2008–2009 External Quality Review Technical Report

for

Colorado Medicaid

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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 the Code of Federal Regulations (CFR), 42 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' health plans. 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 the health plans addressed any previous recommendations. 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 regarding the external quality review (EQR) activities performed on the State's contracted health plans. In prior years separate reports were produced for the behavioral health and physical health systems. In response to a request from the Centers for Medicare & Medicaid Services (CMS), this external quality review technical report provides managed care results for both physical health and behavioral health.

Results are presented and assessed for the following physical health plans:

- Colorado Access, a managed care organization (MCO)
- Denver Health Medicaid Choice (DHMC), an MCO
- Rocky Mountain Health Plans (RMHP), a prepaid inpatient health plan (PIHP)
- Primary Care Physician Program (PCPP), a primary care case management (PCCM) program

Results are also presented and assessed for the following behavioral health organizations (BHOs):

- Access Behavioral Care (ABC)
- Behavioral HealthCare, Inc. (BHI)
- Colorado Health Partnerships, LLC (CHP)
- Foothills Behavioral Health, LLC (FBH)
- Northeast Behavioral Health, LLC (NBH)

Scope of EQR Activities—Physical Health

The physical health plans were subject to three federally mandated BBA activities and one optional activity. As set forth in 42 CFR 438.352, these activities were:

- **Compliance monitoring evaluations.** These evaluations were designed to determine the health plans' compliance with their contract with the State and with State and federal regulations. HSAG determined compliance through review of various compliance monitoring standards.
- **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 a health plan. The validation also determined the extent to which Medicaid-specific performance measures calculated by a health plan followed specifications established by the Department.
- **Validation of performance improvement projects (PIPs).** HSAG reviewed PIPs to ensure that the projects were designed, conducted, and reported in a methodologically sound manner.

An optional activity was conducted for the physical health plans:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.** Each health plan was responsible for conducting a survey of its members and forwarding the results to HSAG for inclusion in this report. HSAG conducted the survey for PCPP on behalf of the Department.

Scope of EQR Activities—Behavioral Health

The behavioral health plans were subject to the three federally mandated EQR activities that HSAG 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 with the State and with State and federal regulations through review of performance in four areas (i.e., components).
- **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 PIPs.** HSAG reviewed PIPs to ensure that the projects were designed, conducted, and reported in a methodologically sound manner.

An optional activity was conducted for the behavioral health plans:

- **Encounter Data Validation (EDV) study.** HSAG performed a study of outpatient and inpatient behavioral health encounters to address the extent to which behavioral health services were omitted from administrative and medical record sources and the extent to which behavioral health services were correctly coded.

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] CMS has chosen the domains of quality, access, and timeliness as the keys to evaluating the performance of MCOs and PIHPs. HSAG used the following definitions 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

The National Committee for Quality Assurance (NCQA) defines timeliness 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] NCQA further discusses that the intent of this standard is 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 the 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 for 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

To draw conclusions about the quality and timeliness of, and access to, care provided by the health plans, HSAG assigned each of the components reviewed for each activity (compliance monitoring, performance measure validation, PIP validation, CAHPS, and EDV) to one or more of these three domains. This assignment to the domains is depicted in Table 1-1 and Table 1-2 and described throughout Section 3 and Section 5 of this report.

This section provides a high-level, statewide summary of the conclusions drawn from the findings of the activities regarding the plans' strengths with respect to quality, timeliness, and access. Section 3 and Section 5 describe in detail the plan-specific findings, strengths, and recommendations or required actions.

Quality—Physical Health

HSAG's evaluation of Colorado health plans showed strong performance in the quality domain. The standards of the fiscal year (FY) 2008–2009 compliance site review that assessed quality were Coordination of Care, Provider Participation and Program Integrity, and Subcontracts and Delegation. Results from the compliance monitoring review revealed several best practices in Provider Participation and Program Integrity. The validation of performance measures also indicated some strong performance by all plans; however, these results were more varied than the compliance results.

All of the health plans experienced statistically significant increases in performance areas with rates comparable to the prior year, and many new measures performed within the 2008 Healthcare Effectiveness Data and Information Set (HEDIS) 90th percentile. In fact, one health plan experienced an increase of 47 percentage points over the prior year. Another health plan experienced statistically significant increases in five of six measures with comparable results and ranked within the 2008 HEDIS 90th percentile for five measures. Although all health plans received some less-than-desirable scores, only two reported measures associated with the quality domain ranked below the 25th percentile of national 2008 rates.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Four of the five PIPs reviewed by HSAG earned a validation status of *Met*. These four PIPs all scored *Met* for 100 percent of the critical elements. One PIP received a *Partially Met* validation status; however, HSAG is confident that the plan will address and correct the one critical element impacting the validation status. Overall, Colorado physical health plans have demonstrated strong performance in the quality domain.

All of the measures within the CAHPS survey addressed quality. Statewide, the child survey showed slight increases in rates for three measures and the adult survey showed a slight increase in the rate for one measure. While only one measure experienced a decrease in statewide results for the child survey, the adult survey experienced slight decreases for seven measures. While none of these decreases was statistically significant (more than 5 percent), the reduced rates may indicate areas for improvement.

Quality—Behavioral Health

HSAG assigned three of the four compliance standards to the quality domain: Member Information, Notices of Action, and Appeals. Statewide averages for these standards were fair. All five BHOs scored 100 percent for Member Information. Four of the five BHOs had required actions related to an inaccurate or incomplete definition of "action," and four of the five BHOs had required actions related to notices of action that were not easy to understand. All five BHOs had required actions related to inaccurate or unclear policies regarding the time frames and requirements for filing appeals when the member requests the continuation of benefits for appeals related to the termination, suspension, or reduction of previously authorized services.

Statewide performance for the validation of performance measures, as it related to the quality domain, was fair. While four of the quality-related measures with results from last year showed a decline in rates, the decline was not significant. Rates for Hospital Recidivism (a first-time measure) ranged from 3.0 percent for 7-day recidivism to 17.2 percent for 90-day recidivism. These results suggest opportunities for improvement.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Eight of the nine PIPs validated by HSAG received a validation status of *Met*. The BHOs demonstrated a strong understanding of CMS protocols and were effective in using those protocols to conduct their PIPs.

Timeliness—Physical Health

HSAG assigned Coverage and Authorization of Services and Access and Availability to the quality domain. While each health plan was required to complete corrective actions related to these standards, the corrective actions were due to the completeness of policies rather than the actual processes and procedures used by the plans. The overall results of compliance monitoring indicated strong performance in the quality domain.

Results from the review of validation of performance measures were not as strong. While one plan experienced improvement in both measures and ranked within the 90th percentile of the national HEDIS 2008 rates, statewide performance on the two timeliness measures (*Childhood Immunization Status Combo #2* and *#3*) showed a modest decline from last year. These results indicated an opportunity for improvement.

Timeliness—Behavioral Health

The compliance monitoring components that addressed timeliness were Notices of Action and Appeals. As mentioned earlier, four of the five BHOs had required actions related to an inaccurate or incomplete definition of "action," and four of the five BHOs had required actions related to notices of action that were not easy to understand. All five BHOs had required actions related to inaccurate or unclear policies regarding the time frames and requirements for filing appeals when the member

requests the continuation of benefits for appeals related to the termination, suspension, or reduction of previously authorized services. These results indicated opportunities for improvement.

Only one performance measure reported in FY 2008–2009 addressed timeliness. The *Follow-up After Hospitalization for Mental Illness* measure and its related submeasures were introduced this year. BHO variations in rates for all the submeasures were larger than 10 percent, with the 30-day follow-up measure for non-state hospitals exhibiting the smallest variation. Wide BHO performance variations suggested that the BHOs have room for improvement.

Access—Physical Health

The compliance monitoring standards associated with the access domain were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VII—Provider Participation and Program Integrity. As with the timeliness domain, although the health plans experienced some mixed results in the evaluation of standards related to access, the majority of the corrective actions required of the plans related to the accuracy and completeness of their policies. Compliance monitoring performance related to access was not as strong as it was with quality and timeliness; however, the health plans, again, demonstrated a strong performance.

Statewide, all three submeasures under *Adults' Access to Preventive/Ambulatory Health Services* experienced a significant increase over last year's rates. Yet, rates for *Annual Dental Visits* and all four submeasures under *Children's & Adolescents' Access to Primary Care Providers (PCPs)* ranked below the 25th percentile of the 2008 national rates. While some of the plans scored remarkably well individually, statewide performance in the access domain provided Colorado with the most opportunities for improvement.

Access—Behavioral Health

HSAG evaluated compliance monitoring performance as it relates to access through review of Member Information and Underutilization. All five BHOs scored 100 percent on both components. There were no required actions related to the access domain. Each BHO demonstrated particular strengths in these areas as detailed in Section 5 of this report.

Statewide, BHO performance experienced improvement in three of the four rates with results comparable to the prior year: Penetration Rate—Children, Penetration Rate—Adults, and Consumer Perception of Access. Only one measure—Consumers Linked to Primary Care—had a rate that declined. However, none of the rate changes was statistically significant. For the first-time, access-related measures, BHO variations were fairly consistent.

Table 1-1—Assignment of Activities to Performance Domains for Physical Health Plans			
Physical Health Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard I. Coverage and Authorization of Services		✓	✓
Standard II. Access and Availability		✓	✓
Standard III. Coordination and Continuity of Care	✓	✓	✓
Standard VII. Provider Participation and Program Integrity	✓		✓
Standard IX. Subcontracts and Delegation	✓		
Performance Measures	**Quality**	**Timeliness**	**Access**
Childhood Immunization Status	✓	✓	
Well-Child Visits in the First 15 Months of Life	✓	✓	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓	✓	
Adolescent Well-Care Visits	✓	✓	
Annual Dental Visits			✓
Children's & Adolescents' Access to Primary Care Providers (PCPs)			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Prenatal Care		✓	✓
Postpartum Care		✓	✓
Use of Services: Inpatient Utilization—General Hospital Acute Care			✓
Ambulatory Care			✓
Cholesterol Management for Patients With Cardiovascular (CV) Conditions	✓		
Annual Monitoring for Patients on Persistent Medications	✓		
Use of Appropriate Medications for People With Asthma	✓		
Comprehensive Diabetes Care	✓		
Antibiotic Utilization			✓
Frequency of Selected Procedures			✓
PIPs	**Quality**	**Timeliness**	**Access**
Performance Improvement Projects	✓		
CAHPS Topics	**Quality**	**Timeliness**	**Access**
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Shared Decision Making	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

Table 1-2—Assignment of Activities to Performance Domains for Behavioral Health			
Behavioral Health Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Component 1—Member Information	✓		✓
Component 2—Notices of Action	✓	✓	
Component 3—Appeals	✓	✓	
Component 4—Underutilization			✓
Performance Measures	**Quality**	**Timeliness**	**Access**
Penetration Rates by Age Category			✓
Penetration Rates by Service Category			✓
Overall Penetration Rates			✓
Hospital Recidivism	✓		
Hospital Average Length of Stay			✓
Emergency Department Utilization			✓
Inpatient Utilization			✓
Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)		✓	
Consumer Perception of Access			✓
Consumer Perception of Quality and Appropriateness (Consumer Perception of Quality/Appropriateness)	✓		
Consumer Perception of Outcomes of Services (Consumer Perception of Outcome)	✓		
Consumer General Satisfaction (Consumer Satisfaction)	✓		
Consumer Perception of Participation in Treatment Planning (Consumer Perception of Participation)	✓		
Consumers Linked to Physical Health (Consumers Linked to Primary Care)			✓
PIPs	**Quality**	**Timeliness**	**Access**
Performance Improvement Projects	✓		
EDV			
Encounter Data Validation	✓		

Physical Health

This EQR report includes a description of four performance activities for the physical health plans: compliance monitoring evaluations, validation of performance measures, validation of PIPs, and CAHPS. HSAG conducted compliance monitoring site reviews, validated the performance measures, validated the PIPs, and summarized the CAHPS results.

Appendices A–E detail and describe how HSAG conducted each activity, addressing:

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

Section 3 presents conclusions drawn from the data and recommendations related to health care quality, timeliness, and access for each health plan and statewide, across the health plans.

Behavioral Health

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. HSAG conducted each activity 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, B, and C, respectively, and address:

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

Section 5 presents conclusions drawn from the data related to health care quality, timeliness, and access for each BHO and statewide, across the BHOs.

3. Physical Health 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 health plan's strengths and opportunities for improvement related to health care quality, timeliness, and access derived from analysis of the results of the four EQR activities. This section also includes HSAG's recommendations for improving the quality and timeliness of, and access to, health care services furnished by each health plan. A subpart of this section details for each health plan the findings from the four EQR activities conducted. This section also includes for each activity a summary of overall statewide performance related to the quality and timeliness of, and access to, care and services.

Compliance Monitoring Site Reviews

This was the first year that HSAG performed compliance monitoring reviews of the physical health plans. For the FY 2008–2009 site review process, the Department requested a focused review of four areas of performance. These areas were: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. HSAG developed a review strategy that corresponded with the four areas identified by the Department. For each standard, HSAG conducted a desk review of documents sent by the health plans prior to the on-site portion of the review, conducted interviews with key health plan staff members on-site, and reviewed additional key documents on-site.

In response to the Department's ongoing focus on coordination of care, HSAG also reviewed Standard III—Coordination and Continuity of Care for Colorado Access, a newly contracted MCO, for FY 2008–2009. In addition to the desk and on-site review of documents and the on-site interviews for this additional standard, HSAG conducted a record review of Colorado Access' medical and case management records to identify examples of care coordination.

The site review activities were consistent with the February 11, 2003, CMS final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).*

Recognizing the interdependence of quality, timeliness, and access, HSAG assigned each of the components to one or more of these three domains as depicted in Table 3-1. By doing so, HSAG was able to draw conclusions and make overall assessments about the quality and timeliness of, and access to, care provided by the health plans. Following discussion of each health plan's strengths and required actions, as identified during the compliance monitoring site reviews, HSAG evaluated and discussed the sufficiency of that health plan's performance related to quality, timeliness, and access.

Appendix A contains further details about the methodology used to conduct the EQR compliance monitoring site review activities.

Table 3-1—Assignment of Standards to Performance Domains			
Standards	**Quality**	**Timeliness**	**Access**
Standard I—Coverage and Authorization of Services		X	X
Standard II—Access and Availability		X	X
Standard III—Coordination and Continuity of Care*	X		
Standard VII—Provider Participation and Program Integrity	X		X
Standard IX–Subcontracts and Delegation	X		

*Colorado Access Only

Colorado Access

Table 3-2 presents the number of elements for each of the four standards, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *Not Applicable*), and the overall compliance score for the current year (FY 2008–2009).

Table 3-2—Summary of Scores for the Standards for FY 2008–2009 *for* Colorado Access								
Standard #	**Description of Standard**	**# of Elements**	**# of Applicable Elements**	**# *Met***	**# *Partially Met***	**# *Not Met***	**# *Not Applicable***	**Score (% of *Met* Elements)**
I	Coverage and Authorization of Services	25	25	24	1	0	0	96%
II	Access and Availability	14	14	13	1	0	0	93%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
VII	Provider Participation and Program Integrity	16	15	15	0	0	1	100%
IX	Subcontracts and Delegation	8	8	7	0	1	0	88%
	Totals	**72**	**71**	**68**	**2**	**1**	**1**	**96%***

*The overall score is a weighted average calculated by summing the total number of *Met* elements and dividing by the total number of applicable elements.

Strengths

Without exception, Colorado Access' policies and procedures related to coverage and authorization were consistent with requirements in the BBA and with its contract with the Department. The MCO also had a sophisticated utilization management program in place, including a strong training and

mentoring program for frontline staff and an interface between the clinical management computer application and the claims adjudication computer application overseen by DST Health Solutions (DST). Colorado Access had also implemented several strategies aimed at providing culturally relevant care, including assessing each member's cultural and spiritual preferences upon enrollment and providing a comprehensive set of cultural competency trainings for internal staff and providers.

While reviewing Standard III—Coordination of Care, HSAG found that Colorado Access' privacy practices included physical and electronic safeguards, access based on job needs, comprehensive Health Insurance Portability and Accountability Act of 1996 (HIPAA) training at hiring and annually, and accountability for employees regarding HIPAA requirements through the annual employee performance evaluation process.

Colorado Access' credentialing processes were based on NCQA requirements and included systems to ensure nondiscrimination of providers based on licensure or populations served. Colorado Access had a comprehensive compliance program that included policies and procedures, standards of conduct, and internal monitoring and auditing. HSAG also found evidence that Colorado Access monitored its delegates regularly and required corrective actions of its delegates as needed.

Recommendations

Based on the conclusions drawn from the review activities, Colorado Access was required to submit a corrective action plan to address the following required actions:

Coverage and Authorization of Services

- Colorado Access must monitor its contracted home health services providers to ensure that providers coordinate prior authorization with the single entry point (SEP) agency for those members requiring home health services beyond the 60-day covered services limitation.

Access and Availability

- Colorado Access must require its providers to meet standards for timely access to care and must initiate corrective action to address issues related to provider performance, as appropriate.

Subcontracts and Delegation

- Colorado Access must revise its process for monitoring delegates that encounter member information to include an evaluation of the subcontractor's compliance with HIPAA requirements.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of Colorado Access' compliance monitoring site review results related to the domains of quality, timeliness, and access.

Quality

The standards of the FY 2008–2009 compliance site review for Colorado Access that assessed quality were Coordination of Care, Provider Participation and Program Integrity, and Subcontracts and Delegation. Colorado Access' overall findings related to quality were strong. Colorado Access received a score of 100 percent for Coordination of Care and for Provider Participation and Program Integrity, and a score of 88 percent for Subcontracts and Delegation for an overall weighted quality score of 97 percent. The Coordination of Care record review contained evidence of communication and coordination between medical providers, documentation of case managers facilitating access to medical and community services, evidence of members' direct access to specialty providers, and evidence of authorization of non-formulary medications and services for the purpose of continuity of care. Required actions for the quality domain were related to lack of oversight of the delegate practices regarding HIPAA practices.

Timeliness

The standards that addressed the timeliness domain were Coverage and Authorization of Services and Access and Availability. Colorado Access' overall findings related to timeliness of services were also strong. Colorado Access received a score of 96 percent for Coverage and Authorization of Services and 93 percent for Access and Availability for an overall weighted timeliness score of 95 percent. Colorado Access' electronic utilization management system contributed significantly to its strength in the timeliness domain. Required actions for the timeliness domain were primarily related to lack of oversight of providers' compliance with standards for timely access to services.

Access

The standards that assessed the access domain were Coverage and Authorization of Services, Access and Availability, and Provider Participation and Program Integrity. Colorado Access received a score of 96 percent for Coverage and Authorization of Services, 93 percent for Access and Availability, and 100 percent for Provider Participation and Program Integrity for an overall weighted access score of 96 percent. Colorado Access had effective processes for developing and maintaining a network of providers, credentialing providers, and policies and procedures for detecting and responding to possible instances of fraud. Overall, however, Colorado Access' performance related to access to care was affected by the underlying opportunity for improvement in oversight and monitoring of day-to-day requirements for providers.

Denver Health Medicaid Choice

Findings

Table 3-3 presents the number of elements for each of the four standards, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *Not Applicable*), and the overall compliance score for the current year (FY 2008–2009).

Table 3-3—Summary of Scores for the Standards for FY 2008–2009 *for* Denver Health

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Coverage and Authorization of Services	25	25	21	4	0	0	84%
II	Access and Availability	14	14	13	0	1	0	93%
VII	Provider Participation and Program Integrity	16	16	15	1	0	0	94%
IX	Subcontracts and Delegation	8	0	0	0	0	8	N/A
	Totals	**63**	**55**	**49**	**5**	**1**	**8**	**89%***

*The overall score is a weighted average calculated by summing the total number of *Met* elements and dividing by the total number of applicable elements.

Strengths

DHMC's use of the online, interactive Milliman program helped ensure consistent application of utilization review criteria. DHMC's staff model for providing care set no limits on primary and specialty care provided through Denver Health and Hospital Authority (DHHA) staff and treatment decisions by practitioners. Utilization limits were used only for medical and ancillary services provided by non-DHHA practitioners and out-of-network providers and were used to ensure medical necessity and appropriateness of services.

While reviewing Standard II—Access and Availability, HSAG found that DHMC had policies, procedures, and training in place to address cultural competency and provided required member materials in English, Spanish, and Braille upon request. DHMC's policies described the use of adaptive devices (pocket amplifiers, teletype/telecommunications device for the deaf [TTY/TDD], etc.) as well as interpreters who were on staff, in addition to use of the language line, when necessary. Also, DHMC's quality improvement program staff members had completed projects using HEDIS data to analyze patterns of accessing care and compare cultural patterns, and were planning to use the data in the coming fiscal year for evaluating access to care and providing services.

Since DHMC provided the majority of services via a staff model, its monitoring mechanism for subcontracted providers consisted of a review of 100 percent of cases by the UM staff to ensure the quality and appropriateness of care and compliance with documentation requirements.

DHMC did not delegate any Medicaid managed care responsibilities, so Standard IX—Subcontracts and Delegation was not applicable.

Recommendations

Based on the conclusions drawn from the review activities, DHMC was required to submit a corrective action plan to address the following required actions:

Coverage and Authorization of Services

- DHMC must revise applicable policies to include the time frames for extending standard and expedited authorization decisions.
- DHMC had no documents that specifically addressed poststabilization services. DHMC must revise applicable documents to address and define poststabilization services.
- DHMC must ensure that all applicable policies, member materials, and provider materials consistently state that prior authorization is not required for urgent care services.
- DHMC must revise all applicable policies and documents to address the fact that members temporarily out of the service area may also receive urgently needed services.

Access and Availability

- When communicating results of secret shopper studies or other studies indicating that providers are noncompliant with standards set by DHMC or the Medicaid managed care contract, DHMC must clearly describe the noncompliance and require that the provider(s) submit corrective action plans to DHMC.

Provider Participation and Program Integrity

- DHMC must revise its policy related to fraud reporting to include the content of the report to the Department.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of DHMC's compliance monitoring site review results related to the domains of quality, timeliness, and access.

Quality

The standards that assessed quality were Provider Participation and Program Integrity, and Subcontracts and Delegation. DHMC did not delegate any Medicaid administrative tasks. DHMC received a score of 94 percent for Provider Participation and Program Integrity. The required action related to Provider Participation and Program Integrity was regarding the lack of a detailed procedure in its policy, not DHMC's actual processes. Strong performance in this component was primarily related to monitoring providers through the UM process.

Timeliness

The standards that addressed the timeliness domain were Coverage and Authorization of Services and Access and Availability. DHMC's overall findings related to timeliness of services were mixed. DHMC received a score of 84 percent for Coverage and Authorization of Services, representing opportunities for improvement, and 93 percent for Access and Availability, representing strong performance. DHMC's overall weighted score for the timeliness domain was 87 percent. While DMHC's use of the online interactive utilization management program was a clear strength for DMHC, the required actions related to completeness of policies, procedures, and other documents negatively affected DMHC's performance in the timeliness domain.

Access

The standards that assessed the access domain were Coverage and Authorization of Services, Access and Availability, and Provider Participation and Program Integrity. DHMC received a score of 84 percent for Coverage and Authorization of Services, 93 percent for Access and Availability, and 94 percent for Provider Participation and Program Integrity for an overall weighted access score of 89 percent for the access domain. Overall, DHMC's opportunities for improvement and required actions were related to the accuracy and completeness of its policies.

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Findings

Table 3-4 presents the number of elements for each of the four standards, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, *and NA*), and the overall compliance score for the current year (FY 2008–2009).

Table 3-4—Summary of Scores for the Standards for FY 2008–2009 *for* RMHP

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Coverage and Authorization of Services	25	25	22	3	0	0	88%
II	Access and Availability	14	14	13	1	0	0	93%
VII	Provider Participation and Program Integrity	16	15	15	0	0	1	100%
IX	Subcontracts and Delegation	8	8	7	0	1	0	88%
	Totals	**63**	**62**	**57**	**4**	**1**	**1**	**92%***

*The overall score is a weighted average calculated by summing the total number of *Met* elements and dividing by the total number of applicable elements.

Strengths

When reviewing Standard I—Coverage and Authorization of Services, HSAG found that RMHP's member handbook and the provider manual informed members and providers of RMHP's processes and policies. The provider manual included details about the care management program, and the member handbook was written in easily understood language. In addition to its policies, RMHP provided employees with desktop procedures or a manual with additional details to comply with Medicaid managed care regulations.

RMHP had a well-organized mechanism to monitor its network of providers and ensure that provider relationships were supported by written agreements. RMHP's cultural competency program was robust and represented a best practice for RMHP. The cultural competency discussion in the member handbook, as well as RMHP-developed cultural competency training provided to employees, were comprehensive and in-depth.

RMHP's compliance program also represented a best practice. In addition to standard features, such as clear methods for employee reporting and auditing activities, RMHP's compliance program included frequent reminders to employees about compliance issues through biannual newsletters and annual compliance week activities. HSAG found RMHP's compliance training to be comprehensive.

RMHP had a signed, executed agreement and a business associate agreement with each delegate that were compliant with HIPAA. Together, the agreements included all the requirements of the Medicaid managed care contract.

Recommendations

Based on the conclusions drawn from the review activities, RMHP was required to submit a corrective action plan to address the following required actions:

Coverage and Authorization of Services

- RMHP must clarify its policies and/or written processes to address sending notices of action for limited authorization of services to be consistent with RMHP's reported practice.
- RMHP must clarify its policies and written processes to delineate the policy specifically for the Medicaid line of business and clearly state that RMHP may not deny payment for emergency services previously rendered based on a member's failure to provide notice.
- RMHP must clarify any applicable policies and communicate with appropriate staff members to ensure that RMHP does not require preauthorization for urgent services.

Access and Availability

- RMHP must clarify the claims manual and any applicable policies to inform staff members that second opinions are available to members at no cost to the member. In addition, RMHP must notify members (via the member handbook or other appropriate member materials) that second opinions are available at no cost to the member.

Subcontracts and Delegation

- While RMHP had ample evidence that it monitored its delegates, RMHP did not have evidence that it monitored its delegates to ensure compliance with HIPAA regulations (45 CFR Parts 160 and 164). RMHP must revise its process for monitoring delegates that use member information to include an evaluation of delegates' compliance with HIPAA.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of RMHP's compliance monitoring site review results related to the domains of quality, timeliness, and access.

Quality

The standards that assessed quality were Provider Participation and Program Integrity, and Subcontracts and Delegation. RMHP's overall findings related to quality were mixed. RMHP received a score of 100 percent for Provider Participation and Program Integrity, and a score of 88 percent for Subcontracts and Delegation, representing an opportunity for improvement. RMHP's overall weighted score for the quality domain was 96 percent. RMHP had several best practices evident in the Provider Participation and Program Integrity standard. Required actions in the quality domain were related to monitoring delegates (performing administrative tasks) for compliance with HIPAA practices.

Timeliness

The standards that addressed the timeliness domain were Coverage and Authorization of Services and Access and Availability. RMHP'S overall findings related to timeliness of services were mixed. RMHP received a score of 88 percent for Coverage and Authorization of Services, representing opportunities for improvement, and 93 percent for Access and Availability, representing strong performance. RMHP's overall weighted score for the timeliness domain was 90 percent. RMHP's strength in the timeliness domain was related to RMHP's clear communication of its processes and requirements to both providers and members.

Access

The standards that assessed the access domain were Coverage and Authorization of Services, Access and Availability, and Provider Participation and Program Integrity. RMHP received a score of 88 percent for Coverage and Authorization of Services, 93 percent for Access and Availability, and 100 percent for Provider Participation and Program Integrity for an overall weighted access score of 92 percent for the access domain. As with the timeliness standard, RMHP's strength in the access domain was related to RMHP's clear communication of its processes and requirements to both providers and members. Required actions in the access domain were related to clarity of policies and procedures.

