHOs:

- Reviewing and revising the content of the BHOs' written delegation agreements and of policies and procedures related to delegation, advance directives, and credentialing and recredentialing to ensure compliance with the BBA and State contract requirements.
- Implementing mechanisms to ensure that accurate and complete grievance and appeal records are maintained.
- Continuing to actively oversee and monitor the receipt, completeness, timeliness, and accuracy of encounter data and Colorado Client Assessment Record (CCAR) data from providers, placing all providers who do not meet standards on a plan of corrective action, and providing additional education about data collection during the medical record review process.
- Reexamining the State's specifications to ensure that submitted encounter and claims data fulfill all requirements.
- Conducting an analysis as to the causal factors leading to trends in any apparently low rates for quality performance measures, especially for Consumer Perceptions of Outcome and Positive Change in Problem Severity—Adults. As a result of this analysis, appropriate interventions should be implemented to remove identified barriers and enhance the provision of quality health care.
- Selecting, if appropriate, a new study topic for fiscal year (FY) 07-08 that targets improvement in high-priority areas of clinical care and that reflects the BHOs' Medicaid enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences of disease.
- Conducting additional data and causal/barrier analysis to identify if interventions for the PIPs are addressing the root causes, revising the interventions if appropriate.
- Developing and implementing appropriate corrective actions to address specific areas of quality identified for improvement at the individual BHO level.

Timeliness

Overall, statewide BHO performance in the domain of timeliness was strong, with the majority of BHOs performing well in complying with timeliness standards. (The evaluation for timeliness was limited to compliance standards for the BHOs as there were no performance measures that provided data for the evaluation of timeliness and all PIPs were assigned to the quality domain.) Compared with last year, the BHOs made substantial improvements in a number of compliance areas related to timeliness. The statewide average scores for the access and availability standard, an area that was identified as an opportunity for improvement last year, increased from 87 percent to 98 percent. The statewide average record review score for documentation of services increased by 13 percentage points, and the statewide average for denials was 91 percent. The decreases in the statewide average scores in the area of grievances (both for the standard and record review) were primarily due to one low-scoring BHO. Improvement by this lowest-scoring BHO in the area of grievances will help move the statewide average in a positive direction.

All the BHOs showed strong performance in the areas of access and availability and continuity-of-care system, with all of the BHOs scoring 100 percent in the compliance area of continuity-of-care system. The BHOs had processes in place to evaluate and report on timeliness of access to services and to take corrective action if appropriate. Some BHOs had implemented collaborative partnerships and initiatives, and several BHOs had PIPs that addressed improvement in timeliness of services, e.g., screening for bipolar disorder and follow-up care after hospital discharge.

In the domain of timeliness, HSAG recommends for certain BHOs:

- Developing a process to ensure that notices of action are sent in a timely manner to consumers and providers following utilization review (UR) denial decisions.
- Continuing to monitor and take action when trends are identified to ensure all services are provided within timeliness standards under the contract.
- Developing and implementing appropriate corrective actions to address specific areas of timeliness identified for improvement at the individual BHO level.
- Considering development of other performance measures that assist in evaluating BHO performance in the area of timeliness of services rendered. Other states' Medicaid mental health performance measures should be evaluated in terms of their ability to collect performance data that are meaningful to Colorado's mental health program.

Access

Overall, statewide BHO performance in the domain of access was strong. Compared with last year, the BHOs' statewide average scores improved for a number of the compliance areas for both the standards and review of records. These areas included: access and availability, continuity-of-care system, credentialing, and denials. All of the statewide average compliance scores related to access exceeded 90 percent, indicating that structures and operations were in place to support timely access to care and services. However, there were no marked improvements in the statewide averages for performance measures related to access, with both increases and decreases being less than a percentage point. While all PIPs were assigned to the quality domain, several BHOs had PIPs that targeted improvement in access to services, e.g., access to initial medication evaluations, and identification and use of alternative/crisis services.

The BHOs showed strong performance in the compliance areas of access and availability, utilization management (UM), and continuity-of-care system. The BHOs had mechanisms in place to evaluate the sufficiency of the network in meeting the needs of the consumers, including the provision of alternative services to support consumers in their local community. There was a strong BHO commitment to the recovery model, with the majority of BHOs having implemented numerous initiatives to further promote this model in their community. The BHOs also had established active UM programs with effective measures for detecting under- and overutilization and ensuring the consistent application of review criteria. Lastly, the BHOs used care coordinators to link consumers to needed medical, mental health, and social services within the community, and participated in a wide variety of collaborative projects with community stakeholders in order to further facilitate consumers' easy access to needed services.

In the domain of access, HSAG recommends for certain BHOs:

- Developing a process for notifying the Department in writing of any decision to terminate an existing provider agreement when the termination impacts the accessibility of services.
- Conducting an analysis as to the causal factors leading to trends in any apparent lack of improvement in the access-related performance measures. As a result of this analysis, appropriate interventions should be implemented to remove identified barriers and enhance the provision of quality health care.
- Continuing to monitor and take action when trends are identified to ensure that all services are provided within access standards under the contract.
- Developing and implementing appropriate corrective actions to address specific areas of access identified for improvement at the individual BHO level.

2. External Quality Review Activities

HSAG conducted compliance monitoring site reviews, validation of performance measures required by the State, and validation of PIPs required by the State for each BHO. Each activity was conducted in accordance with CMS protocols for determining compliance with Medicaid managed care regulations. Details of how HSAG conducted the compliance monitoring site reviews, validation of performance measures, and validation of PIPs are described in Appendices A–C, respectively, and address:

- Objectives for conducting the activity.
- Technical methods of data collection.
- Descriptions of data obtained.
- Data aggregation and analysis.

Conclusions drawn from the data and recommendations related to health care quality, timeliness, and access for each BHO and statewide, across the BHOs, are presented in Section 3 of this report.

3. Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access

Introduction

This section of the report addresses the findings from the assessment of each BHO's strengths and required actions related to quality, timeliness, and access derived from analysis of the results of the three EQR activities. Recommendations are made for improving the quality and timeliness of, and access to, health care services furnished by each BHO. The BHO-specific findings from the three EQR activities conducted are detailed in the applicable subpart of this section (i.e., Compliance Monitoring Site Reviews, Validation of Performance Measures, and Validation of Performance Improvement Projects). This section also includes for each activity a summary of overall statewide performance related to quality, timeliness, and access to care and services.

Compliance Monitoring Site Reviews

The findings for the FY 06–07 compliance monitoring site reviews were determined from: (1) a desk review of the documents submitted to HSAG by each BHO prior to the on-site portion of the review, (2) interviews with key BHO staff members, and (3) a review of additional documents and records conducted during the on-site review.

For the review of the 10 compliance areas (standards), the individual elements (i.e., contract requirements) reviewed for each standard were assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable (N/A)*. A summary score was then determined by calculating the percentage of applicable elements found compliant (i.e., *Met*). For the review of records for grievances, documentation of services, coordination of care, and denials, elements in each record reviewed were assigned a score of *Yes* (compliant), *No* (not compliant), or *N/A* (not applicable). For each of the scored record reviews, a summary score was then determined by calculating the percentage of applicable elements found compliant.

Recognizing the interdependence of quality, timeliness, and access, and in order to draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the BHOs using findings from the compliance monitoring site reviews, HSAG assigned each of the standards and record reviews to one or more of these three domains as depicted in the two tables on the next page.

Table 3-1—Assignment of Standards to Performance Domains			
Standards	**Quality**	**Timeliness**	**Access**
Delegation	✓		
Provider Issues	✓		✓
Practice Guidelines	✓		
Member Rights and Responsibilities	✓		
Access and Availability		✓	✓
Utilization Management		✓	✓
Continuity-of-Care System	✓	✓	✓
Quality Assessment and Performance Improvement Program	✓		
Grievances, Appeals, and Fair Hearings	✓	✓	
Credentialing	✓		✓

Table 3-2—Assignment of Record Reviews to Performance Domains			
Record Reviews	**Quality**	**Timeliness**	**Access**
Grievances	✓	✓	
Documentation of Services	✓	✓	
Coordination of Care—Children's Transition From Inpatient to Outpatient Services	✓		✓
Denials		✓	✓

Further details about the compliance monitoring site review activities are contained in Appendix A of this report.

Access Behavioral Care

Findings

Table 3-3 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A)*, and, for both the current year (FY 06–07) and the prior year (FY 05–06), the compliance score (percentage of compliance) for each standard and the overall compliance score for the review of standards.

Table 3-3—Summary of Scores for the Standards for FY 06–07 and FY 05–06 *for* ABC

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	FY 06–07 Score (% of *Met* Elements)	Prior Year (FY 05–06) Score (% of *Met* Elements)
I	Delegation	13	12	6	6	0	1	50%	91%
II	Provider Issues	26	25	23	1	1	1	92%	100%
III	Practice Guidelines	5	5	5	0	0	0	100%	100%
IV	Member Rights and Responsibilities	18	18	17	1	0	0	94%	100%
V	Access and Availability	20	20	19	1	0	0	95%	89%
VI	Utilization Management	8	8	7	1	0	0	88%	100%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%	93%
VIII	Quality Assessment and Performance Improvement Program	12	12	11	1	0	0	92%	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	6	5	0	0	55%	91%
X	Credentialing	32	32	30	2	0	0	94%	97%
	Totals	**160**	**158**	**139**	**18**	**1**	**2**	**88%**	**96%**

Table 3-4 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each scored record review as well as a combined record review compliance score for FY 06–07 and for the prior year's review (FY 05–06).

Table 3-4—Summary of Scores for the Review of Records for FY 06–07 and FY 05–06 *for* ABC

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	FY 06–07 Score* (% of Compliant Elements)	Prior Year (FY 05–06) Score*
II	Documentation of Services	10	21	19	90%	71%
VI	Denials	10	30	28	93%	Not Performed
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	10	Not Scored	Not Scored	Not Scored	Not Performed
IX	Grievances	10	40	0	0%	100%
	Totals	**40**	**91**	**47**	**52%**	**95%**

* Percentages from the prior and current fiscal years should be compared with the understanding that some of the elements differed between the two review years.

Table 3-5 presents the overall scores for the review of the standards, the review of records, and the review of the standards and records combined for the FY 06–07 and FY 05–06 compliance monitoring site reviews.

Table 3-5—Overall Scores for FY 06–07 and FY 05–06 *for* ABC

Type of Review	FY 06–07 Score	Prior Year (FY 05–06) Score
Review of the Standards	88%	96%
Review of Records	52%	95%
Overall Score	**75%**	**96%**

Strengths

While ABC's overall scores reflected a decline from the previous year, ABC showed marked improvement in several compliance areas. Of the compliance standards reviewed, the largest increase was for continuity-of-care system, where the percentage of fully compliant elements improved from 93 percent to 100 percent. This increase was closely followed by access and availability, which had a 6 percentage-point increase. Finally, in the area of record reviews, ABC's score significantly improved from 71 percent to 90 percent for contract compliance related to the documentation of services for submitted encounters.

Based on the results of this year's compliance site review, ABC's recognized strengths included the following:

- Comprehensive and compliant policies and procedures in the areas related to practice guidelines, consumer rights and responsibilities, continuity of care, access to services, and the QAPI program.
- Effective systems for tracking provider agreements, documenting the credentialing and recredentialing of providers, and tracking due dates and completion dates of service authorizations, denials, actions, and appeals. ABC's electronic tracking system was recognized as a best practice.
- Practice guidelines in place for the treatment of major depression, attention deficit/hyperactivity disorder, and bipolar disorder. Additionally, as in the previous year, ABC was in compliance with all the practice guidelines requirements.
- Close collaborative partnerships with providers, State agencies, public schools, and community programs, including participation in several community initiatives. ABC was recognized for two best practices in this area: 1) an initiative to encourage primary care providers to screen (using PHQ-9 scores) and refer for depression, and 2) its active participation in the interagency collaborative to integrate service recommendations to the court for youth being considered for commitment.

Recommendations

Overall, ABC's compliance review scores declined from the prior year: 96 percent to 75 percent for the overall compliance score, 96 percent to 88 percent for the review of standards score, and 95 percent to 52 percent for the review-of-records score. Although all three compliance scores were the lowest among the BHOs, ABC's performance on the grievance record review, which resulted in a score of zero, significantly impacted both its overall compliance score and its score for the review of records. ABC's score on the review of standards was just 4 percentage points below the statewide average.

Of the 10 compliance standards reviewed, ABC had 2 standards scoring 100 percent compared with 5 standards scoring 100 percent the previous year, and had a total of 7 standards with decreases in the compliance scores. The largest declines were seen in the review of standards for delegation and for grievances, appeals, and fair hearings, where the decreases were 41 percentage points and 36 percentage points, respectively. Additionally, due to a lack of documented evidence and the brevity of notes in the database, HSAG was not able to evaluate the grievance record sample, causing ABC's record review score for grievances to fall from 100 percent to zero percent.

Recommendations for improving ABC's performance included:

- Revising policy and procedures related to termination of provider contracts, utilization review determinations, and credentialing and recredentialing notification and appeals.
- Developing and implementing monitoring processes related to performance of delegated activities, provision of alternative services, and provider compliance with medical record requirements.

- Entering into a formal delegation agreement with the Mental Health Center of Denver (MHCD) to process Medicaid consumer grievances if ABC chooses to require MHCD to process consumer grievances on its behalf.
- Ensuring providers submit accurate encounter codes and appropriately submit requested medical records.
- Providing training and education to staff and providers on advance directives requirements.
- Ensuring notices of action are sent in a timely manner to consumers and providers following UR denial decisions.
- Ensuring compliance with State and federal regulations in the processing of all Medicaid consumer grievances and the handling of expressions of dissatisfaction.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of ABC's compliance monitoring results related to each of the three domains.

- **Quality**: ABC's compliance with the individual standards assessing quality was mixed. While six out of eight quality-related scores declined from the previous year, six quality-related standards received scores of 90 percent or more. Practice guidelines and continuity-of-care system both received scores of 100 percent, showing strong performance in these areas. ABC showed the greatest need for improvement in the quality-related areas of delegation and grievances, with scores of 50 percent and 55 percent, respectively. The scores for record reviews assessing quality were also mixed, with a marked improvement in the score for documentation of services and a significant decrease in the score for grievances.
- **Timeliness**: ABC's performance as it related to compliance with standards assessing timeliness was also mixed. As discussed above for the quality domain, ABC showed the greatest need for improvement in the timeliness-related area of grievances as reflected in the low compliance standard and record review scores. ABC's scores for two of the four timeliness-related standards (access and availability and continuity-of-care system) were 95 percent and 100 percent respectively. Additionally, ABC's scores for two of the three timeliness-related reviews of records (documentation of services and denials) were at or above 90 percent.
- **Access**: ABC demonstrated strength in the access-related compliance standards, with four of five access-related scores above 90 percent and the fifth score at 88 percent. Additionally, ABC showed strong performance in the access-related area of continuity-of-care system, with a score of 100 percent. The only access-related record review score (i.e., denials) received a score of 93 percent.

Behavioral HealthCare, Inc.

Findings

Table 3-6 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A)*, and, for both the current year (FY 06–07) and the prior year (FY 05–06), the compliance score (percentage of compliance) for each standard and the overall compliance score for the review of standards.

Table 3-6—Summary of Scores for the Standards for FY 06–07 and FY 05–06 *for* BHI

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	FY 06–07 Score (% of *Met* Elements)	Prior Year (FY 05–06) Score (% of *Met* Elements)
I	Delegation	13	12	11	1	0	1	92%	100%
II	Provider Issues	26	25	23	2	0	1	92%	100%
III	Practice Guidelines	5	2	2	0	0	3	100%	100%
IV	Member Rights and Responsibilities	18	18	18	0	0	0	100%	100%
V	Access and Availability	20	20	19	1	0	0	95%	89%
VI	Utilization Management	8	8	8	0	0	0	100%	100%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%	93%
VIII	Quality Assessment and Performance Improvement Program	12	12	12	0	0	0	100%	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	10	1	0	0	91%	91%
X	Credentialing	32	32	30	2	0	0	94%	88%
	Totals	**160**	**155**	**148**	**7**	**0**	**5**	**95%**	**95%**

Table 3-7 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review compliance score for the FY 06–07 and for the prior year's review (FY 05–06).

Table 3-7—Summary of the Scores for the Review of Records for FY 06–07 and FY 05–06 *for* BHI

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	FY 06–07 Score* (% of Compliant Elements)	Prior Year (FY 05–06) Score*
II	Documentation of Services	10	20	19	95%	77%
VI	Denials	10	30	29	97%	Not Performed
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	10	Not Scored	Not Scored	Not Scored	Not Performed
IX	Grievances	10	41	40	98%	100%
	Totals	**40**	**91**	**88**	**97%**	**95%**

* Percentages from the prior and current fiscal years should be compared with the understanding that some of the elements differed between the two review years.

Table 3-8 presents the overall scores for the review of the standards, the review of records, and the review of the standards and records combined for the FY 06–07 and FY 05–06 compliance monitoring site reviews.

Table 3-8—Overall Scores for FY 06–07 and FY 05–06 *for* BHI

Type of Review	FY 06–07 Score	Prior Year (FY 05–06) Score
Review of the Standards	95%	95%
Review of Records	97%	95%
Overall Score	**96%**	**95%**

Strengths

BHI demonstrated high overall compliance with BBA regulations and State contractual requirements. BHI received an overall compliance score of 96 percent, the highest among all the BHOs and 7 percentage points above the statewide average of 89 percent. BHI's score of 95 percent for the compliance monitoring standards was 3 percentage points above the statewide average, and its score of 97 percent for the review of records was 9 percentage points above the average score for all BHOs. The review-of-records score improved 2 percentage points and the score for the review of standards remained unchanged from last year.

All of BHI's 10 compliance standard scores and all of its 3 record review scores were above 90 percent and were at or above the statewide averages for all BHOs. Five standards had compliance scores of 100 percent. BHI showed improvement in three compliance areas: access and availability, continuity-of-care system, and credentialing. Additionally, BHI's record review score for documentation of services dramatically improved from 77 percent to 95 percent.