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

Table 3-5 shows the overall statewide average for each standard followed by conclusions drawn from the results of the compliance monitoring activity. Appendix E contains summary tables displaying the detailed site review scores for the standards by health plan and the statewide average.

Table 3-5—Summary of Data From the Review of Standards

Standards	FY 2008–2009 Statewide Average*
Standard I—Coverage and Authorization of Services	89%
Standard II—Access and Availability	93%
Standard III—Coordination of Care**	100%
Standard VII—Provider Participation and Program Integrity	98%
Standard IX—Subcontracts and Delegation	88%
Overall Statewide Compliance Score for Standards	**94%**

* Statewide average rates are weighted averages calculated by dividing the sum of the individual numerators by the sum of the individual denominators

** Standard III was reviewed for Colorado Access only.

Statewide recommendations (i.e., those in common across two of the three plans) include:

Quality

For the quality domain, both RMHP and Colorado Access had required actions related to the monitoring of delegates for compliance with HIPAA regulations.

Timeliness and Access

In the timeliness and access domains, Colorado Access and DHMC had required actions related to monitoring providers for compliance with requirements for timely access to services.

Validation of Performance Measures

The Department elected to use HEDIS methodology to satisfy the CMS validation of performance measure protocol requirements, which also includes an assessment of information systems. DHMC and RMHP had existing business relationships with licensed organizations that conducted HEDIS audits for its other lines of business. The Department allowed the health plans to use their existing auditors. Although HSAG did not audit all of the health plans, HSAG did review the audit reports produced by the other licensed organizations. HSAG did not discover any questionable findings or inaccuracies in the reports and, therefore, agreed that these reports were an accurate representation of the health plans.

To make overall assessments about the quality and timeliness of, and access to, care provided by the health plans, HSAG assigned each of the measures to one or more of the three domains as depicted in Table B-1 in Appendix B. Appendix B contains further details about the NCQA audit process and the methodology used to conduct the EQR validation of performance measure activities.

Seventeen performance measures were required by the Department for validation in FY 2008–2009. Ten of these measures also were required by the Department for validation in FY 2007–2008. Seven performance measures (*Children's & Adolescents' Access to PCPs*, *Annual Dental Visits*, *Use of Services: Inpatient Utilization—General Hospital Acute Care*, *Use of Appropriate Medications for People With Asthma*, *Comprehensive Diabetes Care*, *Antibiotic Utilization*, *and Frequency of Selected Procedures*) were not reported last year; therefore, comparisons with last year's results could not be made. A complete list of the measures required by the Department to be validated in FY 2008–2009 can be found in Table 3-6.

Table 3-6—FY 2008–2009 Performance Measures Required for Validation
Childhood Immunization Status
Well-Child Visits in the First 15 Months of Life
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Adolescent Well-Care Visits
Annual Dental Visit
Children's & Adolescents' Access to PCPs
Adults' Access to Preventive/Ambulatory Health Services
Prenatal Care
Postpartum Care
Use of Services: Inpatient Utilization—General Hospital Acute Care
Ambulatory Care
Cholesterol Management for Patients With Cardiovascular Conditions
Annual Monitoring for Patients on Persistent Medications
Use of Appropriate Medications for People with Asthma
Comprehensive Diabetes Care
Antibiotic Utilization
Frequency of Selected Procedures

All 11 measures with FY 2007–2008 and FY 2008–2009 results contained HEDIS specification changes in 2009. Despite the noted changes in HEDIS specifications involving the addition and deletion of procedure and/or diagnosis codes, HSAG determined that the impact on the yearly comparisons would be minimal at most.

Colorado Access

The FY 2008–2009 HEDIS calculation required data collection during calendar year 2008. Because Colorado Access did not join the Medicaid program until August 2008, it was not required to participate in this activity.

Denver Health Medicaid Choice

Table 3-7 displays the DHMC rates and audit designations for each performance measure and submeasure. Changes between the FY 2007–2008 and FY 2008–2009 rates for the *Use of Services: Inpatient Utilization—General Hospital Acute Care* and *Use of Services: Ambulatory Care* measures may not conclusively denote an improvement or decline.[3-1] In addition, since the procedures listed under *Frequency of Selected Procedures* often showed wide variations and might generate concern regarding potentially inappropriate utilization, caution should be applied when interpreting the percentile ratings associated with the rates reported. Consequently, information displayed for these measures was for informational purposes only, and the health plan's performance on these measures was not evaluated.

Table 3-7—Review Results and Audit Designation *for* DHMC

Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Childhood Immunization Status					
Combo #2	85.16%	87.59%	>90th	R	R
Combo #3	84.18%	87.10%	>90th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	63.11%	56.20%	25th–50th	R	R
Well-Child Visits 3–6 Years of Life	56.93%	63.02%	25th–50th	R	R
Adolescent Well-Care Visits	31.85%	41.85%	25th–50th	R	R
Annual Dental Visits	—	0.02%	<10th	—	R
Children's & Adolescents' Access to PCPs					
12–24 months	—	90.63%	10th–25th	—	R
25 months–6 years	—	77.64%	10th–25th	—	R

[3-1] Decrease in service utilization in terms of discharges, days or average length of stay may suggest improvement for institutional service utilization only when there was a corresponding increase in service use in ambulatory services. In addition, HSAG could not ascertain whether a decrease in utilization in both service types was a result of service improvement or limited service access. As such, changes in rates were presented for information purposes.

Table 3-7—Review Results and Audit Designation *for* DHMC					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
7–11 years	—	81.91%	10th–25th	—	R
12–19 years	—	83.64%	25th–50th	—	R
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	66.11%	68.87%	10th–25th	R	R
45–64 Years	68.69%	70.69%	<10th	R	R
65+ Years	56.36%	59.91%	10th–25th	R	R
Timeliness of Prenatal Care	82.73%	86.13%	50th–75th	R	R
Postpartum Care	55.23%	59.12%	25th–50th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	9.74	5.68	10th	R	R
Days (Per 1,000 Member Months)	39.66	21.73	10th–25th	R	R
Average Length of Stay	4.07	3.82	50th–75th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	—	2.47	10th–25th	—	R
Days (Per 1,000 Member Months)	—	9.40	25th–50th	—	R
Average Length of Stay	—	3.81	50th–75th	—	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	—	0.93	25th–50th	—	R
Days (Per 1,000 Member Months)	—	6.32	50th–75th	—	R
Average Length of Stay	—	6.83	75th–90th	—	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months aged 10–64 years)	—	5.03	25th–50th	—	R
Days (Per 1,000 Member Months aged 10–64 years)	—	13.01	25th–50th	—	R
Average Length of Stay	—	2.58	25th–50th	—	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	246.58	219.95	10th–25th	R	R
ED Visits	36.29	9.43	<10th	R	R
Ambulatory Surgery/Procedures	3.44	16.46	>90th	R	R
Observation Room Stays Resulting in Discharge	1.60	0.81	10th–25th	R	R
Cholesterol Management for People With CV Conditions					
LDL-C Screening Performed	70.59%	85.19%	75th–90th	R	R
LDL-C Control (< 100 mg/dL)	50.98%	75.93%	>90th	R	R
Annual Monitoring for Patients on Persistent Medications	77.28%	80.84%	25th–50th	R	R

Table 3-7—Review Results and Audit Designation *for* DHMC					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Use of Appropriate Medications for People With Asthma	—	86.35%	25th–50th	—	R
Comprehensive Diabetes Care					
HbA1c Testing	—	88.33%	75th–90th	—	R
HbA1c Poor Control (> 9.0%)	—	25.83%	<10th	—	R
HbA1c Control (<8.0%)	—	47.78%	NA	—	R
Eye Exam	—	50.69%	25th–50th	—	R
LDL-C Screening	—	75.97%	50th–75th	—	R
LDL-C Level < 100 mg/dl	—	52.08%	>90th	—	R
Medical Attention for Nephropathy	—	83.06%	75th–90th	—	R
Blood Pressure Controlled <130/80 mmHg	—	42.22%	>90th	—	R
Blood Pressure Controlled <140/90 mmHg	—	66.81%	75th–90th	—	R
Antibiotic Utilization					
Average Scrips PMPY for Antibiotics	—	0.39	<10th	—	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips	—	25.59%	10th–25th	—	R
Frequency of Selected Procedures					
Myringotomy (0–4 Male & Female)	—	0.02	<10th	—	R
Myringotomy (5–19 Male & Female)	—	0.00	<10th	—	R
Tonsillectomy (0–9 Male & Female)	—	0.04	<10th	—	R
Tonsillectomy (10–19 Male & Female)	—	0.00	10th	—	R
Dilation & Curettage (15–44 Female)	—	0.03	<10th	—	R
Dilation & Curettage (45–64 Female)	—	0.00	10th	—	R
Hysterectomy, Abdominal (15–44 Female)	—	0.09	<10th	—	R
Hysterectomy, Abdominal (45–64 Female)	—	0.17	<10th	—	R
Hysterectomy, Vaginal (15–44 Female)	—	0.06	25th–50th	—	R
Hysterectomy, Vaginal (45–64 Female)	—	0.08	25th	—	R
Cholecystectomy, Open (30–64 Male)	—	0.03	<75th	—	R
Cholecystectomy, Open (15–44 Female)	—	0.01	<90th	—	R
Cholecystectomy, Open (45–64 Female)	—	0.04	<75th	—	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	—	0.06	<10th	—	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	—	0.25	<10th	—	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	—	0.12	<10th	—	R
Back Surgery (20–44 Male)	—	0.17	10th–25th	—	R

Table 3-7—Review Results and Audit Designation *for* DHMC					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Back Surgery (20–44 Female)	—	0.05	<25th	—	R
Back Surgery (45–64 Male)	—	0.15	10th–25th	—	R
Back Surgery (45–64 Female)	—	0.29	25th–50th	—	R
Mastectomy (15–44 Female)	—	0.00	<90th	—	R
Mastectomy (45–64 Female)	—	0.08	<25th	—	R
Lumpectomy (15–44 Female)	—	0.03	<10th	—	R
Lumpectomy (45–64 Female)	—	0.04	<10th	—	R

— is shown when no data were available or the measure was not reported in last year's technical report.
R is shown when the rate was reportable, according to NCQA standards.
NA is shown when there were fewer than 30 cases in the denominator for the rate.

Strengths

Overall, DHMC showed strong results for performance measures. All DHMC's performance measures received an audit result of *Reportable* (R) for the current measurement cycle. The majority of measures with both previous and current measurement results demonstrated improvement. In particular, DMHC's FY 2008–2009 performance on several measures has improved by at least 5 percentage points: *Well-Child Visits 3–6 Years of Life* (6.09 percentage points); *Adolescent Well-Care Visits* (10.00 percentage points); *Cholesterol Management for People With CV Conditions, LDL-C Screening Performed* (14.60 percentage points); and *LDL-C Control <100 mg/dL* (24.95 percentage points). In addition, the two *Childhood Immunization Status* measures (*Combo #2* and *#3*) and the *LDL-C Control <100 mg/dL* measure under *Cholesterol Management for People With CV Conditions* ranked above the 90th percentile of HEDIS 2008 national rates, demonstrating DMHC's strength.

DHMC's strength was also noted in a few measures reporting for the first time in FY 2008–2009. Three submeasures under *Comprehensive Diabetes Care* (*HbA1c Poor Control >9.0 %, LDL-C Level < 100 mg/dL*, and *Blood Pressure Controlled <130/80 mmHg*) and the *Average Scrips PMPY for Antibiotics* measure under *Antibiotic Utilization* were within the top 10 percent of national performance, based on the HEDIS 2008 national rates.

Recommendations

Results of DMHC's performance measures yielded several opportunities for improvement. One comparable measure (*Well-Child Visits in the First 15 Months of Life, 6+ Visits*) declined in performance from the previous measurement year more than 5 percentage points. In addition, two measures ranked below the national 10th percentile: *Annual Dental Visits* and *Adults' Access to Preventive/Ambulatory Health Services* (*45–64 Years*).

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

- Implementing quality strategies to improve the rate for *Well-Child Visits in the First 15 Months of Life, 6+ Visits*.
- Implementing quality improvement strategies to improve the rate for *Annual Dental Visits*.
- Implementing quality strategies tailored to the 45-to-64-year-old age group to improve the rate for *Adults' Access to Preventive/Ambulatory Health Services*.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, DHMC improved on the majority of measures reported for both previous and current measurement cycles. Several measures reported the first time for the current measurement year attained the 2008 HEDIS national Medicaid top 10 percentile performance. The following is a summary assessment of DMHC's performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** DHMC's overall performance in the quality domain was strong, with potential areas for improvement in a few measures. Five of the six measures with previous and current measurement results showed strong improvements, with four measures having increased rates by more than 5 percentages points. One comparable measure (*Cholesterol Management for People With CV Condition, LDL-C Control < 100 mg/dL*) and four first-time measures (three *Comprehensive Diabetes Care* submeasures and the *Average Scrips PMPY for Antibiotics* measure) also performed within the top 10 percent of 2008 HEDIS national performance. Opportunities for improvement were noted in the *Well-Child Visits in the First 15 Months of Life 6+ Visits* measure. The rate for this measure for the current measurement year declined by 6.91 percentage points.
- **Timeliness:** DMHC demonstrated strengths and improvement in its timeliness measures. The two *Childhood Immunization Status* measures (*Combo #2* and *#3*) had increased performance from last measurement year. These measures also ranked among the top 10 percent of 2008 national performance.
- **Access:** DHMC had mixed performance in the access domain. The MCO exhibited improvements in all three measures with previous and current measurement years (*Adults' Access to Preventive/Ambulatory Health Services*, *Timeliness of Prenatal Care*, and *Postpartum Care*). Nonetheless, the *Adults' Access to Preventive/Ambulatory Health Services* for the *45–64 Years* age group ranked below the 10th percentile. Although most of the measures under *Children's & Adolescents' Access to PCP* were scored above 80 percent, three of them ranked below the 25th percentile of 2008 national rates.

Rocky Mountain Health Plans

Table 3-8 displays the RMHP rates and audit results for each performance measure. Changes between the FY 2007–2008 and FY 2008–2009 rates for the *Use of Services: Inpatient Utilization—General Hospital Acute Care* and *Use of Services: Ambulatory Care* measures may not conclusively denote an improvement or decline.[3-2] In addition, since the procedures listed under *Frequency of Selected Procedures* often showed wide variations and might generate concern regarding potentially inappropriate utilization, caution should be applied when interpreting the percentile ratings associated with the rates reported. Consequently, information displayed for these measures was for informational purposes only, and the MCO's performance on these measures was not evaluated.

Table 3-8—Review Results and Audit Designation *for* RMHP

Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Childhood Immunization Status					
Combo #2	81.50%	78.32%	50th–75th	R	R
Combo #3	75.86%	73.71%	50th–75th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	30.60%	77.32%	>90th	R	R
Well-Child Visits 3–6 Years of Life	59.55%	63.47%	25th–50th	R	R
Adolescent Well-Care Visits	40.84%	45.50%	50th–75th	R	R
Annual Dental Visits	—	NB	—	—	R
Children's & Adolescents' Access to PCPs					
12–24 months	—	98.29%	75th–90th	—	R
25 months–6 years	—	89.06%	50th–75th	—	R
7–11 years	—	92.33%	75th–90th	—	R
12–19 years	—	91.88%	90th	—	R
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	83.71%	86.08%	75th–90th	R	R
45–64 Years	87.99%	87.64%	50th–75th	R	R
65+ Years	94.98%	95.22%	>90th	R	R
Timeliness of Prenatal Care	97.12%	95.22%	>90th	R	R
Postpartum Care	72.84%	71.94%	>90th	R	R

[3-2] Decrease in service utilization in terms of discharges, days, or average length of stay may suggest improvement for institutional service utilization only when there was a corresponding increase in service use in ambulatory services. In addition, HSAG could not ascertain whether a decrease in utilization in both service types was a result of service improvement or limited service access. As such, changes in rates were presented for informational purposes.

Table 3-8—Review Results and Audit Designation *for* RMHP					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	14.80	13.9	>90th	—	R
Days (Per 1,000 Member Months)	48.45	46.48	>90th	—	R
Average Length of Stay	3.27	3.34	25th–50th	—	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	—	5.05	75th–90th	—	R
Days (Per 1,000 Member Months)	—	18.60	75th–90th	—	R
Average Length of Stay	—	3.68	25th–50th	—	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	—	2.92	>90th	—	R
Days (Per 1,000 Member Months)	—	16.31	>90th	—	R
Average Length of Stay	—	5.58	50th–75th	—	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months aged 10–64 years)	—	12.23	>90th	—	R
Days (Per 1,000 Member Months aged 10–64 years)	—	23.76	75th–90th	—	R
Average Length of Stay	—	1.94	<10th	—	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	440.63	461.34	>90th	R	R
ED Visits	54.09	59.16	25th–50th	R	R
Ambulatory Surgery/Procedures	12.17	13.60	>90th	R	R
Observation Room Stays Resulting in Discharge	1.17	1.25	25th–50th	R	R
Cholesterol Management for People With CV Conditions (changed in 2007)					
LDL-C Screening Performed	74.39%	69.88%	10th–25th	R	R
LDL-C Control (< 100 mg/dL)	57.32%	45.78%	50th–75th	R	R
Annual Monitoring for Patients on Persistent Medications	65.20%	71.38%	<10th	R	R
Use of Appropriate Medications for People With Asthma	—	88.97%	50th–75th	—	R

Table 3-8—Review Results and Audit Designation *for* RMHP					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Comprehensive Diabetes Care					
HbA1c Testing	—	85.69%	75th–90th	—	R
HbA1c Poor Control (> 9.0%)	—	25.77%	<10th	—	R
HbA1c Control (<8.0%)	—	64.42%	NA	—	R
Eye Exam	—	61.96%	50th–75th	—	R
LDL-C Screening	—	70.14%	25th–50th	—	R
LDL-C Level < 100 mg/dl	—	43.76%	>90th	—	R
Medical Attention for Nephropathy	—	76.07%	50th	—	R
Blood Pressure Controlled <130/80 mmHg	—	47.03%	>90th	—	R
Blood Pressure Controlled <140/90 mmHg	—	79.14%	>90th	—	R
Antibiotic Utilization					
Average Scrips PMPY for Antibiotics	—	1.13	50th–75th	—	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips	—	38.77%	25th–50th	—	R
Frequency of Selected Procedures					
Myringotomy (0–4 Male & Female)	—	3.88	75th–90th	—	R
Myringotomy (5–19 Male & Female)	—	0.48	50th–75th	—	R
Tonsillectomy (0–9 Male & Female)	—	0.96	75th–90th	—	R
Tonsillectomy (10–19 Male & Female)	—	0.92	>90th	—	R
Dilation & Curettage (15–44 Female)	—	0.16	25th–50th	—	R
Dilation & Curettage (45–64 Female)	—	0.42	75th–90th	—	R
Hysterectomy, Abdominal (15–44 Female)	—	0.33	75th–90th	—	R
Hysterectomy, Abdominal (45–64 Female)	—	0.42	25th–50th	—	R
Hysterectomy, Vaginal (15–44 Female)	—	0.85	>90th	—	R
Hysterectomy, Vaginal (45–64 Female)	—	0.42	>90th	—	R
Cholecystectomy, Open (30–64 Male)	—	0.00	<75th	—	R
Cholecystectomy, Open (15–44 Female)	—	0.03	<90th	—	R
Cholecystectomy, Open (45–64 Female)	—	0.21	>90th	—	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	—	0.33	50th–75th	—	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	—	1.54	>90th	—	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	—	1.27	>90th	—	R
Back Surgery (20–44 Male)	—	1.32	>90th	—	R
Back Surgery (20–44 Female)	—	0.56	>90th	—	R
Back Surgery (45–64 Male)	—	0.37	25th–50th	—	R

Table 3-8—Review Results and Audit Designation *for* RMHP					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Back Surgery (45–64 Female)	—	1.38	>90th	—	R
Mastectomy (15–44 Female)	—	0.10	>90th	—	R
Mastectomy (45–64 Female)	—	0.21	75th–90th	—	R
Lumpectomy (15–44 Female)	—	0.29	75th–90th	—	R
Lumpectomy (45–64 Female)	—	0.74	75th–90th	—	R

— is shown when no data were available or the measure was not reported in last year's technical report.
R is shown when the rate was reportable, according to NCQA standards.
NA is shown when there were fewer than 30 cases in the denominator for the rate.
NB is shown when the organization did not offer the health benefits required by the measure.

Strengths

Overall, RMHP showed strong results for its performance measures. All performance measures received an audit result of *Reportable* for the current measurement year. The majority of measures with both previous and current measurement results demonstrated improvement. In particular, performance on two measures has improved by at least 5 percentage points: *Well-Child Visits in the First 15 Months of Life 6+ Visits* (46.72 percentage points) and *Annual Monitoring for Patients on Persistent Medications* (6.18 percentage points).

RMHP's strength was also noted in a few measures reported for the first time in FY 2008–2009. The *Children's & Adolescents' Access to PCPs* for the *12-19 Years* age group and four measures under *Comprehensive Diabetes Care* (*HbA1c Poor Control >9.0 %*, *LDL-C Level < 100 mg/dL*, *Blood Pressure Controlled <130/80 mmHg*, and *Blood Pressure Controlled < 140/90 mmHg*) were in the top 10 percent of national performance based on the HEDIS 2008 national rates.

Recommendations

Results of RMHP's performance measures yielded several opportunities for improvement. The *LDL-C Control < 100 mg/dL* measure under *Cholesterol Management for People With CV Conditions* declined in performance from the previous measurement year by more than 5 percentage points. In addition, although the *Annual Monitoring for Patients on Persistent Medications* had improved 6.18 percentage points from last measurement year, the FY 2008–2009 rate was still at the bottom 10 percent of national performance.

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

- Implementing quality strategies to improve the rate for *LDL-C Control < 100 mg/dL* under *Cholesterol Management for People With CV Conditions*.
- Implementing quality improvement strategies to improve the rate for *Annual Monitoring for Patients on Persistent Medications*.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, about half of the RMHP measures reported for the previous measurement year improved in the current year. Rates for several first-time measures were in the 2008 HEDIS national Medicaid top 10th percentile. The following is a summary assessment of RMHP's performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** RMHP's overall performance in the quality domain was mixed. Four of the six measures with previous measurement results showed strong improvements. In particular, the *Well-Child Visits in the First 15 Months of Life 6+ Visits* measure has improved from 30.60 percent to 77.32 percent. This measure also ranked above the 90th percentile. However, the two measures under *Cholesterol Management for People With CV Conditions* indicated opportunities for improvement, especially for the *LDL-C Control < 100 mg/dL* measure with a drop of 11.54 percentage points. Although *Annual Monitoring for Patients on Persistent Medications* had improved 6.18 percentage points from last measurement year, the FY 2008–2009 rate was still in the bottom 10 percent of national performance. First-time quality measures under *Comprehensive Diabetes Care* (*HbA1c Poor Control >9.0 %, LDL-C Level < 100 mg/dL, Blood Pressure Controlled <130/80 mmHg,* and *Blood Pressure Controlled < 140/90 mmHg*) were in the top 10 percent of performance based on the HEDIS 2008 national rates.
- **Timeliness:** RMHP's performance in this domain presented opportunities for improvement. The rates for the two *Childhood Immunization Status* measures (*Combo #2* and *#3*) had declined from last measurement year, although the decline was less than 5 percentage points. These measures ranked between the 50th and 75th percentiles of 2008 national performance.
- **Access:** Improvement was noted in two measures (*Adults' Access to Preventive/Ambulatory Health Services for 20-44 Years and 65+ Years*), although these improvements were less than 5 percentage points. In addition, most of the access-related measures were in the top 10 percent of national performance. All measures under *Children's & Adolescents' Access to PCPs* were scored above 85 percent, with three of them ranked above the 75th percentile of 2008 national rates.

Primary Care Physician Program

HSAG conducted an NCQA HEDIS Compliance Audit for PCPP. The NCQA HEDIS Compliance Audit followed NCQA audit methodology. This audit methodology complied with both NCQA and CMS specifications and allowed for a complete and reliable evaluation of the health plan. The auditor's responsibility was to express an opinion on the performance report based on an examination using NCQA procedures that the auditor considered necessary to obtain a reasonable basis for rendering an opinion.

Table 3-9 displays the key types of data sources used in the validation of performance measures and the time period to which the data applied.

Table 3-9—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
HEDIS Record of Administration, Data Management and Processes (Roadmap)	CY 2008
Certified Software Report	CY 2008
Performance Measure Reports	CY 2008
Supporting Documentation	CY 2008
On-site Interviews and Information Systems Demonstrations	CY 2008
Note: CY stands for calendar year.	

HSAG gave one of four audit findings to each measure: *Reportable* (R), *Not Applicable* (NA), *No Benefit* (NB), or *Not Reportable* (NR) based on NCQA standards.

Findings

Table 3-10 displays the PCPP rates and audit results for each performance measure. Changes between the FY 2007–2008 and FY 2008–2009 rates for the *Use of Services: Inpatient Utilization—General Hospital Acute Care* and *Use of Services: Ambulatory Care* measures may not conclusively denote an improvement or decline.[3-3] In addition, since the procedures listed under *Frequency of Selected Procedures* often showed wide variations and might generate concern regarding potentially inappropriate utilization, caution should be applied when interpreting the percentile ratings associated with the rates reported. Consequently, information displayed for these measures was for informational purposes only, and the MCO's performance on these measures was not evaluated.

[3-3] Decrease in service utilization in terms of discharges, days or average length of stay may suggest improvement for institutional service utilization only when there was a corresponding increase in service use in ambulatory services. In addition, HSAG could not ascertain whether a decrease in utilization in both service types was a result of service improvement or limited service access. As such, changes in rates were presented for information purposes.