Based on the results of this year's compliance monitoring site review, BHI's recognized strengths included the following:

- Comprehensive and compliant policies and procedures in the areas related to monitoring providers and corporate compliance, practice guidelines, consumer rights and responsibilities, the continuity of care, the UM and QAPI programs, and processing of grievances, appeals, and fair hearings.
- Effective systems for monitoring delegation activities and consumer access to covered services and for tracking provider agreements, credentialing and recredentialing of providers, and grievances, appeals and fair hearings.
- A practice guideline development process that was based on clinician feedback and the development of new technologies (e.g., vagal nerve and transcranial magnetic stimulation guidelines and eye movement desensitization and reprocessing guidelines). In addition to being recognized as a best practice, all the practice guideline requirements were compliant, as in the previous year.
- The B.E.S.T. Program (Bipolar Education and Skills Training), a recognized best practice that included practice guidelines for bipolar spectrum disorders, consumer and family education, and development of outcomes measures.
- Strong commitment to the use of alternative services and services that supported empowerment and the recovery model. BHI's implementation of a recovery model was recognized as a best practice.
- Numerous collaborative projects with medical providers, including initiatives to colocate mental health services in medical provider offices and the provision of mental health services in schools and correctional facilities.
- A comprehensive and fully compliant QAPI program in which BHI routinely analyzed and integrated data from multiple sources as part of the quality improvement process. Recognized as a best practice, BHI published a quarterly report card with quality improvement data and results that was provided to providers, consumers, special interest groups, and the community.

Recommendations

In general, BHI experienced no significant decreases in its compliance review scores from the previous year. Of the 10 compliance standards reviewed, declines were seen only in the compliance scores for delegation and provider issues. These scores both decreased by 8 percentage points, from 100 percent to 92 percent. The review-of-records score for grievances also fell slightly from 100 percent to 98 percent.

Recommendations for improving BHI's performance included:

- Revising policies and procedures related to routine appointment standards and credentialing and recredentialing.
- Ensuring processes are in place for sending timely acknowledgments of receipt of grievances and notices of action following UR denial decisions, and notifying the Department of provider terminations that may impact consumers' access to services.
- Ensuring providers submit accurate encounter codes.
- Updating provider agreements with the community mental health centers (CMHCs) to reflect current activities and responsibilities.
- Ensuring that all expressions of dissatisfaction are handled in accordance with federal and State regulation and that the data are tracked and trended.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of BHI's compliance monitoring results related each of these three domains.

- **Quality**: BHI's compliance with the individual standards assessing quality was good. BHI showed strong performance in the areas of practice guidelines, member rights and responsibilities, continuity-of-care system, and the QAPI program. These areas all received scores of 100 percent. Only two of the eight scores for quality-related standards declined, decreasing from 100 percent to 92 percent. BHI also demonstrated strength in the quality-related record reviews. These scores ranged from 95 percent to 98 percent, with an 18 percent improvement in the score for documentation of services.
- **Timeliness**: BHI's performance as it related to compliance with standards assessing timeliness was strong. Of the scores for the four timeliness-related standards, two increased (access and availability and continuity-of-care system) from the previous year and the other two stayed the same. Two compliance standards received scores of 100 percent (utilization management and continuity-of-care system). Additionally, BHI's scores for the three timeliness-related reviews of records (documentation of services, denials, and grievances) were at 95 percent, 97 percent, and 98 percent, respectively.
- **Access**: BHI demonstrated strength in access-related compliance standards, with two of five access-related standards scoring 100 percent (utilization management and continuity-of-care system). Three of the access-related scores increased (access and availability, continuity-of-care system, credentialing). The provider issues standard was the only access-related standard that declined from the previous year as a result of two *Partially Met* elements. The one access-related record review score (i.e., denials) received a score of 97 percent.

Colorado Health Partnerships, LLC

Findings

Table 3-9 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A*), and, for both the current year (FY 06–07) and the prior year (FY 05–06), the compliance score (percentage of compliance) for each standard and the overall compliance score for the review of standards.

Table 3-9—Summary of Scores for the Standards for FY 06–07 and FY 05–06 *for* CHP

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	FY 06–07 Score (% of *Met* Elements)	Prior Year (FY 05–06) Score (% of *Met* Elements)
I	Delegation	13	12	6	4	2	1	50%	NA
II	Provider Issues	26	25	24	1	0	1	96%	96%
III	Practice Guidelines	5	2	2	0	0	3	100%	100%
IV	Member Rights and Responsibilities	18	18	15	3	0	0	83%	76%
V	Access and Availability	20	20	20	0	0	0	100%	89%
VI	Utilization Management	8	8	7	1	0	0	88%	100%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%	93%
VIII	Quality Assessment and Performance Improvement Program	12	12	12	0	0	0	100%	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	11	0	0	0	100%	91%
X	Credentialing	32	8	6	0	2	24	75%	84%
	Totals	**160**	**131**	**118**	**9**	**4**	**29**	**90%**	**90%**

Table 3-10 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review score for the FY 06–07 and for the prior year (FY 05–06) review.

Table 3-10—Summary of the Scores for the Review of Records for FY 06–07 and FY 05–06 *for* CHP

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	FY 06–07 Score* (% of Compliant Elements)	Prior Year (FY 05–06) Score*
II	Documentation of Services	10	20	20	100%	95%
VI	Denials	10	30	29	97%	Not Performed
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	10	Not Scored	Not Scored	Not Scored	Not Performed
IX	Grievances	10	40	39	98%	91%
	Totals	**40**	**90**	**88**	**98%**	**98%***

* Percentages from the prior and current fiscal years should be compared with the understanding that some of the elements differed between the two review years.

Table 3-11 presents the overall scores for the review of the standards, the review of records, and the review of the standards and records combined for the FY 06–07 and FY 05–06 compliance monitoring site reviews.

Table 3-11—Overall Scores for FY 06–07 and FY 05–06 *for* CHP

Type of Review	FY 06–07 Score	Prior Year (FY 05–06) Score
Review of the Standards	90%	90%
Review of Records	98%	98%
Overall Score	**93%**	**94%**

Strengths

CHP received an overall compliance score of 93 percent, with scores of 90 percent for the compliance monitoring standards and 98 percent for the review of records, the highest score among the BHOs and 12 percentage points above the statewide average. The overall scores were essentially unchanged from last year. CHP showed marked improvement in a number of the compliance areas. Five of the 10 compliance standards (two more than the previous year) received scores of 100 percent. These areas were practice guidelines, access and availability, continuity-of-care system, the QAPI program, and grievances, appeals, and fair hearings. The compliance score for member rights

and responsibilities also increased from 76 percent in FY 05–06 to 83 percent this year. CHP demonstrated strong performance in all three record reviews. CHP received a score of 97 percent for denials and achieved improvements over last year in the scores for documentation of services (95 percent to 100 percent) and grievances (91 percent to 98 percent).

Based on the results of this year's compliance site review, CHP's recognized strengths included the following:

- Comprehensive and compliant policies and procedures in the areas related to practice guidelines, access and availability of services, the continuity of care, the QAPI program, and the processing of grievances, appeals, and fair hearings.
- Effective systems for tracking provider agreements.
- A substantial number of evidenced-based clinical practice guidelines, including both diagnostic-based and treatment modalities-based guidelines, that were made available to providers, consumers, and the community. This area was recognized as a best practice.
- Further enhancement of CHP's recovery practice model through numerous initiatives such as hiring advocates and peer specialists in the delivery system, developing a family crisis pilot program, and disseminating recovery literature.
- A "buddy" preceptor program, recognized as a best practice, which paired new utilization review staff with senior clinicians as part of a training program to learn level-of-care criteria and the utilization review processes.
- Collaborative projects with its partner CMHCs that included the colocation of mental health staff in juvenile detention facilities and the provision of crisis intervention training for local police officers and sheriff's services.
- Use of telemedicine/video-conferencing and employment of nurse practitioners and physician assistants in rural and frontier areas to enhance access to prescribers, which was recognized as a best practice.
- A comprehensive and fully compliant QAPI program in which CHP routinely analyzed and integrated data from multiple data sources as part of the quality improvement process.

Recommendations

CHP's compliance review scores were relatively low in two areas, i.e., delegation and credentialing. Delegation, which was a new compliance review area for CHP this year, received a score of 50 percent, with four *Partially Met* elements and two *Not Met* elements out of 12 applicable elements. CHP's score for credentialing declined from 84 percent to 75 percent this year. In addition to having two *Not Met* elements, CHP had 24 credentialing-related elements that were determined to be *Not Applicable*. CHP had not yet developed its own credentialing policies, but instead had been relying on its delegate's credentialing policies and procedures, a practice that does not meet the NCQA requirements that had been adopted by the State.

Recommendations for improving CHP's performance included:

- Revising delegation agreements and policy and procedures related to monitoring of delegation activities, consumer rights and responsibilities, advance directives, the UM program, and credentialing and recredentialing.
- Reviewing, as part of the encounter claims audit, for the presence of medical record documentation as well as compliance with other contract criteria for submission of encounter claims.
- Ensuring notices of action are sent in a timely manner to consumers and providers following UR denial decisions.
- Ensuring all persons making clinical grievance decisions have the appropriate qualifications and that their credentials are documented.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of CHP's compliance monitoring results related to each of the three domains.

- **Quality**: CHP's compliance with the individual standards assessing quality was generally good. CHP showed strong performance in the areas of practice guidelines, access and availability, continuity-of-care system, the QAPI program, and grievances, appeals, and fair hearings. These areas all received scores of 100 percent. Additionally, three of the quality-related scores increased from the previous year. CHP also demonstrated strength in the quality-related reviews of records, with scores ranging from 97 percent to 100 percent. CHP showed the greatest need for improvement in the quality-related areas of delegation and credentialing, with scores of 50 percent and 75 percent, respectively.
- **Timeliness**: CHP demonstrated strength in the area of compliance with standards assessing timeliness. Of the scores for the four timeliness-related standards, three (access and availability, continuity-of-care system, and grievances, appeals, and fair hearing) received a score of 100 percent, which was an increase from the previous year. The fourth timeliness-related standard, utilization management, decreased from 100 percent to 88 percent as a result of one *Partially Met* element. CHP's strong performance was also reflected in its scores for the three timeliness-related record reviews (documentation of services, denials, and grievances) at 100 percent, 97 percent, and 98 percent, respectively.
- **Access**: CHP's performance as it related to compliance with standards evaluating access was mixed. While two of five access-related scores were 100 percent (access and availability and continuity-of-care system), two other access-related scores declined from the previous year (utilization management and credentialing). Additionally, two of the scores were less than 90 percent, with utilization management at 88 percent and credentialing at 75 percent. The one access-related record review score (i.e., denials) received a score of 97 percent.

Foothills Behavioral Health, LLC

Findings

Table 3-12 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A)*, and, for both the current year (FY 06–07) and the prior year (FY 05–06), the compliance score (percentage of compliance) for each standard and the overall compliance score for the review of standards.

Table 3-12—Summary of Scores for the Standards for FY 06–07 and FY 05–06 *for* FBH

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	FY 06–07 Score (% of *Met* Elements)	Prior Year (FY 05–06) Score (% of *Met* Elements)
I	Delegation	13	12	11	1	0	1	92%	92%
II	Provider Issues	26	25	24	1	0	1	96%	100%
III	Practice Guidelines	5	5	5	0	0	0	100%	100%
IV	Member Rights and Responsibilities	18	18	17	1	0	0	94%	94%
V	Access and Availability	20	20	20	0	0	0	100%	89%
VI	Utilization Management	8	8	7	1	0	0	88%	100%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%	93%
VIII	Quality Assessment and Performance Improvement Program	12	12	12	0	0	0	100%	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	11	0	0	0	100%	100%
X	Credentialing	32	32	31	1	0	0	97%	88%
	Totals	**160**	**158**	**153**	**5**	**0**	**2**	**97%**	**94%**

Table 3-13 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review compliance score for the FY 06–07 and for the prior year (FY 05–06) review.

Table 3-13—Summary of the Scores for the Review of Records for FY 06–07 and FY 05–06 *for* FBH

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	FY 06–07 Score* (% of Compliant Elements)	Prior Year (FY 05–06) Score*
II	Documentation of Services	10	21	15	71%	48%
VI	Denials	10	27	23	85%	86%
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	10	Not Scored	Not Scored	Not Scored	Not Performed
IX	Grievances	10	41	41	100%	77%
	Totals	**40**	**89**	**79**	**89%**	**71%***

***** Percentages from the prior and current fiscal years should be compared with the understanding that some of the elements differed between the two review years.

Table 3-14 presents the overall scores for the review of the standards, the review of records, and the review of the standards and records combined for the FY 06–07 and FY 05–06 compliance monitoring site reviews.

Table 3-14—Overall Scores for FY 06–07 and FY 05–06 *for* FBH

Type of Review	FY 06–07 Score	Prior Year (FY 05–06) Score
Review of the Standards	97%	94%
Review of Records	89%	71%
Overall Score	**94%**	**81%**

Strengths

FBH was a strong overall performer, making significant improvements this year in its compliance with BBA and State contractual requirements. FBH's overall compliance score increased from 81 percent to 94 percent, with the overall score for compliance standards increasing from 94 percent to 97 percent, the highest among the BHOs and 5 percentage points above the statewide average score for compliance standards. FBH's score for the review of records increased from 71 percent to 89 percent.

Five standards had compliance scores of 100 percent, three of which were continuations of 100 percent scores last year. FBH showed improvement in three compliance areas: access and availability, continuity-of-care system, and credentialing. Additionally, FBH's record review scores for documentation of services and grievances improved dramatically from the previous year, 48 percent to 71 percent and 77 percent to 100 percent, respectively.

Based on the results of this year's compliance monitoring site review, FBH's recognized strengths included the following:

- Comprehensive and compliant provider agreements as well as policies and procedures in the areas related to monitoring providers and corporate compliance, practice guidelines, consumer rights and responsibilities, access to services, continuity of care, the QAPI program, and processing grievances, appeals, and fair hearings.
- Effective systems for monitoring delegation activities and consumer access to covered services, for tracking provider agreements, and for documenting grievances, appeals, and fair hearings.
- A practice guideline development process that was based on valid and reliable clinical evidence, a consensus of local and regional health care experts, and feedback from consumers and family members.
- Commitment to the recovery model, with an approach that included several unique and creative, as well as more traditional, initiatives.
- An active UM program that included FlexServ, an automated data system using level of function and global assessment scores to guide decisions about the type and number of authorized services the member needs. FBH used FlexServ, recognized as a best practice, to predict consumer service needs, assess patterns of service utilization, and measure compliance with access-to-care standards.
- Numerous collaborative projects with community stakeholders. FBH's collaborative partnership with Imagine! (a community-centered board providing case management services to individuals with developmental disabilities) was recognized as a best practice for its integration of services to address both mental health and developmental disability issues in one service location.
- A comprehensive and fully compliant QAPI program in which FBH routinely analyzed and integrated data from multiple sources as part of the quality improvement process.
- A compliant grievance system that included the provision of grievance-related information and assistance to consumers.

Recommendations

FBH experienced no decreases in its overall compliance review scores from the previous year. Of the 10 compliance standards reviewed, declines were seen only in the compliance scores for provider issues and utilization management. Due to a *Partially Met* element in each area, the scores fell from 100 percent to 96 percent and 100 percent to 88 percent, respectively. Although FBH made substantial improvement in its review-of-records scores from the previous year, there were still opportunities for improvement. The review-of-records score for documentation of services was 71 percent, and for denials it was 85 percent.

Recommendations for improving FBH's performance included:

- Revising delegation agreements and policies and procedures related to credentialing and recredentialing.
- Ensuring policies and procedures regarding decisions to deny requests for authorization of services are followed.
- Developing processes for reviewing the appropriateness and accuracy of providers' encounter data, notifying the Department of provider termination decisions, and ensuring that the independent provider network appropriately documents whether there is an executed advanced directive.
- Ensuring notices of action are sent in a timely manner to consumers and providers following UR denial decisions.

Summary Assessment Related to Quality, Timeliness, and Access

Following is a summary assessment of FBH's compliance monitoring results related to each of the three domains.

- **Quality**: FBH's compliance with the individual standards assessing quality was strong. FBH showed strong performance in the areas of practice guidelines, continuity-of-care system, the QAPI program, and grievances, appeals, and fair hearings. These areas all received scores of 100 percent. Three of the eight scores for quality-related standards increased this year, with only one (provider issues) decreasing from 100 percent to 96 percent. All of the scores for the quality-related standards exceeded 90 percent. FBH also showed significant improvement on the two quality-related review-of-records scores, with both (documentation of services and grievances) increasing 23 percentage points.
- **Timeliness**: FBH demonstrated strength in the area of compliance standards related to timeliness. Of the scores for the four timeliness-related standards, three received scores of 100 percent. Two timeliness-related scores increased (access and availability and continuity-of-care system) from the previous year, one decreased (utilization management), and the other stayed the same. Additionally, FBH significantly improved its timeliness-related record review scores for documentation of services and grievances, while the score for denials remained about the same.
- **Access**: FBH's performance related to compliance with standards evaluating access was generally good. Of the five access-related standard scores, two were 100 percent (access and availability and continuity-of-care system) and only one was less than 90 percent (utilization management at 88 percent). Three of the standard scores increased (access and availability, continuity-of-care system, and credentialing) and two declined (provider issues and utilization management) due to each having one *Partially Met* element. The one access-related record review score (i.e., denials) received a score of 85 percent, declining 1 percentage point from the previous year.

Northeast Behavioral Health, LLC

Findings

Table 3-15 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A)*, and, for both the current year (FY 06–07) and the prior year (FY 05–06), the compliance score (percentage of compliance) for each standard and the overall compliance score for the review of standards.

Table 3-15—Summary of Scores for the Standards for FY 06–07 and FY 05–06 *for* NBH

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	FY 06–07 Score (% of *Met* Elements)	Prior Year (FY 05–06) Score (% of *Met* Elements)
I	Delegation	13	12	8	4	0	1	67%	45%
II	Provider Issues	26	25	21	3	1	1	84%	100%
III	Practice Guidelines	5	5	5	0	0	0	100%	0%
IV	Member Rights and Responsibilities	18	18	16	2	0	0	89%	100%
V	Access and Availability	20	20	20	0	0	0	100%	78%
VI	Utilization Management	8	8	8	0	0	0	100%	100%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%	93%
VIII	Quality Assessment and Performance Improvement Program	12	12	12	0	0	0	100%	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	9	2	0	0	82%	100%
X	Credentialing	32	31	29	1	1	1	94%	84%
	Totals	**160**	**157**	**143**	**12**	**2**	**3**	**91%**	**86%**

Table 3-16 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review compliance score for the FY 06–07 and for the prior year (FY 05–06) review.

Table 3-16—Summary of the Scores for the Review of Records for FY 06–07 and FY 05–06 *for* NBH

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	FY 06–07 Score (% of Compliant Elements)	Prior Year (FY 05–06) Score
II	Documentation of Services	10	20	20	100%	100%
VI	Denials	2	6	5	83%	Not Performed
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	10	Not Scored	Not Scored	Not Scored	Not Performed
IX	Grievances	6	24	23	96%	89%
	Totals	**28**	**50**	**48**	**96%**	**85%***

* Percentages for the prior and current fiscal years should be compared with the understanding that some of the elements differed between the two review years.

Table 3-17 presents the overall scores for the review of the standards, the review of records, and the review of the standards and records combined for the FY 06–07 and FY 05–06 compliance monitoring site reviews.

Table 3-17—Overall Scores for FY 06–07 and FY 05–06 *for* NBH

Type of Review	FY 06–07 Score	Prior Year (FY 05–06) Score
Review of the Standards	91%	86%
Review of Records	96%	85%
Overall Score	**92%**	**86%**

Strengths

NBH made significant improvements this year in its overall compliance with BBA and State contractual requirements. NBH's overall compliance score increased from 86 percent to 92 percent, with its overall score for compliance standards increasing from 86 percent to 91 percent and its score for record reviews increasing from 85 percent to 96 percent. Five standards had compliance scores of 100 percent, two of which were continuations of 100 percent scores last year. NBH showed improvement in five compliance areas: delegation, practice guidelines, access and

availability, continuity-of-care system, and credentialing. Particularly notable was the score for practice guidelines, which improved from zero to 100 percent as a result of NBH's development of at least two practice guidelines. Additionally, NBH's score of 96 percent for the review of grievance records increased from the previous year's score of 89 percent.

Based on the results of this year's compliance monitoring site review, NBH's recognized strengths included the following:

- Comprehensive and compliant policies and procedures in the areas related to practice guidelines, access to services, continuity of care, and the UM and QAPI programs.
- Effective systems for monitoring consumer access to and appropriate utilization of covered services, and for tracking provider agreements.
- Practice guidelines in place for the treatment of attention deficit hyperactivity disorder and mood disorders.
- Processes in place to promote the recovery model, with numerous initiatives under way that responded to local community needs, e.g., recovery training and tool kits in provider newsletters.
- An active UM program with numerous measures to detect under- and overutilization and ensure the consistent application of medical necessity criteria, including after-hours authorization decisions.
- Close, collaborative, working partnerships between NBH and its contracted providers and other community organizations (e.g., probation offices, local judges, developmental disability providers, child welfare workers).
- A comprehensive and fully compliant QAPI program in which NBH routinely analyzed and integrated data from multiple sources as part of the quality improvement process. The program was recognized for two best practices: 1) a focused study on coordination of care with adult consumers who have medical issues, and 2) use of stipends to increase consumer participation on quality management-related committees.
- An operational grievance procedures manual that was an excellent model for ensuring delegates' compliance with NBH's expectations, and consumer-friendly and custom-developed member grievance letters that were recognized as a best practice.

Recommendations

Although NBH experienced an increase in its overall compliance review scores from the previous year, there was a decline in the scores for three compliance standards reviewed (provider issues, member rights and responsibilities, and grievances, appeals, and fair hearings). All three of these standards had received a score of 100 percent the previous year. Despite this year's 22 percentage-point increase in the area of delegation, the score of 67 percent indicated continuing opportunities for improvement.

Recommendations for improving NBH's performance included:

- Revising the CMHC written agreements and the corporate compliance plan.

- Revising policies and procedures related to monitoring of delegates versus providers, termination of provider agreements, member responsibilities, processing of grievances and appeals, and credentialing and recredentialing of providers.
- Monitoring the appropriateness of covered services provided by its network.
- Implementing mechanisms to ensure member rights are taken into account by external providers.
- Ensuring notices of action are sent in a timely manner to consumers and providers following UR denial decisions.
- Processing all expressions of dissatisfaction as grievances, and reporting and trending this information for quality improvement purposes.

In addition to the specific compliance-related recommendations listed above, HSAG strongly recommends that NBH management staff establish a more effective method for preparing for future site reviews. This method needs to ensure completeness of documentation submitted for the desk audit, relevance to the time period for review, clarity and consistency of labeling and organization of submitted documents, responsiveness in terms of requested information, and use of content area experts in the preparation of materials for the site review process.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of NBH's compliance monitoring results related to each of the three domains.

- **Quality**: NBH's compliance with the individual standards assessing quality was mixed. NBH showed strong performance in the areas of practice guidelines, continuity-of-care system, and the QAPI program. These areas all received scores of 100 percent. While three of the eight scores for quality-related standards decreased this year, four of the scores increased. The 67 percent score for the delegation compliance standard was low. All of NBH's 14 noncompliant elements (*Partially Met* and *Not Met*) were for quality-related standards. NBH showed strong performance for the quality-related record reviews, receiving scores of 100 percent for documentation of services and 96 percent for grievances.
- **Timeliness**: NBH demonstrated strength in the area of compliance standards related to timeliness. Of the scores for the four timeliness-related standards, three received scores of 100 percent. Two timeliness-related scores increased (access and availability and continuity-of-care system) from the previous year, one decreased (grievances, appeals, and fair hearings), and one (utilization management) stayed the same at 100 percent. Additionally, NBH received scores of 100 percent and 96 percent for the timeliness-related record reviews for documentation of services and grievances, respectively. The record review for denials, which was not performed the previous year, received a score of 83 percent.
- **Access**: NBH's performance related to compliance with standards evaluating access was strong. Of the five access-related standard scores, three were 100 percent (access and availability, utilization management, and continuity-of-care system) and only one was below 90 percent (provider issues at 84 percent). Three of the standard scores increased (access and availability, continuity-of-care system, and credentialing) and one declined (provider issues). The one access-related record review score (i.e., denials) received a score of 83 percent.

Overall Statewide Performance Related to Quality, Timeliness, and Access for the Compliance Monitoring Site Reviews

The overall statewide results from the compliance monitoring activity are shown in Table 3-18. The range of the BHOs' scores for each of the individual standards and record review types is followed by the statewide average score. Also, displayed in the last row of the following two tables are the overall ranges of BHO scores and the statewide average scores for both the review of standards and the review of records for FY 06–07 and FY 05–06. The tables are followed by conclusions drawn from the results of the compliance monitoring activity. Appendix D contains summary tables displaying the detailed site review scores for the standards and for the record reviews by BHO and statewide when applicable.

Table 3-18—Summary of Data From the Review of Standards

Standards	FY 06–07 Range of Scores	FY 06–07 Statewide Average Score	Prior Year (FY 05–06) Statewide Average Score
Delegation	50% to 92%	70%	82%
Provider Issues	84% to 96%	92%	99%
Practice Guidelines	all 100%	100%	78%
Member Rights and Responsibilities	83% to 100%	92%	94%
Access and Availability	95% to 100%	98%	87%
Utilization Management	88% to 100%	93%	100%
Continuity-of-Care System	all 100%	100%	93%
Quality Assessment and Performance Improvement Program	92% to 100%	98%	100%
Grievances, Appeals, and Fair Hearings	55% to 100%	85%	95%
Credentialing	75% to 97%	91%	88%
Overall Statewide Compliance Score for Standards	**88% to 97%**	**92%**	**92%**

Table 3-19—Summary of Data From the Review of Records

Record Review	FY 06–07 Range of Scores	FY 06–07 Statewide Average Score*	Prior Year (FY 05–06) Statewide Average Score*
Grievances	0% to 100%	78%	91%
Documentation of Services	71% to 100%	91%	78%
Coordination of Care—Children's Transition From Inpatient to Outpatient Services	N/A—Not Scored	N/A—Not Scored	Not Performed
Denials	83% to 97%	91%	86%**
Overall Statewide Compliance Score for Record Reviews	**52% to 98%**	**86%**	**89%**

* Percentages from the prior and current fiscal years should be compared with the understanding that some of the elements differed between the two review years.

** This reflects the score from only one BHO, as the review of records was not performed for the other four BHOs as part of the FY 05–06 site review.

Table 3-20—Overall Compliance Scores		
Type of Review	FY 06–07 Statewide Average Score	Prior Year (FY 05–06) Statewide Average Score
Review of the Standards	92%	92%
Review of Records	86%	89%
Statewide Average of Compliance Scores for the Review of Standards and Records	**89%**	**91%**

The following is a statewide summary of the conclusions drawn from the compliance monitoring results regarding the BHOs' strengths, opportunities for improvement, and recommendations with respect to quality, timeliness, and access.

Quality

Overall, statewide BHO performance in the domain of quality for compliance with individual standards was mixed. The statewide average scores for the eight quality-related standards ranged from a low of 70 percent for delegation to a high of 100 percent for practice guidelines and continuity-of-care system. The statewide average scores for the two quality-related record reviews were 91 percent for documentation of services and 78 percent for grievances. The low statewide average for the grievance record review was driven by one BHO that received a score of zero. All the other BHOs' scores for the grievance record review were between 96 percent and 100 percent.

All the BHOs showed strong performance in the areas of practice guidelines, continuity-of-care system, and QAPI program. Each BHO had put in place a number of practice guidelines that were based upon clinician and consumer input, and each BHO had implemented a wide array of collaborative partnerships and initiatives such as colocation of mental health services in medical provider offices. All the BHOs also had comprehensive and compliant QAPI programs in which they routinely analyzed and integrated data from multiple sources as part of their quality improvement process. Lastly, the majority of the BHOs had effective systems for tracking provider agreements.

The majority of the BHOs' compliance standard scores for delegation and for grievances, appeals, and fair hearings indicated some room for improvement in the domain of quality. HSAG recommends that, where applicable, the individual BHOs:

- Review the content of their written delegation agreements and policies and procedures for delegation, advance directives, and credentialing and recredentialing to ensure compliance with all BBA and State contractual requirements.
- Implement mechanisms to ensure accurate and complete grievance and appeal records are maintained.

Timeliness

Overall, statewide BHO performance in the domain of timeliness for compliance with individual standards was good. The statewide average scores for the four timeliness-related standards ranged from a low of 85 percent for grievances, appeals, and fair hearings to a high of 100 percent for continuity-of-care system. The statewide average scores for the three timeliness-related record reviews were 91 percent for both documentation of services and denials, and 78 percent for grievances. The low statewide average for the grievance record review was due to one BHO that received a score of zero because of a lack of documentation in the grievance records and database. All the other BHOs' scores for the grievance record review were between 96 percent and 100 percent.

All the BHOs showed strong performance in the areas of access and availability and continuity-of-care system. The BHOs had processes in place to evaluate and report on timeliness of access to services and to take corrective action if appropriate.

In terms of opportunities for improvement, HSAG recommends that, where applicable, the individual BHOs develop a process to ensure that notices of action are sent in a timely manner to consumers and providers following UR denials.

Access

Overall, statewide BHO performance in the domain of access for compliance with individual standards was strong. The statewide average scores for the four access-related standards ranged from a low of 91 percent for credentialing to a high of 100 percent for continuity-of-care system. The statewide average score for the one access-related record review—denials—was 91 percent.

The BHOs showed strong performance in the areas of access and availability, utilization management, and continuity-of-care system. The BHOs had mechanisms in place to evaluate the sufficiency of the network in meeting the needs of consumers, including the provision of alternative services to support consumers in their local community. There was a strong BHO commitment to the recovery model, with the majority of BHOs having implemented numerous initiatives to further promote this model in their community. The BHOs had also established active UM programs with effective measures for detecting under- and overutilization and ensuring the consistent application of review criteria. Lastly, the BHOs used care coordinators to link consumers to needed medical, mental health, and social services within the community, and the BHOs participated in a wide variety of collaborative projects with community stakeholders in order to further facilitate consumers' easy access to needed services.

In terms of opportunities for improvement, HSAG recommends that, where applicable, the individual BHOs develop a process for notifying the Department in writing of any decision to terminate an existing provider agreement when the termination will impact the accessibility of services.

Validation of Performance Measures

The Department, on behalf of the BHOs, calculated 13 performance measures using data submitted by the BHOs. The same process was followed for each performance measure validation conducted by HSAG for each BHO and included both pre-review and on-site activities. An Information Systems Capabilities Assessment Tool (ISCAT) that was customized to Colorado's service delivery system was used to collect the necessary background information on the BHOs' policies, processes, and data needed for the on-site performance measure 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 State. As identified in the CMS protocol, the following key types of data were obtained and reviewed as part of the validation of performance measures: ISCAT, source code (programming language) for performance measures, previous performance measure reports, supporting documentation, current performance measure results, and on-site interviews and demonstrations. Table 3-21 displays the data sources used in the validation of performance measures and the time period to which the data applied.

Table 3-21—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
ISCAT (From BHOs and the Department)	FY 05–06
Source Code (Programming Language) for Performance Measures (From the Department)	FY 05–06
Previous Year's Performance Measure Reports	FY 04–05
Current Performance Measure Results (From BHOs and the Department)	See note*
Supporting Documentation (From BHOs and the Department)	FY 05–06
On-site Interviews and Demonstrations (From BHOs and the Department)	FY 05–06

***Note:** Colorado's selected performance measures represent data from different time periods, depending on the source of the performance measure data. The performance measures that derived data from the Mental Health Statistics Improvement Program (MHSIP) survey covered CY 05. Performance measures derived from the CCAR and encounter data represented the state fiscal year (July 05 through June 06).

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's 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* (*NV*) 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*.

To draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the BHOs using findings from the validation of performance measures, HSAG assigned each of the measures to one or more of these three domains as depicted in Table 3-22.

Table 3-22—Assignment of Performance Measures to Performance Domains

Performance Measures	Quality	Timeliness	Access
Penetration Rate—Children			✓
Penetration Rate—Adults			✓
Consumer Perception of Access (Positive Response)	✓		✓
Consumer Perception of Quality/Appropriateness (Positive Response)	✓		
Consumer Perception of Outcome (Positive Response)	✓		
Consumer Satisfaction With Services (Positive Response)	✓		
Consumer Perception of Participation in Service Planning (Positive Response)	✓		
Consumers Linked to Primary Care			✓
Children Living in a Family-Like Environment	✓		
Adults Living Independently	✓		
Employment	✓		
Positive Change in Problem Severity—Children	✓		
Positive Change in Problem Severity—Adults	✓		

Further details about the activities for the validation of performance measures are contained in Appendix B of this report.

Access Behavioral Care

Findings

Table 3-23 below displays the review results and audit designations for ABC for each performance measure.

Table 3-23—Review Results and Audit Designation *for* ABC

Performance Measures	Rate		Audit Designation	
	FY 05–06	Prior Year	FY 05–06	Prior Year
Penetration Rate—Children	6.8%	6.4%	*Fully Compliant*	*Fully Compliant*
Penetration Rate—Adults	17.2%	15.3%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Access	76.4%	63.9%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality/Appropriateness	72.7%	60.8%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	50.4%	62.8%	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	77.9%	75.6%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	61.6%	57.1%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	75.8%	76.3%	*Fully Compliant*	*Fully Compliant*
Children Living in a Family-like Setting (Maintaining/Improving)	99.4%/12.5%	NV/NV	*Substantially Compliant*	*NV*
Adults Living Independently (Maintaining/Improving)	95.4%/17.1%	NV/NV	*Substantially Compliant*	*NV*
Employment (Maintaining/Improving)	90.9%/17.8%	NV/NV	*Substantially Compliant*	*NV*
Positive Change in Problem Severity—Children	0.48	NV	*Substantially Compliant*	*NV*
Positive Change in Problem Severity—Adults	0.16	NV	*Substantially Compliant*	*NV*

Not valid (NV) 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.

Table 3-24 displays the five performance measure results that can be reported as z-scores. Z-scores show whether the BHO's scores are above or below the statewide average, and to what extent. Positive scores show above-average performance. Negative scores show below-average performance. Statistically, z-scores measure the distance from the overall average mean in standard deviations.

Table 3-24—Z-Score Results for Performance Measures: FY 05–06 and Prior Year *for* ABC

Performance Measure	Z-Score	
	FY 05–06	Prior Year
Children Living in a Family-Like Setting	0.47	*NV*
Adults Living Independently	1.60	*NV*
Employment	0.45	*NV*
Positive Change in Problem Severity—Children	-1.18	*NV*
Positive Change in Problem Severity—Adults	-1.77	*NV*

NV 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.

Strengths

ABC's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were all determined to be *Acceptable* this year. In the previous year's finding, data control and performance measure documentation had been *Not Acceptable*. As in the previous year, no concerns were identified with the eligibility data processing system. ABC's staff demonstrated excellent communication and an in-depth knowledge of data reporting processes. ABC also had efficient and highly automated claims/encounter data processing systems to enhance data accuracy, and good oversight of its providers to encourage timely and complete submission of service data.

ABC's validation findings improved this year, as all 13 performance measure rates were determined to be valid. The five measures using CCAR data that were *Not Valid* last year were found to be *Substantially Compliant* this year.

In addition to having valid results for the five performance measures using CCAR data, ABC achieved an increase in six of the eight performance rates between assessment years. ABC had six measures that were above the statewide average for the BHOs. For the five *NV* measures, the z-score results showed that three of five measures were above the average for the BHOs.

Recommendations

The performance measure validation results presented some opportunities for improvement for ABC. Although the five performance measures using CCAR data returned valid rates this year, the measures were all found to be *Substantially Compliant* due to some errors that remained in the data, but did not significantly bias the rate. ABC was the only BHO that did not achieve full compliance on all measures. Additionally, ABC's 411 encounter data audit found several inconsistencies in the fields that were compared to the medical record.

While six performance rates increased between assessment years, one performance measure—Consumer Perception of Outcome—decreased by 12.4 percentage points between assessment years. Additionally, 10 of 16 performance measure rates were below the statewide average for the BHOs.