Table 3-10—Review Results and Audit Designation *for* PCPP					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Childhood Immunization Status					
Combo #2	78.60%	70.07%	25th–50th	R	R
Combo #3	69.82%	65.45%	25th–50th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	56.48%	15.94%	<10th	R	R
Well-Child Visits 3–6 Years of Life	42.58%	46.23%	<10th	R	R
Adolescent Well-Care Visits	15.16%	27.98%	10th–25th	R	R
Annual Dental Visits	—	61.90%	>90th	—	R
Children's & Adolescents' Access to PCPs					
12–24 months	—	14.88%	<10th	—	R
25 months–6 years	—	22.77%	<10th	—	R
7–11 years	—	33.67%	<10th	—	R
12–19 years	—	38.71%	<10th	—	R
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	64.59%	81.76%	50th–75th	R	R
45–64 Years	63.67%	86.73%	50th–75th	R	R
65+ Years	15.15%	81.92%	50th–75th	R	R
Timeliness of Prenatal Care	63.45%	70.21%	10th–25th	R	R
Postpartum Care	65.27%	58.22%	25th–50th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	8.29	9.02	50th–75th	R	R
Days (Per 1,000 Member Months)	40.94	48.62	>90th	R	R
Average Length of Stay	4.94	5.39	>90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	—	5.39	75th–90th	—	R
Days (Per 1,000 Member Months)	—	26.10	>90th	—	R
Average Length of Stay	—	4.84	>90th	—	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	—	2.38	>90th	—	R
Days (Per 1,000 Member Months)	—	19.19	>90th	—	R
Average Length of Stay	—	8.05	>90th	—	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months aged 10–64 years)	—	2.25	<10th	—	R
Days (Per 1,000 Member Months aged 10–64 years)	—	6.00	<10th	—	R
Average Length of Stay	—	2.67	50th–75th	—	R

Table 3-10—Review Results and Audit Designation *for* PCPP					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	298.67	434.21	>90th	R	R
ED Visits	50.18	63.78	50th–75th	R	R
Ambulatory Surgery/Procedures	7.14	14.47	>90th	R	R
Observation Room Stays Resulting in Discharge	1.43	1.57	25th–50th	R	R
Cholesterol Management for People With CV Conditions (changed in 2007)					
LDL-C Screening Performed	69.23%	58.61%	<10th	R	R
LDL-C Control (< 100 mg/dL)	24.48%	24.54%	10th–25th	R	R
Annual Monitoring for Patients on Persistent Medications	79.96%	82.24%	50th–75th	R	R
Use of Appropriate Medications for People With Asthma	—	87.81%	25th–50th	—	R
Comprehensive Diabetes Care					
HbA1c Testing	—	66.91%	10th–25th	—	R
HbA1c Poor Control (> 9.0%)	—	64.96%	75th–90th	—	R
HbA1c Control (< 8.0%)	—	29.20%	NA	—	R
Eye Exam	—	37.96%	10th–25th	—	R
LDL-C Screening	—	57.66%	<10th	—	R
LDL-C Level < 100 mg/dl	—	23.60%	10th–25th	—	R
Medical Attention for Nephropathy	—	55.47%	<10th	—	R
Blood Pressure Controlled <130/80 mmHg	—	24.09%	10th–25th	—	R
Blood Pressure Controlled <140/90 mmHg	—	36.74%	<10th	—	R
Antibiotic Utilization					
Average Scrips PMPY for Antibiotics	—	1.14	50th–75th	—	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips	—	41.33%	25th–50th	—	R
Frequency of Selected Procedures					
Myringotomy (0–4 Male & Female)	—	2.95	50th–75th	—	R
Myringotomy (5–19 Male & Female)	—	0.68	75th–90th	—	R
Tonsillectomy (0–9 Male & Female)	—	0.90	75th	—	R
Tonsillectomy (10–19 Male & Female)	—	0.63	>90th	—	R
Dilation & Curettage (15–44 Female)	—	0.15	25th–50th	—	R
Dilation & Curettage (45–64 Female)	—	0.16	25th–50th	—	R
Hysterectomy, Abdominal (15–44 Female)	—	0.32	75th–90th	—	R
Hysterectomy, Abdominal (45–64 Female)	—	0.38	10th–25th	—	R
Hysterectomy, Vaginal (15–44 Female)	—	0.41	>90th	—	R

Table 3-10—Review Results and Audit Designation *for* PCPP					
Performance Measures	Rate		2008 HEDIS Percentile Ratings	Audit Designation	
	FY 2007–2008	FY 2008–2009		FY 2007–2008	FY 2008–2009
Hysterectomy, Vaginal (45–64 Female)	—	0.19	25th–50th	—	R
Cholecystectomy, Open (30–64 Male)	—	0.00	<75th	—	R
Cholecystectomy, Open (15–44 Female)	—	0.04	<90th	—	R
Cholecystectomy, Open (45–64 Female)	—	0.19	75th–90th	—	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	—	0.62	>90th	—	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	—	1.03	75th–90th	—	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	—	1.01	75th–90th	—	R
Back Surgery (20–44 Male)	—	0.36	25th–50th	—	R
Back Surgery (20–44 Female)	—	0.29	50th–75th	—	R
Back Surgery (45–64 Male)	—	0.61	50th–75th	—	R
Back Surgery (45–64 Female)	—	1.11	>90th	—	R
Mastectomy (15–44 Female)	—	0.04	>90th	—	R
Mastectomy (45–64 Female)	—	0.03	10th–25th	—	R
Lumpectomy (15–44 Female)	—	0.11	25th–50th	—	R
Lumpectomy (45–64 Female)	—	0.38	10th–25th	—	R

— is shown when no data were available or the measure was not reported in last year's technical report.
R is shown when the rate was reportable, according to NCQA standards.
NA is shown when there were fewer than 30 cases in the denominator for the rate.

Strengths

Overall, PCPP showed very strong performance for some of its measures. All but one of PCPP's performance measures received an audit result of *Reportable*. The majority of measures with both previous and current measurement results demonstrated improvements. Performance on four measures has improved by at least 10 percentage points: *Adolescent Well-Care Visits* (12.82 percentage points) and *Adults' Access to Preventive /Ambulatory Health Services* measures for the *20–44 Years* (17.17 percentage points), *45–64 Years* (23.06 percentage points), and *65+ Years* (66.77 percentage points) age groups. The substantial improvement identified in the *Adults' Access to Preventive/Ambulatory Health Services* measures placed PCPP between the 50th and 75th percentile of 2008 national performance. PCPP's strength was also noted in the *Annual Dental Visits* measure, with a rate that ranked within the top 10 percent of national performance.

Recommendations

Results of PCPP's performance measures yielded several opportunities for improvement. Three comparable measures (*Well-Child Visits in the First 15 Months of Life 6+ Visits*, *Postpartum Care*, and *LDL-C Screening Performed* under *Cholesterol Management for People With CV Conditions*) declined in performance from the previous measurement cycle by more than 5 percentage points. More specifically, the drop in performance for the *Well-Child Visits in the First 15 Months of Life 6+ Visits* measure placed PCPP below the 10th percentile. Several other measures also ranked in the bottom 10 percent of national performance, including *Well-Child Visits 3–6 Years of Life*, *LDL-C Screening Performed* under *Cholesterol Management for People With CV Conditions*, and four measures under *Comprehensive Diabetes Care* (*HbA1c Poor Control > 9.0%*, *LDL-C Screening*, *Medical Attention for Nephropathy*, and *Blood Pressure Controlled < 140/90 mmHg*).

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

- Implementing quality improvement strategies to improve the rate for *Well-Child Visits in the First 15 Months of Life 6+ Visits* and *Well-Child Visits 3–6 Years of Life*.
- Implementing quality improvement strategies to improve the rate for *Postpartum Care*.
- Implementing quality strategies to improve the rate for *LDL-C Screening Performed* under *Cholesterol Management for People With CV Conditions*.
- Implementing quality improvement strategies to improve the overall rates for *Comprehensive Diabetes Care*, especially *HbA1c Poor Control > 9.0%*, *LDL-C Screening*, *Medical Attention for Nephropathy*, *and Blood Pressure Controlled < 140/90 mmHg*.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, more than half of the PCPP measures reported for both previous and current measurement years improved in FY 2008–2009. Several measures reported for the first time in the current measurement year performed above the median HEDIS national performance. The following is a summary assessment of PCPP's performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** PCPP's performance in the quality domain provided ample opportunities for improvement. Noticeable improvement and decline were observed in measures with previous and current measurement years. Four measures showed improvements, especially the *Adolescent Well-Care Visits* measure, for which the rate improved by 12.82 percentage points. However, the rates of two quality measures (*Well-Child Visits in the First 15 Months of Life 6+ Visits* and *LDL-C Screening Performed* under *Cholesterol Management for People With CV Conditions*) declined by more than 10 percentage points. These declines placed PCPP performance below the 10th percentile of 2008 national rates. Several other measures also ranked in the bottom 10 percent of national performance, including four measures under *Comprehensive Diabetes Care* (*HbA1c Poor Control > 9.0%*, *LDL-C Screening*, *Medical Attention for Nephropathy*, and *Blood Pressure Controlled < 140/90 mmHg)* and the *Well-Child Visits 3–6 Years of Life* measure.

- **Timeliness:** PCPP's overall performance in this domain presented opportunities for improvement. The rates for the two *Childhood Immunization Status* measures (*Combo #2* and *#3*) declined from last measurement year, especially for *Combo #2* (an 8.53 percentage-point drop). Performance in FY 2008–2009 placed PCPP between the 25th and 50th percentile of 2008 HEDIS national rates.
- **Access:** PCPP had mixed performance in the access domain. The program exhibited strong improvement in *Adults' Access to Preventive/Ambulatory Health Services* and *Timeliness of Prenatal Care*, with the former measures demonstrating improvement of at least 15 percentage points. On the other hand, Postpartum Care had a decline of 7.05 percentage points from last measurement year. For measures reporting for the first time, *Annual Dental Visits* ranked above the 90th percentile and all measures under *Children's & Adolescents' Access to PCPs* ranked below the 10th percentile of 2008 national rates. These rates presented a diverse performance profile for PCPP in the access domain.

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

Table 3-11 provides a statewide summary of the rates of the performance measures for FY 2007–2008 and FY 2008–2009. Changes between the FY 2007–2008 and FY 2008–2009 rates for the *Use of Services: Inpatient Utilization—General Hospital Acute Care* and *Use of Services: Ambulatory Care* measures may not conclusively denote an improvement or decline. In addition, since the procedures listed under *Frequency of Selected Procedures* often showed wide variations and might generate concern regarding potentially inappropriate utilization, caution should be applied when interpreting the percentile ratings associated with the rates reported. Consequently, information displayed for these measures was for informational purposes only, and the MCO's performance on these measures was not evaluated.

Table 3-11—Statewide Summary of Rates for the Performance Measures

Performance Measures	Overall Rates		2008 HEDIS Percentile Ratings
	FY 2007–2008	FY 2008–2009	
Childhood Immunization Status			
Combo #2	81.75%	78.66%	50th–75th
Combo #3	76.62%	75.42%	75th–90th
Well-Child Visits in the First 15 Months of Life, 6+ Visits	50.06%	49.82%	25th–50th
Well-Child Visits 3–6 Years of Life	53.02%	57.57%	10th–25th
Adolescent Well-Care Visits	29.28%	38.44%	25th–50th
Annual Dental Visits	—	30.96%	10th–25th
Children's & Adolescents' Access to PCPs			
12–24 months	—	67.93%	<10th
25 months–6 years	—	63.16%	<10th
7–11 years	—	69.30%	<10th
12–19 years	—	71.41%	10th–25th

Table 3-11—Statewide Summary of Rates for the Performance Measures			
Performance Measures	Overall Rates		2008 HEDIS Percentile Ratings
	FY 2007–2008	FY 2008–2009	
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	71.47%	78.90%	25th–50th
45–64 Years	73.45%	81.69%	25th–50th
65+ Years	55.50%	79.02%	25th–50th
Timeliness of Prenatal Care	81.10%	83.85%	25th–50th
Postpartum Care	64.45%	63.09%	50th–75th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)			
Discharges (Per 1,000 Member Months)	10.94	9.53	50th–75th
Days (Per 1,000 Member Months)	43.02	38.94	75th–90th
Average Length of Stay	4.09	4.18	75th–90th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)			
Discharges (Per 1,000 Member Months)	—	4.30	50th–75th
Days (Per 1,000 Member Months)	—	18.03	50th–75th
Average Length of Stay	—	4.11	75th–90th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)			
Discharges (Per 1,000 Member Months)	—	2.08	>90th
Days (Per 1,000 Member Months)	—	13.94	>90th
Average Length of Stay	—	6.82	75th–90th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)			
Discharges (Per 1,000 Member Months aged 10–64 years)	—	6.50	50th–75th
Days (Per 1,000 Member Months aged 10–64 years)	—	14.26	50th–75th
Average Length of Stay	—	2.40	10th–25th
Use of Services: Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	328.63	371.83	75th–90th
ED Visits	46.85	44.12	10th–25th
Ambulatory Surgery/Procedures	7.58	14.84	>90th
Observation Room Stays Resulting in Discharge	1.40	1.21	25th–50th
Cholesterol Management for People With CV Conditions			
LDL-C Screening Performed	71.40%	71.23%	10th–25th
LDL-C Control (< 100 mg/dL)	44.26%	48.75%	75th–90th
Annual Monitoring for Patients on Persistent Medications	74.15	78.15%	25th–50th
Use of Appropriate Medications for People With Asthma	—	87.71%	25th–50th

Table 3-11—Statewide Summary of Rates for the Performance Measures			
Performance Measures	Overall Rates		2008 HEDIS Percentile Ratings
	FY 2007–2008	FY 2008–2009	
Comprehensive Diabetes Care			
HbA1c Testing	—	80.31%	50th–75th
HbA1c Poor Control (> 9.0%)	—	38.85%	25th–50th
HbA1c Control (<8.0%)	—	47.13%	NA
Eye Exam	—	50.20%	25th–50th
LDL-C Screening	—	67.92%	25th–50th
LDL-C Level < 100 mg/dl	—	39.81%	75th–90th
Medical Attention for Nephropathy	—	71.53%	25th–50th
Blood Pressure Controlled <130/80 mmHg	—	37.78%	75th–90th
Blood Pressure Controlled <140/90 mmHg	—	60.90%	50th–75th
Antibiotic Utilization			
Average Scrips PMPY for Antibiotics	—	0.89	10th–25th
Percentage of Antibiotics of Concern of all Antibiotic Scrips	—	35.23%	25th–50th
Frequency of Selected Procedures			
Myringotomy (0–4 Male & Female)	—	2.28	50th–75th
Myringotomy (5–19 Male & Female)	—	0.39	25th–50th
Tonsillectomy (0–9 Male & Female)	—	0.63	25th–50th
Tonsillectomy (10–19 Male & Female)	—	0.52	75th–90th
Dilation & Curettage (15–44 Female)	—	0.11	25th–50th
Dilation & Curettage (45–64 Female)	—	0.19	25th–50th
Hysterectomy, Abdominal (15–44 Female)	—	0.25	50th–75th
Hysterectomy, Abdominal (45–64 Female)	—	0.32	10th–25th
Hysterectomy, Vaginal (15–44 Female)	—	0.44	>90th
Hysterectomy, Vaginal (45–64 Female)	—	0.23	50th–75th
Cholecystectomy, Open (30–64 Male)	—	0.01	<75th
Cholecystectomy, Open (15–44 Female)	—	0.03	<90th
Cholecystectomy, Open (45–64 Female)	—	0.15	75th–90th
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	—	0.34	50th–75th
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	—	0.94	75th–90th
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	—	0.80	75th
Back Surgery (20–44 Male)	—	0.62	75th–90th
Back Surgery (20–44 Female)	—	0.30	75th
Back Surgery (45–64 Male)	—	0.38	25th–50th
Back Surgery (45–64 Female)	—	0.93	>90th
Mastectomy (15–44 Female)	—	0.05	>90th

Table 3-11—Statewide Summary of Rates for the Performance Measures			
Performance Measures	Overall Rates		2008 HEDIS Percentile Ratings
	FY 2007–2008	FY 2008–2009	
Mastectomy (45–64 Female)	—	0.11	50th–75th
Lumpectomy (15–44 Female)	—	0.14	25th–50th
Lumpectomy (45–64 Female)	—	0.39	10th–25th

— is shown when no data were available or the measure was not reported in last year's technical report.
R is shown when the rate was reportable, according to NCQA standards.
NA is shown when there were fewer than 30 cases in the denominator for the rate.

Strengths

Overall, the statewide results for performance measures were mixed. Eight measures with rates for both the previous and current measurement years improved. In particular, four measures increased their rates by more than 5 percentages points (*Adolescent Well-Care Visits* and measures for all three age groups under *Adults' Access to Preventive/Ambulatory Health Services*). One measure (*LDL-C Control < 100 mg/dL* under *Cholesterol Management for People With CV Conditions)* ranked above the 75th percentile for 2008. Among measures with first-time reporting in FY 2008–2009, two submeasures under *Comprehensive Diabetes Care* (*LDL-C Level < 100 mg/dL* and *Blood Pressure Controlled < 130/80 mmHg*) ranked above the national 75th percentile of HEDIS 2008 national rates.

Recommendations

Five measures (*Childhood Immunization Status Combo #2* and *#3*, *Well-Child Visits in the First 15 Months of Life 6+ Visits*, *Postpartum Care*, *LDL-C Screening Performed under Cholesterol Management for People with CV Conditions*) declined in performance, although the decrease was less than 5 percentage points. One measure's rate for FY 2008–2009 fell below the 25th percentile of national HEDIS 2008 rates.

The Medicaid program also showed opportunities for improvement for a few performance measures reported for the first time in the current measurement year. Statewide rankings for three age groups (*12–24 months*, *25 months–6 years*, and *7–11 years*) under *Children's & Adolescents' Access to PCPs* were below the 10th percentile of national HEDIS rates.

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

- Implementing quality strategies to improve the rates for *Well-Child Visits in the First 15 Months of Life (6+ Visits)*.
- Implementing quality strategies to improve the rate for *Childhood Immunization Status Combo #2* and *Combo #3*.
- Implementing quality strategies tailored to specific age or gender groups to improve the rate for *Children's & Adolescents' Access to PCPs*.

Summary Assessment Related to Quality, Timeliness, and Access

Statewide performance on the comparable measures with previous and current years' results was mixed, with strong improvement for eight measures and a modest decline for the other five measures. The following is a summary assessment of statewide performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** Results in the quality domain demonstrated mixed performance. Four of the six measures with previous measurement results improved (*Well-Child Visits 3–6 Years of Life*, *Adolescent Well-Care Visits*, *Annual Monitoring for Patients on Persistent Medications*, and *LDL-C Control < 100 mg/dL* under *Cholesterol Management for People With CV Conditions*). All improved by at least 4 percentage points from last year's results. The decline for the other two measures was minimal (< 0.5 percent). Statewide performance on several first-time measures ranked above the 75th percentile of national HEDIS 2008 rates, including *LDL-C Level < 100 mg /dL* and *Blood Pressure Controlled < 130/80 mmHg* under *Comprehensive Diabetes Care*. Among all the measures reported for this year, only two (*LDL-C Screening Performed* under *Cholesterol Management for People With CV Conditions* and *Average Scripts PMPY for Antibiotics* under *Antibiotic Utilization*) ranked below the 25th percentile of national 2008 rates.
- **Timeliness:** Current statewide performance on the two timeliness measures (*Childhood Immunization Status Combo #2* and *#3*) showed a modest decline from last year. For *Combo #2* the decline was 3.08 percentage points and for *Combo #3* the decline was 1.2 percentage points.
- **Access:** Statewide performance in the access domain demonstrated strong improvement for some measures but also suggested opportunities for improvement for other measures. Four of the five measures with last year's results exhibited improvement, with three (all under *Adults' Access to Preventive/Ambulatory Health Services*) having an increase of more than 7 percentage points. The rate for the *Postpartum Care* measure had a slight decline (1.36 percentage points) from last year. In addition, three of the five first-time measures (*Children's & Adolescents' Access to PCP – 12–24 months*, *25 months–6 years*, and *7–11 years*) ranked below the 10th percentile of national 2008 rates, and the remaining two (*Annual Dental Visits* and the *12–19 years* submeasure under *Children's & Adolescents' Access to PCPs*) ranked between 10th and 25th percentile of national performance.

Validation of Performance Improvement Projects

HSAG validated PIPs for Colorado Access, DHMC, and RMHP only. PCPP did not participate in this activity because it is not required for a PCCM plan.

For FY 2008–2009, the Department offered each health plan the option of conducting two PIPs or one PIP and one focused study with an intervention. Colorado Access opted to conduct one PIP and one focused study. DHMC and RMHP each conducted two PIPs. HSAG performed validation activities on one PIP for Colorado Access and two PIPs for DHMC and RMHP. The Department evaluated the Colorado Access focused study, and those results can be found in Section 7, State Initiatives.

In recent years the Department has focused on an initiative to improve coordination of care between Medicaid behavioral and physical health providers. As part of this initiative, the Department mandated a collaborative PIP across all Medicaid plans (both behavioral and physical health) with the goal of improving consumer health, functional status, and satisfaction with the health care delivery system by developing interventions that increase coordination of care and communication between providers. Because the health plans were in various stages of the PIP process, the State required that as each plan retired a current PIP, it must begin the State-mandated collaborative.

HSAG, in collaboration with the Department, developed the PIP Summary Form, which each health plan completed and submitted to HSAG for review and evaluation. For ongoing PIP studies, the health plan updated the form to include new data to support activities from the previous validation cycle. HSAG obtained data needed to conduct the PIP validation from the health plan's PIP Summary Form. This form provided detailed information about each health plan's PIP as it related to the 10 CMS protocol steps reviewed and evaluated by HSAG. The HSAG PIP Review Team scored the evaluation elements within each step as *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)* and included *Points of Clarification* when applicable. A *Point of Clarification* is used for elements with a *Met* score when documentation for an evaluation element includes the basic components to meet the requirements (as described in the narrative of the PIP), but additional documentation or an enhanced explanation in the next submission cycle would demonstrate a stronger understanding of CMS protocols.

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

- *Met*: High confidence/confidence in the reported PIP results.
- *Partially Met*: Low confidence in the reported PIP results.
- *Not Met*: Reported PIP results that were not credible.

The MCOs had an opportunity to resubmit additional documentation after the initial HSAG review to improve their scores prior to finalization of the FY 2008–2009 PIP Validation Report.

The HSAG PIP Review Team provided technical assistance to the health plans December 18, 2008. The presentation focused on how to complete the HSAG PIP Summary Form using CMS protocols as a guide. The presentation outlined the PIP study phases: study design, study implementation, and quality outcomes achieved. HSAG's PIP Review Team described the submission process and reviewed the current timeline for the annual submission and validation cycle. HSAG provided ongoing technical assistance to the plans throughout the contract year by responding to e-mail inquiries or scheduling conference calls with the plans, as requested.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain.

Appendix C contains further details about the EQR validation of PIP activities.

Colorado Access

Findings

Colorado Access conducted one PIP, *Coordination of Care*, which was new for this validation cycle. This study was a State-mandated, collaborative PIP.

For the *Coordination of Care* PIP, HSAG reviewed Steps I through IV. Table 3-12 and Table 3-13 show Colorado Access' scores based on HSAG's evaluation. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 3-12—PIP Validation Scores *for* Coordination of Care *for* Colorado Access

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	Not Assessed				1	Not Assessed			
VI. Review Data Collection Procedures	11	Not Assessed				1	Not Assessed			

Table 3-12—PIP Validation Scores *for* Coordination of Care *for* Colorado Access										
Review Step	**Total Possible Evaluation Elements** (Including Critical Elements)	**Total *Met***	**Total *Partially Met***	**Total *Not Met***	**Total *NA***	**Total Possible Critical Elements**	**Total Critical Elements *Met***	**Total Critical Elements *Partially Met***	**Total Critical Elements *Not Met***	**Total Critical Elements *NA***
VII. Assess Improvement Strategies	4	Not Assessed				1	Not Assessed			
VIII. Review Data Analysis and Study Results	9	Not Assessed				2	Not Assessed			
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**15**	**0**	**0**	**3**	**13**	**8**	**0**	**0**	**0**

Table 3-13—FY 2008-2009 Overall PIP Validation Scores and Validation Status *for* Coordination of Care *for* Colorado Access	
Percentage Score of Evaluation Elements *Met**	**100%**
Percentage Score of Critical Elements *Met* **	**100%**
Validation Status***	***Met***

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

** The percentage score for 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 high confidence/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

Colorado Access' score of 100 percent demonstrated a strong understanding of how to develop the study design and conduct a valid PIP. Colorado Access presented a well-defined study topic and study population. Colorado Access had an answerable study question that stated the problem in simple terms and set the focus of the study.

Recommendations

Based on the score of 100 percent for critical elements, HSAG had no required actions for Colorado Access' *Coordination of Care* PIP.

HSAG also provided *Points of Clarification* as opportunities for improvement. In most cases, if a *Point of Clarification* is not addressed, it will affect the score in future submissions. As a *Point of Clarification*, HSAG recommended that Colorado Access include in Activity I of the PIP Summary Form a discussion about the link between coordination of care and emergency room visits and hospital admissions, and how these are proxy measures for coordination of care.

Summary Assessment Related to Quality, Timeliness, and Access

The EQR activities related to PIPs were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, the summary assessment of Colorado Access's PIP validation results related to the domain of quality.

Colorado Access' performance regarding its PIP and the quality domain was strong. The goal of the study was to impact the quality of care provided to Colorado Access consumers by improving coordination of care between physical and behavioral health providers. Colorado Access will increase the likelihood of desired health outcomes for its consumers by improving coordination of care between behavioral and physical health providers. This PIP received a validation status of *Met*, with overall scores and critical elements scores of 100 percent. Colorado Access developed a solid study design in compliance with CMS protocols.

For this validation cycle, *Coordination of Care* was a Year 1 submission, with no baseline data reported. Therefore, HSAG was unable to provide a comparison of validation cycles.

Denver Health Medicaid Choice

Findings

DHMC conducted two PIPs: *Childhood Immunizations* and *Member Satisfaction With Access to Pharmacy Services Within Denver Health.* Both PIPs were selected by the MCO and were continued from the prior year.

For the FY 2008–2009 *Childhood Immunizations* PIP, HSAG reviewed Steps I through X. Table 3-14 and Table 3-15 show DHMC's scores based on HSAG's evaluation. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 3-14—PIP Validation Scores *for* Childhood Immunizations *for* DHMC

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic(s)	6	6	0	0	0	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	6	0	0	0	1	1	0	0	0
VI. Review Data Collection Procedures	11	10	0	0	1	1	1	0	0	0
VII. Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	9	0	0	0	2	2	0	0	0
IX. Assess for Real Improvement	4	1	2	1	0	0	0		No Critical Elements	
X. Assess for Sustained Improvement	1	0	1	0	0	0	0		No Critical Elements	
Totals for All Steps	**53**	**46**	**3**	**1**	**3**	**13**	**13**	**0**	**0**	**0**

Table 3-15—FY 2007–2008 and FY 2008–2009 Overall PIP Validation Scores and Validation Status *for* ***Childhood Immunizations*** *for* DHMC		
	FY 2007–2008	**FY 2008–2009**
Percentage Score of Evaluation Elements *Met**	**93%**	**92%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 High confidence/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

DHMC demonstrated strength in its study design and study implementation phases by receiving *Met* scores for all applicable evaluation elements in Steps I through VIII.

Recommendations

HSAG determined recommendations based on those evaluation elements that received a *Partially Met* or a *Not Met* score. DHMC received *Partially Met* scores in Step IX—which assesses for real improvement, and received a *Partially Met* score for Step X—which assesses for sustained improvement. To receive *Met* scores for Steps IX and X, DHMC must demonstrate improvement across all study indicators. HSAG recommends that in future PIP submissions, DHMC limit the number of study indicators.

HSAG also provided *Points of Clarification* as opportunities for improvement. In most cases, if a *Point of Clarification* is not addressed, it will affect the score in future submissions. HSAG recommended the following *Points of Clarification* for DHMC's *Childhood Immunizations* PIP:

- DHMC should provide the dates on which the causal/barrier analyses were performed.
- In the data table in the PIP Summary Form, Study Indicator 9 was for Combination 3 (all of Combination 2 plus VZV). Combination 3 should include PCV and not VZV as VZV was included in Combination 2.
- The *p* values from baseline to Remeasurement 1 should also be included in the PIP documentation.

For the *Member Satisfaction With Access to Pharmacy Services Within Denver Health* PIP, HSAG reviewed Steps I through X. Table 3-16 and Table 3-17 show DHMC's scores based on HSAG's evaluation. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 3-16—PIP Validation Scores
***for* Member Satisfaction With Access to Pharmacy Services Within Denver Health**
***for* DHMC**

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic(s)	6	6	0	0	0	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	6	0	0	0	1	1	0	0	0
VI. Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII. Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	9	0	0	0	2	2	0	0	0
IX. Assess for Real Improvement	4	2	2	0	0	0	No Critical Elements			
X. Assess for Sustained Improvement	1	1	0	0	0	0	No Critical Elements			
Totals for All Steps	**53**	**44**	**2**	**0**	**7**	**13**	**12**	**0**	**0**	**1**

Table 3-17—FY 2007–2008 and FY 2008–2009 Overall PIP Validation Scores and Validation Status
***for* Member Satisfaction With Access to Pharmacy Services Within Denver Health**
***for* DHMC**

	FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**95%**	**96%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 High confidence/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

When validating the *Member Satisfaction With Access to Pharmacy Services Within Denver Health* PIP, HSAG found that DHMC demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VIII. DHMC developed its interventions based on causes/barriers, and the interventions were system changes that would have a long-term effect on the results. Overall, the PIP demonstrated sustained improvement and had a positive impact on member satisfaction.

Recommendations

HSAG determined recommendations based on those evaluation elements that received a *Partially Met* or a *Not Met* score. DHMC received *Partially Met* scores in Step IX—which assesses for real improvement. To receive *Met* scores for Step IX, DHMC must demonstrate improvement across all study indicators. HSAG recommends that in future PIP submissions, DHMC limit the number of study indicators.

HSAG recommended the following *Points of Clarification* for DHMC's *Member Satisfaction With Access to Pharmacy Services Within Denver Health* PIP:

- DHMC should ensure that the question number in the study indicator matches the question number on the CAHPS survey.
- The study population definition should include the exclusion criteria discussed in the PIP Summary Form.
- The cover letter that was sent out with the CAHPS survey should be provided with the PIP submission.
- The PIP should include *p* values for comparisons of all measurement periods, starting with baseline to Remeasurement 1 and continuing through the final remeasurement period.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of DHMC's two PIPs, *Childhood Immunizations* and *Member Satisfaction With Access to Pharmacy Services Within Denver Health*, was to improve both the quality of, and access to, care and services, the EQR activities related to PIPs were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, the summary assessment of DHMC's PIP validation results related to the domain of quality.

Overall, DHMC's processes for conducting valid PIPs were strong. Both PIPs received a validation status of *Met*, with HSAG having confidence in the reported results.

Rocky Mountain Health Plans

Findings

RMHP conducted two PIPs: *Improving Well-Care Rates for Adolescents*, a plan-selected topic, and *Improving Coordination of Care for Members With Behavioral Health Conditions*, the State-mandated collaborative PIP. Both were new for this validation cycle. With the Department's permission, RMHP changed its *Improving Well-Care Rates for Children and Adolescents* PIP to focus on improving the rates of the adolescent population.

For the *Improving Well-Care Rates for Adolescents* PIP, HSAG reviewed Steps I through VIII. Table 3-18 and Table 3-19 show RMHP's scores based on HSAG's evaluation. HSAG reviewed and evaluated each step according to HSAG's validation methodology.

Table 3-18—PIP Validation Scores *for* Improving Well-Care Rates for Adolescents *for* RMHP

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic(s)	6	6	0	0	0	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI. Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII. Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	4	0	0	5	2	1	0	0	1
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**29**	**0**	**0**	**19**	**13**	**10**	**0**	**0**	**3**

Table 3-19—FY 2008-2009 Overall PIP Validation Scores and Validation Status for *Improving Well-Care Rates for Adolescents* for RMHP	
	FY 2008-2009
Percentage Score of Evaluation Elements *Met**	**100%**
Percentage Score of Critical Elements *Met***	**100%**
Validation Status***	***Met***

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

** The percentage score for 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 high confidence/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

When reviewing RMHP's *Improving Well-Care Rates for Adolescents* PIP, HSAG found that RMHP demonstrated strength in its study design and study implementation phases as evidenced by its score of 100 percent and *Met* validation status. RMHP conducted the baseline data analysis according to the data analysis plan in the study and provided clear and accurate baseline data.

Recommendations

HSAG recommended, as a *Point of Clarification,* that future submissions of the *Improving Adolescent Well-Care Visits* PIP include a complete interpretation of the results, including baseline results.

For the *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP, HSAG reviewed Steps I through IV. Table 3-20 and Table 3-21 show RMHP's scores based on HSAG's evaluation. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 3-20—PIP Validation Scores *for* Improving Coordination of Care for Members With Behavioral Health Conditions *for* RMHP

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	3	2	0	2	3	2	1	0	0

Table 3-20—PIP Validation Scores
***for* Improving Coordination of Care for Members With Behavioral Health Conditions**
***for* RMHP**

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	Not Assessed				1	Not Assessed			
VI. Review Data Collection Procedures	11	Not Assessed				1	Not Assessed			
VII. Assess Improvement Strategies	4	Not Assessed				1	Not Assessed			
VIII. Review Data Analysis and Study Results	9	Not Assessed				2	Not Assessed			
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**13**	**2**	**0**	**3**	**13**	**7**	**1**	**0**	**0**

Table 3-21—FY 2008-2009 Overall PIP Validation Scores and Validation Status
***for* Improving Coordination of Care for Members With Behavioral Health Conditions**
***for* RMHP**

Percentage Score of Evaluation Elements *Met**	**87%**
Percentage Score of Critical Elements *Met***	**88%**
Validation Status***	***Partially Met***

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

** The percentage score for 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 high confidence/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

RMHP demonstrated strength in its background documentation in Activity I of its *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP Summary Form. RMHP stated the study question in simple terms, and the question was in the correct format to meet CMS protocols. There were data available to be collected on both study indicators, and the study population was well defined and captured all members to whom the study question applied.

Recommendations

Based on the score of 88 percent for critical elements, HSAG has required actions for RMHPs' *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP. RMHP received *Partially Met* scores in Step III, Selected Study Indicators. HSAG recommends that RMHP revise Study Indicator 2 so that the intent of what the study indicator is measuring is clear.

Summary Assessment Related to Quality, Timeliness, and Access

The focus of RMHP's *Improving Well-Care Rates for Adolescents* PIP was to improve access to care and services, and the focus of the *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP was to improve both the quality of and access to care and services. The EQR activities related to PIPs, however, were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, the summary assessment of RMHP's PIP validation results related to the domain of quality.

Overall, RMHP had effective processes for conducting valid PIPs. This was clearly demonstrated by the *Met* validation status received for its *Improving Well-Care Rates for Adolescents* PIP. While RMHP received a validation status of *Partially Met* for its *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP, HSAG is confident that RMHP will make the necessary revisions and improve the validation status during the next review cycle.

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

Table 3-22 shows the health plans' overall performance based on HSAG's validation of the FY 2008–2009 PIPs that were submitted for validation.

Table 3-22—Summary of Each MCO's PIP Validation Scores and Validation Status

MCO	PIP Study	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Colorado Access	*Coordination of Care*	100%	100%	*Met*
DHMC	*Childhood Immunizations*	92%	100%	*Met*
DHMC	*Member Satisfaction With Access to Pharmacy Services Within Denver Health*	96%	100%	*Met*
RMHP	*Improving Well-Care Rates for Adolescents*	100%	100%	*Met*
RMHP	*Improving Coordination of Care for Members With Behavioral Health Conditions*	87%	88%	*Partially Met*

Overall, the health plans' PIPs demonstrated strong performance. HSAG gave 4 of the 5 PIPs reviewed a validation status of *Met*, with scores of 100 percent for critical elements *Met* and scores ranging from 92 percent to 100 percent for all evaluation elements *Met*. For the one RMHP PIP

receiving a *Partially Met* validation status, HSAG is confident the plan will address and correct the one critical element impacting the validation status.

The overall goal of the health plans' PIPs was to impact the quality of care provided to their members. The PIP scores demonstrate compliance with CMS protocols and the likelihood the plans will achieve the desired health outcomes for their members.

Table 3-23—Summary of Data From Validation of Performance Improvement Projects

Validation Step	Number of PIPs Meeting All Evaluation Elements/Number Reviewed		Number of PIPs Meeting All Critical Elements/Number Reviewed	
	FY 2007–2008	FY 2008–2009	FY 2007–2008	FY 2008–2009
I. Review the Selected Study Topic(s)	4/4	5/5	4/4	5/5
II. Review the Study Question(s)	4/4	5/5	4/4	5/5
III. Review the Selected Study Indicator(s)	4/4	4/5	4/4	4/5
IV. Review the Identified Study Population	4/4	5/5	4/4	5/5
V. Review Sampling Methods	2/2*	3/3	2/2	3/3
VI. Review Data Collection Procedures	4/4	3/3	4/4	3/3
VII. Assess Improvement Strategies	4/4	3/3	N/A**	3/3
VIII. Review Data Analysis and Study Results	4/4	3/3	4/4	3/3
IX. Assess for Real Improvement	0/3	0/2	No Critical Elements	
X. Assess for Sustained Improvement	1/1	1/2	No Critical Elements	

The shaded areas represent those steps in which not all elements were *Met*.

* The scoring methodology for Step V. Valid Sampling Techniques was changed. If sampling was not used, the evaluation element received a *Not Applicable*.

** For the FY 2007–2008 validation cycle, Step VII did not have any critical elements.

Table 3-23 provides a year-to-year comparison of the total number of PIPs submitted by the health plans that achieved a score of *Met* for all evaluation elements and for all critical elements by step. In both years, all PIPs that were submitted received scores of *Met* for all evaluation elements and for all critical elements for Steps I and II, represented by 4/4 and 5/5. In FY 2008–2009, two PIPs had progressed to Activity X in the PIP Summary Form. While some evaluation elements for these two PIPs may have been scored *Met*, *Partially Met*, or *Not Met*, only one of the two PIPs received a *Met* score for all evaluation elements in that step, represented as 1/2. DHMC achieved sustained improvement for its *Member Satisfaction With Access to Pharmacy Services Within Denver Health* PIP. DHMC plans to retire this PIP and will replace it with a new PIP or focus study for FY 2009–2010.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of the resulting health plan data.

Colorado Access did not join the Medicaid program until August 2008 and, therefore, was not required to conduct CAHPS surveys for FY 2008–2009. DHMC and RMHP were responsible for conducting their annual CAHPS surveys. The health plans forwarded results to HSAG for analysis. HSAG conducted the surveys on behalf of the Department for PCPP.

For each of the four global ratings, the rates were based on responses by members who chose a value of 9 or 10 on a scale of 0 to 10. For the composites, the rates were based on responses by members who chose "Always" or "Definitely Yes." Appendix E contains additional details about the technical methods of data collection and analysis of survey data and the 2008 NCQA CAHPS national averages.

For all of the health plans findings, a substantial increase is noted when a measure's rate increased by more than 5 percentage points. A substantial decrease is noted when a measure's rate decreased by more than 5 percentage points.

Denver Health Medicaid Choice

Findings

Table 3-24 displays the child Medicaid results achieved by DHMC for the current year (FY 2008–2009) and the prior year (FY 2007–2008).

Table 3-24—Child Medicaid Question Summary Rates and Global Proportions *for* DHMC

Measure	FY 2007–2008 Rate	FY 2008–2009 Rate
Getting Needed Care	*	NA
Getting Care Quickly	*	52.9%
How Well Doctors Communicate	61.8%	69.2%
Customer Service	*	NA
Shared Decision Making	**	NA
Rating of Personal Doctor	67.6%	64.4%
Rating of Specialist Seen Most Often	NA	NA

Table 3-24—Child Medicaid Question Summary Rates and Global Proportions *for* DHMC		
Measure	**FY 2007–2008 Rate**	**FY 2008–2009 Rate**
Rating of All Health Care	58.0%	50.5%
Rating of Health Plan	58.1%	57.8%

NA indicates that the measure had fewer than 100 respondents.

* The results for these measures are not comparable across the two years reported in the table, per NCQA, due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.

** The Shared Decision Making composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys.

Table 3-25 displays the adult Medicaid results achieved by DHMC during the current year (FY 2008–2009) and the prior year (FY 2007–2008).

Table 3-25—Adult Medicaid Question Summary Rates and Global Proportions *for* DHMC		
Measure	**FY 2007–2008 Rate**	**FY 2008–2009 Rate**
Getting Needed Care	44.9%	30.6%
Getting Care Quickly	48.1%	40.6%
How Well Doctors Communicate	73.8%	69.8%
Customer Service	NA	NA
Shared Decision Making	59.0%	53.0%
Rating of Personal Doctor	71.6%	68.8%
Rating of Specialist Seen Most Often	60.0%	NA
Rating of All Health Care	52.2%	42.4%
Rating of Health Plan	56.4%	47.6%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

The child Medicaid survey results showed a substantial decrease for one of the five comparable measures, *Rating of All Health Care*. Also, results showed slight decreases for *Rating of Personal Doctor* and *Rating of Health Plan*; however, these decreases were not substantial. DHMC should continue to direct quality improvement activities toward these measures.

The adult Medicaid survey results showed substantial decreases for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*. Therefore, DHMC should continue to direct quality improvement activities toward these measures.

Recommendations for improving performance for the adult and child populations include:

- ***Getting Needed Care***—Having scheduling models that allow for appointment flexibility, simplified patient flow, increased electronic communications that may reduce the need for an appointment, and improved access to health care information via the Internet to provide patients with instant feedback and education.
- ***Getting Care Quickly***—Having scheduling models that allow for appointment flexibility, simplified patient flow that limits bottlenecks and redundancies in the care process, increased electronic communications that allow for prompt care to patients who may not require an appointment, and improved access to health care information via the Internet to provide patients with instant feedback and education.
- ***Shared Decision Making***—Encouraging client participation in decision making, providing provider education on the importance of shared decision making, and ensuring enough time is spent with clients to allow for client education.
- ***Rating of Personal Doctor***—Having increased levels of patient-physician communication and decreased wait times by eliminating barriers that may prohibit patients from receiving prompt, adequate care.
- ***Rating of All Health Care***—Increasing access to care and improving overall patient satisfaction with patient health care and health plan experiences.
- ***Rating of Health Plan***—Increasing the distribution of information about the plan, improving customer service and client satisfaction with physicians, and having physician offices schedule routine appointments and obtain interpreters.

Summary Assessment Related to Quality, Timeliness, and Access

All of the measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness.

For the child Medicaid population, one of the five comparable measures' rates increased substantially: *How Well Doctors Communicate* (7.4 percentage points). Three comparable measures' rates decreased. One of the measures' rates decreased substantially: *Rating of All Health Care* (7.5 percentage points). DHMP had the lowest rates among the health plans in FY 2008–2009 for five measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of All Health Care,* and *Rating of Health Plan.*

For the adult Medicaid population, none of the measures' rates increased. However, DHMC did have the highest rate among the health plans in FY 2008–2009 for one measure, *Rating of Personal Doctor*.

Seven of the measures decreased for the adult Medicaid population: *Getting Needed Care* (14.3 percentage points), *Getting Care Quickly* (7.5 percentage points), *How Well Doctors Communicate* (4.0 percentage points), *Shared Decision Making* (6.0 percentage points), *Rating of Personal Doctor* (2.8 percentage points), *Rating of All Health Care* (9.8 percentage points), and *Rating of Health Plan* (8.8 percentage points). Five of the measures for the adult Medicaid population—*Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of All Health Care,* and *Rating of Health Plan*—had the lowest rates among the health plans in FY 2008–2009.

Rocky Mountain Health Plans

Findings

Table 3-26 displays the child Medicaid results achieved by RMHP for the current year (FY 2008–2009).

Table 3-26—Child Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2007–2008 Rate	FY 2008–2009 Rate
Getting Needed Care	†	63.2%
Getting Care Quickly	†	74.8%
How Well Doctors Communicate	†	76.7%
Customer Service	†	NA
Shared Decision Making	†	69.2%
Rating of Personal Doctor	†	70.4%
Rating of Specialist Seen Most Often	†	NA
Rating of All Health Care	†	56.6%
Rating of Health Plan	†	65.5%

NA indicates that the measure had fewer than 100 respondents.

† RMHP did not administer the child Medicaid survey in FY 2007–2008; therefore, 2008 results for RMHP are not reported.

Table 3-27 displays the adult Medicaid results achieved by RMHP during the current year (FY 2008–2009) and the prior year (FY 2007–2008).

Table 3-27—Adult Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2007–2008 Rate	FY 2008–2009 Rate
Getting Needed Care	61.3%	59.1%
Getting Care Quickly	63.4%	58.6%
How Well Doctors Communicate	69.7%	70.7%
Customer Service	66.3%	61.8%
Shared Decision Making	59.3%	63.8%
Rating of Personal Doctor	68.4%	66.3%
Rating of Specialist Seen Most Often	68.4%	66.1%
Rating of All Health Care	54.8%	50.9%
Rating of Health Plan	63.5%	58.9%

Recommendations

RMHP had seven measures with decreasing rates for the adult population; however, none of the measures decreased substantially. While rates dropped slightly for *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*, RMHP should consider continuing to direct quality improvement activities toward these measures.

Summary Assessment Related to Quality, Timeliness, and Access

All of the measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness.

RMHP did not administer the child Medicaid survey in FY 2007–2008; therefore, 2008 results were not reported for RMHP. HSAG could not perform a year-to-year comparison for RMHP or provide recommendations for the child Medicaid population.

For the child Medicaid population, RMHP had the highest rates among the health plans in FY 2008–2009 for five measures: *Rating of Health Plan*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*.

For the adult Medicaid population, two of RMHP's measures' rates increased: *How Well Doctors Communicate* (1.0 percentage point) and *Shared Decision Making* (4.5 percentage points). Furthermore, RMHP had the highest rates among the health plans in FY 2008–2009 for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*.

Primary Care Physician Program

Findings

Table 3-28 displays the child Medicaid results achieved by PCPP during the current year (FY 2008–2009) and the prior year (FY 2007–2008).

Table 3-28—Child Medicaid Question Summary Rates and Global Proportions *for* PCPP

Measure	FY 2007–2008 Rate	FY 2008–2009 Rate
Getting Needed Care	*	54.9%
Getting Care Quickly	*	74.7%
How Well Doctors Communicate	68.4%	76.6%
Customer Service	*	49.6%
Shared Decision Making	**	67.1%
Rating of Personal Doctor	66.4%	73.0%
Rating of Specialist Seen Most Often	65.2%	66.5%
Rating of All Health Care	67.8%	65.2%
Rating of Health Plan	63.0%	62.5%

NA indicates that the measure had fewer than 100 respondents.

* The results for these measures are not comparable across the two years reported in the table, per NCQA, due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.

** The *Shared Decision Making* composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys.

Table 3-29 displays the adult Medicaid results achieved by PCPP during the current year (FY 2008–2009) and the prior year (FY 2007–2008).

Table 3-29—Adult Medicaid Question Summary Rates and Global Proportions *for* PCPP

Measure	FY 2007–2008 Rate	FY 2008–2009 Rate
Getting Needed Care	49.9%	51.5%
Getting Care Quickly	55.8%	54.5%
How Well Doctors Communicate	62.5%	63.0%
Customer Service	NA	NA
Shared Decision Making	61.1%	59.9%
Rating of Personal Doctor	60.9%	61.7%
Rating of Specialist Seen Most Often	62.0%	65.9%
Rating of All Health Care	46.1%	50.1%
Rating of Health Plan	48.2%	51.2%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

The child Medicaid survey rates increased on three of the five comparable measures: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. While rates dropped slightly for *Rating of All Health Care* and *Rating of Health Plan*, PCPP should continue to direct quality improvement activities toward these measures. Recommendations for quality improvement include:

- ***Rating of All Health Care***—Increasing access to care and improving patient satisfaction with patient health care and health plan experiences.
- ***Rating of Health Plan***—Increasing distribution of information about the plan, improving customer service and client satisfaction with physicians, and having physician offices schedule routine appointments and obtain interpreters.

The adult Medicaid survey rates increased on six measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. The adult Medicaid survey results showed slight decreases for two measures: *Getting Care Quickly* and *Shared Decision Making*. Therefore, PCPP should continue to direct quality improvement activities toward these measures. Recommendations for improving performance include:

- ***Getting Care Quickly***—Having scheduling models that allow for appointment flexibility, simplified patient flow that limits bottlenecks and redundancies in the care process, increased electronic communications that allow for prompt care to patients who may not require an appointment, and improved access to health care information via the Internet to provide patients with instant feedback and education.
- ***Shared Decision Making***—Encouraging client participation in decision making, providing provider education on the importance of shared decision making, and ensuring enough time is spent with clients to allow for client education.

Summary Assessment Related to Quality, Timeliness, and Access

All of the measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness.

For the child Medicaid population, three comparable measures' rates increased. Two of these measures' rates increased by more than 5 percentage points: *How Well Doctors Communicate* (8.2 percentage points) and *Rating of Personal Doctor* (6.6 percentage points). Two of the measures' rates decreased from FY 2007–2008 to FY 2008–2009: *Rating of All Health Care* and *Rating of Health Plan*; however, neither of these reductions in rates was substantial. Furthermore, PCPP had the highest rates among the health plans in FY 2008–2009 for two measures: *Rating of All Health Care* and *Rating of Personal Doctor*.

For the adult Medicaid population, six of the measures' rates increased from FY 2007–2008; however, these increases were not substantial. Two of the measures' rates decreased; however, none

of the measures decreased by more than 5 percentage points. PCPP did not have the highest rates among the health plans in FY 2008–2009 on any measures.

Overall Statewide Performance for Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Table 3-30 displays the child Medicaid statewide averages for the current year (FY 2008–2009) and the prior year (FY 2007–2008).

Table 3-30—Child Medicaid Statewide Averages		
Measure	**FY 2007–2008**	**FY 2008–2009**
Getting Needed Care	*	59.1%
Getting Care Quickly	*	67.5%
How Well Doctors Communicate	65.1%	74.2%
Customer Service	*	***
Shared Decision Making	**	68.2%
Rating of Personal Doctor	67.0%	69.3%
Rating of Specialist Seen Most Often	***	***
Rating of All Health Care	62.9%	57.4%
Rating of Health Plan	60.6%	61.9%

Note: RMHP's rates for FY 2007–2008 were not included in the child Medicaid statewide average due to RMHP not administering a child Medicaid survey in FY 2007–2008.

* The results for these measures are not comparable across the two years reported in the table, per NCQA, due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.

** The *Shared Decision Making* composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys.

*** Only one health plan was able to report the *Customer Service* and *Rating of Specialist Seen Most Often* measures; therefore, a State average was not calculated for either measure.

Table 3-31 displays the adult Medicaid statewide averages during the current year (FY 2008–2009) and the prior year (FY 2007–2008).

Table 3-31—Adult Medicaid Statewide Averages		
Measure	**FY 2007–2008**	**FY 2008–2009**
Getting Needed Care	52.0%	47.1%
Getting Care Quickly	55.8%	51.2%
How Well Doctors Communicate	68.7%	67.8%
Customer Service	*	*
Shared Decision Making	59.8%	58.9%
Rating of Personal Doctor	67.0%	65.6%
Rating of Specialist Seen Most Often	63.5%	66.0%
Rating of All Health Care	51.0%	47.8%
Rating of Health Plan	56.0%	52.6%

* Only one health plan was able to report the *Customer Service* measure; therefore, a State average was not calculated.

Recommendations

Recommendations for improvement were made for each health plan based on its performance on the measures and included:

- ***Getting Needed Care***—Having flexible scheduling, simplified patient flow, increased electronic communications that may reduce the need for an appointment, and improved access to health care information via the Internet.
- ***Getting Care Quickly—***Having scheduling models that allow for appointment flexibility, simplified patient flow that limits bottlenecks and redundancies in the care process, increased electronic communications that allow for prompt care to patients who may not require an appointment, and improved access to health care information via the Internet to provide patients with instant feedback and education.
- ***Shared Decision Making***—Encouraging client participation in decision making, providing provider education on the importance of shared decision making, and ensuring enough time is spent with clients to allow for client education.
- ***Rating of Personal Doctor***—Having increased levels of patient-physician communication and decreased wait times by eliminating barriers that may prohibit patients from receiving prompt, adequate care.
- ***Rating of Health Plan***—Increasing distribution of information about the plan, improving customer service and client satisfaction with physicians, and having physician offices schedule routine appointments and obtain interpreters.
- ***Rating of All Health Care***—Increasing access to care and improving overall patient satisfaction with patient health care and health plan experiences.

Summary Assessment Related to Quality, Timeliness, and Access

All of the measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness.

For the statewide child Medicaid population, three measures' rates increased from FY 2007–2008 to FY 2008–2009: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. One of these measures' rates increased substantially: *How Well Doctors Communicate* (9.1 percentage points). The statewide child Medicaid survey results decreased substantially for one measure: *Rating of All Health Care* (5.5 percentage points). The State should continue to direct quality improvement activities toward this measure.

For the statewide adult Medicaid population, one measure's rate increased from FY 2007–2008 to FY 2008–2009: *Rating of Specialist Seen Most Often*; however, the increase was not substantial.

The statewide adult Medicaid survey results decreased for seven of the measures. However, none of these decreases was substantial. Nonetheless, the State should continue to direct quality improvement activities toward these measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan*.

4. Assessment of Health Plan Follow-up on Prior Recommendations

Introduction

The Department required each health plan to address the recommendations and required actions the health plan had following EQR activities conducted in FY 2007–2008. This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations from the previous year.

Colorado Access

Because Colorado Access did not join the Medicaid program until August 2008, it did not participate in any of the FY 2007–2008 activities. Therefore, this section of the report is not applicable to Colorado Access.

Denver Health Medicaid Choice

Compliance Monitoring Site Reviews

As a result of the FY 2007–2008 site review, DHMC was required to submit a corrective action plan that addressed six recommendations made by the Department in the standard areas of Grievance and Appeals (two), Quality Assurance Program (three), and EPSDT Program (one). DHMC submitted its corrective action plan and supporting documents to the Department, as required. After careful review of all applicable materials, the Department determined that DHMC successfully completed all of the FY 2007–2008 required actions.

Validation of Performance Measures

In FY 2007–2008, DHMC had two measures (*Well-Child Visits 3–6 Years of Life* and *Adolescent Well-Care Visits*) with decreased performance from the previous year and several measures that fell below the national HEDIS Medicaid 10th percentile (*Adults' Access to Preventive/Ambulatory Health Services* and *Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase*). HSAG recommended that DHMC implement quality strategies to improve rates for these measures. Performance for the two well-child measures improved in FY 2008–2009 by more than 5 percentage points. The rates for all age groups of the *Adults' Access to Preventive/Ambulatory Health Services* measure also increased. These improvements may suggest the MCO followed up on HSAG's recommendations. HSAG could not ascertain whether DMHC followed up on recommendations related to the *Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase* measure because the measure was not reported for FY 2008–2009.

Validation of Performance Improvement Projects

The FY 2007–2008 validation cycle represented the third year for both of DHMC's PIPs. HSAG reviewed Steps I through IX for both of DHMC's PIPs. After validating the *Childhood Immunization* PIP, HSAG recommended that in Step II, Study Question, DHMC make the "hypothesis" the main study question and ensure that the study question was in an X/Y format to meet CMS protocols. The three existing baseline questions should be removed or have a strike-through indicating that they are no longer the focus of the study question. HSAG also recommended that in Step IX, Real Improvement, a second causal/barrier analysis be performed to assess for necessary changes that could be made to achieve the desired outcomes for all of the study indicators. Based on the results of the causal/barrier analysis, either existing interventions could be revised or new interventions could be implemented.

After reviewing the *Member Satisfaction With Access to Pharmacy Services Within Denver Health*, HSAG recommended that DHMC re-evaluate the interventions for the declining indicators and perform a causal/barrier analysis to assess necessary changes that could be made to existing interventions or implementation of new interventions.

After reviewing the FY 2008–2009 PIP submissions, HSAG found evidence that DHMC adequately addressed each recommendation made during the FY 2007–2008 PIP validation cycle.

Consumer Assessment of Healthcare Providers and Systems

Although the CAHPS results for *Getting Care Quickly* did not decrease substantially (more than 5 percent) between FY 2006–2007 and 2007–2008, HSAG did note that DHMC received a slight decrease in the adult summary rate and global proportions reported for *Getting Care Quickly*. For this reason, HSAG recommended that DHMC continue to direct quality improvement activities toward this area. Unfortunately, DHMC experienced a continued and substantial decline in this area between FY 2007–2008 and FY 2008–2009. HSAG was not able to determine if DHMC followed up on its recommendations, nor was it able to determine the cause of this decline.