Based on the results of this year's performance measure validation findings, recommendations for improving ABC's performance include:

- Continuing to oversee and monitor the receipt, completeness, timeliness, and accuracy of encounter data and CCAR data from the CMHCs, placing all providers who do not meet standards on a plan of corrective action and providing additional education about data collection during the medical record review process. ABC should explore the possibility of providing incentives to providers for timely completion/correction of their members' CCAR data.
- Implementing a formalized process for the submission of timely, accurate, and complete encounter data and CCAR data to the Department that includes a monthly tracking report to facilitate monitoring of data submittals.
- Conducting an analysis as to the causal factors leading to low or declining performance measure results, especially for Consumer Perception of Outcome, Consumers Linked to Primary Care, and Positive Change in Problem Severity. As a result of this analysis, ABC should, as appropriate, implement interventions to remove identified barriers and enhance the provision of health care to consumers.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of ABC's validation of performance measure results related to the domains of quality and access. (None of the performance measures were assigned to the domain of timeliness.)

- **Quality**: ABC's performance in the domain of quality indicated some room for improvement. Overall, ABC made improvements in the performance measures assessing quality, with the rates for four of the five measures increasing between assessment years, and the five measures using CCAR data, which were determined valid this year. ABC's rates for the quality-related performance measures, Consumer Perception of Access and Consumer Perception of Quality/Appropriateness, increased by 12.5 and 11.9 percentage points, respectively, from the prior year. Another quality-related measure that showed improvement was Adults Living Independently, which went from a *Not Valid* to a z-score of 1.60, indicating above-average performance relative to the mean. However, opportunities for improvement in the quality domain were identified related to the completeness and accuracy of ABC's encounter and CCAR data files and the actual performance measure rates themselves. The rate for Consumer Perception of Outcome declined 12.4 percentage points between assessment years, decreasing from 62.8 percent to 50.4 percent. The rates for Consumer Perception of Outcome, Consumer Satisfaction, Consumer Perception of Participation, Positive Change in Problem Severity—Children, and Positive Change in Problem Severity—Adults all fell below the statewide average rates. Performance on the Positive Change in Problem Severity—Children and Positive Change in Problem Severity—Adults performance measures demonstrated below-average performance with negative z-score results.

- **Access**: ABC's performance in the domain of access was mixed. ABC made improvements in the performance measures evaluating access, with the rates for three of the four measures increasing between assessment years. The rate of 76.4 percent for Consumer Perception of Access was 5.5 percentage points higher than the statewide average. While there was only a slight decline in the rate for Consumers Linked to Primary Care, from 76.3 percent to 75.8 percent, ABC's rate for this measure was below the statewide average of 82.7 percent. ABC's rate of 6.8 percent for the Penetration Rate—Children performance measure was also lower than the statewide average of 8.4 percent.

Behavioral HealthCare, Inc.

Findings

Table 3-25 below displays the review results and audit designations for BHI for each performance measure.

Table 3-25—Review Results and Audit Designation *for* BHI

Performance Measures	Rate		Audit Designation	
	FY 05–06	Prior Year	FY 05–06	Prior Year
Penetration Rate—Children	6.6%	6.3%	*Fully Compliant*	*Fully Compliant*
Penetration Rate—Adults	12.2%	12.4%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Access	67.0%	75.6%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality/Appropriateness	64.7%	75.1%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	54.9%	62.3%	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	70.6%	76.5%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	58.4%	64.8%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	80.2%	81.3%	*Fully Compliant*	*Fully Compliant*
Children Living in a Family-like Setting (Maintaining/Improving)	98.6%/12.3%	98.4%/3.3%	*Fully Compliant*	*Fully Compliant*
Adults Living Independently (Maintaining/Improving)	95.8%/15.3%	95.5%/28.9%	*Fully Compliant*	*Fully Compliant*
Employment (Maintaining/Improving)	89.6%/20.9%	71.8%/3.7%	*Fully Compliant*	*Fully Compliant*
Positive Change in Problem Severity—Children	0.57	0.65	*Fully Compliant*	*Fully Compliant*
Positive Change in Problem Severity—Adults	0.54	0.67	*Fully Compliant*	*Fully Compliant*

Table 3-26 displays the five performance measure results that can be reported as z-scores. Z-scores show whether the BHO's scores are above or below the statewide average, and to what extent. Positive scores show above-average performance. Negative scores show below-average performance. Statistically, z-scores measure the distance from the overall average mean in standard deviations.

Table 3-26—Z-Score Results for Performance Measures: FY 05–06 and Prior Year *for* BHI

Performance Measure	Z-Score	
	FY 05–06	Prior Year
Children Living in a Family-Like Setting	-0.79	0.32
Adults Living Independently	0.20	1.72
Employment	-0.19	-0.72
Positive Change in Problem Severity—Children	-0.25	0.91
Positive Change in Problem Severity—Adults	0.44	1.36

Strengths

BHI's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were all determined to be *Acceptable* this year. In the previous year's finding, data control had been rated *Not Acceptable*. As in the previous year, no concerns were identified with the eligibility data processing system. BHI had improved on its data integrity by refining its processes and oversight of InNET. Additionally, BHI had acceptable processes in place to monitor the accuracy and timeliness of CCAR and encounter data from its providers to InNET.

As in the previous year, all 13 performance measures were found to be *Fully Compliant*. BHI achieved an increase in 6 of the 16 performance measure rates between assessment years, with 5 rates above the statewide average for the BHOs.

Recommendations

BHI's 411 encounter data audit found a number of inaccuracies in fields compared with the medical record as well as in fields not compared with the medical record. In addition to the accuracy issues, several fields were found to be incomplete.

BHI's performance on the individual performance measures was low and indicated some room for improvement. Ten of the 16 performance measure rates decreased between assessment years and 11 of the measures' rates were below the statewide average. Also, the z-score results showed that four of the five measures decreased between assessment years, indicating a decline in BHI's performance in relationship to the other BHOs.

Based on the results of this year's performance measure validation findings, recommendations for improving BHI's performance include:

- Continuing to oversee and monitor data completeness and accuracy among its providers, placing all providers who do not meet standards on a plan of corrective action and providing additional education about data collection during the medical record review process.
- Reexamining the State's specifications to ensure submitted encounter and claims data fulfill all requirements.
- Conducting an analysis as to the causal factors leading to low or declining performance measure results, especially for rates for Penetration Rate—Children, Penetration Rate—Adults, Consumer Perception of Access, Consumer Perception of Quality/Appropriateness, Consumer Satisfaction, Consumer Perception of Participation, Children Living in a Family-Like Environment (Improving), and Employment (Maintaining). As a result of this analysis, BHI should, as appropriate, implement interventions to remove identified barriers and enhance the provision of health care to consumers.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of BHI's validation of performance measure results related to the domains of quality and access. (None of the performance measures were assigned to the domain of timeliness.)

- **Quality**: BHI's performance in the domain of quality indicated some room for improvement. While BHI improved its data integrity, the majority of BHI's rates for performance measures assessing quality declined between assessment years. Seven of BHI's quality-related performance measure rates were lower than the statewide average rates: Consumer Perception of Quality/Appropriateness, Consumer Perception of Outcomes, Consumer Satisfaction, Consumer Perception of Participation, Children Living in a Family-Like Setting (Improving), Employment (Maintaining), and Positive Change in Problem Severity—Children. Four of these seven rates showed a decline from the previous year's rate by more than 5 percentage points. In addition, the Children Living in a Family-Like Setting measure's z-score was -0.79, meaning there was below-average performance for this measure. The z-score for Adults Living Independently, while still a positive score, fell from 1.72 last year to 0.20 for FY 05–06. BHI did perform well for two quality-related measures: its rate of 20.9 percent for Employment (Improving) was 4.4 percentage points higher than the statewide average, and its rate for Positive Change in Problem Severity—Adults was 0.09 percentage points higher than the statewide average.
- **Access**: BHI's performance in the domain of access indicated some room for improvement. As in the quality domain, the majority of BHI's rates for performance measures assessing access declined between measurement years. The most marked decline was for Consumer Perception of Access, which decreased 8.6 percentage points. All four of BHI's access-related performance measure rates (Penetration Rate—Children, Penetration Rate—Adults, Consumer Perception to Access, and Consumers Linked to Primary Care) were below the statewide average.

Colorado Health Partnerships, LLC

Findings

Table 3-27 below displays the review results and audit designations for CHP for each performance measure.

Table 3-27—Review Results and Audit Designation *for* CHP

Performance Measures	Rate		Audit Designation	
	FY 05–06	Prior Year	FY 05–06	Prior Year
Penetration Rate—Children	9.4%	9.6%	*Fully Compliant*	*Fully Compliant*
Penetration Rate—Adults	15.5%	14.5%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Access	73.1%	75.0%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality/Appropriateness	73.8%	72.6%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	60.6%	63.0%	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	79.0%	76.7%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	63.6%	65.0%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	83.8%	87.5%	*Fully Compliant*	*Fully Compliant*
Children Living in a Family-like Setting (Maintaining/Improving)	97.2%/22.6%	97.0%/6.2%	*Fully Compliant*	*Substantially Compliant*
Adults Living Independently (Maintaining/Improving)	97.6%/12.6%	97.7%/11.5%	*Fully Compliant*	*Substantially Compliant*
Employment (Maintaining/Improving)	92.9%/12.7%	82.9%/2.0%	*Fully Compliant*	*Substantially Compliant*
Positive Change in Problem Severity—Children	0.60	0.39	*Fully Compliant*	*Substantially Compliant*
Positive Change in Problem Severity—Adults	0.52	0.35	*Fully Compliant*	*Substantially Compliant*

Table 3-28 displays the five performance measure results that can be reported as z-scores. Z-scores show whether the BHO's scores are above or below the statewide average and to what extent. Positive scores show above-average performance. Negative scores show below-average performance. Statistically, z-scores measure the distance from the overall average mean in standard deviations.

Table 3-28—Z-Score Results for Performance Measures: FY 05–06 and Prior Year *for* CHP

Performance Measure	Z-Score	
	FY 05–06	Prior Year
Children Living in a Family-Like Setting	-1.33	1.30
Adults Living Independently	-0.26	-0.94
Employment	1.00	0.67
Positive Change in Problem Severity—Children	0.17	-1.59
Positive Change in Problem Severity—Adults	0.50	-1.58

Strengths

CHP's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were all determined to be *Acceptable* again this year. Also, as in the previous year, no concerns were identified with the eligibility data processing system. CHP was recognized for its dedication to the timely reporting of complete and accurate data at all levels of the organization. CHP's Encounter Design Project was considered a best practice for ensuring that all of the CMHCs were submitting data in a standardized fashion. Additionally, CHP's Finance and Audit Committee ensured coordination between the clinical, information technology, and finance departments of the BHO and CMHCs.

This year, all CHP's performance measures were scored as *Fully Compliant*, improving on the five *Substantially Compliant* scores from last year for the measures using CCAR data. CHP also achieved an increase on 10 of 16 performance rates between assessment years. Twelve performance measure rates were at or above the statewide average for the BHOs. Three of the five measures using CCAR data were above a zero z-score, meaning that these three scores were above the average for the BHOs.

Recommendations

CHP's 411 encounter data audit found six of CHP's nine provider networks had 100 percent data accuracy, with the other entities having accuracy rates of 77 percent, 89 percent, and 93 percent. However, due to the inconsistency in measurement criteria used by the contracted audit firms, these percentages were not comparable.

While 6 out of 16 performance measure rates decreased between assessment years, none of the declines were substantial.

Based on the results of this year's performance measure validation findings, recommendations for improving CHP's performance include:

- Continuing to oversee and monitor the receipt, completeness, timeliness, and accuracy of encounter data and CCAR data from its mental health centers, placing all providers who do not meet standards on a plan of corrective action and providing additional education about data collection during the medical record review process.
- Reexamining the State's specifications to ensure submitted encounter and claims data fulfill all requirements.
- Evaluating the feasibility of using one audit firm to ensure consistency across the reviews.
- Conducting an analysis as to the causal factors leading to low or apparently declining performance measure results or trends, especially for Children Living in a Family-Like Setting, Adults Living Independently, and Employment. As a result of this analysis, CHP should, as appropriate, implement interventions to remove any identified barriers and enhance the provision of health care to consumers.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of CHP's validation of performance measure results related to the domains of quality and access. (None of the performance measures were assigned to the domain of timeliness.)

- **Quality**: CHP's performance in the domain of quality was generally strong. CHP made improvements to the completeness and accuracy of its CCAR data, resulting in *Fully Compliant* scores for the five performance measures using CCAR data. Additionally, CHP made improvements in 9 of 13 quality-related performance measure rates. There were large relative improvements from the previous year to the current year for Positive Change in Problem Severity—Children, with a z-score that increased from -1.59 to 0.17, and Positive Change in Problem Severity—Adults, with a z-score that increased from -1.58 to 0.50. CHP's quality-related rates for Consumer Perception of Quality/Appropriateness, Consumer Perception of Outcome, Consumer Satisfaction, Consumer Perception of Participation, Children Living in a Family-like Setting (Improving), Adults Living Independently (Maintaining), Employment (Maintaining), and Positive Change in Problem Severity—Adults were all higher than the statewide average. Lastly, the decrease in CHP's rate for Children Living in a Family-Like Setting showed below-average performance, with z-scores decreasing from 1.30 the prior year to -1.33 in FY 05–06.
- **Access**: CHP's performance in the domain of access was mixed. Three of the four rates for access-related performance measures decreased between assessment years: Penetration Rate—Children, Consumer Perception of Access, and Consumers Linked to Primary Care. However, all four rates were at or above the statewide average for the BHOs.

Foothills Behavioral Health, LLC

Findings

Table 3-29 below displays the review results and audit designations for FBH for each performance measure.

Table 3-29—Review Results and Audit Designation *for* FBH

Performance Measures	Rate		Audit Designation	
	FY 05–06	Prior Year	FY 05–06	Prior Year
Penetration Rate—Children	9.8%	8.9%	*Fully Compliant*	*Fully Compliant*
Penetration Rate—Adults	17.5%	15.7%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Access	63.5%	65.4%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality/Appropriateness	68.3%	62.2%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	62.1%	61.7%	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	80.8%	79.2%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	67.3%	57.0%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	86.5%	83.7%	*Fully Compliant*	*Fully Compliant*
Children Living in a Family-like Setting (Maintaining/Improving)	96.3%/48.1%	93.0%/7.2%	*Fully Compliant*	*Fully Compliant*
Adults Living Independently (Maintaining/Improving)	92.9%/17.7%	95.5%/20.4%	*Fully Compliant*	*Fully Compliant*
Employment (Maintaining/Improving)	90.8%/18.0%	77.5%/4.3%	*Fully Compliant*	*Fully Compliant*
Positive Change in Problem Severity—Children	0.87	0.73	*Fully Compliant*	*Fully Compliant*
Positive Change in Problem Severity—Adults	0.47	0.61	*Fully Compliant*	*Fully Compliant*

Table 3-30 displays the five performance measure results that can be reported as z-scores. Z-scores show whether the BHO's scores are above or below the statewide average and to what extent. Positive scores show above-average performance. Negative scores show below-average performance. Statistically, z-scores measure the distance from the overall average mean in standard deviations.

Table 3-30—Z-Score Results for Performance Measures: FY 05–06 and Prior Year *for* FBH

Performance Measure	Z-Score	
	FY 05–06	Prior Year
Children Living in a Family-Like Setting	0.74	-0.58
Adults Living Independently	-1.06	0.22
Employment	0.37	0.21
Positive Change in Problem Severity—Children	1.56	1.08
Positive Change in Problem Severity—Adults	0.22	0.73

Strengths

FBH's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were all determined to be *Acceptable* this year. In the previous year's finding, data control had been *Not Acceptable*. As in the previous year, no concerns were identified with the eligibility data processing system. FBH had improved its encounter data oversight and internal validation activities from the previous year through the allocation of additional resources and staff to support this function. In addition, FBH emphasized data integrity in its business practice through numerous quality improvement and analysis activities.

As in the previous year, all 13 performance measures were found to be *Fully Compliant*. FBH achieved an increase in 12 of the 16 performance rates between assessment years, with the majority of its rates being above the statewide average for the BHOs.

Recommendations

FBH's 411 encounter data audit found that fields requiring comparisons with the medical record were less than 100 percent accurate, although other fields not requiring comparisons with the medical record were accurate. Additionally, while encounter and claims data were found to be complete, it was not clear from the documentation provided whether the data submitted to the Department were the most current version of adjusted claims.

Four of the 16 performance measure rates for FBH decreased between assessment years, with 2 of these rates falling below the statewide average for the BHOs.

Based on the results of this year's performance measure validation findings, recommendations for improving FBH's performance include:

- Continuing to ensure that gaps in processing and validating encounter data do not compromise data completeness by cross-training staff and establishing documented policies and procedures.
- Giving consideration to the implementation of more formal oversight of CCAR submissions by the CMHCs.
- Implementing the corrective action steps proposed by FBH as a result of the findings from the 411 sample audit.
- Reexamining the State's specifications to ensure submitted encounter and claims data fulfill all requirements.
- Conducting an analysis as to the causal factors leading to low or apparently declining performance measure results or trends, especially for Consumer Perception of Access, Children Living in a Family-Like Setting (Maintaining), and Adults Living Independently. As a result of this analysis, FBH should, as appropriate, implement interventions to remove any identified barriers and enhance the provision of health care to consumers.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of FBH's validation of performance measure results related to the domains of quality and access. (None of the performance measures were assigned to the domain of timeliness.)

- **Quality:** FBH's performance in the domain of quality was strong. FBH had improved its encounter data oversight and validation activities from the previous year. Additionally, FBH made improvements in 9 of 13 performance measure rates related to quality. While the z-scores for two measures decreased (i.e., Adults Living Independently and Positive Change in Problem Severity—Adults), the z-scores for three measures improved. Particularly noteworthy were the improvements in the rates for Children Living in a Family-Like Setting, which had z-scores that increased from -0.58 to 0.74, and for Consumer Perception of Participation, which increased about 10 percentage points between assessment years. FBH's quality-related rates for Consumer Perception of Outcome, Consumer Satisfaction, Consumer Perception of Participation, Children Living in a Family-Like Setting (Improving), Adults Living Independently (Improving), Positive Change in Problem Severity—Children, and Positive Change in Problem Severity—Adults were all higher than the statewide average. The z-score for Positive Change in Problem Severity—Children was 1.56, indicating above-average performance.
- **Access:** FBH's performance in the domain of access was good. Three of the four rates for access-related performance increased between assessment years, with only a slight decrease in the rate for Consumer Perception of Access. FBH's rates for Penetration Rate—Children (9.8 percent) and Penetration Rate—Adults (17.5 percent), were 1.4 and 2.0 percentage points higher than the statewide average, respectively. The rate for Consumer Perception of Access was 7.4 percentage points lower than the statewide average.