Rocky Mountain Health Plans

Compliance Monitoring Site Reviews

As a result of the FY 2007–2008 site review, RMHP was required to submit a corrective action plan that addressed six recommendations made by the Department in the standard areas of Grievance and Appeals (two), Quality Assurance Program (one), Credentialing and Recredentialing (two), and EPSDT Program (one). RMHP submitted its corrective action plan and supporting documents to the Department, as required. After careful review of all applicable materials, the Department determined that RMHP successfully completed all of the FY 2007–2008 required actions.

Validation of Performance Measures

In FY 2007–2008, RMHP had one measure that fell below the national HEDIS Medicaid 10th percentile (*Well-Child Visits in the First 15 Months of Life [6+ Visits]* and *Annual Monitoring for Patients on Persistent Medications*) and one measure with decreased performance (*Well-Child Visits 3–6 Years of Life)* from the previous year. HSAG recommended that RMHP implement quality strategies to improve rates for these measures. Performance for the two well-child measures improved in FY 2008–2009. In particular, the rate for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* increased by 46.72 percentage points. The rate for the *Annual Monitoring for Patients on Persistent Medications* measure also improved more than 5 percentage points. These improvements may suggest that the MCO followed up on HSAG's recommendations.

Validation of Performance Improvement Projects

Because FY 2008–2009 represented the first year for RMHP's *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP and its *Improving Well-Care Rates for Adolescents*, there were no prior recommendations to address.

Consumer Assessment of Healthcare Providers and Systems

RMHP had no measures with decreasing rates between FY 2006–2007 and FY 2007–2008 for the adult population. Therefore, HSAG made no recommendations.

Primary Care Physician Program

Validation of Performance Measures

In FY 2007–2008, PCPP had several measures that fell below the national HEDIS Medicaid 10th percentile (*Well-Child Visits 3–6 Years of Life, Adolescent Well-Care Visits, Adults' Access to Preventive/Ambulatory Health Services* [all three age groups], and *Timeliness of Prenatal Care*) and one measure with decreased performance (*Adolescent Well Care)* from the previous year. HSAG recommended that PCPP implement quality strategies to improve rates for these measures. Performance for these measures improved in FY 2008–2009. In particular, the rates for the *Adolescent Well Care* and *the Adults' Access to Preventive/Ambulatory Health Services* (all three age groups) measures increased by more than 10 percentage points. These improvements may suggest that PCPP followed up on HSAG's recommendations.

Validation of Performance Improvement Projects

As a primary care case management program run by CO Medicaid, PCPP was not required to conduct PIPs.

Consumer Assessment of Healthcare Providers and Systems

The PCPP adult Medicaid survey results showed substantial decreases (more than 5 percent) between FY 2006–2007 and FY 2007–2008 for two measures: *Getting Needed Care* and *Rating of All Health Care*. Based on these decreases, HSAG recommended that PCPP direct quality improvement activities toward these measures. Both of these areas experienced increases between FY 2007–2008 and FY 2008–2009. HSAG was not able to determine if PCPP followed up on its recommendations; however, these increases, although not substantial (more than 5 percent), do indicate improvement in consumer satisfaction.

For the five comparable measures between FY 2006–2007 and FY 2007–2008, HSAG did note that PCPP received a slight decline in the child summary rate and global proportions reported for *Rating of Specialist Seen Most Often*. However, this measure experienced an increase between FY 2007–2008 and FY 2008–2009. Although HSAG was not able to determine if PCPP followed up on its recommendations, this increase, although not substantial (more than 5 percent), does indicate improvement in consumer satisfaction. PCPP did have one measure that increased substantially between FY 2006–2007 and FY 2007–2008: *Rating of Personal Doctor*. In addition, PCPP child Medicaid survey results showed increases between FY 2006–2007 and FY 2007–2008 for three comparable measures: *How Well Doctors Communicate, Rating of All Health Care,* and *Rating of Health Plan*.

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

Introduction

This section addresses the findings from the assessment of each BHO related to quality, timeliness, and access, which were derived from an analysis of the results of the three EQR activities. HSAG makes recommendations 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 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 the quality and timeliness of, and access to, care and services.

Compliance Monitoring Site Reviews

The Department chose to focus the FY 2008–2009 compliance site review on four selected areas of performance.[5-1] The Department also requested a more in-depth evaluation of certain aspects of the areas reviewed (components of the review). HSAG developed a review strategy for each of the four components: Member Information (Component 1), Notices of Action (Component 2), Appeals (Component 3), and Underutilization (Component 4).

HSAG evaluated compliance with selected federal regulations and contract requirements through its review of the four components. For each of the components, HSAG conducted a desk review of documents sent by the BHOs prior to the on-site portion of the review, conducted interviews with key BHO staff members on-site, and reviewed additional key documents on-site.

For the Notices of Action and Appeals components, HSAG conducted a record review of documentation associated with notices of action and appeals.

The site review activities were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).*

Recognizing the interdependence of quality, timeliness, and access, HSAG assigned each of the components to one or more of these three domains, as depicted in Table 5-1. By doing so, HSAG was able to draw conclusions and make overall assessments about the quality and timeliness of, and

[5-1] The Department developed these performance areas through surveys of participants from the Medicaid Mental Health Advisory Committee (MHAC) and the Medicaid Mental Health Planning and Advisory Council (MHPAC). The Department developed the MHAC to exchange information and identify, evaluate, and communicate issues related to the Colorado Medicaid Community Mental Health Services Program. MHPAC was created as a result of federal laws passed in 1986 and 1992 that require states and territories to perform mental health planning to receive federal Mental Health Block Grant funds (Sections 1911–1920 of the Public Health Service [PHS] Act [42 USC 300x-1 through 300x-9] and Sections 1941–1956 of the PHS Act [42 USC 300x-51 through 300x-66]).

access to, care provided by the BHOs. Following discussion of each BHO's strengths and required actions, as identified during the compliance monitoring site reviews, HSAG evaluated and discussed the sufficiency of that BHO's performance related to quality, timeliness, and access.

Table 5-1—Assignment of Standards to Performance Domains			
Standards	**Quality**	**Timeliness**	**Access**
Component 1—Member Information	X		X
Component 2—Notices of Action	X	X	
Component 3—Appeals	X	X	
Component 4—Underutilization			X

Appendix A contains further details about the compliance monitoring site review activities.

Access Behavioral Care

Findings

Table 5-2 presents the ABC score for each of the five components.

Table 5-2—Summary of Scores for ABC								
Component #	**Description of Component**	**# of Elements**	**# of Applicable Elements**	**# *Met***	**# *Partially Met***	**# *Not Met***	**# *Not Applicable or Not Scored***	**Score (% of *Met* Elements)**
1	Member Information	25	22	22	0	0	3	100%
2	Notices of Action	9	9	6	3	0	0	67%
	Notices of Action Record Review	50	40	38	0	2	10	95%
3	Appeals	23	22	20	2	0	1	91%
	Appeals Record Review	42	42	38	0	4	0	90%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**153**	**139**	**128**	**5**	**6**	**14**	**92%***

*The overall score is a weighted average calculated by summing the total number of *Met* elements and dividing by the total number of applicable elements.

Strengths

ABC employed a variety of methods to help members and potential members understand the requirements and benefits of the plan. Quarterly member newsletters rotated subject matter that covered information about specific illnesses as well as services available. ABC's Consumer and Family Board quarterly meetings were open to all Medicaid members enrolled for services at ABC. ABC used $15 gift certificates for groceries as an incentive to attend. The meeting agenda was published in the quarterly newsletters with an advertisement of the incentive offering. The content

of both the member newsletters and the Consumer and Family Board meetings was driven by those in attendance at the previous board meeting.

ABC's notice of action template letters included all required information. ABC had an effective mechanism to track the timeliness of notices sent, that qualified clinicians made decisions, and that the electronic utilization management (UM) system included complete documentation of individuals involved and discussions regarding the authorization decision.

Records reviewed on-site contained evidence that ABC met all time frames for acknowledgment and resolution of appeals. The on-site record review also demonstrated that ABC used the extension process when it was in the member's interest to do so, and met all requirements about notifying the member of the extension. Additionally, HSAG reviewed evidence that ABC provided assistance to members during the appeal process.

ABC had a variety of routine reports that analyzed and trended utilization data and that were designed to identify over- and underutilization. ABC provided documentation of follow-up calls made by the ABC customer service department following member discharge from inpatient hospitalization. The medical record audit tool included a section for the reviewer to document whether the treatment record contained evidence of appropriate coordination of care during the member transition between levels of care.

Recommendations

Based on conclusions drawn from the review activities, ABC was required to submit a CAP to address the following required actions:

Notices of Action

- ABC must revise all applicable policies and related documents to include a definition of an action that is consistent with the BBA definition and is consistent across types of actions.
- ABC must ensure that notices of action are easily understood from a member perspective.

Appeals

- ABC used language in the appeal resolution letters that was very technical and appeared to be for a professional audience rather than for the member. ABC must ensure that members can easily understand the appeal resolution letters.
- ABC must revise its applicable policies and related documents to accurately reflect the requirement and time frames for continuation of benefits during the appeal and State fair hearing processes.

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

The components of the FY 2008–2009 compliance site review that assessed quality were Member Information, Notices of Action, and Appeals. ABC's overall findings related to the Quality component were mixed. ABC received a score of 100 percent for the Member Information component, a score of 67 percent for the Notices of Action component and 95 percent for the Notices of Action record review, and a score of 91 percent for the Appeals standard area and 90 percent for the Appeals record review, for an overall weighted quality score of 92 percent. ABC's most significant factor representing opportunity for improvement was the lack of clarity in policies related to notices of action and appeals and the lack of understandable language in notices of action that were sent to members.

Timeliness

The components that addressed the timeliness domain were Notices of Action and Appeals. ABC received a score of 67 percent for the Notices of Action standard area and 95 percent for the Notices of Action record review and scores of 91 percent for the Appeals standard area and 90 percent for the Appeals record review for an overall weighted timeliness score of 90 percent. Again, ABC's performance in the timeliness domain was negatively affected by its score in the Notices of Action standard area (67 percent); however, specifically related to timeliness, in both the Appeals and Notices of Action record reviews, ABC sent all acknowledgements, notices and resolution letters within the required time frames. Required actions in this domain were related to lack of policy clarity.

Access

The components that assessed the access domain were Member Information and Underutilization. ABC's performance in the Access domain was very strong, having received 100 percent scores for both components in the access domain. Particular strengths in this domain were related to ABC's communication to members via its quarterly member newsletters and incentives for attendance at the consumer advisory council meetings.

Behavioral HealthCare, Inc.

Findings

Table 5-3 presents the score for BHI for each of the five components.

Table 5-3—Summary of Scores for BHI

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	23	23	0	0	2	100%
2	Notices of Action	9	9	7	2	0	0	78%
	Notices of Action Record Review	50	40	35	0	5	10	88%
3	Appeals	23	22	21	1	0	0	95%
	Appeals Record Review	42	42	42	0	0	0	100%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**153**	**140**	**132**	**3**	**5**	**12**	**94%***

*The overall score is a weighted average calculated by summing the total number of *Met* elements and dividing by the total number of applicable elements.

Strengths

BHI's member materials demonstrated a clear member focus and member orientation. BHI had multiple methods of helping members and potential members understand the services it offered. Many of these methods included personal contact with either BHI staff members or consumer representatives during outreach programming that occurred within community mental health center (CMHC) activities and inpatient hospital settings.

Overall, BHI's notice-of-action letters were consumer-friendly and very easy to understand. BHI's notice-of-action training was comprehensive and described the regulations by providing examples and case studies. Its documentation system also contained clear records of what had occurred with each case. In addition, BHI kept the notice-of-action records and appeals records in the same case-specific file, allowing staff members to easily access and follow cases from the beginning.

BHI's case-specific appeal records clearly described the communication that occurred between BHI and the member during the appeal process. BHI had an effective system to ensure that the review panel for an appeal was composed of professionals located at a CMHC other than the one that made the original decision. All appeal panels included professionals with credentials similar to the original decision-maker and a psychiatrist.

BHI employed creative methods to identify and address over- and underutilization. BHI provided evidence of having conducted a three-year study to determine if a correlation existed between

shorter hospital lengths of stay and hospital recidivism. BHI also had examined encounter data to identify outlier practice patterns of providers. Hospital Review Committee meeting minutes reflected analysis and discussion regarding evidence of follow-up after discharge from hospitalization. In addition, BHI had developed a study to be implemented in 2009. The study was designed to analyze the gap between the number of initial Colorado Client Assessment Records (CCARs) and data on subsequent encounters for those members who had initial CCARs.

Recommendations

Based on conclusions drawn from the review activities, BHI was required to submit a CAP to address the following required actions:

Notices of Action

- BHI must revise any applicable policies and documents to include the time frame for mailing the notice of action for actions related to a denial of payment for a service in whole or in part.
- BHI must ensure that each notice of action is sent within the required time frames and is easy to understand.

Appeals

- BHI must revise applicable policies and related member and provider materials to reflect the accurate time frame for requesting continuation of benefits and filing appeals related to the termination, suspension, or reduction of a previously authorized service.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality

The components of the FY 2008–2009 compliance site review that assessed quality were Member Information, Notices of Action, and Appeals. BHI's overall findings related to quality were mixed. BHI received a score of 100 percent for Member Information, a score of 78 percent for the Notices of Action standard area and 88 percent for the Notices of Action record review, and a score of 95 percent for the Appeals standard area and 100 percent for the Appeals record review, for an overall weighted quality score of 94 percent. BHI's most significant factor representing opportunity for improvement was the lack of clarity in policies related to notices of action and appeals and the lack of understandable language in notices of action that were sent to members.

Timeliness

The components that addressed the timeliness domain were Notices of Action and Appeals. BHI received a score of 78 percent for the Notices of Action standard area and 88 percent for the Notices of Action record review, and scores of 95 percent for the Appeals standard area and 100 percent for the Appeals record review, for an overall weighted timeliness score of 93 percent. BHI's performance in the timeliness domain was negatively affected by its score in both the Notices of

Action standard area (78 percent) and the Notices of Action record review (88 percent). Specifically related to timeliness in the Appeals record review, BHI sent all acknowledgements, notices, and resolution letters within the required time frames. However, BHI did have deficiencies in the Notice of Action record review regarding timeliness of notices of action in four of nine records. Required actions in this domain were also related to lack of policy clarity.

Access

The components that assessed the access domain were Member Information and Underutilization. BHI's performance in the access domain was very strong and received 100 percent scores for both components in the domain. Particular strengths in this domain were related to BHI's communication to members via outreach programming within community mental health center (CMHC) activities and inpatient hospital settings.

Colorado Health Partnerships, LLC

Findings

Table 5-4 presents the CHP score for each of the five components.

Table 5-4—Summary of Scores for CHP

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	23	23	0	0	2	100%
2	Notices of Action	9	8	4	3	1	1	50%
	Notices of Action Record Review	50	40	38	0	2	10	95%
3	Appeals	23	22	16	4	2	1	73%
	Appeals Record Review	21	19	19	0	0	2	100%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**132**	**116**	**104**	**7**	**5**	**16**	**90%***

*The overall score is a weighted average calculated by summing the total number of *Met* elements and dividing by the total number of applicable elements.

Strengths

CHP's advance directives materials included all of the required content. The Office of Consumer and Family Affairs representatives from each CMHC had frequent contact with the CHP director of consumer and family affairs.

CHP's documentation system for utilization management and tracking denials and appeals contained complete descriptions of communication and decision-making processes. There was evidence that authorization decisions were based on medical necessity, and the record review demonstrated that individuals making adverse member determinations were individuals who had appropriate clinical expertise and were not involved in a previous level of review.

CHP's appeal records included evidence that CHP provided assistance to members in filing appeals and during the appeal process. All required time frames were met, as evidenced by the on-site review of appeal records. The record review also demonstrated that CHP had an expedited process and used and extension to allow a member to obtain additional information for review.

CHP had initiated a performance improvement project to evaluate and impact the penetration rate for members 60 years of age and older. Specific studies analyzed emergency service and compared emergency utilization data to utilization data for other treatments and member-specific data to identify trends.

Recommendations

Based on conclusions drawn from the review activities, CHP was required to submit a CAP to address the following required actions:

Notices of Action

- CHP must revise applicable policies and other documents, such as member materials, to include an accurate and complete definition of action.
- CHP must ensure that each notice of action sent to a member is easy to understand.
- CHP must review and revise all applicable policies to ensure accurate time frames for mailing notices of action.

Appeals

- CHP must clarify its applicable policies to ensure members' access to the State fair hearing process, regardless of who requested the appeal.
- CHP must review and revise all applicable policies to ensure accurate time frames for mailing notices of appeal resolution, and include the requirements and time frames to continue benefits during the appeal and State fair hearing process.

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

The components of the FY 2008–2009 compliance site review that assessed quality were Member Information, Notices of Action, and Appeals. CHP's overall findings related to quality were mixed. CHP received a score of 100 percent for Member Information, a score of 50 percent for the Notices of Action standard area and 95 percent for the Notices of Action record review, and a score of 73 percent for the Appeals standard area and 100 percent for the Appeals record review, for an overall weighted quality score of 89 percent. CHP's most significant factor representing opportunity for improvement was the lack of clarity in policies related to notices of action and appeals and the lack of understandable language in notices of action that were sent to members.

Timeliness

The components that addressed the timeliness domain were Notices of Action and Appeals. CHP received a score of 50 percent for the Notices of Action standard area and 95 percent for the Notices of Action record review, and scores of 73 percent for the Appeals standard area and 100 percent for the Appeals record review, for an overall weighted timeliness score of 87 percent. CHP's performance in the timeliness domain was affected negatively by its score in both the Notices of Action standard area (50 percent) and the Appeals standard area (73 percent). Specifically related to timeliness, in both the Notices of Action and the Appeals record reviews, CHP sent all

acknowledgements, notices, and resolution letters within the required time frames. Required actions in this domain were related primarily to lack of policy clarity.

Access

The components that assessed the access domain were Member Information and Underutilization. CHP's performance in the Access domain was very strong, having received 100 percent scores for both components in the domain. Particular strengths were related to CHP conducting targeted quality improvement studies to evaluate particular aspects of underutilization.

Foothills Behavioral Health, LLC

Findings

Table 5-5 presents the score for FBH for each of the five components.

Table 5-5—Summary of Scores for FBH

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	24	24	0	0	1	100%
2	Notices of Action	9	9	5	4	0	0	56%
	Notices of Action Record Review	50	39	32	0	7	11	82%
3	Appeals	23	22	18	4	0	1	82%
	Appeals Record Review	28	28	27	0	1	0	96%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**139**	**126**	**110**	**8**	**8**	**13**	**87%***

*The overall score is a weighted average calculated by summing the total number of *Met* elements and dividing by the total number of applicable elements.

Strengths

FBH's member handbook divided the large amount of required information into small sections that made the information easier to understand. In addition to the grievance and appeal information contained in the member handbook, FBH had developed a Grievance and Appeal Guide that included more specific requirements and time frames. This was sent to members with notices of action and appeal acknowledgement letters.

While FBH used templates for the notices of action, FBH staff members also added a significant amount of non-template language to explain the situation and reasons for the action. In addition, the case-specific denial records contained ample documentation to demonstrate that FBH's

authorization decisions were based on medical necessity determinations and a standard set of UM criteria.

Members were well-informed about their rights to access the appeal and State fair hearing process. The Grievance and Appeal Guide (distributed with notices of action and appeal acknowledgment letters) encouraged members to pursue the State fair hearing process while undergoing the FBH appeal process. This was due to the limited time frame for requesting a State fair hearing. Appeal resolution letters reviewed by HSAG staff members explained fully the process of investigation, the resolution, and the reason for the decision in an easy-to-understand format.

Since all services except emergency services were authorized by FBH or its UM delegates, FBH's data included both authorized and nonauthorized services.

Recommendations

Based on conclusions drawn from the review activities, FBH was required to submit a CAP to address the following required actions:

Notices of Action

- FBH must revise its applicable policies and member materials to include an accurate and complete definition of an action, as specified in the BBA.
- Based on the on-site review of notice-of-action records, FBH must:
  - Ensure that it mails all notices of action within 10 days of receiving a request for services.
  - Ensure that each notice of action includes the reason for the action in an easy-to-understand format.
  - Ensure that notice of action records contain documentation that decisions to deny, terminate, or authorize services in a limited amount, duration, or scope are made by individuals with the appropriate clinical expertise, as described in the FBH policies.
  - Discontinue the use of an effective date (10 days in the future) for actions related to the denial or limited authorization of a newly requested service.

Appeals

- FBH must ensure that appeals are resolved and that notification is sent within the required time frame (10 days)
- FBH must revise applicable policies and other applicable materials to include a process for extending the time frames for resolution of expedited appeals when the member requests the extension, or when FBH shows that the extension would be in the interest of the member.
- FBH must clarify its applicable policies to describe all the required processes related to the expedited review process for processing appeals.
- FBH must revise applicable policies and materials to accurately reflect the required time frames (10 days) for filing appeals and continuing benefits when the appeal is related to the termination, suspension, or reduction of previously authorized services.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality

The components of the FY 2008–2009 compliance site review that assessed quality were Member Information, Notices of Action, and Appeals. FBH's overall findings related to quality were mixed. FBH received a score of 100 percent for Member Information, a score of 56 percent for the Notices of Action standard area and 82 percent for the Notices of Action record review, and a score of 82 percent for the Appeals standard area and 96 percent for the Appeals record review, for an overall weighted quality score of 87 percent. FBH's most significant factor representing opportunity for improvement was the lack of clarity in policies related to notices of action and appeals.

Timeliness

The components that addressed the timeliness domain were Notices of Action and Appeals. FBH received a score of 56 percent for the Notices of Action standard area and 82 percent for the Notices of Action record review, and scores of 82 percent for the Appeals standard area and 96 percent for the Appeals record review, for an overall weighted timeliness score of 84 percent. FBH's performance in the Timeliness domain was negatively affected by its score in the Notices of Action standard area (56 percent) and the Appeals standard area (82 percent), as well as the Appeals record review (82 percent). Specifically related to timeliness, in both the Notices of Action and the Appeals record reviews, FBH did have deficiencies regarding timeliness of notices of action (four of nine compliant) and appeal resolutions (three of four compliant). Required actions in this domain were also related to lack of policy clarity.

Access

The components that assessed the access domain were Member Information and Underutilization. FBH's performance in the access domain was very strong, having received 100 percent scores for both components in the access domain. Particular strengths in this domain were related to the strength and understandability of FBH's member materials.

Northeast Behavioral Health, LLC

Findings

Table 5-6 presents the NBH score for each of the five components.

Table 5-6—Summary of Scores for NBH

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	20	20	0	0	5	100%
2	Notices of Action	9	9	6	3	0	0	67%
	Notices of Action Record Review	5	4	3	0	1	1	75%
3	Appeals	23	22	18	4	0	1	82%
	Appeals Record Review	7	7	6	0	1	0	86%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**73**	**66**	**57**	**7**	**2**	**7**	**86%***

*The overall score is a weighted average calculated by summing the total number of *Met* elements and dividing by the total number of applicable elements.

Strengths

NBH employed several methods to inform members that written materials were available in alternative formats. NBH had implemented a secret shopper program that evaluated the CMHCs' compliance with access standards. One scenario NBH used during the secret shopper calls was a member calling in another language (NBH used Spanish and German) to evaluate the centers' ability to use an interpreter or the language line.

NBH had a mechanism for appropriate utilization control, ensuring that medically necessary services were provided in an amount, duration, and scope needed to achieve the purpose for which they were provided. Also, members were informed of the appeal and State fair hearing processes via the consumer handbook which, in addition to being mailed to members, was distributed and discussed in a variety of community and member-specific forums. Providers were informed of the appeal process using both the provider manual and mandatory in-person training.

HSAG found that NBH had several mechanisms to obtain information regarding missed appointments from the CMHCs and to evaluate the information for trends. In addition, NBH provided specific direction to the CMHCs regarding missed appointments based on risks associated with certain members.

Recommendations

Based on conclusions drawn from the review activities, NBH was required to submit a CAP to address the following required actions:

Notices of Action

- The preamble to the BBA specifically states that actions are triggered by an MCO or PIHP decision, not by the provider's treatment decision. Therefore, NBH must revise all pertinent materials to include the correct definition of an action.
- NBH must ensure that notices of action sent to members are accurate, offer benefits only if applicable, and contain the correct timelines for filing to qualify for continued benefits.
- NBH must ensure that notices of action are sent within the required time frames.

Appeals

- NBH must revise its policies and other documents pertaining to the appeal process to specify the notification time frames for standard and expedited appeals and to ensure that the time frames comply with the requirements. NBH must also develop a mechanism to document verbal communication pertinent to the appeal, particularly when documentation of verbal communication could affect compliance with the required time frames.
- NBH must revise its policies and other pertinent documents to clarify that time frames to resolve both standard and expedited appeals may be extended for up to 14 days if the member requests the extension or if NBH shows the need for additional information and how a delay is in the member's interest.
- NBH's appeal records must include documentation of reasonable efforts to provide oral notice of appeal resolution.
- NBH must develop a mechanism to ensure that notices of action inform members of each of the qualifications and include accurate information regarding the request for continued benefits during the appeals 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

The components of the FY 2008–2009 compliance site review that assessed quality were Member Information, Notices of Action, and Appeals. NBH's overall findings related to quality were mixed. NBH received a score of 100 percent for Member Information, a score of 67 percent for the Notices of Action standard area and 75 percent for the Notices of Action record review, and a score of 82 percent for the Appeals standard area and 86 percent for the Appeals record review, for an overall weighted quality score of 85 percent. NBH's most significant factor representing opportunity for improvement was the lack of clarity in policies related to notices of action and appeals.

Timeliness

The components that addressed the timeliness domain were Notices of Action and Appeals. NBH received a score of 67 percent for the Notices of Action standard area and 75 percent for the Notices of Action record review, and scores of 82 percent for the Appeals standard area and 86 percent for the Appeals record review, for an overall weighted timeliness score of 79 percent. NBH's performance in the timeliness domain was negatively affected by its score in the Notices of Action standard area (67 percent) and the Appeals standard area (75 percent), the Notices of Action record review (75 percent), and the Appeals record review (86 percent). Specifically related to timeliness, in both the Notices of Action and the Appeals record reviews, NBH did have deficiencies regarding timeliness of notices of action and the appeal resolution (one record reviewed for both actions and appeals). Required actions in this domain were also related to lack of policy clarity.

Access

The components that assessed the access domain were Member Information and Underutilization. NBH's performance in the access domain was very strong, having received 100 percent scores for both components in the domain. Particular strengths were related to the strength and understandability of NBH's communication with its CMHCs regarding underutilization and utilization patterns for specific members.

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

Table 5-7 shows the overall statewide average for each site review component followed by conclusions drawn from the results of the compliance monitoring activity. Appendix E contains summary tables displaying the detailed site review scores for the site review components by BHO and the statewide average.

Table 5-7—Statewide Averages

Standards	FY 2008–2009 Statewide Average*
Component 1— Member Information	**100%**
Component 2— Notices of Action	**64%**
Notices of Action Record Review	**90%**
Component 3— Appeals	**85%**
Appeals Record Review	**96%**
Component 4— Underutilization	**100%**
Overall Statewide Compliance Score	**90%**

* Statewide average rates are weighted averages calculated by summing the individual numerators and dividing by the sum of the individual denominators.

Statewide recommendations (i.e., those in common across at least three of the five BHOs) include:

Quality and Timeliness

The findings in the Notices of Action and the timeliness domains affected both the quality and the timeliness domains. Four of five BHOs (ABC, CHP, FBH, and NBH) had required actions related to an inaccurate or incomplete definition of action. Four of five BHOs (ABC, BHI, CHP, and FBH) had required actions related to the notices of action not being easily understood. All BHOs had required actions related to inaccurate or unclear policies regarding the time frames and requirements for filing appeals when the member requests continuation of benefits for appeals related to the termination, suspension, or reduction of previously authorized services.

Access

There were no required actions related to the access domain (the Member Information and Underutilization components). All BHOs are working with the Department to review and revise the member handbook and other information that may be affected by clarifying policies related to time frames and requirements for filing appeals when the member requests continued benefits for appeals related to the termination, suspension, or reduction of previously authorized services.

Validation of Performance Measures

The Department required the collection and reporting of 14 performance measures for the FY 2008–2009 validation process: five HEDIS-like measures, three measures developed by the Department, and six survey-based measures. Some of these measures have sub-category measures (e.g., *Hospital Average Length of Stay has two sub-measures—Non-State Hospitals and All Hospitals*). These measures originate from a number of sources, including claims/encounter data and Mental Health Statistics Improvement Program (MHSIP) consumer surveys. Seven measures were validated and reported in this year's report for the first time: *Overall Penetration Rate*, *Penetration Rates by Service Category*, *Hospital Recidivism*, *Hospital Average Length of Stay*, *Emergency Room Utilization*, *Inpatient Utilization*, and *Follow-Up After Hospitalization for Mental Illness*; therefore, comparisons with last year's results are not available. The specifications for these measures are included in a "scope document," which was drafted collaboratively between the BHOs and the Department. The scope document contained detailed information related to data collection and rate calculation for each measure under the scope of the audit, as well as reporting requirements.

HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities, final protocol*, Version 1.0, May 1, 2002 (CMS performance Measure Validation Protocol). The validation results were based on three sources: the BHO and Department versions of the Information Systems Capabilities Assessment Tool (ISCAT), site reviews, and source code (programming language) review. Source code review compared the scope document specifications for each measure against the programming language used to calculate rates.

The ISCAT contains documentation detailing the information systems used by the BHO and the Department for performance measure reporting activities, and this is reviewed by auditors prior to

the on-site visit. During the on-site visit, a detailed assessment is done of the information systems, including systems demonstrations.

Based on all validation activities, HSAG determined the results for each performance measure. As set forth in the CMS protocol, HSAG gave a validation finding of *Fully Compliant*, *Substantially Compliant*, *Not Valid*, or *Not Applicable* for each performance measure. HSAG based each validation finding 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 HSAG gave the indicator a designation of *Substantially Compliant*.

To draw conclusions and make overall assessments about the quality and timeliness of care and access to care provided by the BHOs, HSAG assigned each of the measures to one or more of the three performance domains depicted in Table 5-8 using findings from the validation of performance measures.

Table 5-8—Assignment of Performance Measures to Performance Domains

Performance Measures	Quality	Timeliness	Access
Penetration Rates by Age Category			✓
Penetration Rates by Service Category			✓
Overall Penetration Rates			✓
Hospital Recidivism	✓		
Hospital Average Length of Stay			✓
Emergency Department Utilization			✓
Inpatient Utilization			✓
Follow-up After Hospitalization for Mental Illness (7 and 30-day follow up)		✓	
Consumer Perception of Access			✓
Consumer Perception of Quality and Appropriateness (Consumer Perception of Quality/Appropriateness)	✓		
Consumer Perception of Outcomes of Services (Consumer Perception of Outcome)	✓		
Consumer General Satisfaction (Consumer Satisfaction)	✓		
Consumer Perception of Participation in Treatment Planning (Consumer Perception of Participation)	✓		
Consumers Linked to Physical Health (Consumers Linked to Primary Care)			✓

Appendix B contains further details about the activities for the validation of performance measures.

Access Behavioral Care

Findings

Table 5-9 shows the ABC review results and audit designations for each performance measure.

Table 5-9—Review Results and Audit Designation *for* ABC

Performance Measures	Rate		Audit Designation	
	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
Penetration Rate by Age Category				
Children	8.3%	8.0%	*Fully Compliant*	*Fully Compliant*
Adults	20.5%	19.5%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	—	1.1%	—	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	—	0.1%	—	*Fully Compliant*
Ambulatory Care	—	11.1%	—	*Fully Compliant*
Overall Penetration Rates	—	12.7%	—	*Fully Compliant*
Hospital Recidivism				
Non-State Hospitals – 7 days	—	6.0%	—	*Fully Compliant*
30 days	—	13.0%	—	*Fully Compliant*
90 days	—	21.0%	—	*Fully Compliant*
All Hospitals – 7 days	—	6.0%	—	*Fully Compliant*
30 days	—	16.0%	—	*Fully Compliant*
90 days	—	24.0%	—	*Fully Compliant*
Hospital Average Length of Stay				
Non-State Hospitals	—	8.70	—	*Fully Compliant*
All Hospitals	—	14.17	—	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	—	11.35	—	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	—	7.77	—	*Fully Compliant*
All Hospitals	—	10.86	—	*Fully Compliant*

Table 5-9—Review Results and Audit Designation *for* ABC				
	Rate		Audit Designation	
Performance Measures	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals – 7–day	—	30.8%	—	*Fully Compliant*
30–day	—	72.6%	—	*Fully Compliant*
State Hospitals – 7–day	—	31.5%	—	*Fully Compliant*
30–day	—	73.1%	—	*Fully Compliant*
Consumer Perception of Access	69.8%	76.6%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality	72.6%	74.0%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	66.3%	62.2%	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	75.6%	76.3%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	60.0%	70.1%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	78.4%	74.4%	*Fully Compliant*	*Fully Compliant*

Claims and Encounters: HSAG had no concerns with ABC's claims and encounters system and processes other than what is noted in the Recommendation section below. The auditors noted that, in previous years, ABC conducted an internal 411 audit on an annual basis, comparing encounter data to medical record documentation. For the current year HSAG conducted this activity, so ABC suspended the internal audit activity. The auditors suggested that as a means to ensure that claims and encounter data are complete and accurate, the BHO should continue its own internal audits, which do not need to involve large numbers such as those used in the 411 audit.

Eligibility: HSAG had no concerns with the processing of membership data. ABC processed the State eligibility files in a standardized fashion, and the provider network had multiple means to check member eligibility at the time of service.

Strengths

HSAG determined that ABC's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were *Acceptable* in FY 2007–2008. In addition, HSAG identified no major issues in ABC's eligibility data system and claims/encounter data systems and processes. ABC organized an encounter work group that met biweekly to ensure complete and accurate encounter data submission. ABC's use of MedStat (NCQA-certified software) to calculate the HEDIS-like measures not only provided a well-documented quality assurance process on the data extract, but also ensured a consistent pull of measures and the availability of core reports through its Web-based application. In addition, ABC was developing a tool called SharePoint to facilitate communication, training, and data retrieval within the organization.

ABC received a *Fully Compliant* status in its audit for all 14 performance measures. Seven of these measures also had results for FY 2006–2007; therefore, they allowed an evaluation of ABC's yearly

progress with these measures.[5-2] Four performance measures had improved rates from the previous year (i.e., *Consumer Perception of Access, Consumer Perception of Quality, Consumer Satisfaction,* and *Consumer Perception of Participation*). Six measures (i.e., *Penetration Rate—Adults, Consumer Perception of Access, Consumer Perception of Quality, Consumer Perception of Outcome, Consumer Satisfaction,* and *Consumer Perception of Participation*) were above the current year's statewide averages, with the *Consumer Perception of Participation* measure (70.1 percent) scoring more than 5 percentage points above the statewide average (64.3 percent) (see Table 5-15).

The rates of a few first-time measures were also above or the same as the current year's statewide performance. These measures included *Penetration Rates for Inpatient Care, Penetration Rates for Intensive Outpatient/Partial Hospitalization,* and *30-day Follow-Up After Hospitalization for Mental Illness (for both Non-State and State Hospitals).* In particular, the rate for the 30-day follow-up measure for non-state hospitals (72.6 percent) was more than 5 percentage points above the statewide average (67.1 percent).

Recommendations

The ABC performance measure validation results present some opportunities for improvement. Four measures showed a decline in the rates from the prior measurement year, two of which (*Consumer Perception of Outcome* and *Consumers Linked to Primary Care*) decreased by approximately 4 percentage points. Most of the first-time performance measures reflected performance that was below the statewide performance.[5-3] These measures were *Overall Penetration Rates, Penetration Rate for Ambulatory Care, Hospital Recidivism, Hospital Average Length of Stay, Emergency Room Utilization, Inpatient Utilization,* and *7-day Follow-Up After Hospitalization for Mental Illness*. Of note was that the 30-day and 90-day Hospital Recidivism for all hospitals[5-4] and the two 7-day Follow-Up measures (for both non-state and state hospitals) had a lower performance level of more than 5 percentage points from the statewide averages.

Additionally, the on-site review indicated that the scope documents and attachments, although a work in progress, did not explicitly define certain data elements for the measures that were calculated (*Inpatient Utilization, Hospital Average Length of Stay, Follow-up After Hospitalization for Mental Illness, Emergency Department Utilization,* and *Hospital Recidivism*). Based on the results of the performance measure validation findings for FY 2007–2008, suggestions for improving ABC's performance include:

- Collaborating with the Department to: (1) reformat Attachment A to ensure better version control and streamline tables and codes; and (2) modify Attachment B to ensure the diagnosis codes match with those covered by State contract. An alternative solution would be to incorporate the revised information from these two documents into the scope document.

[5-2] Last year's validation reported two measures that were related to Penetration Rate by Age Category: Penetration Rate by Children and Penetration Rate by Adults. The age groups reported in this measure were Children 12 years of age or younger, Adolescents between 13 and 17 years of age, Adults between 18 and 64 years of age, and Adults 65 years or age or older. To facilitate comparison with last year's results, these age groups were aggregated into two major groups: Children (17 years of age or younger) and Adults (18 years of age or older).

[5-3] Some measures with high rates than the statewide averages (e.g., hospital recidivism) suggested poorer performance.

[5-4] Since the 90-day Hospital Recidivism rate for non-state hospitals (4.4 percent) was lower than the rate for all hospitals (6.8 percent), the higher rate (lower performance) may be attributed to the performance from the state hospitals.

- Increasing formal oversight of Mental Health Center of Denver (MHCD).
- Reinstating the suspended annual internal audits.
- Conducting an analysis to identify causal factors for performance measure results that have declined or fallen below the statewide average, especially for the 30-day and 90-day Hospital Recidivism for all hospitals and the two 7-day Follow-Up measures (for both non-state and state hospitals). Based on the results, ABC should design appropriate interventions to remove identified barriers, thereby improving performances for these measures.

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, timeliness, and access.

- **Quality:** ABC's performance in the domain of quality was mixed. Of the measures with results from the prior year, three of the four quality measures (*Consumer Perception of Quality, Consumer Satisfaction*, and *Consumer Perception of Participation*) demonstrated an improvement from the previous year. One measure (*Consumer Perception of Outcome*) reported a 4.1 percentage point decline. Despite the decline, this measure was performing above the current year's statewide average. Hospital Recidivism was the only first-time quality measure in the current year. All the sub-measures under Hospital Recidivism were below the statewide average performance, with the 30-day and 90-day recidivism rates for all hospitals performing at least 5 percentage points lower than the statewide performance.
- **Timeliness:** The *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure. Although ABC's 30-day follow-up rates were above the statewide rates (72.6 percent compared to 67.1 percent for non-state hospitals and 73.1 percent compared to 68.9 percent for state hospitals), both of its 7-day Follow-Up rates were below the statewide average performances. In fact, its 7-day Follow-Up rates were at least 13 percentage points lower than the statewide averages. These two sub-measures present a tremendous opportunity for improvement.
- **Access**: ABC's performance in the domain of quality was mixed, with fewer measures reflecting the BHO's strength or improvement since last year. Of the measures with last year's results, only one (*Consumer Perception of Access*) demonstrated an improvement from the previous year (from last year's 69.8 percent to 76.6 percent). Of the three measures that had a decline from the prior measurement year, the rate of *Consumers Linked to Primary Care* measure decreased four percentage points (from 78.4 percent to 74.4 percent). Among the five first-time access measures (*Overall Penetration Rate, Penetration Rate by Service Category, Hospital Average Length of Stay, Emergency Room Utilization*, and *Inpatient Utilization*), four were below the statewide average performance. The remaining measure (*Penetration Rate by Service Category*) had higher than statewide performance in only one of the three sub-measures (*Inpatient Care*).

Behavioral HealthCare, Inc.

Findings

Table 5-10 shows the BHI review results and audit designations for each performance measure.

Table 5-10—Review Results and Audit Designation *for* BHI

Performance Measures	Rate		Audit Designation	
	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
Penetration Rate by Age Category				
Children	7.2%	7.1%	*Fully Compliant*	*Fully Compliant*
Adults	13.4%	15.2%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	—	0.7%	—	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	—	0.1%	—	*Fully Compliant*
Ambulatory Care	—	9.9%	—	*Fully Compliant*
Overall Penetration Rate	—	10.0%	—	*Fully Compliant*
Hospital Recidivism				
Non-State Hospitals – 7 days	—	3.0%	—	*Fully Compliant*
30 days	—	11.0%	—	*Fully Compliant*
90 days	—	16.0%	—	*Fully Compliant*
All Hospitals – 7 days	—	3.0%	—	*Fully Compliant*
30 days	—	13.0%	—	*Fully Compliant*
90 days	—	19.0%	—	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	—	7.16	—	*Fully Compliant*
All Hospitals	—	13.00	—	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	—	7.60	—	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	—	2.56	—	*Fully Compliant*
All Hospitals	—	5.84	—	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals – 7–day	—	51.4%	—	*Fully Compliant*
30–day	—	62.7%	—	*Fully Compliant*
State Hospitals – 7–day	—	56.3%	—	*Fully Compliant*
30–day	—	68.8%	—	*Fully Compliant*
Consumer Perception of Access	75.3%	78.2%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality	69.9%	74.0%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	62.9%	63.5%	*Fully Compliant*	*Fully Compliant*

Table 5-10—Review Results and Audit Designation *for* BHI				
	Rate		Audit Designation	
Performance Measures	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
Consumer Satisfaction	82.0%	79.4%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	66.1%	66.0%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	81.0%	77.1%	*Fully Compliant*	*Fully Compliant*

Claims and Encounters: HSAG had no concerns with BHI's claims and encounters system and processes other than what is noted in the Recommendations section below. HSAG encouraged BHI to continue working with the Department to resolve any issues related to the successful submission of the 837 files, including reports and other challenges to data transmission.

Eligibility: The auditors had no concerns regarding BHI's eligibility data system. InNET, BHI's administrative services organization, downloaded the daily eligibility file from the State and ongoing validations occurred to ensure data accuracy. Reconciliation took place at the CMHC level, which helped to ensure that data were accurate and consistent at the point of care. The CMHCs used the InNET eligibility file, as well as the State's portal, to confirm consumer enrollment.

Strengths

Similar to the prior year's results, HSAG determined that BHI's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were *Acceptable* in FY 2007–2008. HSAG identified no major issues in BHI's eligibility data system and claims/encounter data systems and processes. The BHO's data validation check for FY 2008, the newly implemented encounter data validation process for FY 2009, as well as its engagement with the CMHCs to review and analyze data, helped ensure the accuracy and completeness of the claims and encounters before they were submitted to the Department. BHI's contract with Allurdata focused on increasing business efficiency and data analysis capability.

As in the previous year, BHI received a *Fully Compliant* status in its audit for all 14 performance measures. Of the seven performance measures that had previous year's results, four (*Penetration Rate—Adults*, *Consumer Perception of Access*, *Consumer Perception of Quality*, and *Consumer Perception of Outcome*) demonstrated some improvement (ranging from increases of 0.6 percentage points to 4.1 percentage points). In addition, five of these measures, all related to consumer perceptions, performed above the statewide average (see Table 5-15).

Several of the first-time measures were above the statewide average performance levels. BHI had a better than statewide average performance in the 7-day and 30-day hospital recidivism measures for non-state hospitals (3.0 percent and 16.0 percent compared to 3.4 percent and 16.6 percent, respectively) and the Hospital Average Length of Stay measure for all hospitals (13.00 days compared to the statewide 13.54 days). In addition, BHI's rate for the 7-day Follow-Up measure for state hospitals was 10.4 percentage points higher than the statewide average.

Recommendations

Some areas for improvement were noted for BHI. Four measures showed a decline in the rates from the prior measurement year, one of which (*Consumers Linked to Primary Care*) decreased by four percentage points. Seven of the first-time measures were below the statewide average performance and represented opportunity for improvement, although only one (*30-day Follow-Up for Non-State Hospitals*, 62.7 percent) was performing about four percentage points lower than the statewide average (67.1 percent).

The on-site review indicated that the scope documents and attachments, although a work in progress, did not explicitly define certain data elements for the measures calculated by the BHO (*Inpatient Utilization, Hospital Average Length of Stay, Follow-up After Hospitalization for Mental Illness, Emergency Department Utilization,* and *Hospital Recidivism*). Additionally, the on-site review showed that there may be potential issues related to the use of dummy provider IDs and the ability to capture all patient encounters from Community Connections.

Based on the results of performance measure validation findings for FY 2008–2009, suggestions for improving BHI's performance include:

- Continuing collaboration with the Department regarding the 837 submission process, ways to resolve the dummy provider ID issue, and exploring ways to identify potential missing data.
- Continuing collaboration with Community Connections to capture complete patient encounters.
- Collaborating with the Department to reformat the Attachment A document to ensure better version control, streamline tables and codes to avoid confusion, and modify the Attachment B document to ensure that the diagnosis codes match with those covered by State contract. An alternative solution would be to incorporate the revised information from these two documents into the scope document.
- Documenting claims entry accuracy checks in a more formal manner and increasing the quantity of accuracy checks to represent at least 5 percent of the total entered/processed.
- Conducting an analysis to identify causal factors for those performance measures with results demonstrating a decline from last year and those results that were below the statewide average. Based on the results of this analysis, BHI should design appropriate interventions to remove identified barriers, thereby improving the rates for these measures.

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, timeliness, and access.

- **Quality**: Overall, BHI's performance in the domain of quality was mixed, with relatively more measures demonstrating either an improvement from last year's results or a performance higher than the statewide average. Of the measures with last year's results, two of the four quality measures (*Consumer Perception of Quality* and *Consumer Perception of Outcome*) showed an improvement from the previous year. Although the other two measures had rates lower than last year's results, the decreases were not more than 5 percentage points and all were performing

above the current year's statewide average. Results from the first-time *Hospital Recidivism* measure were also mixed, with three of the six sub-measures above or equal to the statewide average performance.

- **Timeliness**: The *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure. BHI's performance on this measure was mixed. Although its *7-day Follow-Up* performance was at least 5 percentage points above the statewide rate, both of its *30-day Follow-Up* rates were below the statewide average performance. The rate for the *30-day Follow-Up* measure for non-state hospitals was 4.4 percentage points lower than the statewide average, representing an opportunity for improvement.
- **Access**: BHI's performance in the domain of access was also mixed. Four of the eight measures with last year's results demonstrated improvement from the prior measurement year. Of the four that did not report an improvement, one (*Consumers Linked to Primary Care*) showed a 4 percentage point decline from last year's rate. Among the five first-time access measures, two (*Emergency Room Utilization* and *Inpatient Utilization*) performed better than the statewide average performance. The other three measures had at least one sub-measure with rates below the statewide average performance.

Colorado Health Partnerships, LLC

Findings

Table 5-11 shows the CHP review results and audit designations for each performance measure.

Table 5-11—Review Results and Audit Designation *for* CHP

Performance Measures	Rate		Audit Designation	
	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
Penetration Rate by Age Category				
Children	10.0%	10.1%	*Fully Compliant*	*Fully Compliant*
Adults	17.3%	18.4%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	—	0.08%	—	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	—	0.1%	—	*Fully Compliant*
Ambulatory Care	—	13.5%	—	*Fully Compliant*
Overall Penetration Rate	—	13.7%	—	*Fully Compliant*
Hospital Recidivism				
Non-State Hospitals – 7 days	—	3.0%	—	*Fully Compliant*
30 days	—	9.0%	—	*Fully Compliant*
90 days	—	15.0%	—	*Fully Compliant*
All Hospitals – 7 days	—	2.0%	—	*Fully Compliant*
30 days	—	7.0%	—	*Fully Compliant*

Table 5-11—Review Results and Audit Designation *for* CHP				
	Rate		Audit Designation	
Performance Measures	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
90 days	—	12.0%	—	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	—	7.05	—	*Fully Compliant*
All Hospitals	—	14.56	—	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	—	8.93	—	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	—	3.22	—	*Fully Compliant*
All Hospitals	—	5.63	—	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals – 7–day	—	41.7%	—	*Fully Compliant*
30–day	—	64.3%	—	*Fully Compliant*
State Hospitals – 7–day	—	45.0%	—	*Fully Compliant*
30–day	—	66.3%	—	*Fully Compliant*
Consumer Perception of Access	72.2%	70.5%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality	71.9%	70.7%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	59.6%	59.6%	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	78.3%	72.2%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	64.8%	63.0%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	80.4%	82.3%	*Fully Compliant*	*Fully Compliant*

Claims and Encounters: HSAG identified no issues with systems or processes related to claims and encounter data. The use of optical character recognition (OCR) software to process paper claims minimized potential data entry errors. CHP processed data in a timely manner and monitored data trends to identify any potential for data loss. CHP should continue to work with the Department on the submission of the 837 file and ensure that the process for submitting the file to the State is well-documented.

Eligibility: There were no concerns with CHP's processing of eligibility data. CHP worked to ensure that all eligibility data are processed and validated in a timely manner each month. CHP trains its community mental health center (CMHC) on how to use the State's system for verifying enrollment and works closely with the State's staff on issues as they arise.

Strengths

CHP's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be *Acceptable* in FY 2007–2008. As in the previous year's results, HSAG identified no issues in CHP's eligibility data system

and claims/encounter data systems and processes. CHP's encounter data design project continues to be a best practice among the BHOs. CHP provides data log reports to the CMHCs for speedy correction of any data errors prior to the 837 submission to the Department. Collaboration between CHP's finance and audit team facilitated consistent interpretation for service code assignment and tracking CMHCs' performance and compliance.

HSAG scored all of CHP's performance measures as *Fully Compliant.* Three performance measures improved from the previous year (*Penetration Rate—Children, Penetration Rate—Adults*, and *Consumers Linked to Primary Care*) and one measure remained unchanged (*Consumer Perception of Outcome*). Three measures (*Penetration Rate—Children, Consumer Perception of Quality*, and *Consumers Linked to Primary Care*) were above statewide averages (see Table 5-15) in FY 2007–2008.

Three first-time measures were above the current year's statewide performance. These measures included *Overall Penetration Rate*, *Hospital Recidivism*, and *Inpatient Utilization*. In particular, the rate for the *90-day Hospital Recidivism* measure for all hospitals was 5.2 percentage points lower (hence a better performance) than the statewide average. For first-time sub-measure, *CHP's Penetration Rate for Ambulatory Care* (under Penetration Rate by Service Category) also performed better than the statewide average.

Recommendations

This year's CHP results highlighted several areas for improvement. Comparison with last year's results showed that four of the seven measures, all based on consumers' input, had a decreased rate from last year. In particular, the FY 2007–2008 *Consumer Satisfaction* measure scored 6.1 percentage points lower than the previous year. Three of the seven first-time measures—*Hospital Average Length of Stay*, *Emergency Room Utilization*, and *Follow-Up After Hospitalization for Mental Illness*—performed below the statewide average, although none had a performance greater than a 5 percentage point difference from the statewide average. These measures nonetheless presented opportunities for improvement.

The on-site review indicated that the scope documents and attachments, although a work in progress, did not explicitly define certain data elements for the measures calculated by the BHO (*Inpatient Utilization, Hospital Average Length of Stay*, *Follow-up After Hospitalization for Mental Illness*, *Emergency Department Utilization,* and *Hospital Recidivism*). Based on the results of performance measure validation findings for FY 2007–2008, suggestions for improving CHP's performance include:

- Continuing collaboration with the Department on the 837 submission and ensuring that the process for the file submission is well-documented.
- Collaborating with the Department to reformat the Attachment A document to ensure better version control, streamline tables and codes to avoid confusion, and modify the Attachment B document to ensure the diagnosis codes match with those covered by State contract. An alternative solution would be to incorporate the revised information from these two documents into the scope document.
- Maintaining close oversight during the CMHC's transition to the UNICARE system to minimize any data loss.

- Maintaining adequate documentation for the encounter file submission process to the Department for new staff members.
- Conducting an analysis to identify causal factors for the performance measures with results that decreased or were below the statewide average, especially for *Consumer Satisfaction*, which had a decrease of more than 5 percentage points. Based on the results of these analyses, CHP should design appropriate interventions to remove identified barriers, thereby improving the rates for these measures.

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, timeliness, and access.

- **Quality**: CHP's performance in the domain of quality was mixed, with roughly the same number of measures demonstrating either a decline from last year's results or a higher performance than the statewide average. Three of the four quality measures with last year's results, (*Consumer Perception of Quality*, *Consumer Satisfaction*, and *Consumer Perception of Participation*) showed a decline in rates from the previous year. The *Consumer Satisfaction* measure in particular decreased its performance by 6.1 percentage points from last year. Two of these measures also performed below the current year's statewide average. Nonetheless, CHP's performance on the first-time quality measure (*Hospital Recidivism*) had a higher performance than the statewide average. Specifically, the 90-day *Hospital Recidivism* measure for all hospitals performed better than the statewide average by 5.2 percentage points.

- **Timeliness**: CHP's performance on the only timeline measure (*Follow-Up After Hospitalization for Mental Illness*) suggested an opportunity for improvement. All related sub-measures had rates below the statewide average performances, and the two 30-day measures were at least 2.5 percentage points below the statewide average rate.

- **Access**: CHP's performance in the domain of access was also mixed. Three of the four measures with last year's results (*Penetration Rate—Children*, *Penetration Rate—Adult*, and *Consumers Linked to Primary Care*) demonstrated improvement from the prior measurement year. Among the five first-time access measures, two (*Hospital Average Length of Stay* and *Emergency Room Utilization*) performed below and another two (*Inpatient Utilization* and *Overall Penetration Rate*) performed above the statewide average. The *Penetration Rate by Service Category* measure had one sub-measure (*Inpatient Care*) performing below the statewide average performance and the other two sub-measures with rates either above or at the same level as the statewide average.

Foothills Behavioral Health, LLC

Findings

Table 5-12 shows the FBH review results and audit designations for each performance measure.

Table 5-12—Review Results and Audit Designation *for* FBH

Performance Measures	Rate		Audit Designation	
	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
Penetration Rate by Age Category				
Children	10.6%	13.6%	*Fully Compliant*	*Fully Compliant*
Adults	19.6%	22.5%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	—	0.9%	—	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	—	0.2%	—	*Fully Compliant*
Ambulatory Care	—	17.4%	—	*Fully Compliant*
Overall Penetration Rate	—	17.5%	—	*Fully Compliant*
Hospital Recidivism				
Non-State Hospitals – 7 days	—	3.0%	—	*Fully Compliant*
30 days	—	9.0%	—	*Fully Compliant*
90 days	—	16.0%	—	*Fully Compliant*
All Hospitals – 7 days	—	2.0%	—	*Fully Compliant*
30 days	—	7.0%	—	*Fully Compliant*
90 days	—	15.0%	—	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	—	6.28	—	*Fully Compliant*
All Hospitals	—	15.73	—	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	—	9.19	—	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	—	2.70	—	*Fully Compliant*
All Hospitals	—	6.40	—	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals – 7–day	—	58.2%	—	*Fully Compliant*
30–day	—	73.4%	—	*Fully Compliant*
State Hospitals – 7–day	—	58.7%	—	*Fully Compliant*
30–day	—	75.0%	—	*Fully Compliant*
Consumer Perception of Access	61.7%	70.8%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality	74.5%	66.7%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	63.0%	50.7%	*Fully Compliant*	*Fully Compliant*

Table 5-12—Review Results and Audit Designation *for* FBH				
	Rate		Audit Designation	
Performance Measures	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
Consumer Satisfaction	79.1%	69.4%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	58.8%	60.3%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	83.3%	83.3%	*Fully Compliant*	*Fully Compliant*

Claims and Encounters: HSAG had no concerns with FBH's claims and encounters system and processes other than what is noted in the Recommendations section below. FBH monitored encounter data volumes and had no issues with late submissions or rejections in FY 2008. HSAG encouraged FBH to continue working with the Department to resolve any issues related to the successful submission of the 837 files, including reports and other challenges to data transmission.