Northeast Behavioral Health, LLC

Findings

Table 3-31 below displays the review results and audit designations for NBH for each performance measure.

Table 3-31—Review Results and Audit Designation *for* NBH

Performance Measures	Rate		Audit Designation	
	FY 05–06	Prior Year	FY 05–06	Prior Year
Penetration Rate—Children	9.4%	8.6%	*Fully Compliant*	*Fully Compliant*
Penetration Rate—Adults	15.1%	13.6%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Access	74.5%	77.5%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality/Appropriateness	73.7%	75.4%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	59.1%	71.0%	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	85.2%	82.3%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	66.4%	71.2%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	87.2%	85.4%	*Fully Compliant*	*Fully Compliant*
Children Living in a Family-like Setting (Maintaining/Improving)	99.5%/15.3%	99.0%/0.44%	*Fully Compliant*	*Substantially Compliant*
Adults Living Independently (Maintaining/Improving)	96.7%/13.5%	96.0%/16.6%	*Fully Compliant*	*Substantially Compliant*
Employment (Maintaining/Improving)	91.9%/13.2%	85.8%/3.0%	*Fully Compliant*	*Substantially Compliant*
Positive Change in Problem Severity—Children	0.52	0.54	*Fully Compliant*	*Substantially Compliant*
Positive Change in Problem Severity—Adults	0.55	0.47	*Fully Compliant*	*Substantially Compliant*

Table 3-32 displays the five performance measure results that can be reported as z-scores. Z-scores show whether the BHO's scores are above or below the statewide average, and to what extent. Positive scores show above-average performance. Negative scores show below-average performance. Statistically, z-scores measure the distance from the overall average mean in standard deviations.

Table 3-32—Z-Score Results for Performance Measures: FY 05–06 and Prior Year *for* NBH

Performance Measure	Z-Score	
	FY 05–06	Prior Year
Children Living in a Family-Like Setting	0.92	-1.04
Adults Living Independently	-0.48	-0.36
Employment	-1.62	1.25
Positive Change in Problem Severity—Children	-0.29	-0.19
Positive Change in Problem Severity—Adults	0.61	-0.32

Strengths

NBH's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were all determined to be *Acceptable* this year. In the previous year's finding, data control had been *Not Acceptable*. As in the previous year, no concerns were identified with the eligibility data processing system. NBH was recognized for its commitment to performance measure reporting through strong oversight activities related to data capture and reporting. NBH had implemented multiple committees (e.g., the Financial Information Technology Committee) and ad hoc task forces that focused on quality improvement initiatives.

This year, all of NBH's performance measures were scored as *Fully Compliant*, improving on the five *Substantially Compliant* scores from the prior year for the measures using CCAR data. NBH also achieved an increase in 10 of the 16 performance measure rates between assessment years. Eleven performance measures were above the statewide average for the BHOs. Two of the five measures were above a zero z-score, meaning that these two scores were above the average for the BHOs.

Recommendations

NBH's 411 encounter data audit found that fields requiring comparisons with the medical record were less than 100 percent accurate, although other fields not requiring comparisons with the medical record were accurate. Additionally, while encounter and claims data were found to be complete, it was not clear from the documentation provided whether the data submitted to the Department contained the most current version of adjusted claims.

Six of the 16 performance measure rates for NBH decreased between assessment years, with 2 of these measures falling below the statewide average for the BHOs. One of these rates—Consumer Perception of Outcome—decreased by 11.9 percentage points. Also, the z-scores for three measures decreased.

Based on the results of this year's performance measure validation findings, recommendations for improving NBH's performance include:

- Developing a validation process for manual data entry of external provider networks' CCAR data.
- Giving consideration to cross-training staff, developing formal policies and procedures for submitting and reconciling encounter data with InNET, and educating providers regarding data completeness and accuracy during the medical record review process.
- Implementing the corrective action steps proposed by NBH as a result of the findings from the 411 sample audit.
- Reexamining the State's specifications to ensure submitted encounter and claims data fulfill all requirements.
- Conducting an analysis as to the causal factors leading to low or declining performance measure results, especially for Consumer Perception of Outcome, Employment, and Positive Change in Problem Severity—Children. As a result of this analysis, NBH should, as appropriate, implement interventions to remove identified barriers and enhance the provision of health care to consumers.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of NBH's validation of performance measure results related to the domains of quality and access. (None of the performance measures were assigned to the domain of timeliness.)

- **Quality:** NBH's performance in the domain of quality was good. NBH had improved data reporting activities from the previous year, especially in terms of monitoring CCAR data submission. NBH's quality-related performance measure rates for Consumer Satisfaction, Consumer Perception of Participation, Children Living in a Family-Like Setting (Maintaining), Adults Living Independently (Maintaining), Employment (Maintaining), and Positive Change in Problem Severity—Adults were above the statewide average. Particularly noteworthy was the relative improvement in the rate for Children Living in a Family-Like Setting, which moved from a z-score of -1.04 for the prior year to a z-score of 0.92 for FY 05–06. While 11 of the 16 quality-related performance measure rates were above the statewide average, 6 of NBH's rates declined between assessment years. The z-score for Employment declined from 1.25 to -1.62, indicating below-average performance for this measure.
- **Access**: NBH's performance in the domain of access was strong. Three of the four rates for access-related performance measures increased between assessment years, with only a small decrease of 3.0 percentage points in the rate for Consumer Perception of Access. NBH's rate of 87.2 percent for Consumers Linked to Primary Care was 4.5 percentage points above the statewide average.

Overall Statewide Performance Related to Quality, Timeliness, and Access for the Validation of Performance Measures

Table 3-33 presents the statewide number and percentage of BHOs achieving each validation status for each performance measure for FY 05–06 and the prior year.

Table 3-33—Summary of Data from Validation of Performance Measures: Number and Percent of BHOs Achieving Each Validation Status by Measure

Performance Measures	FY 05–06 Fully Compliant	Prior Year Fully Compliant	FY 05–06 Substantially Compliant	Prior Year Substantially Compliant	FY 05–06 Not Valid	Prior Year Not Valid
Penetration Rate—Children	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Penetration Rate—Adults	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumer Perception of Access	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumer Perception of Quality/Appropriateness	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumer Perception of Outcome	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumer Satisfaction	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumer Perception of Participation	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumers Linked to Primary Care	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Children Living in a Family-like Setting	4/80%	2/40%	1/20%	2/40%	0/0%	1/20%
Adults Living Independently	4/80%	2/40%	1/20%	2/40%	0/0%	1/20%
Employment	4/80%	2/40%	1/20%	2/40%	0/0%	1/20%
Positive Change in Problem Severity—Children	4/80%	2/40%	1/20%	2/40%	0/0%	1/20%
Positive Change in Problem Severity—Adults	4/80%	2/40%	1/20%	2/40%	0/0%	1/20%

Table 3-34 provides a summary of the statewide averages for the performance measure rates for FY 05–06 and the prior year.

Table 3-34—Statewide Average Rates for the Performance Measures		
Performance Measures	Rate	
	FY 05–06	Prior Year
Penetration Rate—Children	8.4%	8.0%
Penetration Rate—Adults	15.5%	14.3%
Consumer Perception of Access	70.9%	71.5%
Consumer Perception of Quality/Appropriateness	70.6%	69.2%
Consumer Perception of Outcome	57.4%	64.2%
Consumer Satisfaction	78.7%	78.1%
Consumer Perception of Participation	63.5%	63.0%
Consumers Linked to Primary Care	82.7%	82.8%
Children Living in a Family-like Setting (Maintaining/Improving)	98.2%/22.2%	96.9%/4.3%
Adults Living Independently (Maintaining/Improving)	95.7%/15.2%	96.2%/19.4%
Employment (Maintaining/Improving)	91.2%/16.5%	79.5%/3.3%
Positive Change in Problem Severity—Children	0.61	0.58
Positive Change in Problem Severity—Adults	0.45	0.53

The following is a statewide summary of the conclusions drawn from the performance measure results regarding the BHOs' strengths, opportunities for improvement, and recommendations with respect to quality, timeliness, and access.

Quality

Overall, statewide BHO performance in the domain of quality for performance measures was good. The BHOs' 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. This year, all the BHOs received *Acceptable* scores for data integration, data control processes, and performance measure documentation. Many of the BHOs had improved data integrity and oversight processes this year by using a variety of strategies (e.g., special initiatives, new committees or task forces, additional staffing). All of the BHOs' 411 encounter data audits, however, reported a number of inaccuracies in fields that were compared with the medical record.

Unlike the previous year, all of the performance measures for all BHOs were valid this year, with the majority of BHOs receiving a score of *Fully Compliant* for all their performance measures. Eight of the 13 statewide average rates for the quality-related performance measures increased between assessment years, and 5 decreased. In general, the changes in the measures were not substantial, except for: Employment (for both Maintaining and Improving), which increased 11.7 and 13.2 percentage points respectively; Children Living in a Family-like Setting (Improving), which increased 17.9 percentage points; Consumer Perception of Outcome, which decreased 6.8 percentage points; and Positive Change in Problem Severity—Adults, which decreased from 0.53 to 0.45.

HSAG recommends that, where applicable, the BHOs:

- Continue to actively oversee and monitor the receipt, completeness, timeliness, and accuracy of encounter data and CCAR data from their providers, placing all providers who do not meet standards on a plan of corrective action and providing additional education about data collection during the medical record review process.
- Reexamine the State's specifications to ensure submitted encounter and claims data fulfill all requirements.
- Conduct an analysis as to the causal factors leading to low rates for the quality-related performance measures, especially for Consumer Perceptions of Outcome and Positive Change in Problem Severity—Adults. As a result of this analysis, appropriate interventions should be implemented to remove identified barriers and enhance the provision of quality health care.

Access

Overall, statewide BHO performance in the domain of access for performance measures was good. Two of the four statewide average rates for the access-related performance measures increased between assessment years, and two of the statewide averages decreased. The changes in the measures, however, were generally less than a percentage point.

HSAG recommends that, where applicable, the individual BHOs conduct an analysis as to the causal factors leading to a lack of improvement in the access-related performance measures. As a result of this analysis, appropriate interventions should be implemented to remove identified barriers and enhance the provision of quality health care.

Additional Statewide Recommendations

In addition to the recommendations provided to the BHOs, HSAG also identified statewide areas for improvement. These recommendations are specific to the Department and include the following:

- The Department should reevaluate the data collection and reporting of the Mental Health Statistics Improvement Program (MHSIP) survey to be more in line with the other performance measures. It would be beneficial to shorten the turnaround time for performance measure reporting and comparisons.
- The Department should review the sample size requirements for the MHSIP survey to ensure that the appropriate sample size is being used for future reporting at the CMHC level.
- When developing new performance measures in the future, the Department should work closely with the Division of Mental Health (DMH) to document all aspects of source code specifications and methodology. HSAG recommends cross-training staff to ensure consistency with calculations. This recommendation also applies to any changes in CCAR measures.
- The Department should ensure that for CCAR reporting, e.g., the Clients Requiring Updates report, results should be broken out and shown separately for Medicaid only and for non-Medicaid consumers.

Validation of Performance Improvement Projects

For each BHO, HSAG performed validation activities on two PIPs. HSAG, in collaboration with the Department, developed the PIP Summary Form, which each BHO completed and submitted to HSAG for review and evaluation. The data needed to conduct the PIP validation were obtained from the BHO's PIP Summary Form. This form provided detailed information about each BHO's PIP as it related to the 10 CMS protocol activities being reviewed and evaluated. The evaluation elements within each activity were scored by the HSAG PIP review team as *Met*, *Partially Met*, *Not Met*, or *Not Applicable (N/A)*. To ensure a valid and reliable review, some of the elements were designated as critical elements by HSAG. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results.

In addition to the validation status, each PIP was given a percentage score for critical elements *Met* and an overall percentage score for all evaluation elements (including critical elements). HSAG assessed the implications of the study's findings on the likely validity and reliability of the results, as follows:

- *Met*: Confidence/high confidence in reported PIP results.
- *Partially Met*: Low confidence in reported PIP results.
- *Not Met*: Reported PIP results not credible.

The BHOs had an opportunity to resubmit additional documentation after the first HSAG review to improve their scores prior to the finalization of the FY 06–07 PIP Validation Report. This process was not available to the BHOs in FY 05–06.

Although a BHO's purpose for conducting a PIP may have been to improve performance in an area related to quality and/or timeliness and/or access to care and services, the purpose of EQR activities related to PIPs is to evaluate the validity and quality of the BHO's processes in conducting PIPs. Therefore, to draw conclusions and make overall assessments about each BHO's performance in conducting valid PIPs, HSAG assigned all PIPs to the quality domain.

Further details about the EQR validation of PIP activities are contained in Appendix C of this report.

Access Behavioral Care

Findings

ABC conducted two PIPs (i.e., *Improving Follow-up After an Inpatient Stay* and *Improving Outcomes for High-Risk Youth Through AFFIRM Care Management*). Both PIPS were continued from the prior year.

For the first PIP, HSAG reviewed Activities I through X. Table 3-35 and Table 3-36 show ABC's scores based on HSAG's evaluation of *Improving Follow-up After an Inpatient Stay*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-35—PIP Validation Scores *for* Improving Follow-up After an Inpatient Stay *for* ABC

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	2	1	0	0	1
VII. Appropriate Improvement Strategies	4	4	0	0	0	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1	1	0	0	0	1
IX. Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	1	0	0	0	No Critical Elements				
Totals for All Activities	**53**	**40**	**0**	**0**	**13**	**11**	**8**	**0**	**0**	**3**

Table 3-36—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Improving Follow-up After an Inpatient Stay *for* ABC

	FY 06–07	Prior Year FY 05–06
Percentage Score of Evaluation Elements *Met**	**100%**	**100%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

For the second PIP, HSAG reviewed Activities I through X. Table 3-37 and Table 3-38 show ABC's scores based on HSAG's evaluation of *Improving Outcomes for High-Risk Youth Through AFFIRM Care Management*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-37—PIP Validation Scores
***for* Improving Outcomes for High-Risk Youth Through AFFIRM Care Management**
***for* ABC**

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	11	0	0	0	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	3	0	0	1	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX. Real Improvement Achieved	4	3	1	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	0	1	0	0	No Critical Elements				
Totals for All Activities	**53**	**42**	**2**	**0**	**9**	**11**	**9**	**0**	**0**	**2**

Table 3-38—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Improving Outcomes for High-Risk Youth Through AFFIRM Care Management *for* ABC		
	FY 06–07	Prior Year (FY 05–06)
Percentage Score of Evaluation Elements *Met**	**95%**	**100%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

Strengths

ABC received a *Met* validation status for both PIPs, with 100 percent scores for all applicable critical elements having received a *Met.* ABC's overall scores were 100 percent for *Improving Follow-Up After an Inpatient Stay*, with all applicable elements *Met*, and 95 percent for *Improving Outcomes for High-Risk Youth*, with 42 of 44 applicable elements *Met*. ABC continued to maintain its strong performance from the previous year, even though additional activities and elements were evaluated this year.

For both studies, ABC presented a well-defined study topic and study population and had answerable study questions that stated the problem in simple terms and set the focus of the study. The study indicators were also well-designed to address CMS' requirements to evaluate the quality of and access to care and services. The data collection techniques and processes used for the studies were found to be appropriate and well-implemented, with data elements defined accurately and completely. The subsequent data analyses were conducted according to the study plans, and the study results were presented in a clear and easily understood format, accompanied by detailed interpretation of the data for each measurement period.

For *Improving Follow-Up After an Inpatient Stay*, ABC met all the evaluation elements for Activity IX, Real Improvement Achieved, and Activity X, Sustained Improvement Achieved. ABC's intervention strategy for this PIP, which had been in place for more than three years, led to documented, sustained, and statistically significant improvements in rates of follow-up within seven days and follow-up within 30 days after a psychiatric inpatient discharge.

Recommendations

While ABC's overall score of 95 percent for *Improving Outcomes for High-Risk Youth Through AFFIRM Care Management* declined from the previous year's score of 100 percent, this was attributed to new activities and elements that were reviewed and evaluated this year. Activity IX, Real Improvement Achieved, and Activity X, Sustained Improvement Achieved, each had an evaluation element that was scored as *Partially Met.* The PIP study results did not show any statistically significant improvement in one of two study indicators or any sustained improvement

over time. As a result of deficiencies in the design of the AFFIRM intervention and outcomes measured, it was determined by ABC that it was no longer possible to continue the program as originally designed and, therefore, the PIP will be discontinued.

Based on the results of this year's PIP validation findings, recommendations for improving ABC's performance include:

- Selecting two new study topics for FY 07–08 that target improvement in high-priority areas of clinical care and reflect ABC's Medicaid enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences of disease.
- Continuing to periodically monitor the study indicators from *Improving Follow-Up After an Inpatient Stay* to ensure that the improvement ABC achieved is sustained.

Summary Assessment Related to Quality, Timeliness, and Access

As discussed previously, HSAG assigned all PIPs to the quality domain. Therefore, the following summary assessment of ABC's PIP validation results relate to the domain of quality.

Overall, ABC's performance with regard to its PIPs and the quality domain was strong. The goal of both studies was to impact the quality of care provided to ABC consumers. Both PIPs were given a validation status of *Met*, with overall scores of 100 percent and 95 percent. For this validation cycle, ABC successfully addressed all of the PIP validation activities for critical elements. ABC received scores of *Partially Met* for only two noncritical elements related to lack of sustained and statistically significant improvement for one of its studies.