Eligibility: The auditors had no concerns regarding FBH's eligibility data system or related processes. InNET, the BHO's administrative services organization, downloaded the daily eligibility file from the State, and ongoing validations occurred to ensure data accuracy.

Strengths

FBH's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be *Acceptable* in FY 2007–2008. As in the previous year's results, HSAG identified no issues with FBH's eligibility data system and claims/encounter data systems and processes. FBH continued improving the validation of its encounter data and completing its crosswalk revision, which will result in uniform interpretation of service code descriptions and higher data comparability between the two mental health centers. A continuous feedback loop was in place to facilitate real-time necessary changes in the business rules for applying the crosswalk logic. FBH's strong commitment to data quality and integrity was recognized in its ongoing feedback provided to mental health centers regarding data volumes and accuracy.

HSAG scored all of FBH's performance measures as *Fully Compliant.* Rates improved from the previous year for four measures (*Penetration Rate—Children, Penetration Rate—Adults, Consumer Perception of Access,* and *Consumer Perception of Participation*). Of these four measures, *Consumer Perception of Access* improved substantially from 61.7 percent in the prior year to 70.8 percent in FY 2007–2008. Three of the performance measures with last year's results were also above statewide averages (see Table 5-15) in FY 2007–2008.

FBH's performance for five of the seven first-time measures was better than the statewide average. These measures included *Overall Penetration Rate, Penetration Rate by Service Category, Hospital Recidivism, Inpatient Utilization,* and *Follow-Up After Hospitalization for Mental Illness*. One sub-measure under *Hospital Average Length of Stay* also performed better than the statewide average. In particular, not only did all the follow-up measures have rates that were at least 5 percentage points higher than the statewide average, the performance of the *7-day Follow Up* measures for both non-state and state hospitals were at least 12 percentage points higher.

Recommendations

Areas for improvements were presented in several performance measures for FBH. Three consumer-perception measures (*Consumer Perception of Quality, Consumer Perception of Outcome*, and *Consumer Satisfaction*) had rates at least 7 percentage points lower than the prior year's results. These measures also performed lower than the current year's statewide average, especially the *Consumer Perception of Outcome* measure where the discrepancy was 9.7 percentage points. The *Emergency Room Utilization* measure and the *Hospital Average Length of Stay* measure for non-state hospitals both performed slightly below the statewide performance.

The on-site review indicated that the scope documents and attachments, although a work in progress, did not explicitly define certain data elements for five measures (*Inpatient Utilization, Hospital Average Length of Stay, Follow-up After Hospitalization for Mental Illness, Emergency Department Utilization,* and *Hospital Recidivism*).

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

- Conducting a comparative data analysis to ensure that the administrative transitions do not impact encounter data integrity or completeness.
- Continuing its collaboration with the Department and other BHOs to resolve concerns related to the 837 submission process.
- Collaborating with the Department to reformat the Attachment A document to ensure better version control, streamline tables and codes to avoid confusion, and modifying the Attachment B document to ensure that the diagnosis codes match with those covered by State contract. An alternative solution would be to incorporate the revised information from these two documents into the scope document.
- Conducting an analysis to identify causal factors for performance measure rates that are declining or below the statewide average, especially for those measures with more than a 5 percentage point decrease from last year's rates. Based on the results of these analyses, FBH should design appropriate interventions to remove identified barriers, thereby improving the rates of these measures.

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, timeliness, and access.

- **Quality**: FBH's performance in the domain of quality was mixed. Three of the four measures with last year's results (*Consumer Perception of Quality, Consumer Perception of Outcome*, and *Consumer Satisfaction*) showed a decreased rate of at least 7 percentage points from the previous year. The *Consumer Perception of Outcome* measure in particular decreased in its performance by 12.3 percentage points from last year. Additionally, all four quality measures also performed below the current year's statewide average, with the *Consumer Perception of Outcome* rate being 9.7 percentage points below the statewide average. Nonetheless, FBH's performance on the first-

time *Hospital Recidivism* measure was a strength; all of its sub-measures performed above the statewide average.

- **Timeliness**: FBH's performance on the only timeline measure (*Follow-Up After Hospitalization for Mental Illness*) suggested a strength. All related sub-measures had a rate above the statewide average performance of at least 5 percentage points. FBH's *7-day Follow-Up* performance for both non-state and state hospitals was particularly strong—at least 12 percentage point higher than the statewide average.
- **Access**: FBH's performance in the domain of access was also mixed, with relatively more measures either demonstrating an improvement over last year's results or a higher performance than the statewide average than those indicating a decline or lower performance. All four measures with last year's results (*Penetration Rate—Children*, *Penetration Rate—Adult*, *Consumer Perception of Access*, and *Consumers Linked to Primary Care*) demonstrated an improved rate or the same rate as the prior measurement year. Specifically, the *Consumer Perception of Access* measure increased 9.1 percentage points since last year. Among the five first-time access measures, three (*Overall Penetration Rate*, *Penetration Rate by Service Category*, and *Inpatient Utilization*) performed above the statewide average and one (*Emergency Room Utilization*) performed below. The *Hospital Average Length of Stay* measure for non-state hospitals performed below the statewide average but the rate for all hospitals actually performed better than the statewide average.

Northeast Behavioral Health, LLC

Findings

Table 5-13 shows the NBH review results and audit designations for each performance measure.

Table 5-13—Review Results and Audit Designation *for* NBH

Performance Measures	Rate		Audit Designation	
	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
Penetration Rate by Age Category				
Children	10.7%	11.2%	*Fully Compliant*	*Fully Compliant*
Adults	15.6%	17.6%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	—	0.9%	—	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	—	0.02%	—	*Fully Compliant*
Ambulatory Care	—	13.7%	—	*Fully Compliant*
Overall Penetration Rate	—	13.8%	—	*Fully Compliant*
Hospital Recidivism				
Non-State Hospitals – 7 days	—	2.0%	—	*Fully Compliant*
30 days	—	6.0%	—	*Fully Compliant*
90 days	—	15.0%	—	*Fully Compliant*

Table 5-13—Review Results and Audit Designation *for* NBH				
	Rate		Audit Designation	
Performance Measures	FY 2006–2007	FY 2007–2008	FY 2006–2007	FY 2007–2008
All Hospitals – 7 days	—	2.0%	—	*Fully Compliant*
30 days	—	9.0%	—	*Fully Compliant*
90 days	—	16.0%	—	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	—	5.23	—	*Fully Compliant*
All Hospitals	—	10.23	—	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	—	6.06	—	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	—	5.17	—	*Fully Compliant*
All Hospitals	—	7.20	—	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals – 7–day	—	37.5%	—	*Fully Compliant*
30–day	—	62.5%	—	*Fully Compliant*
State Hospitals – 7–day	—	38.1%	—	*Fully Compliant*
30–day	—	61.3%	—	*Fully Compliant*
Consumer Perception of Access	70.7%	71.6%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Quality	70.5%	65.9%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Outcome	61.3%	65.9%	*Fully Compliant*	*Fully Compliant*
Consumer Satisfaction	74.3%	77.6%	*Fully Compliant*	*Fully Compliant*
Consumer Perception of Participation	66.4%	61.9%	*Fully Compliant*	*Fully Compliant*
Consumers Linked to Primary Care	80.9%	78.7%	*Fully Compliant*	*Fully Compliant*

Claims and Encounters: HSAG had no concerns with NBH's claims and encounters system and processes other than what is noted in Recommendations section below. The BHO is encouraged to continue working with the Department to resolve issues related to the successful submission of the 837 files, including reports and other challenges to data transmission.

Eligibility: The auditors had no concerns regarding NBH's eligibility data system. InNET, NBH's administrative services organization, downloads the daily eligibility file from the State, and ongoing validations occur to ensure data accuracy. Reconciliation occurs at the CMHC level, which also helps to ensure that data are accurate and consistent at the point of care. The CMHCs use the InNET eligibility file, as well as the State's portal, to confirm consumer enrollment.

Strengths

NBH's data integration processes, data control processes, and performance measure documentation included in the calculation of performance measures were determined to be *Acceptable* in FY 2007–2008. HSAG identified no major issues in NBH's eligibility data system and claims/encounter data systems and processes. NBH's commitment to complete and accurate performance measure reporting was considered a strength. Sufficient checks and balances were in place to ensure accurate and complete submission to the Department. Staff members were cross-trained in various data validation activities and demonstrated a thorough knowledge of the specifications for the new measures. Activities from the BHO's Financial Information Technology Committee continued to help mitigate internal data issues and inconsistencies by the addition of a quality improvement coordinator.

HSAG scored all of NBH's performance measures as *Fully Compliant.* Rates improved from the previous year for five measures (*Penetration Rate—Children, Penetration Rate—Adults, Consumer Perception of Access, Consumer Perception of Outcome,* and *Consumer Satisfaction*). Three of these measures with results from last year (*Penetration Rate—Children, Consumer Perception of Outcome*, and *Consumer Satisfaction*) were also above statewide averages (see Table 5-15) in FY 2007–2008.

NBH's performance on four of the seven first-time measures was better than the statewide average. These measures included *Overall Penetration Rate, Hospital Recidivism, Hospital Average Length of Stay,* and *Emergency Room Utilization*. Two sub-measures under *Penetration Rate by Service Category* also performed better than the statewide average. Of these measures that demonstrated strength, the *Hospital Average Length of Stay* measure for all hospitals (10.23 days) was more than three days lower than the statewide average (13.54 days).

Recommendations

Table 5-13 identified several areas of improvement for NBH. Compared to last year's results, three measures (*Consumer Perception of Quality, Consumer Perception of Participation,* and *Consumers Linked to Primary Care*) had decreased rates in the current year. In particular the *Consumer Perception of Quality* and *Consumer Perception of Participation* measures had a decline of at least 4.5 percentage points from last year. These measures also performed lower than the current year's statewide average. Another area for improvement was in several first-time measures, particularly the *Follow-Up After Hospitalization for Mental Illness* measures. All sub-measures performed at least 4.6 percentage points below the statewide averages with three of the four sub-measures having at least a 5 percentage point difference from the statewide average.

The on-site review indicated that the scope documents and attachments, although a work in progress, did not explicitly define certain data elements for five measures calculated by the BHO (*Inpatient Utilization, Hospital Average Length of Stay, Follow-Up After Hospitalization for Mental Illness, Emergency Department Utilization,* and *Hospital Recidivism*).

Based on the results of performance measure validation findings in FY 2007–2008, suggestions for improving NBH's performance include:

- Developing a process to document the claims entry accuracy checks more formally.
- Increasing the quantity of claims entry accuracy checks to at least 5 percent of the total entered/processed.
- Continuing to work with North Range and Larimer in their conversion to an appointment/schedule-based system to ensure that every kept appointment results in an encounter.
- Continuing collaboration with the Department to resolve issues related to the successful submission of the 837 files, including reports and other challenges to data transmission.
- Collaborating with the Department to reformat the Attachment A document to ensure better version control, streamline tables and codes to avoid confusion, and modify the Attachment B document to ensure that the diagnosis codes match with those covered by State contract. An alternative solution would be to incorporate the revised information from these two documents into the scope document.
- Conducting an analysis to identify causal factors for performance measure rates that reported a decline from last year's results or below the current statewide average rates (see Table 5-15), especially the *Follow-Up After Hospitalization for Mental Illness* measure. Based on the results, NBH should design appropriate interventions to remove identified barriers, thereby improving performance of these measures.

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, timeliness, and access.

- **Quality**: NBH's performance in the domain of quality was mixed. Two of the four measures with last year's results (*Consumer Perception of Outcome* and *Consumer Satisfaction*) had an improved rate from last year, with *Consumer Satisfaction* also performing better than the statewide average. The other two measures (*Consumer Perception of Quality* and *Consumer Perception of Participation*) showed a decrease of at least 4.5 percentage points from the previous year. These two measures also performed below the current year's statewide averages. Nonetheless, NBH's performance on the first-time *Hospital Recidivism* measure was a strength; all of the sub-measures performed at least 1 percentage point above the statewide average.

- **Timeliness**: NBH's performance on the only timeline measure (*Follow-Up After Hospitalization for Mental Illness*) suggested an area for improvement. All related sub-measures had rates below the statewide average performance, with three measures having at least a 5 percentage-point difference from the statewide average rate.

- **Access**: NBH's performance in the domain of access was also mixed. Three of the four measures with last year's results (*Penetration Rate—Children*, *Penetration Rate—Adult*, and *Consumer Perception of Access*) demonstrated an improved rate from the prior measurement year. One measure (*Consumers Linked to Primary Care*) showed a decline from 80.9 percent to 78.7 percent, which was also below the current year's statewide average. Among the five first-time access measures, three (*Overall Penetration Rate*, *Hospital Average Length of Stay*, and *Emergency Room Utilization*) performed above and one (*Inpatient Utilization*) performed below

the statewide average. Two of the three sub-measures under *Penetration Rate by Service Category (Inpatient Care and Ambulatory Care)* performed above the statewide average, while the *Penetration Rate for Intensive Outpatient/Partial Hospitalization* measure performed slightly below the statewide average.

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

Table 5-14 presents the statewide number and percentage of BHOs achieving each validation status for each performance measure for FY 2007–2008 and the prior year.

Table 5-14—Summary of Data From Validation of Performance Measures: Number and Percent of BHOs Achieving Each Validation Status by Measure

Performance Measures	FY 2006–2007 *Fully Compliant*	FY 2007–2008 *Fully Compliant*	FY 2006–2007 *Substantially Compliant*	FY 2007–2008 *Substantially Compliant*	FY 2006–2007 *Not Valid*	FY 2007–2008 *Not Valid*
Penetration Rates by Age Category	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Penetration Rates by Service Category		5/100%		0/0%		0/0%
Overall Penetration Rates		5/100%		0/0%		0/0%
Hospital Recidivism		5/100%		0/0%		0/0%
Hospital Average Length of Stay		5/100%		0/0%		0/0%
Emergency Department Utilization		5/100%		0/0%		0/0%
Inpatient Utilization		5/100%		0/0%		0/0%
Follow-up After Hospitalization for Mental Illness (7 and 30-day follow up)		5/100%		0/0%		0/0%
Consumer Perception of Access	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumer Perception of Quality and Appropriateness	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumer Perception of Outcomes of Services (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%

Table 5-14—Summary of Data From Validation of Performance Measures: Number and Percent of BHOs Achieving Each Validation Status by Measure						
Performance Measures	FY 2006–2007 *Fully Compliant*	FY 2007–2008 *Fully Compliant*	FY 2006–2007 *Substantially Compliant*	FY 2007–2008 *Substantially Compliant*	FY 2006–2007 *Not Valid*	FY 2007–2008 *Not Valid*
Consumer Perception of Participation in Treatment Planning (Consumer Perception of Participation)	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Consumers Linked to Physical Health (Consumers Linked to Primary Care)	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%

Table 5-15 provides a summary of the statewide averages for the performance measure rates for FY 2007–2008 and the prior year.

Table 5-15—Statewide Average Rates for the Performance Measures			
Performance Measures	Rate		BHO FY 2007-2008 Rate Variations
	FY 2006–2007	FY 2007–2008	
Penetration Rate by Age Category			
Children	9.4%	10.0%	7.1% – 13.6%
Adults	17.3%	18.6%	15.2% – 22.5%
Penetration Rate by Service Category			
Inpatient Care	—	0.7%	0.08% – 1.1 %
Intensive Outpatient/Partial Hospitalization	—	0.1%	0.02% – 0.2%
Ambulatory Care	—	13.1%	9.9% – 17.4%
Overall Penetration Rate	—	13.5%	10.0% – 17.5%
Hospital Recidivism			
Non-State Hospitals – 7 days	—	3.4%	2.0% – 6.0%
30 days	—	9.6%	6.0% – 13.0%
90 days	—	16.6%	15.0% – 21.0%
All Hospitals – 7 days	—	3.0%	2.0% – 6.0%
30 days	—	10.4%	7.0% – 16.0%
90 days	—	17.2%	12.0% – 24.0%
Hospital Average Length of Stay			
Non-State Hospitals	—	6.88	5.23 – 8.70
All Hospitals	—	13.54	10.23 – 15.73
Emergency Room Utilization (Rate/1000 Members, All Ages)	—	8.63	6.06 – 9.19

Table 5-15—Statewide Average Rates for the Performance Measures			
	Rate		
Performance Measures	FY 2006–2007	FY 2007–2008	BHO FY 2007-2008 Rate Variations
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	—	4.28	2.56 – 7.77
All Hospitals	—	7.19	5.63 – 10.86
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals – 7–day	—	43.9%	30.8% – 58.2%
30–day	—	67.1%	62.7% – 73.4%
State Hospitals – 7–day	—	45.9%	31.5% – 58.7%
30–day	—	68.9%	61.3% – 75.0%
Consumer Perception of Access	69.9%	73.5%	70.5% – 78.2%
Consumer Perception of Quality	71.9%	70.3%	65.9% – 74.0%
Consumer Perception of Outcome	62.6%	60.4%	59.6% – 65.9%
Consumer Satisfaction	77.9%	75.0%	69.4% – 79.4%
Consumer Perception of Participation	63.2%	64.3%	60.3% – 70.1%
Consumers Linked to Primary Care	80.9%	79.2%	74.4% – 83.3%

Based on the data presented, the following is a statewide summary of the conclusions drawn from the performance measure results regarding the BHOs' strengths, opportunities for improvement, and suggestions related to quality, timeliness, and access.

Strengths

Overall, statewide BHO performance in safeguarding data integrity and quality and in reporting performance measures continued to improve from the prior year. First, all the BHOs continued to exert satisfactory efforts to ensure that their eligibility and claims/encounter data systems were solid for the processing of data used for performance measure reporting. Secondly, similar to the prior year, all the BHOs continued to receive *Acceptable* scores for data integration, data control processes, and performance measure documentation.

Like the prior year, all of the performance measures for all BHOs received a score of *Fully Compliant*. In addition, the rates for four of the eight measures increased from the prior year's results, especially for *Consumer Perception of Access*, which had an increase of 3.6 percentage points.

Because seven measures were introduced for the first time in this current year, comparisons with last year's results were not available. The statewide performance for these measures could only be considered baseline information. Nonetheless, several first-time measures (e.g., *Hospital Recidivism, Overall Penetration Rate*) reflected similar performance across most of the BHOs instead of a wide variation in rates. For example, the statewide 7-days *Hospital Recidivism* rate for non-state hospitals (3 percent) reflected similar performance for four of the five BHOs, whose rates ranged from 2 to 3 percent. One BHO was a performance outlier with a rate of 6 percent.

Quality

Statewide BHO performance in the domain of quality for performance measures was mixed, with an improved rate for one of the four quality-related measures with last year's results (*Consumer Perception of Participation*) and declined rates for three measures (*Consumer Perception of Quality, Consumer Perception of Outcome*, and *Consumer Satisfaction*). However, none of these measures had a declined rate of more than 5 percentage points. Rates for *Hospital Recidivism* (a first-time measure) ranged from 3.0 percent for 7-days recidivism to 17.2 percent for the 90-day recidivism. *Hospital Recidivism* rates for non-state and all hospitals were similar with longer durations having higher recidivism. BHO variations in rates were smallest for the 7-day *Hospital Recidivism* (4 percent) and largest for the 90-day recidivism for all hospitals (12 percent). These results suggest that the BHOs have room for improvement.

Timeliness

The *Follow-Up After Hospitalization for Mental Illness* measures were introduced the first time this year. The rates for the *7-day Follow Up* rates for non-state and state hospitals (43.9 percent and 45.9 percent, respectively) were at least 20 percentage points below those for the *30-day Follow-Up* measures (67.1 percent and 68.9 percent, respectively). BHO variations in rates for all the sub-measures were larger than 10 percent, with the *30-day Follow Up* measure for non-state hospitals exhibiting the smallest BHO variations. Wide BHO performance variations were observed for both *7-day Follow-Up* measures: for non-state hospitals the variation was 27.4 percent and for state hospitals the variation was 27.2 percent. These variations suggest that the BHOs have room for improvement.

Access

Overall, statewide BHO performance in the domain of access for performance measures was mixed, with improved rates between measurement years for three of the four rates. The measures with improved rates were the actual penetration rates (*Penetration Rate—Children and Penetration Rate—Adults*) and consumer-perceived access. The improved performance in the *Penetration Rate by Age Category* also contributed to the current year's *Overall Penetration Rate* of 13.5 percent. The *Consumer Perception of Access* measure improved from 69.9 percent to 73.5 percent, a 3.6 percentage point increase. One measure—*Consumers Linked to Primary Care*—had a declined rate from last year (from 80.9 percent to 79.2 percent). For the first-time access-related measures, BHO variations were fairly consistent across *Emergency Room Utilization* and *Inpatient Utilization*, where the range of variations was approximately five per 1,000 members. In addition, BHO variation among the *Hospital Average Length of Stay* rates was larger for all hospitals (5.5 days) than for the non-state hospitals (3.47 days).

Statewide Recommendations

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

- Adding a service code editor/scrubber (valid service codes) to the process for determining the penetration rate.

- Creating a survey methodology that would allow only one (MHSIP) survey to be completed by a single consumer.
- Re-evaluating the use of the response to a survey question as a means to determine actual eligibility because responses to the question could be incorrect.

Validation of Performance Improvement Projects

For FY 2008–2009, the Department offered each BHO the option of conducting two PIPs or one PIP and one focused study that included interventions. All of the BHOs opted to conduct two PIPs except BHI. BHI opted to conduct one PIP and one focused study. The Department evaluated the BHI focused study and those results can be found in Section 7, State Initiatives.

In recent years, the Department has focused on an initiative to improve coordination of care between Medicaid behavioral and physical health providers. As part of this initiative, the Department mandated a collaborative PIP across all Medicaid plans (both behavioral and physical health) with the goal of improving consumer health, functional status, and satisfaction with the health care delivery system by developing interventions that increase coordination of care and communication between providers. Because the health plans were in various stages of the PIP process, the State required that as each plan retired a current PIP, it had to begin the State-mandated collaborative.

HSAG, in collaboration with the Department, developed the PIP Summary Form, which each BHO completed and submitted to HSAG for review and evaluation. HSAG obtained the data needed to conduct the PIP validation 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 Steps reviewed and evaluated. The HSAG PIP Review Team scored the evaluation elements within each step as *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)*. *Points of Clarification* were also included. A *Point of Clarification* is used when documentation for an evaluation element includes the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP). The BHOs would have received a *Met* validation score for that evaluation element; however, by providing additional documentation or an enhanced explanation in the next submission cycle, it would demonstrate a stronger understanding of CMS Protocols.

To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results.

In addition to giving a validation status, HSAG gave each PIP 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*: High confidence/confidence in the reported PIP results.
- *Partially Met*: Low confidence in the reported PIP results.
- *Not Met*: Reported PIP results were not credible.

The BHOs had an opportunity to resubmit additional documentation after the initial HSAG review to improve their scores prior to the finalization of the FY 2008–2009 PIP Validation Report. This process became available to the BHOs in the FY 2006–2007 validation cycle.

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 was 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.

Appendix C contains further details about the EQR validation of PIP activities.

Access Behavioral Care

Findings

ABC conducted two PIPs: *Coordination of Care Between Psychiatric Emergency Services* and *Outpatient Treatment* and *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*. The first PIP was selected by the BHO and the second PIP was State-mandated. Both studies were a continuation from the previous year.

For the first PIP, HSAG reviewed Steps I through VIII. Table 5-16 and Table 5-17 show ABC's scores based on HSAG's evaluation of *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment*. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 5-16—PIP Validation Scores *for* Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment *for* ABC

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	2	0	0	1	2	2	0	0	0
V. Review Sampling Methods	6	0	0	0	6	1	0	0	0	1

Table 5-16—PIP Validation Scores *for* Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment *for* ABC

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
VI. Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII. Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	3	1	0	5	2	1	0	0	1
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**26**	**1**	**0**	**21**	**13**	**10**	**0**	**0**	**3**

Table 5-17—FY 2007–2008 and FY 2008–2009 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment *for* ABC

	Prior Year FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**100%**	**96%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 high confidence/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

For the *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP, ABC demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Steps I through VII. In addition, ABC developed its interventions based on causal/barrier analysis and the interventions were system changes likely to have a long-term effect on outcomes.

Recommendations

There were no required actions for the *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP. HSAG provided *Points of Clarification* as opportunities for improvement. In most cases, if a *Point of Clarification* is not addressed, it will affect the score in future submissions. As a *Point of Clarification*, HSAG recommended that ABC:

- Place information about the eligible study population in Activity I.
- Include a statement specifying that consumers with special health care needs were not excluded from the study.
- Provide complete date ranges for all measurement periods, including future measurement periods.

ABC's second PIP was the State-mandated collaborative PIP. HSAG reviewed Steps I through VIII. Table 5-18 and Table 5-19 show ABC's scores based on HSAG's evaluation of *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 5-18—PIP Validation Scores
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* ABC**

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI. Review Data Collection Procedures	11	8	0	0	3	1	1	0	0	0
VII. Assess Improvement Strategies	4	1	1	0	2	1	0	1	0	0
VIII. Review Data Analysis and Study Results	9	3	0	1	5	2	0	0	1	1
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**28**	**1**	**1**	**18**	**13**	**9**	**1**	**1**	**2**

Table 5-19—FY 2007–2008 and FY 2008–2009 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers *for* ABC		
	Prior Year FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**100%**	**93%**
Percentage Score of Critical Elements *Met***	**100%**	**82%**
Validation Status***	***Met***	***Not Met***

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

** The percentage score for 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 high confidence/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

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, ABC demonstrated strength by receiving *Met* scores for all applicable evaluation elements in Steps I through VI. In addition, ABC developed interventions that were system changes likely to have a long-term effect on study outcomes.

Recommendations

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, ABC had required actions in Steps VII and VIII. In Step VII, the required action was to provide a discussion about the causal/barrier analysis and quality improvement processes used in developing the interventions. In Step VIII, the required action was to provide a data analysis plan in future submissions to explain how data analysis will occur.

In addition to the required actions, HSAG suggested, as *Points of Clarifications*, that ABC provide complete and consistent date ranges for all measurement periods in Activities III, VI, and IX. HSAG also suggested that ABC provide the year of the HEDIS technical specifications used, and that the year be updated annually as the study progresses.

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. ABC's PIPs addressed CMS' requirements related to quality outcomes—specifically, quality of care and services. By increasing coordination of care for its consumers, ABC will increase the likelihood of desired health outcomes.

A comparison of the PIP validation cycle for ABC's PIPs yielded the following:

- *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* (Year 1 through Year 2): For the FY 2007–2008 validation cycle, ABC completed Activities I through

V in the PIP Summary Form, receiving scores of 100 percent for evaluation elements and critical elements *Met*, and a *Met* validation status. HSAG identified two opportunities for improvement in Steps I and III with regard to documenting information about the eligible study population in Activity I and updating the definitions of the numerator and denominator for Study Indicator 1.