A comparison of the PIP validation cycles (Years 1 through 3) for each of ABC's PIPs yielded the following:

- *Improving Follow-Up After an Inpatient Stay*: For Year 1, ABC achieved improvement in 7- and 30-day follow-up rates after an inpatient discharge. For the Year 2 validation cycle, ABC used more recent baseline and remeasurement years, but determined that a potential error in the query to identify hospital discharges had occurred. The results of the error may have resulted in underreporting of discharges and follow-up for this study. ABC was required to submit an updated PIP, including reconciled data results, analysis, and interpretations for the three years outlined in the study. For Year 3, ABC recalculated follow-up rates for calendar year (CY) 03, CY 04, and CY 05 to allow for comparison of rates from baseline to the third remeasurement. ABC achieved sustained and statistically significant improvement in the rates of follow-up within 7 and 30 days after a psychiatric inpatient discharge.
- *Improving Outcomes for High-Risk Youth Through AFFIRM Care Management*: For the Year 1 validation cycle, ABC had only completed intervention implementation at the time of the PIP submission. For Year 2, ABC determined that although there was statistically significant improvement in readmission rates from baseline to the second remeasurement, the difference was clinically negligible. For Year 2, ABC had completed two measurements of Study Indicator 2. There was improvement in Study Indicator 2; however, the improvement was not statistically significant. Because there was such a small number of consumers enrolled in the AFFIRM program for FY 06–07, ABC determined that it would develop a new PIP that was better aligned with the needs of its consumers.

Behavioral HealthCare, Inc.

Findings

BHI conducted two PIPs (i.e., *Screening for Bipolar Disorder* and *Access to Initial Medication Evaluation*). Both PIPS were continued from the prior year.

For the first PIP, HSAG reviewed Activities I through IX. Table 3-39 and Table 3-40 show BHI's scores based on HSAG's evaluation of *Screening for Bipolar Disorder*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-39—PIP Validation Scores *for* Screening for Bipolar Disorder *for* BHI

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0	1	1	0	0	0
VI. Accurate/Complete Data Collection	11	9	2	0	0	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	2	0	0	2	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	9	0	0	0	2	2	0	0	0
IX. Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**47**	**2**	**0**	**3**	**11**	**11**	**0**	**0**	**0**

Table 3-40—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Screening for Bipolar Disorder *for* BHI		
	FY 06–07	Prior Year (FY 05–06)
Percentage Score of Evaluation Elements *Met**	**96%**	**69%**
Percentage Score of Critical Elements *Met* **	**100%**	**67%**
Validation Status***	***Met***	***Not Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

For the second PIP, HSAG reviewed Activities I through IX. Table 3-41 and Table 3-42 show BHI's scores based on HSAG's evaluation of *Access to Initial Medication Evaluation*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-41—PIP Validation Scores *for* Access to Initial Medication Evaluation *for* BHI

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	9	1	0	1	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	4	0	0	0	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX. Real Improvement Achieved	4	1	2	1	0	No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**38**	**3**	**1**	**10**	**11**	**9**	**0**	**0**	**2**

Table 3-42—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Access to Initial Medication Evaluation *for* BHI		
	FY 06–07	Prior Year (FY 05–06)
Percentage Score of Evaluation Elements *Met**	**90%**	**58%**
Percentage Score of Critical Elements *Met***	**100%**	**64%**
Validation Status***	***Met***	***Not Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

Strengths

BHI received a *Met* validation status for both PIPs, with 100 percent scores for all critical elements having received a *Met.* BHI's overall scores were 96 percent for *Screening for Bipolar Disorder*, with 47 out of 49 applicable elements being *Met*, and 90 percent for *Access to Initial Medication Evaluation*, with 38 out of 42 applicable elements being *Met*. For both studies, Activity X, Sustained Improvement Achieved, was not assessed. BHI made substantial improvements since last year, when both PIPs were given a *Not Met* validation status, receiving overall scores of 69 percent and 58 percent, and scores of 64 percent and 67 percent for critical elements *Met*.

For both studies, BHI presented a well-defined study topic that had the potential to affect consumer health, a complete and accurate study population, and answerable study questions that stated the problem in simple terms and set the focus of the study. Also, the study indicators were well-designed, with data available for each indicator. Both the data elements to be collected and the data sources to be used were clearly identified. BHI used the findings from its causal/barrier analyses to develop planned interventions for each PIP. The subsequent data analyses were conducted according to the study plans, and the study results were presented in a clear and easily understood format, accompanied by a detailed interpretation of the findings.

For *Screening for Bipolar Disorder*, BHI met all the evaluation elements for Activity IX, Real Improvement Achieved. BHI's intervention strategy had led to documented and statistically significant improvements in the use of screening tools for children, adolescents, and adults.

Recommendations

Both of BHI's studies had *Partially Met* elements for Activity VI, Accurate/Complete Data Collection. *Screening for Bipolar Disorder* had two *Partially Met* elements related to its data collection description and *Access to Initial Medication Evaluation* had one *Partially Met* element related to the completeness of its administrative data. In addition, the latter PIP also had two *Partially Met* elements and one *Not Met* element for Activity IX, Real Improvement Achieved.

Based on the results of this year's PIP validation findings, recommendations for improving BHI's performance were:

- For *Screening for Bipolar Disorder*, include in the PIP Summary Form a description of the training and qualifications of all manual data collection staff and written instructions for completing the manual data collection tool.
- For *Access to Initial Medication Evaluation*, improve the completeness of administrative data collected, completing additional data and causal/barrier analysis to determine if the interventions are addressing the root causes and revising the interventions, if appropriate.

Summary Assessment Related to Quality, Timeliness, and Access

As discussed previously, HSAG assigned all PIPs to the quality domain. Therefore, the summary assessment of BHI's PIP validation results relate to the domain of quality.

Overall, BHI's performance regarding its PIPs and the quality domain was good. The goal of both studies was to impact access to and the timeliness and quality of health care provided to BHI consumers. Both PIPs were given a validation status of *Met*, with overall scores of 96 percent and 90 percent. For this validation cycle, BHI successfully addressed all of the PIP validation activities for critical elements. For one study, BHI received scores of *Partially Met* for two noncritical elements in Activity VI, Accurate/Complete Data Collection. For the other study, BHI received scores of *Partially Met* for three noncritical elements and a *Not Met* score for one noncritical element in Activity IX, Real Improvement Achieved.

A comparison of the PIP validation cycles (Years 1 through 3) for each of BHI's PIPs yielded the following:

- *Screening for Bipolar Disorder*: For the Year 1 validation cycle, only baseline data analysis was completed at the time of the submission. For Year 2, the study had completed a baseline and first remeasurement at the time of the submission. BHI showed statistically significant improvement in the rates of adults, children, and adolescents screened for bipolar disorder between Year 1 to Year 2.
- *Access to Initial Medication Evaluation*: For Year 1, BHI's four study indicators were at different stages of evaluations. The indicator for access to medication evaluations only had baseline data. The MHSIP survey question (accessibility of psychiatrist) and the MHCA survey question (appointment availability for psychiatrist) showed no statistical differences in scores between measurement periods. And the clinician satisfaction indicator showed a statistically significant decrease in satisfaction by clinicians. For Year 2, there were no significant improvements in the rates for three of the study indicators. A new tool and new baseline were established for the fourth indicator, clinician satisfaction with appointment scheduling for intakes. For Year 3, BHI had only two study indicators (access and clinician satisfaction). BHI observed improvement in access to initial medication evaluations within 30 days; however, BHI clinicians overall reported less satisfaction with appointment scheduling for initial medication evaluations than the previous year.

Colorado Health Partnerships, LLC

Findings

CHP conducted two PIPs (i.e., *Ambulatory Follow-up within Seven Days of Hospital Discharge for Youth and Adults* and *The Identification and Use of Alternative and/or Crisis Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents*). Both PIPS were continued from the prior year.

For the first PIP, HSAG reviewed Activities I through X. Table 3-43 and Table 3-44 show CHP's scores based on HSAG's evaluation of CHP's PIP *Ambulatory Follow-up within Seven Days of Hospital Discharge for Youth and Adults*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-43—PIP Validation Scores
***for* Ambulatory Follow-up within Seven Days of Hospital Discharge for Youth and Adults**
***for* CHP**

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	4	0	0	0	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX. Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	1	0	0	0	No Critical Elements				
Totals for All Activities	**53**	**39**	**0**	**0**	**14**	**11**	**8**	**0**	**0**	**3**

Table 3-44—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Ambulatory Follow-up within Seven Days of Hospital Discharge for Youth and Adults *for* CHP

	FY 06–07	Prior Year (FY 05–06)
Percentage Score of Evaluation Elements *Met**	**100%**	**89%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

For the second PIP, HSAG reviewed Activities I through X. Table 3-45 and Table 3-46 show CHP's scores based on HSAG's evaluation of *The Identification and Use of Alternative and/or Crisis Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-45—PIP Validation Scores *for* The Identification and Use of Alternative and/or Crisis Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents *for* CHP

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	3	0	0	1	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX. Real Improvement Achieved	4	1	0	3	0	No Critical Elements				
X. Sustained Improvement Achieved	1	0	0	1	0	No Critical Elements				
Totals for All Activities	**53**	**34**	**0**	**4**	**15**	**11**	**8**	**0**	**0**	**3**

Table 3-46—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* The Identification and Use of Alternative and/or Crisis Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents *for* CHP

	FY 06–07	Prior Year FY 05–06
Percentage Score of Evaluation Elements *Met**	**89%**	**89%**
Percentage Score of Critical Elements *Met***	**100%**	**90%**
Validation Status***	***Met***	***Partially Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

Strengths

CHP received a *Met* validation status for both PIPs, with 100 percent scores for all critical elements having received a *Met.* CHP's overall scores were 100 percent for *Ambulatory Follow-up within Seven Days of Hospital Discharge*, with all applicable elements being *Met*, and 89 percent for the *Identification and Use of Alternative and/or Crisis Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents*, with 34 out of 38 applicable elements being *Met*. CHP made substantial improvements since last year's PIP validation findings. For *Ambulatory Follow-up within Seven Days of Hospital Discharge*, the overall score for all evaluation elements was 89 percent in FY 05–06. For *Identification and Use of Alternative and/or Crisis Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents*, BHI received a validation status of *Partially Met*, with a score for critical elements of 90 percent and an overall score for all evaluation elements of 89 percent in FY 05–06. Although the overall score stayed the same for this PIP (i.e., 89 percent), CHP received scores of *Met* for all the elements needing improvement based on the previous year's validation findings. Also, there were areas for improvement identified this year in activities that had previously not been evaluated.

For both studies, CHP presented a well-defined study topic, a complete and accurate study population, and answerable study questions that stated the problem in simple terms and set the focus of the study. The study indicators were well-designed and developed to answer the study questions. The data collection techniques and processes used for the studies were found to be appropriate and resulted in a high degree of administrative data completeness. CHP used its causal/barrier analyses to identify planned interventions for each PIP. The subsequent data analyses were conducted according to the study plans, and the study results were presented in a clear and easily understood format, accompanied by a detailed interpretation of the findings.

For *Ambulatory Follow-up within Seven Days of Hospital Discharge*, CHP met all the evaluation elements for Activity IX, Real Improvement Achieved, and Activity X, Sustained Improvement Achieved. The ambulatory follow-up rate showed improvement from CY 03 through CY 06, with statistically significant improvements between CY 04 and CY 05 and sustained gains in CY 05 through CY 06.

Recommendations

CHP's PIP, *Identification and Use of Alternative and/or Crisis Services Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents,* had three *Not Met* elements for Activity IX, Real Improvement Achieved, and one *Not Met* element for Activity X, Sustained Improvement Achieved. Although CHP completed statistical testing for this study, the control charts and chi-square testing showed no improvements in rates for youth admissions or bed days. CHP had identified factors that may be impacting the remeasurements and had outlined follow-up activities to improve the PIP results.

Based on the results of this year's PIP validation findings, recommendations for improving CHP's performance include:

- Selecting a new study topic for FY 07–08 that targets improvement in high-priority areas of clinical care and reflects CHP's Medicaid enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences of disease.
- Continuing to periodically monitor the study indicators from *Ambulatory Follow-up within Seven Days of Hospital Discharge* to ensure that the improvement CHP has achieved is sustained.
- For *Identification and Use of Alternative and/or Crisis Services Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents,* completing all planned follow-up activities, including: 1) additional data and causal/barrier analysis to identify whether the interventions are addressing the root causes and revising the interventions, if appropriate, and 2) an evaluation as to whether the focus of the PIP should be changed.

Summary Assessment Related to Quality, Timeliness, and Access

As discussed previously, HSAG assigned all PIPs to the quality domain. Therefore, the following summary of CHP's PIP validation results relate to the domain of quality.

Overall, CHP's performance regarding its PIPs and the quality domain was good. The goal of both studies was to impact the quality of health care provided to CHP consumers, the timeliness of care for one PIP, and access to care for the other PIP. Both of its PIPs were given a validation status of *Met*, with overall scores of 100 percent and 89 percent. For this validation cycle, CHP successfully addressed all of the PIP validation activities for critical elements. CHP received scores of *Not Met* for only four noncritical elements related to lack of sustained and statistically significant improvement for one of its studies.

A comparison of the PIP validation cycles (Years 1 through 3) for each of CHP's PIPs yielded the following:

- *Ambulatory Follow-Up Within Seven Days of Hospital Discharge for Youth and Adults*: For Year 1, the rate for follow-up within seven days of hospital discharge decreased from 43.7 percent to 41.9 percent for the first remeasurement and increased to 42.8 percent for the second remeasurement. The benchmark was set at 51 percent. For Year 2, CHP changed its data collection and analysis methodology, which resulted in a new rate of 51.5 percent for the second remeasurement and a new benchmark of 56.6 percent. The rate increased from 51.5 percent to

57.5 percent for the third remeasurement period, but the improvement was not statistically significant. From the third to the fourth remeasurement period, there was a statistically significant improvement in the rate, which increased to 68.1 percent. For Year 3, the fifth remeasurement period, CHP's ambulatory follow-up rate was 70 percent. While the 1.9 percentage-point increase was not statistically significant, the statistically significant improvement achieved from the third to the fourth remeasurement was sustained to the fifth remeasurement for this PIP study.

- *Identification and Use of Alternative/Crisis Service to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents*: For Year 1, the study had only completed intervention implementation and the early phases of data analysis. For Year 2, from the first to the second remeasurement there were statistically significant increases in the youth admission rates per 1,000 consumers and in the bed day rates per 1,000 admissions.

Foothills Behavioral Health, LLC

Findings

FBH conducted two PIPs (i.e., *Improving Use and Documentation of Clinical Guidelines* and *Supporting Recovery*). Both PIPS were continued from the prior year.

For the first PIP, HSAG reviewed Activities I through IX. Table 3-47 and Table 3-48 show FBH's scores based on HSAG's evaluation of *Improving Use and Documentation of Clinical Guidelines*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-47—PIP Validation Scores
***for* Improving Use and Documentation of Clinical Guidelines**
***for* FBH**

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0	1	1	0	0	0
VI. Accurate/Complete Data Collection	11	9	0	0	2	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	3	0	0	1	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	9	0	0	0	2	2	0	0	0
IX. Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**48**	**0**	**0**	**4**	**11**	**11**	**0**	**0**	**0**

Table 3-48—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Improving Use and Documentation of Clinical Guidelines *for* FBH		
	FY 06–07	Prior Year (FY 05–06)
Percentage Score of Evaluation Elements *Met**	**100%**	**94%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.
** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

For the second PIP, HSAG reviewed Activities I through VIII. Table 3-49 and Table 3-50 show FBH's scores based on HSAG's evaluation of *Supporting Recovery*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-49—PIP Validation Scores *for* Supporting Recovery *for* FBH

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0	1	1	0	0	0
VI. Accurate/Complete Data Collection	11	6	0	0	5	1	0	0	0	1
VII. Appropriate Improvement Strategies	4	2	0	0	2	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	5	0	0	4	2	2	0	0	0
IX. Real Improvement Achieved	4	Not Assessed				No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**36**	**0**	**0**	**12**	**11**	**10**	**0**	**0**	**1**

Table 3-50—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Supporting Recovery *for* FBH		
	FY 06–07	Prior Year (FY 05–06)
Percentage Score of Evaluation Elements *Met**	**100%**	**93%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

Strengths

FBH received a *Met* validation status for both PIPs and 100 percent scores for having all evaluation elements *Met* and all critical elements *Met*. FBH not only continued to maintain its strong performance from the previous year, but also improved its overall scores from FY 05–06, which were 94 percent and 93 percent. Activity X, Sustained Improvement Achieved, was not assessed for both studies, and Activity IX, Real Improvement Achieved, was not assessed for one of the studies.

For both studies, FBH presented a well-defined study topic and study population and had answerable study questions that stated the problem in simple terms and set the focus of the study. The study indicators were also well-designed to answer the study question and appropriately measure outcomes. The sampling technique used ensured that a representative sample of the eligible population was selected. The data collection techniques and processes used for the studies were found to be appropriate with the data elements to be collected, and the data sources to be used were clearly identified. FBH used the findings from its causal/barrier analyses to develop planned interventions for each PIP. The subsequent data analyses were conducted according to the study plan, and the study results were presented in a clear and easily understood format, accompanied by a detailed interpretation of the data for each measurement period.

For *Improving Use and Documentation of Clinical Guidelines*, FBH met all the evaluation elements for Activity IX, Real Improvement Achieved. FBH's intervention strategies led to documented and statistically significant improvements in: 1) providers' positive perception of the guidelines as being easily understood, user-friendly, easily accessible, and having been explained to them, and 2) providers' attention to documenting their use of the guidelines.

Recommendations

This year, the performance validation study did not identify any opportunities for improvement for either PIP. However, HSAG does recommend FBH continue the PIP process for both studies and:

- For *Improving Use and Documentation of Clinical Guidelines*, complete the planned PIP committee review of the results from the first remeasurement to determine if other strategies are needed to sustain progress.
- For *Supporting Recovery*, complete the planned comparison of the second baseline measurement to the first remeasurement.

Summary Assessment Related to Quality, Timeliness, and Access

As discussed previously, HSAG assigned all PIPs to the quality domain. Therefore, the summary assessment of FBH's PIP validation results relate to the domain of quality.

Overall, FBH's performance regarding its PIPs and the quality domain was strong. The goal of both studies was to impact the quality of care provided to FBH consumers. Both PIPs were given a validation status of *Met*, with overall scores of 100 percent. For this validation cycle, FBH successfully addressed all of the PIP validation activities for critical elements.

A comparison of the PIP validation cycles (Years 1 and 2) for each of FBH's PIPs yielded the following:

- *Improving Use and Documentation of Clinical Guidelines*: For Year 1, only baseline data analysis had been completed at the time of the submission. For Year 2, there were statistically significant improvements in provider documentation and provider perception of clinical guidelines from baseline to the first remeasurement.
- *Supporting Recovery*: For Year 1, FBH had only collected baseline data at the time of the submission. For Year 2, FBH collected a second baseline measurement because the MHSIP survey responses were from consumers receiving services before FBH was formed. FBH had completed the data analysis and planned to compare the results of the second baseline measurement to its first remeasurement for the next annual PIP validation.

Northeast Behavioral Health, LLC

Findings

NBH conducted two PIPs (i.e., *Follow-up After Inpatient Discharge* and *Increase NBH Center Provider Communication/Coordination with Primary Care Physicians and Other Health Providers*). Both PIPS were continued from the prior year.

For the first PIP, HSAG reviewed Activities I through X. Table 3-51 and Table 3-52 show NBH's scores based on HSAG's evaluation of *Follow-up After Inpatient Discharge*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-51—PIP Validation Scores *for* Follow-up After Inpatient Discharge *for* NBH

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Accurate/Complete Data Collection	11	11	0	0	0	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	4	0	0	0	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	8	0	0	1	2	1	0	0	1
IX. Real Improvement Achieved	4	1	3	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	0	1	0	0	No Critical Elements				
Totals for All Activities	**53**	**41**	**4**	**0**	**8**	**11**	**9**	**0**	**0**	**2**

Table 3-52—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Follow-up After Inpatient Discharge *for* NBH		
	FY 06–07	Prior Year (FY 05–06)
Percentage Score of Evaluation Elements *Met**	**91%**	**83%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

For the second PIP, HSAG reviewed Activities I through IX. Table 3-53 and Table 3-54 show NBH's scores based on HSAG's evaluation of *Increase NBH Center Provider Communication/Coordination with Primary Care Physicians and Other Health Providers*. Each activity was reviewed and scored according to HSAG's validation methodology.

Table 3-53—PIP Validation Scores *for* Increase NBH Center Provider Communication/Coordination with Primary Care Physicians and Other Health Providers *for* NBH

Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *N/A*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *N/A*
I. Appropriate Study Topic	6	6	0	0	0	1	1	0	0	0
II. Clearly Defined, Answerable Study Question	2	2	0	0	0	1	1	0	0	0
III. Clearly Defined Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Valid Sampling Techniques	6	6	0	0	0	1	1	0	0	0
VI. Accurate/Complete Data Collection	11	9	0	0	2	1	1	0	0	0
VII. Appropriate Improvement Strategies	4	4	0	0	0	No Critical Elements				
VIII. Sufficient Data Analysis and Interpretation	9	9	0	0	0	2	2	0	0	0
IX. Real Improvement Achieved	4	4	0	0	0	No Critical Elements				
X. Sustained Improvement Achieved	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**48**	**0**	**0**	**4**	**11**	**11**	**0**	**0**	**0**

Table 3-54—FY 06–07 and FY 05–06 PIP Overall Validation Scores and Validation Status *for* Increase NBH Center Provider Communication/Coordination with Primary Care Physicians and Other Health Providers *for* NBH		
	FY 06–07	Prior Year (FY 05–06)
Percentage Score of Evaluation Elements *Met**	**100%**	**97%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** *Met* equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not valid.

Strengths

NBH received a *Met* validation status for both PIPs, with 100 percent scores for all critical elements having received a *Met.* NBH's overall scores were 91 percent for *Follow-up After Inpatient Discharge*, with 41 out of 45 applicable elements *Met*, and 100 percent for *Increase NBH Center Provider Communication/Coordination with Primary Care Physicians and Other Health Providers*, with all applicable elements *Met*. NBH not only continued to maintain its strong performance from the previous year, but also improved upon its overall scores from FY 05–06, which were 83 percent and 97 percent.

For both studies, NBH presented a well-defined study topic and study population and had answerable study questions that stated the problem in simple terms and set the focus of the study. The study indicators were well-designed and developed to answer the study questions. The data collection techniques and processes used for the studies were found to be appropriate with the data elements to be collected, and the data sources to be used were clearly defined. NBH used the findings from its causal/barrier analyses to develop planned interventions for each PIP. The subsequent data analyses were conducted according to the study plan, and the study results were presented in a clear and easily understood format, accompanied by a detailed interpretation of the data for each measurement period.

For *Increase NBH Center Provider Communication/Coordination with Primary Care Physicians and Other Health Providers*, NBH met all the evaluation elements for Activity IX, Real Improvement Achieved. NBH's intervention strategy led to documented and statistically significant improvement in the rate of communication between all three NBH centers and their consumers' primary care providers from baseline to the first remeasurement. While NBH did not meet all the evaluation elements for Activity IX and Activity X of *Follow-up After Inpatient Discharge*, there was statistically significant improvement for the first time in the follow-up rates from the second to the third remeasurement. All four follow-up rates were also above the benchmarks for this measurement period. The Department has approved retiring this PIP.

Recommendations

NBH's PIP, *Follow-up After Inpatient Discharge,* had three *Partially Met* noncritical elements for Activity IX, Real Improvement Achieved, and one *Partially Met* element for Activity X, Sustained Improvement Achieved. This was due to the follow-up rates not achieving statistically significant improvement from baseline to the third remeasurement. However, as discussed previously, the improvement in the rates was statistically significant from the second to the third remeasurement, and the rates were all above the benchmarks for the period.

Based on the results of this year's PIP validation findings, recommendations for improving NBH's performance include:

- Selecting one new study topic for FY 07–08 that targets improvement in high-priority areas of clinical care and reflects NBH's Medicaid enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences of disease.
- For *Increase NBH Provider Communication/Coordination with Primary Care Physicians and Other Health Providers*, continuing the PIP process, including the planned collection of a second remeasurement to show sustained improvement for the next annual PIP submission.

Summary Assessment Related to Quality, Timeliness, and Access

As discussed previously, HSAG assigned all PIPs to the quality domain. Therefore, the summary assessment of NBH's PIP validation results relate to the domain of quality.

Overall, NBH's performance regarding its PIPs and the quality domain was strong. The goal of both studies was to impact the quality of care provided to NBH consumers, the timeliness of care for one PIP, and access to care for the other PIP. Both of its PIPs were given a validation status of *Met,* with overall scores of 91 percent and 100 percent. For this validation cycle, NBH successfully addressed all of the PIP validation activities for critical elements. NBH received scores of *Partially Met* for only four noncritical elements related to lack of sustained and statistically significant improvement in one of its studies.

A comparison of the PIP validation cycles (Years 1 through 3) for each of NBH's PIPs yielded the following:

- *Follow-up After Inpatient Discharge*: For Year 1, NBH had only collected data for baseline and part of the first remeasurement, so the data could not be compared and real improvement could not be determined. For Year 2, there was no demonstrated improvement in any of the follow-up rates. For Year 3, there was statistically significant improvement in both seven-day follow-up rates from the second to the third remeasurement. The only rate that had a statistically significant increase from baseline to the third remeasurement was for seven-day outpatient follow-up.
- *Increase NBH Center Provider Communication/Coordination with Primary Care Physicians and Other Health Providers*: For Year 1, NBH had only completed a baseline measurement at the time of the submission. For Year 2, the rate of communication between all three NBH centers and their consumers' primary care providers improved significantly from baseline to the first remeasurement. The results demonstrated that all NBH centers surpassed the benchmark of 62.4 percent.

Overall Statewide Performance Related to Quality, Timeliness, and Access for the Validation of Performance Improvement Projects

Table 3-55—Summary of Data from Validation of Performance Improvement Projects					
	Validation Activity	FY 06–07 Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Prior Year (FY 05–06) Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	FY 06–07 Number of PIPs Meeting All Critical Elements/ Number Reviewed	Prior Year (FY 05–06) Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Appropriate Study Topic	10/10	9/10	10/10	10/10
II.	Clearly Defined, Answerable Study Question	10/10	10/10	10/10	10/10
III.	Clearly Defined Study Indicator(s)	10/10	9/10	10/10	9/10
IV.	Use a Representative and Generalizable Study Population	10/10	9/10	10/10	9/10
V.	Valid Sampling Techniques	10/10	8/10	10/10	8/10
VI.	Accurate/Complete Data Collection	8/10	5/10	10/10	10/10
VII.	Appropriate Improvement Strategies	10/10	6/9	No Critical Elements	
VIII.	Sufficient Data Analysis and Interpretation	10/10	0/4	10/10	2/4
IX.	Real Improvement Achieved	5/9	0/3	No Critical Elements	
X.	Sustained Improvement Achieved	2/5	0/3	No Critical Elements	

As discussed previously, HSAG assigned all PIPs to the quality domain. Therefore, the summary assessment of the PIP validation results relate to the domain of quality.

Overall, the BHOs showed strong performance regarding their PIPs. All 10 of the PIPs reviewed were given a validation status of *Met*, with scores of 100 percent for critical elements *Met* and scores ranging from 89 percent to 100 percent for all evaluation elements *Met*. The BHOs' performance had improved from the previous year, when only seven of the PIPs were given a validation status of *Met*. While the study goal of all of the BHOs' PIPs was to impact the quality of health care provided to their consumers, a number of the PIPs also focused on improving access to care or the timeliness of care.

For this validation cycle, Activities I through VIII in all 10 PIPs submitted this year were assessed as meeting the validation criteria for every element. Either improvement or maintenance of perfect

scores were seen in every activity. In particular, the scores for critical elements improved for Activity III, Clearly Defined Study Indicator; Activity IV, Correctly Identified Study Population; Activity V, Valid Sampling Techniques; and Activity VIII, Sufficient Data Analysis and Interpretation. The BHOs successfully addressed opportunities identified the previous year, such as staff qualifications, study description, and inconsistencies in the data analysis.

This year, Activity IX, Real Improvement Achieved, and Activity X, Sustained Improvement Achieved, presented opportunities for improvement for most of the BHOs. For four PIPs, there was no evidence that statistically significant improvements were achieved for all the study indicators, and for three PIPs, there was no evidence of sustained improvement. At the same time, six of the PIPs were successful in achieving improved outcomes in quality, ranging from increased rates in follow-up after an inpatient discharge to increased use of evidence-based practices in guiding treatment decisions.

HSAG recommends that, where applicable, the individual BHOs:

- Select a new study topic for FY 07–08 that targets improvement in high-priority areas of clinical care and reflects the BHO's Medicaid enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences of disease.
- Conduct additional data and causal/barrier analysis to determine whether the interventions are addressing the root causes, and revise the interventions if appropriate.

4. Assessment of BHO Follow-up on Prior Recommendations

Introduction

The Department required each BHO to address the recommendations made following the EQR activities that were conducted in FY 05–06. In this section of the report, an assessment is made as to the degree to which the BHOs effectively addressed the improvement recommendations made by HSAG during the previous year.

Access Behavioral Care

Compliance Standards and Record Review

ABC successfully followed up and addressed all of the previous year's improvement recommendations related to compliance standards. Last year, ABC received a score of *Partially Met* for six compliance elements in the areas of delegation, access and availability, continuity-of-care system, grievances, appeals, and fair hearings, and credentialing. As a follow-up to the FY 05–06 site review report, ABC was required to submit a corrective action plan to the Department for making improvement in these areas. The Department's review of the corrective action plan and associated documentation revealed that ABC had completed all corrective actions for FY 05–06. Additionally, in the FY 06–07 site review report, ABC received a score of *Met* for all six compliance elements that had received a score of *Partially Met* in the prior year.

Performance Measures

This year's validation of performance measures indicated that ABC had made a concerted effort to follow up on the recommendations from the previous year's validation study. ABC made improvements in its monitoring of encounter data and CCAR data submission to the Department, resulting in: 1) *Acceptable* (as opposed to *Not Acceptable*) scores for data control and performance measure documentation, and 2) a designation of *Substantially Compliant* for five of the performance measures that received *Not Valid* the previous year. However, ABC had not implemented a formal, documented process for submission of encounter and CCAR data files to the Department, along with a log for tracking.

Performance Improvement Projects

ABC had no prior recommendations related to its PIPs requiring follow-up. Both of its PIPs continued to receive a validation status of *Met*, with all elements from the previous year continuing to receive a score of *Met*. The decrease in one PIP's overall evaluation score from 100 percent to 95 percent was due to receiving a score of *Partially Met* for one element in Activity IX, Real Improvement Achieved, and one element in Activity X, Sustained Improvement Achieved, areas which were not previously evaluated.

Behavioral HealthCare, Inc.

Compliance Standards and Record Reviews

BHI successfully followed up and addressed the majority of the previous year's improvement recommendations related to compliance standards. Last year, BHI received a score of *Partially Met* for eight compliance elements in the areas of access and availability; continuity-of-care system; grievances, appeals, and fair hearings; and credentialing. As a follow-up to the FY 05–06 site review report, BHI was required to submit a corrective action plan to the Department to make improvement in these areas. The Department reviewed and approved BHI's corrective action plan and associated documentation prior to the FY 06–07 site review. During the FY 06–07 site review HSAG evaluated the implementation of BHI's corrective actions and reviewed related documentation (e.g., policies and procedures). BHI received a score of *Met* for six of the eight compliance elements that had previously received a score of *Partially Met*. For the remaining two compliance elements, the scores continued to be *Partially Met*. BHI needs to ensure that all recommendations related to the compliance elements for access to routine services and quality assessment for organizational provider credentialing receive adequate follow-up and corrective action sufficient to bring the BHO into full compliance with the requirements.

Performance Measures

This year's validation of performance measures indicated that BHI had followed up on recommendations made as a result of the previous year's validation study. BHI improved its data integrity by refining its processes and oversight of InNET, its claims and encounter data vendor. As a result, the reviewers found BHI's data control to be *Acceptable* this year (as opposed to the *Not Acceptable* finding last year).

Performance Improvement Projects

BHI made substantial improvements in both PIPs, moving from scores of *Not Met* to *Met*. In one PIP, BHI increased the overall validation score from 69 percent to 96 percent and the critical element score from 67 percent to 100 percent. In the second PIP, BHI increased the overall validation score from 58 percent to 90 percent and the critical element score from 64 percent to 100 percent. In *Access to Initial Medication Evaluation,* BHI continued to not be in full compliance for several elements in Activity IX, Real Improvement Achieved, and for one element in Activity VI, Accurate and Complete Data Collection. In *Screening for Bipolar Disorder,* BHI continued to not be in compliance with one element in Activity VI, Accurate and Complete Data Collection. BHI needs to follow up on the recommendations related to these elements.

Colorado Health Partnerships, LLC

Compliance Standards and Record Reviews

CHP successfully followed up and addressed the majority of the previous year's improvement recommendations related to compliance standards. Last year, CHP received a score of *Partially Met* for 13 compliance elements in the areas of member rights and responsibilities; access and availability; continuity-of-care system; grievances, appeals, and fair hearings; and credentialing. CHP also received a *Not Met* for an element in the area of provider issues. As a follow-up to the FY 05–06 site review report, CHP was required to submit a corrective action plan to the Department to make improvement in these areas. The Department reviewed and approved CHP's corrective action plan and associated documentation prior to the FY 06–07 site review. During the FY 06–07 site review, HSAG evaluated the implementation of CHP's corrective actions and reviewed associated documentation (e.g., policies and procedures). CHP received a score of *Met* for seven of the nine compliance elements for which it had previously received a score of *Partially Met*. The score for two compliance elements continued, as in the prior year, to receive scores of only *Partially Met*. CHP needs to ensure that all recommendations related to the compliance elements for member responsibilities and advance directives receive adequate follow-up and corrective actions sufficient to bring the BHO into compliance with the requirements.

Performance Measures

This year's validation of performance measures indicated that CHP had followed up on recommendations made as a result of the previous year's validation study. CHP made improvements in its monitoring of the manual entry of CCAR data, resulting in a designation of *Fully Compliant* for the five the performance measures that received *Substantially Compliant* the previous year. In this year's validation study, the reviewers recommended that CHP continue to monitor the entry and validation of CCAR data to ensure the completeness and accuracy of these data.

Performance Improvement Projects

CHP clearly followed up on all prior PIP recommendations for both PIPs, substantially improving its compliance scores for the PIPs validated in FY 06–07. For one PIP, there was a noted improvement in the score for all evaluation elements, increasing from 89 to 100 percent. The other PIP's overall score remained at 89 percent. However, CHP received scores of *Met* for all the elements needing improvement based on the previous year's validation findings. The elements identified as needing improvement this year were related to activities that had not previously been evaluated.

Foothills Behavioral Health, LLC

Compliance Standards and Record Reviews

FBH successfully followed up and addressed the majority of the previous year's improvement recommendations related to compliance standards. Last year, FBH received a score of *Partially Met* for nine compliance elements in the areas of delegation, member rights and responsibilities, access and availability, continuity-of-care system, and credentialing. As a follow-up to the FY 05–06 site review report, FBH was required to submit a corrective action plan to the Department for making improvement in these areas. The Department reviewed and approved FBH's corrective action plan and associated documentation prior to the FY 06–07 site review. During the 06–07 site review HSAG evaluated the implementation of the corrective action plan and any associated documentation (e.g., policies and procedures). FBH received a score of *Met* for eight of the nine compliance elements that had previously received a score of *Partially Met*. The score for the remaining compliance element continued, as in the prior year, to receive a score of *Partially Met*. FBH needs to ensure that all recommendations related to the compliance elements for access and availability receive adequate follow-up and corrective action sufficient to bring the BHO into full compliance with the requirements.

Performance Measures

This year's validation of performance measures indicated that FBH had followed up on recommendations made as a result of the previous year's validation study. FBH improved its data integrity through the numerous quality improvement and analysis activities in its business practice. Furthermore, FBH improved its encounter data oversight and validation activities by allocating resources toward encounter data improvement and hiring additional staff to provide support for this function. As a result, the reviewers found FBH's data control to be *Acceptable* this year (as opposed to the *Not Acceptable* finding last year). Although the integrity of encounter data has improved significantly from the previous year, FBH should continue to ensure that gaps in processing and validating encounter data do not compromise data completeness.

Performance Improvement Projects

FBH clearly followed up on all prior PIP recommendations for both PIPs, substantially improving compliance for the PIPs validated in FY 06–07. For both PIPs there was a noted improvement in the score for all evaluation elements, increasing from 94 percent to 100 percent for one PIP and 93 percent to 100 percent for the other PIP.

Northeast Behavioral Health, LLC

Compliance Standards and Record Reviews

NBH successfully followed up and addressed the majority of the previous year's improvement recommendations related to compliance standards. Last year, NBH received a score of *Partially Met* for 17 compliance elements in the areas of delegation, practice guidelines, access and availability, and credentialing. It also received a *Not Met* for four compliance elements in the areas of continuity-of-care system and credentialing. As a follow-up to the FY 05–06 site review report, NBH was required to submit a corrective action plan to the Department to make improvements in these areas. The Department reviewed and approved NBH's corrective action plan prior to the FY 06–07 site review. During the FY 06–07 site review, NBH received a score of *Met* for only 16 of the 21 compliance elements that had previously received a score of *Partially Met* or *Not Met*. The remaining five compliance elements received scores of *Partially Met*, indicating that NBH had not yet implemented sufficient corrections in those areas to achieve full compliance. NBH needs to ensure that all recommendations related to the compliance elements for delegation and credentialing policies and procedures receive adequate follow-up and corrective action.

Performance Measures

This year's validation of performance measures indicated that NBH had followed up on recommendations made as a result of the previous year's validation study. NBH's commitment to performance measure reporting through strong oversight activities related to data capture and reporting resulted in no issues with encounter data integrity. This year, NBH received an *Acceptable* (as opposed to a *Not Acceptable*) score for data control. NBH also implemented a formal audit process for manual CCAR data entry procedures that resulted in minimal missing, overdue, and/or erroneous CCAR data. As a result, NBH received a designation of *Fully Compliant* for the five performance measures that received *Substantially Compliant* designations the previous year.

Performance Improvement Projects

NBH clearly followed up on all prior recommendations for both PIPs, substantially improving compliance for the PIPs validated in FY 06–07. For one PIP, there was a noted improvement in the score for all evaluation elements, increasing from 97 percent to 100 percent. The overall score for the other PIP (*Follow-up After Inpatient Discharge)* increased from 83 percent to 91 percent. NBH continued to have several elements that were identified as needing improvement in Activity IX, Real Improvement Achieved, and Activity X, Sustained Improvement Achieved. However, the Department has approved retiring this PIP.

Appendix A. Compliance Monitoring Site Reviews

Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the compliance monitoring site review activities were conducted and the resulting data were aggregated and analyzed.

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. According to 42 CFR 438.358, the state or its EQRO must conduct a review within a three-year period to determine an MCO's and PIHP's compliance with quality assessment and performance improvement (QAPI) program standards. To complete this requirement, HSAG, through its EQRO contract with the State of Colorado, performed on-site compliance evaluations, i.e., site reviews, of the five BHOs with which the State contracts.

The primary objective of the 06–07 site reviews was to determine the BHOs' compliance with federal and State regulations and with contractual requirements. The review addressed the following 10 compliance areas:

- Standard I. Delegation
- Standard II. Provider Issues
- Standard III. Practice Guidelines
- Standard IV. Member Rights and Responsibilities
- Standard V. Access and Availability
- Standard VI. Utilization Management
- Standard VII. Continuity-of-Care System
- Standard VIII. Quality Assessment and Performance Improvement Program
- Standard IX. Grievances, Appeals, and Fair Hearings
- Standard X. Credentialing

The BHOs' implementation of a number of the requirements in several of the compliance standards was also evaluated through associated record reviews. The following record reviews were conducted:

- Documentation of Services
- Coordination of Care—Children Transitioning From Inpatient to Outpatient Services
- Grievances
- Denials

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

- Evaluate the quality and timeliness of, and access to, behavioral health care furnished by the BHOs.
- Identify, implement, and monitor system interventions to improve quality.

This is the third year that HSAG has performed an evaluation of the BHOs' compliance. The results from these site reviews will provide an opportunity to compare current performance to that of the previous years' evaluations, and to inform the Department and the BHOs of strengths and any corrective actions needed.

Technical Methods of Data Collection

Prior to beginning site reviews of the BHOs, HSAG developed five standardized data collection survey tools for use in the reviews. One tool was for evaluating compliance with requirements in each of the 10 compliance areas (i.e., standards) and the other four tools were for conducting record reviews. 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, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*. Once the review tools and processes were approved by the Department, HSAG provided technical assistance to all the BHOs regarding the tools and the site review process.

For each of the BHO site reviews, HSAG followed the same basic steps, which included:

- **Pre-on-site Review Activities:** Activities included scheduling the site review, developing the site review agenda, and holding a pre-on-site conference call with the BHO, if requested, 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 site review. One important pre-on-site review activity was the desk review of key documents and other information that HSAG obtained from the Department and the BHO. This desk review enabled HSAG reviewers to better understand the BHO's operations, identify areas needing clarification, and begin compiling information before the site review.

  In preparation for the on-site review of records, HSAG generated audit listings based on data provided by either the Department or the BHO. These data came from the following databases: grievance records, denial-of-service records, children discharged from a psychiatric inpatient facility (for the review of care coordination—children transitioning from inpatient to outpatient services), and service encounters (for the review of documentation of services). From each of these databases a random sample of unduplicated records was selected for review. In general, for each record review, 10 records were selected for the sample and 5 additional records for the oversample.
- **On-site Review Activities:** The site reviews, which lasted two days with three reviewers, included an opening conference to review the agenda and objectives of the review, document and record review processes, interviews with key BHO staff members, and a closing conference

during which HSAG summarized preliminary findings and required actions. All findings were documented on the data collection survey tools, which now serve as a comprehensive record of the site review activity.

Description of Data Obtained

To assess the BHOs' compliance with federal and State requirements, HSAG obtained information from a wide range of written documents produced by the BHOs, including:

- Committee meeting agendas, minutes, and handouts.
- Policies and procedures.
- The QAPI program plan, work plan, and annual evaluation.
- Focused study reports.
- Management/monitoring reports (e.g., grievances, utilization).
- Quarterly compliance reports.
- Provider service and delegation agreements and contracts.
- Clinical review criteria.
- Practice guidelines.
- Provider manual and directory.
- Consumer handbook and informational materials.
- Staff training materials and documentation of attendance.
- Consumer satisfaction results.
- Correspondence.
- Records or files related to grievances, denials, documentation of services, and care coordination.

Additional information for the site review was also obtained through interaction, discussions, and interviews with key BHO staff members (e.g., the BHO leadership, consumer services staff, medical director).

Table A-1 lists the BHO data sources used in compliance determinations and the time period to which the data applied.

Table A-1—Description of BHO Data Sources

Data Obtained	Time Period to Which the Data Applied
Desk review documentation	1/1/06–dates of the BHO on-site review
Grievance and denial records	1/1/06–9/30/06
Documentation-of-services records	1/1/06–6/30/06 for the majority of the samples
Coordination-of-care records	10/1/05–6/30/06
Information from interviews conducted on-site	1/1/06–dates of the BHO on-site review

Data Aggregation and Analysis

Upon completion of the site review, HSAG aggregated all information obtained. HSAG analyzed the findings from the document and record reviews and from the interviews. Findings were scored using a *Met*, *Partially Met*, *Not Met*, or *Not Applicable* methodology for the standards, and a *Yes*, *No*, *Not Applicable* methodology for the record reviews. Each BHO was given three overall percentage-of-compliance scores—one for performance in complying with the requirements for the 10 compliance areas (standards), one for record reviews, and one for overall compliance with the standards and record reviews combined. These scores represented the percentage of the applicable elements met by the BHO. This scoring methodology allowed the Department to identify areas of best practice and areas where corrective actions were required or training and technical assistance were needed to improve BHO performance.

After completing data aggregation, analysis, and scoring, HSAG prepared a report of the site review findings and required actions for each BHO. These reports were forwarded to the Department and the BHO.

Appendix B. Validation of Performance Measures

Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the validation of performance measure activities was conducted and how the resulting data were aggregated and analyzed.

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process are 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 BHO (or on behalf of the BHO) followed the specifications established for each performance measure.

The Department, on behalf of the BHOs, calculated 13 performance measures using data submitted by the BHOs.

Technical Methods of Data Collection and Analysis

HSAG conducted the performance measure validation process in accordance with CMS guidelines in *Validating Performance Measures: A Protocol for Use in Conducting Medicaid 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 for each BHO, 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 ISCAT that was customized to Colorado's 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 State.
  - Prior to the on-site reviews, each BHO and the Department were asked to complete the ISCAT. HSAG prepared two different versions of the ISCAT, one that was customized for completion by the BHOs and the other customized for completion by the Department. The BHO version addressed all information systems 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 supporting documentation. Other pre-review activities included scheduling and preparing the agendas for the on-site visits and conducting conference calls with the BHOs to discuss the on-site visit activities and to address any ISCAT-related questions.

- **On-site Review Activities**: HSAG conducted a site visit to each BHO to validate the processes used to collect performance data (encounter data and CCAR data) and a site visit to the Department to validate the performance measure calculation process. The on-site reviews, which lasted one day, included:
  - 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, recipient Medicaid eligibility data, 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 supporting 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 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.
  - An 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 from the review of the ISCAT and the on-site review, and to revisit the documentation requirements for any post-review activities.

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's 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.
- **Previous Performance Measure Reports:** These were obtained from the Department and reviewed to assess trending patterns and rate reasonability.
- **Supporting 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.
- **Current Performance Measure Results:** The calculated results were obtained from the Department for each of the BHOs.
- **On-site Interviews and Demonstrations:** Information was also obtained through interaction, discussion, and formal interviews with key BHO and Department staff members as well as through system demonstrations.

Table B-1 displays the data sources used in the validation of performance measures and the time period to which the data applied.

Table B-1—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
ISCAT (From BHOs and the Department)	FY 05–06
Source Code (Programming Language) for Performance Measures (From the Department)	FY 05–06
Previous Year's Performance Measure Reports	FY 04–05
Current Performance Measure Results (From BHOs and the Department)	See note*
Supporting Documentation (From BHOs and the Department)	FY 05–06
On-site Interviews and Demonstrations (From BHOs and the Department)	FY 05–06

***Note:** Colorado's selected performance measures represent data from different time periods, depending on the source of the performance data. The performance measures that derive data from the MHSIP survey covered CY 05. Performance measures derived from CCAR and encounter data represented the state fiscal year (July 05 through June 06).

Data Aggregation and Analysis

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's 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 errors for several elements had little impact on the reported rate and the indicator was given a designation of *Substantially Compliant*.

After completing the validation process, HSAG prepared a report of the performance measure validation findings and recommendations for each BHO reviewed. These reports were forwarded to the State and the appropriate BHO. Section 3 contains information about BHO-specific performance measure rates and validation status.

Appendix C. Validation of Performance Improvement Projects

Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, the validation of PIP activities was conducted and how the resulting data were aggregated and analyzed.

Objectives

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

The primary objective of 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 systematic 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 validation activities on two PIPs.

Technical Methods of Data Collection and Analysis

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

[C-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Validating Performance Improvement Projects: A protocol for use in conducting Medicaid external quality review activities. *Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans*. Final Protocol, Version 1.0, May 1, 2002. Available at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/, downloadable within EQR Managed Care Organization Protocol.

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

- Activity I. Appropriate Study Topic
- Activity II. Clearly Defined, Answerable Study Question
- Activity III. Clearly Defined Study Indicator(s)
- Activity IV. Use a Representative and Generalizable 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

Description of Data Obtained

The data needed to conduct the PIP validation were obtained from the BHO's PIP Summary Form. This form provided detailed information about each BHO's PIP as it related to the 10 CMS protocol activities being reviewed and evaluated.

Table C-1—Description of BHO Data Sources

Data Obtained	Time Period to Which the Data Applied
PIP Summary Form (completed by the BHO)	FY 06–07

Data Aggregation and Analysis

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

All PIPs were scored as follows:

- *Met*: All critical elements were *Met* and 80 percent to 100 percent of all critical and noncritical elements were *Met*.
- *Partially Met*: All critical elements were *Met* and 60 percent to 79 percent of all critical and noncritical elements were *Met* or one critical element or more was *Partially Met*.
- *Not Met*: All critical elements were *Met* and less than 60 percent of all critical and noncritical elements were *Met* or one critical element or more was *Not Met*.
- *Not Applicable (N/A)*: Elements (including critical elements if they were not assessed) were removed from all scoring.

In addition to the validation status (e.g., *Met*), each PIP was given an overall percentage score for all evaluation elements (including critical elements), which was calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*. A critical element percentage score was then calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results, as follows:

- *Met*: Confidence/high confidence in reported PIP results.
- *Partially Met*: Low confidence in reported PIP results.
- *Not Met*: Reported PIP results not credible.

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

Appendix D. Summary Tables of External Quality Review Activity Results—All BHOs

Introduction

This appendix presents in the following tables the detailed findings for all BHOs for each of the EQR activities performed for FY 06–07.

Results From Compliance Monitoring Site Reviews

Table D-1––Scores for Standards by BHO

Standard	ABC	BHI	CHP	FBH	NBH	Statewide Average
Delegation	50%	92%	50%	92%	67%	70%
Provider Issues	92%	92%	96%	96%	84%	92%
Practice Guidelines	100%	100%	100%	100%	100%	100%
Member Rights and Responsibilities	94%	100%	83%	94%	89%	92%
Access and Availability	95%	95%	100%	100%	100%	98%
Utilization Management	88%	100%	88%	88%	100%	93%
Continuity-of-Care System	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program	92%	100%	100%	100%	100%	98%
Grievances, Appeals, and Fair Hearings	55%	91%	100%	100%	82%	85%
Credentialing	94%	94%	75%	97%	94%	91%
Totals	**88%**	**95%**	**90%**	**97%**	**91%**	**92%**

Table D-2––Scores for Record Reviews by BHO

Record Review	ABC	BHI	CHP	FBH	NBH	Statewide Average
Grievances	0%	98%	98%	100%	96%	78%
Documentation of Services	90%	95%	100%	71%	100%	91%
Coordination of Care—Children's Transition from Inpatient to Outpatient Services	Not Scored					
Denials	93%	97%	97%	85%	83%	91%
Totals	**52%**	**97%**	**98%**	**89%**	**96%**	**86%**

Table D-3––Overall Compliance Scores by BHO						
	ABC	BHI	CHP	FBH	NBH	Statewide Average
Review of the Standards—Percentage Compliance	88%	95%	90%	97%	91%	92%
Review of Records—Percentage Compliance	52%	97%	98%	89%	96%	86%
Overall Compliance Scores	**75%**	**96%**	**93%**	**94%**	**92%**	**89%**

Results From the Validation of Performance Measures

Table D-4––Rates for Performance Measures by BHO						
Performance Measure	ABC	BHI	CHP	FBH	NBH	Statewide Average
Penetration Rate—Children	6.8%	6.6%	9.4%	9.8%	9.4%	8.4%
Penetration Rate—Adults	17.2%	12.2%	15.5%	17.5%	15.1%	15.5%
Consumer Perception of Access	76.4%	67.0%	73.1%	63.5%	74.5%	70.9%
Consumer Perception of Quality/Appropriateness	72.7%	64.7%	73.8%	68.3%	73.7%	70.6%
Consumer Perception of Outcome	50.4%	54.9%	60.6%	62.1%	59.1%	57.4%
Consumer Satisfaction	77.9%	70.6%	79.0%	80.8%	85.2%	78.7%
Consumer Perception of Participation	61.6%	58.4%	63.6%	67.3%	66.4%	63.5%
Consumers Linked to Primary Care	75.8%	80.2%	83.8%	86.5%	87.2%	82.7%
Children Living in a Family-Like Setting (Maintaining/Improving)	99.4%/12.5%	98.6%/ 12.3%	97.2%/22.6%	96.3%/48.1%	99.5%/15.3%	98.2%/22.2%
Adults Living Independently (Maintaining/Improving)	95.4%/17.1%	95.8%/ 15.3%	97.6%/12.6%	92.9%/17.7%	96.7%/13.5%	95.7%/15.2%
Employment (Maintaining/Improving)	90.9%/17.8%	89.6%/ 20.9%	92.9%/12.7%	90.8%/18.0%	91.9%/13.2%	91.2%/16.5%
Positive Change in Problem Severity—Children	0.48	0.57	0.60	0.87	0.52	0.61
Positive Change in Problem Severity—Adults	0.16	0.54	0.52	0.47	0.55	0.45

Table D-5––Audit Designations for Performance Measures by BHO					
Performance Measure	**ABC**	**BHI**	**CHP**	**FBH**	**NBH**
Penetration Rate—Children	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Penetration Rate—Adults	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Access	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality/Appropriateness	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Children Living in a Family-Like Setting	*Substantially Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Adults Living Independently	*Substantially Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Employment	*Substantially Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Positive Change in Problem Severity—Children	*Substantially Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
Positive Change in Problem Severity—Adults	*Substantially Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*

Table D-6––Z-Scores for Performance Measures by BHO					
Performance Measure	**ABC**	**BHI**	**CHP**	**FBH**	**NBH**
Children Living in a Family-Like Setting	0.47	-0.79	-1.33	0.74	0.92
Adults Living Independently	1.60	0.20	-0.26	-1.06	-0.48
Employment	0.45	-0.19	1.00	0.37	-1.62
Positive Change in Problem Severity—Children	-1.18	-0.25	0.17	1.56	-0.29
Positive Change in Problem Severity—Adults	-1.77	0.44	0.50	0.22	0.61

Results From the Validation of Performance Improvement Projects

Table D-7––Summary of Each BHO's PIP Validation Scores and Validation Status				
BHO	PIP Study	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
ABC	*Improving Follow-Up After An Inpatient Stay*	100%	100%	*Met*
ABC	*Improving Outcomes For High-Risk Youth Through AFFIRM Care Management*	95%	100%	*Met*
BHI	*Access to Initial Medication Evaluation*	90%	100%	*Met*
BHI	*Screening for Bipolar Disorder*	96%	100%	*Met*
CHP	*Ambulatory Follow-up Within Seven Days of Hospital Discharge for Youth and Adults*	100%	100%	*Met*
CHP	*Identification and Use of Alternative/Crisis Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents*	89%	100%	*Met*
FBH	*Improving Use and Documentation of Clinical Guidelines*	100%	100%	*Met*
FBH	*Supporting Recovery*	100%	100%	*Met*
NBH	*Follow-up After Inpatient Discharge*	91%	100%	*Met*
NBH	*Increase NBH Center Provider Communication/Coordination with Primary Care Physicians and Other Health Providers*	100%	100%	*Met*