For the FY 2008–2009 validation cycle, ABC progressed through Activity VIII. The PIP received a score of 96 percent for evaluation elements *Met*, 100 percent for critical elements *Met*, and a *Met* validation status. This year, ABC reported Baseline data and addressed one opportunity for improvement from the FY 2007–2008 validation cycle. HSAG identified six new opportunities for improvement in this year's submission.

- *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* (Year 1 through Year 2): For the FY 2007–2008 validation cycle, ABC completed Activities I through IV in the PIP Summary Form, receiving scores of 100 percent for evaluation elements and critical elements *Met*, and a *Met* validation status. HSAG identified an opportunity for ABC to document the rationale for the study indicators in Activity III.

  For the FY 2008–2009 validation cycle, ABC progressed through Activity VIII. The PIP received a score of 93 percent for evaluation elements *Met*, 82 percent for critical elements *Met*, and a *Not Met* validation status. This year, ABC reported Baseline data and addressed the opportunity for improvement from FY 2007–2008. HSAG identified four new opportunities for improvement in this year's validation—two related to critical evaluation elements in Steps VII and VIII.

Behavioral HealthCare, Inc.

Findings

BHI conducted one PIP for validation that was State-mandated. The *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP was continued from the prior year.

HSAG reviewed Steps I through VIII. Table 5-20 and Table 5-21 show BHI's scores based on HSAG's evaluation of *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*. HSAG scored and reviewed each step according to HSAG's validation methodology.

Table 5-20—PIP Validation Scores
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* BHI**

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	6	0	0	0	1	1	0	0	0
VI. Review Data Collection Procedures	11	9	0	1	1	1	1	0	0	0
VII. Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	5	0	0	4	2	2	0	0	0
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**38**	**0**	**1**	**9**	**13**	**13**	**0**	**0**	**0**

Table 5-21—FY 2007–2008 and FY 2008–2009 PIP Overall Validation Scores and Validation Status
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* BHI**

	Prior Year FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**100%**	**97%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 high confidence/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 demonstrated strength in its study design and study implementation phase by receiving *Met* scores for all applicable evaluation elements in Steps I through VII, except for one. In addition, BHI performed data analysis according to the data analysis plan in the study, and the Baseline data were presented in a clear and accurate format.

Recommendations

There were no required actions for BHI's PIP. HSAG did recommend the following *Points of Clarification*:

- Place information regarding the inclusion of consumers with special health care needs in Activity I instead of Activity IV.
- Provide the rationale for the study indicators in Activity III instead of Activity I.
- Provide timelines for all future measurement periods.
- Include an overview of the study in the written instructions for completing the manual data collection tool.

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. BHI's PIP addressed CMS' requirements related to quality outcomes—specifically, quality of care and services. By increasing coordination of care for its consumers, BHI will increase the likelihood of desired health outcomes.

A comparison of the PIP validation cycle for BHI's PIP yielded the following:

- *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* (Year 1 through Year 2): For the FY 2007–2008 validation cycle, BHI completed Activities I through IV in the PIP Summary Form, receiving scores of 100 percent for evaluation elements and critical elements *Met*, and a *Met* validation status. HSAG identified an opportunity for improvement in Step III for BHI to document the rationale for the study indicators.

  For the FY 2008–2009 validation cycle, BHI progressed through Activity VIII. The PIP received a score of 97 percent for evaluation elements *Met*, 100 percent for critical elements *Met*, and a *Met* validation status. This year, BHI reported Baseline data. The opportunity for improvement from last year's validation cycle remained in this year's submission. HSAG identified five additional opportunities for improvement for the 2008–2009 validation. For more details, see the specific BHI PIP Validation Report.

Colorado Health Partnerships, LLC

Findings

CHP conducted two PIPs. The *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP was State-mandated and was continued from the prior year. The *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP was new for this validation cycle and was selected by the BHO.

For the first PIP, HSAG reviewed Steps I through VIII. Table 5-22 and Table 5-23 show CHP's scores based on HSAG's evaluation of *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 5-22—PIP Validation Scores
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* CHP**

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	6	0	0	0	1	1	0	0	0
VI. Review Data Collection Procedures	11	10	0	0	1	1	1	0	0	0
VII. Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	5	0	0	4	2	2	0	0	0
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**38**	**0**	**0**	**10**	**13**	**13**	**0**	**0**	**0**

Table 5-23—FY 2007–2008 and FY 2008–2009 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers *for* CHP		
	Prior Year FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**100%**	**100%**
Percentage Score of Critical Elements *Met* **	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 high confidence/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

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, CHP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements for Steps I through VIII. CHP developed its interventions based on causal/barrier analysis, and the interventions were system changes likely to have a long-term effect on study outcomes.

Recommendations

There were no required actions for this PIP; however, HSAG recommended the following *Points of Clarification*:

- Provide complete date ranges for all measurement periods in Activities III, VI, and IX. Additionally, the BHO should provide the year of the HEDIS specifications that were used.
- Remove the sampling technique from the denominator for Study Indicator 2 since it is not necessary to define the study indicator.
- Move the information regarding the rationale for the study indicators in Activity I to the section provided in Activity III.

For the second PIP, HSAG reviewed Steps I through IV. Table 5-24 and Table 5-25 show CHP's scores based on HSAG's evaluation of the *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 5-24—PIP Validation Scores *for* Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+ *for* CHP										
Review Step	**Total Possible Evaluation Elements** (Including Critical Elements)	**Total *Met***	**Total *Partially Met***	**Total *Not Met***	**Total *NA***	**Total Possible Critical Elements**	**Total Critical Elements *Met***	**Total Critical Elements *Partially Met***	**Total Critical Elements *Not Met***	**Total Critical Elements *NA***
I. Review the Selected Study Topic	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	Not Assessed				1	Not Assessed			
VI. Review Data Collection Procedures	11	Not Assessed				1	Not Assessed			
VII. Assess Improvement Strategies	4	Not Assessed				1	Not Assessed			
VIII. Review Data Analysis and Study Results	9	Not Assessed				2	Not Assessed			
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**15**	**0**	**0**	**3**	**13**	**8**	**0**	**0**	**0**

Table 5-25—FY 2008–2009 PIP Overall Validation Scores and Validation Status *for* Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+ *for* CHP	
Percentage Score of Evaluation Elements *Met**	**100%**
Percentage Score of Critical Elements *Met***	**100%**
Validation Status***	***Met***

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

** The percentage score for 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 high confidence/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

For the *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP, CHP provided a solid study design. CHP selected the study topic following the collection and analysis of data, the study questions were simply stated and answerable, and the study indicators were well-defined, objective, and measurable. CHP defined the study population accurately and completely.

Recommendations

For the *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP, there were no required actions. HSAG's recommended *Point of Clarification* was that CHP provide plan-specific data in Activity I of the PIP submission. The original PIP submission included this information; however, the resubmission did not include it.

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. CHP's PIPs addressed CMS' requirements related to quality outcomes—specifically, quality of care and services. By improving coordination of care for its consumers and increasing the penetration rate of consumers 60 years of age and older, CHP will increase the likelihood of desired health outcomes.

A comparison of the PIP validation cycles for each of CHP's PIPs yielded the following:

- *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* (Year 1 through Year 2): For the FY 2007–2008 validation cycle, CHP completed Activities I through IV in the PIP Summary Form, receiving scores of 100 percent for evaluation elements and critical elements *Met*, and a *Met* validation status. HSAG identified an opportunity for improvement in Step I with regard to providing plan-specific data that support the selection of the study topic.

  For the FY 2008–2009 validation cycle, CHP progressed through Activity VIII. The PIP received a score of 100 percent for evaluation elements *Met*, 100 percent for critical elements *Met*, and a *Met* validation status. This year, CHP reported Baseline data and addressed the opportunity for improvement from FY 2007–2008. HSAG identified three new opportunities for improvement in this year's submission. For more details, see the specific CHP PIP Validation Report.

- *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+*: This was the first annual PIP submission, with no data reported. Therefore, this report cannot provide a comparison of PIP validation cycles at this time.

Foothills Behavioral Health, LLC

Findings

FBH conducted two PIPs. The *Supporting Recovery* PIP was selected by the BHO and the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP was State-mandated. Both were continued from the prior year.

For the first PIP, HSAG reviewed Steps I through X. Table 5-26 and Table 5-27 show FBH's scores based on HSAG's evaluation of *Supporting Recovery*. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 5-26—PIP Validation Scores *for* Supporting Recovery *for* FBH

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic	6	6	0	0	0	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	6	0	0	0	1	1	0	0	0
VI. Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII. Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	9	0	0	0	2	2	0	0	0
IX. Assess for Real Improvement	4	1	3	0	0	0	No Critical Elements			
X. Assess for Sustained Improvement	1	1	0	0	0	0	No Critical Elements			
Totals for All Steps	**53**	**43**	**3**	**0**	**7**	**13**	**12**	**0**	**0**	**1**

Table 5-27—FY 2007–2008 and FY 2008–2009 PIP Overall Validation Scores and Validation Status *for* Supporting Recovery *for* FBH		
	Prior Year FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**91%**	**93%**
Percentage Score of Critical Elements *Met* **	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 high confidence/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

For the *Supporting Recovery* PIP, FBH developed a strong study design and implemented the study successfully. All applicable evaluation elements in Steps I through VIII received a *Met* score. FBH's interventions were related to causes and barriers and included consumer and provider education; creation of a peer specialist position; brochures, notepads, and posters for consumers; staff and provider training; and prescriber packets. While there was a non-significant decrease in satisfaction for Remeasurement 4, the PIP demonstrated sustained improvement overall. Going forward, this PIP will be retired from submission for validation. FBH plans to follow up with a study to assess the effects of the evidence-based practice of illness management and recovery (IMR).

Recommendations

There were no required actions for the *Supporting Recovery* PIP; however, HSAG recommended, as a *Point of Clarification*, that FBH add a standard deviation for the Remeasurement 4 result of Study Indicator 1.

For the second PIP, HSAG reviewed Steps I through VIII. Table 5-28 and Table 5-29 show FBH's scores based on HSAG's evaluation of *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 5-28—PIP Validation Scores
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* FBH**

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	6	0	0	0	1	1	0	0	0
VI. Review Data Collection Procedures	11	11	0	0	0	1	1	0	0	0
VII. Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	5	0	0	4	2	2	0	0	0
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**40**	**0**	**0**	**8**	**13**	**13**	**0**	**0**	**0**

Table 5-29—FY 2007–2008 and FY 2008-2009 PIP Overall Validation Scores and Validation Status
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* FBH**

	Prior Year FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**100%**	**100%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 high confidence/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

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, FBH demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements for Steps I through VIII. In addition, FBH conducted the data analysis according to the data analysis plan in the study and presented the Baseline results in a clear and accurate format.

Recommendations

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, there were no required actions. HSAG recommended the following *Points of Clarification*:

- Specify that consumers with special health care needs were not excluded from the study.
- Further define "statistically improve" as stated in the Baseline goal.
- Clearly define all data sources.

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. FBH's PIPs addressed CMS' requirements related to quality outcomes—specifically, quality of care and services. By improving coordination of care and consumer satisfaction, FBH will increase the likelihood of desired health outcomes for its consumers.

A comparison of the PIP validation cycles for each of FBH's PIPs yielded the following:

- *Supporting Recovery* (Years 1 through 4): For the FY 2005–2006 validation cycle, FBH completed Activities I through VII in the PIP Summary Form, receiving scores of 93 percent for evaluation elements *Met*, 100 percent for critical elements *Met*, and a *Met* validation status. During this period, FBH reported Baseline results. HSAG identified opportunities for improvement in Step VI.

  For the FY 2006–2007 validation cycle, FBH progressed through Activity VIII, receiving scores of 100 percent for evaluation elements *Met*, 100 percent for critical elements *Met*, and a *Met* validation status. During this period, FBH reported Baseline and Remeasurement 1 results. FBH addressed all elements that received *Not Met* scores for the FY 2005–2006 validation.

  For the FY 2007–2008 validation cycle, FBH progressed through Activity X, receiving scores of 91 percent for evaluation elements *Met*, 100 percent for critical elements *Met*, and a *Met* validation status. FBH reported results for Baseline and two remeasurement periods. HSAG identified four *Partially Met* scores in Steps IX and X.

  For the FY 2008–2009 validation cycle, HSAG validated FBH's PIP submission through Step X. The overall score improved slightly to 93 percent. Not all of the study indicators showed statistically significant improvement; this lack of improvement was related to the areas that HSAG identified as requiring improvement from the FY 2007–2008 PIP submission. For this

year's submission, the areas requiring improvement were similar. Despite the areas identified for improvement, FBH's PIP showed sustained improvement in consumer satisfaction from Baseline to Remeasurement 4. HSAG recommended that the PIP be retired from submission for validation.

- *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* (Years 1 through 2)*:* For the FY 2007–2008 validation cycle, FBH completed Activities I through IV in the PIP Summary Form, receiving scores of 100 percent for evaluation elements and critical elements *Met*, and a *Met* validation status. HSAG identified an opportunity for improvement in Step I to document plan-specific information when it becomes available, and in Step IV to include "and enrolled" for consumers who were Medicaid-eligible for at least 10 months with FBH.

  For the FY 2008–2009 validation cycle, FBH progressed through Activity VIII. The PIP received a score of 100 percent for evaluation elements *Met*, 100 percent for critical elements *Met*, and a *Met* validation status. This year, FBH reported Baseline data and addressed the opportunities for improvement from FY 2007–2008. HSAG identified three opportunities for improvement in this year's submission. For more details, see the specific FBH PIP Validation Report.

Northeast Behavioral Health, LLC

Findings

NBH conducted two PIPs: *Therapy With Children and Adolescents: Increasing Caregiver Involvement* and *Coordination of Care Between Psychiatric Providers and Physical Health Providers).* The first PIP was selected by the BHO and the second PIP was State-mandated. Both studies were a continuation from the previous year.

For the first PIP, HSAG reviewed Steps I through IX. Table 5-30 and Table 5-31 show NBH's scores based on HSAG's evaluation of *Therapy With Children and Adolescents: Increasing Caregiver Involvement*. HSAG reviewed and scored each step according to HSAG's validation methodology.

Table 5-30—PIP Validation Scores
***for* Therapy With Children and Adolescents: Increasing Caregiver Involvement**
***for* NBH**

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic	6	6	0	0	0	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	0	0	0	6	1	0	0	0	1
VI. Review Data Collection Procedures	11	6	0	0	5	1	0	0	0	1
VII. Assess Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	7	1	0	1	2	1	0	0	1
IX. Assess for Real Improvement	4	4	0	0	0	0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**37**	**1**	**0**	**14**	**13**	**10**	**0**	**0**	**3**

Table 5-31—FY 2007–2008 and FY 2008-2009 PIP Overall Validation Scores and Validation Status
***for* Therapy With Children and Adolescents: Increasing Caregiver Involvement**
***for* NBH**

	Prior Year FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**100%**	**97%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 high confidence/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

For the *Therapy With Children and Adolescents*: *Increasing Caregiver Involvement* PIP, NBH provided a solid study design and implemented the study successfully. All applicable evaluation elements in Steps I through VII and Step IX received a *Met* score. NBH's interventions were related to causes/barriers and included staff training, a revision to the medical records database, and a caregiver therapy contract. NBH's PIP demonstrated statistically significant improvement from Baseline to Remeasurement 1. Going forward, NBH will collect a second remeasurement to assess for sustained improvement.

Recommendations

There were no required actions for the *Therapy With Children and Adolescents*: *Increasing Caregiver Involvement* PIP. HSAG's recommendations were as follows:

- Provide the benchmarks and the complete date range for Remeasurement 2 in Activity III of the PIP submission.
- Revise the goal for each study indicator to a percentage that the BHO hopes to achieve.
- Document any factors that may affect the ability to compare measurements.

Table 5-32—PIP Validation Scores
***for* Coordination of Care Between Psychiatric Providers and Physical Health Providers**
***for* NBH**

Review Step	Total Possible Evaluation Elements (Including Critical Elements)	Total *Met*	Total *Partially Met*	Total *Not Met*	Total *NA*	Total Possible Critical Elements	Total Critical Elements *Met*	Total Critical Elements *Partially Met*	Total Critical Elements *Not Met*	Total Critical Elements *NA*
I. Review the Selected Study Topic	6	5	0	0	1	1	1	0	0	0
II. Review the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Review the Selected Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Review the Identified Study Population	3	3	0	0	0	2	2	0	0	0
V. Review Sampling Methods	6	6	0	0	0	1	1	0	0	0
VI. Review Data Collection Procedures	11	9	0	0	2	1	1	0	0	0
VII. Assess Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Review Data Analysis and Study Results	9	5	0	0	4	2	2	0	0	0
IX. Assess for Real Improvement	4	Not Assessed				0	No Critical Elements			
X. Assess for Sustained Improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Steps	**53**	**38**	**0**	**0**	**10**	**13**	**13**	**0**	**0**	**0**

Table 5-33—FY 2007–2008 and FY 2008-2009 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Psychiatric Providers and Physical Health Providers *for* NBH

	Prior Year FY 2007–2008	FY 2008–2009
Percentage Score of Evaluation Elements *Met**	**100%**	**100%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

** The percentage score for 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 high confidence/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

For the *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP, NBH demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements for Steps I through VIII. In addition, NBH developed interventions based on causal/barrier analysis; the interventions were system changes likely to have a long-term effect on study outcomes.

Recommendations

There were no required actions for the *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP. HSAG's recommended *Point of Clarification* was to provide complete and consistent date ranges for all measurement periods in Activities III, VI, and IX of the PIP Summary Form.

For the second PIP, HSAG reviewed Steps I through VIII. Table 5-32 and Table 5-33 show NBH's scores based on HSAG's evaluation of *Coordination of Care Between Psychiatric Providers and Physical Health Providers*. HSAG reviewed and scored each step according to HSAG's validation methodology.

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. NBH's PIPs addressed CMS' requirements related to quality outcomes—specifically, quality of care and services. By improving coordination of care and increasing caregiver involvement in therapy for children and adolescents, NBH will increase the likelihood of desired health outcomes for its consumers.

A comparison of the PIP validation cycles for each of NBH's PIPs yielded the following:

- *Therapy With Children and Adolescents*: *Increasing Caregiver Involvement* (Years 1 through 2): For the FY 2007–2008 validation cycle, NBH's PIP received an overall score of 100 percent, a critical element score of 100 percent, and *Met* validation status. NBH collected Baseline data

and completed data analysis according to the plan outlined in the study. There were no opportunities for improvement.

For FY 2008–2009, HSAG validated the PIP through Step IX. NBH collected Remeasurement 1 data. All three study indicators showed statistically significant improvement. There was one *Partially Met* score in Step VIII. Going forward, HSAG anticipates that NBH will address the areas identified for improvement.

- *Coordination of Care Between Psychiatric Providers and Physical Health Providers* (Years 1 through 2): For the FY 2007–2008 validation cycle, NBH completed Activities I through IV in the PIP Summary Form, receiving scores of 100 percent for evaluation elements and critical elements *Met*, and a *Met* validation status. HSAG identified an opportunity for improvement in Step III with regard to moving the rationale for each study indicator to Activity III and specifying that the PIP was a collaborative PIP.

  For the FY 2008–2009 validation cycle, NBH progressed through Activity VIII. The PIP received a score of 100 percent for evaluation elements *Met*, 100 percent for critical elements *Met*, and a *Met* validation status. This year, NBH reported Baseline data and addressed the opportunity for improvement from FY 2007–2008. HSAG identified two opportunities for improvement in this year's submission.

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

Table 5-34 shows the BHOs' overall performance based on HSAG's validation of the FY 2008–2009 PIPs that were submitted for validation.

Table 5-34––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	*Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment*	96%	100%	*Met*
ABC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	93%	82%	*Not Met*
BHI	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	97%	100%	*Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	100%	100%	*Met*
CHP	*Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+*	100%	100%	*Met*
FBH	*Supporting Recovery*	93%	100%	*Met*
FBH	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	100%	100%	*Met*
NBH	*Therapy With Children and Adolescents: Increasing Caregiver Involvement*	97%	100%	*Met*
NBH	*Coordination of Care Between Psychiatric Providers and Physical Health Providers*	100%	100%	*Met*

Overall, the BHOs' PIPs demonstrated strong performance. HSAG gave eight of the nine PIPs reviewed a validation status of *Met*, with scores ranging from 82 percent to 100 percent for critical elements *Met* and scores ranging from 93 percent to 100 percent for all evaluation elements *Met*. The BHOs' performance remained strong from the previous year, when HSAG gave all 13 of the PIPs reviewed a validation status of *Met*. The overall study goal of the BHOs' PIPs was to impact the quality of care provided to their consumers. The PIP scores show compliance with CMS' PIP protocol. This strong performance by the BHOs increases the likelihood of desired health outcomes for its consumers.

Overall, the BHOs were effective in using the CMS Protocols to conduct PIPs. The HSAG PIP Review Team has provided recommendations to ABC, BHI, CHP, FBH, and NBH that will assist them in achieving their desired outcomes for their studies and meet all documentation requirements.

Table 5-35—Summary of Data From Validation of Performance Improvement Projects

Validation Step	Prior Year (FY 2007–2008) Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	FY 2008–2009 Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Prior Year (FY 2007–2008) Number of PIPs Meeting All Critical Elements/ Number Reviewed	FY 2008–2009 Number of PIPs Meeting All Critical Elements/ Number Reviewed
I. Review the Selected Study Topic	13/13	9/9	13/13	9/9
II. Review the Study Question(s)	13/13	9/9	13/13	9/9
III. Review the Selected Study Indicator(s)	13/13	9/9	13/13	9/9
IV. Review the Identified Study Population	13/13	9/9	13/13	9/9
V. Review Sampling Methods	8/8	8/8	8/8	8/8
VI. Review Data Collection Procedures	7/7	7/8	7/7	8/8
VII. Assess Improvement Strategies	7/7	7/8	NA*	7/8
VIII. Review Data Analysis and Study Results	7/7	5/8	7/7	7/8
IX. Assess for Real Improvement	1/6	1/2	No Critical Elements	
X. Assess for Sustained Improvement	2/5	1/1	No Critical Elements	

The shaded areas represent those areas in which not all evaluation elements were *Met*.
* For the FY 2007–2008 validation cycle, Step VII did not have any critical elements.

Table 5-35 provides a year-to-year comparison of the total number of PIPs submitted by the BHOs that achieved a score of *Met* for all evaluation elements and for all critical elements. In both years, all PIPs that were submitted received scores of *Met* for all evaluation elements and for all critical elements in Steps I through V. One PIP submitted for FY 2008–2009 was validated through Step X.

FBH's *Supporting Recovery* PIP achieved sustained improvement and was retired from submission for validation. FBH will be submitting a new PIP for validation in FY 2009–2010.

Encounter Data Validaton

Introduction

The purpose of the 2008 Behavioral Health Encounter Data Validation (EDV) study was to evaluate the extent to which administrative encounters for behavioral health services were accurate and complete. The study focused on inpatient, outpatient, and physician/practitioner behavioral health encounters with dates of services (or discharge dates for institutional encounters) between January 1, 2008, and March 31, 2008, for Colorado Medicaid members enrolled in one of the five participating BHOs.

Methodology

Administrative encounters were evaluated for their completeness and accuracy via behavioral health record review. The study employed a two-stage sampling method to extract administrative encounters for review. In the first stage, an oversample of members using institutional services was selected first for each BHO, then members using non-institutional services were randomly selected so that the final sample reached a total of 411 members. In the second stage, one encounter was randomly selected for the validation for each sample member. The list of sample encounters along with the member's name was distributed to each BHO for record procurement. HSAG certified coders, then conducted a review of all submitted documentation for the sample encounters to determine whether key data elements (i.e., date of service, date of birth, diagnosis, procedure, and unit) obtained from the electronic encounter file were present in the submitted behavioral health records. The coders also determined the accuracy of electronic encounter data based on documentation contained in the behavioral health record.

In addition to the behavioral health record review, HSAG also conducted three supplemental analyses to augment the evaluation and understanding of data quality issues associated with behavioral health encounters submitted to the Department. The crosswalk reasonableness review evaluated the extent to which proprietary crosswalks, developed by the BHOs, facilitated proper translation of home-grown procedure codes to Health Insurance Portability and Accountability Act (HIPAA) compliant codes. The inconsistent coding analysis evaluated the prevalence of procedures in the administrative encounters submitted with units inconsistently or with unreasonable units. Inconsistent coding patterns were individually identified for duration-inherent (time-based), duration-dependent (unit-based), and duration-independent procedures. Lastly, the information system review examined the Information Systems Capabilities Assessment Tool (ISCAT) responses filled out by the BHOs and the Department to identify data quality-related issues identified in the State Medicaid Management Information System (MMIS). HSAG also interviewed select Department staff members to understand the internal mechanisms used to process submitted encounters.

Study Results and Analysis

Administrative Encounter Omission

The behavioral health record review showed that in general, at least 90 percent of the critical data elements (e.g., date of service, diagnosis code, procedure code) in the administrative encounters had documentation support for behavioral health records. Ninety-five percent of sampled encounters had supporting documentation in the behavioral health records for either their first date of service or the discharge date of service. Omission rates tended to vary widely by date of service type. Omission rates for the discharge date of service (15.1 percent) were generally higher than those for the first-admit date of service (4.3 percent). BHO variations in omission rates were greater for discharge date of service (0 percent to 22.6 percent) than for first-admit date of service (2.3 percent to 6.8 percent).

About 135 of the 2,095 diagnoses (6.4 percent) submitted in the encounters were not supported by behavioral health records, with individual BHO omission rates ranging from 2.7 percent to 10.9 percent. The majority of these omissions were encounters for which the dates of services were also omitted in the behavioral health record. These findings suggest that diagnoses documented in the behavioral health records were more likely to be submitted in an encounter.

Approximately 1 out of 10 CPT/HCPCS procedures (9.4 percent) in the administrative data did not have documentation support in the behavioral health records. Wide variations among BHOs were observed for both the behavioral health record and encounter data omission rates. For behavioral health record omission rates, the variation was 10.7 percentage points, with BHO rates ranging from 6.8 percent to 17.5 percent. For encounter data omission rates, the overall rate was 5 percent, with BHO rates varying from 0 percent to 20.9 percent.

Administrative Encounter Accuracy

The administrative encounters in the MMIS appeared to have a higher level of accuracy for date of birth, diagnosis, and procedure but lower for unit of services. The accuracy of members' documented dates of birth was more than 96 percent, with individual BHO rates ranging from 92.9 percent to 99.0 percent. The majority of the invalid entries were related to a lack of documentation in the behavioral health records, rather than a wrong date of birth. In addition, more than 8 out of 10 diagnoses in the administrative data (87.9 percent) among encounters with valid dates of services were deemed valid based on the behavioral health records, with a wide variation among BHOs (73.3 percent to 94.1 percent). About 60 percent of the invalid diagnoses were related to specificity errors. BHOs also varied in the type of errors identified for the diagnoses.

Approximately four out of five procedures (81.6 percent) submitted for an encounter with a valid date of service were supported by documentation in the behavioral health records. Three BHOs exhibited a high degree of accuracy (9 out of 10 procedure codes validated) while two BHOs had fewer than 7 out of 10 validated procedure codes. The incorrect procedures identified appeared to be related to the BHOs' crosswalk not providing definitive guidelines for code assignment rather than the providers' unfamiliarity with the crosswalk or the miscoding the services.

For unit accuracy, slightly more than half of the units reported with a valid procedure (i.e., 902 out of 1,747 procedures) were supported by documentation in the behavioral health records. About 10 percent of the invalid units did not have any unit information documented in the records. The lack of documentation observed among the BHOs ranged from 6 percent to 95.5 percent. Corroborating results from the inconsistent coding analysis suggest that the noticeably lower rates for the two BHOs (BHI and NBH) could be related to a high percentage of encounters with repeated submission—i.e., the same date of service and procedure submitted multiple times to the MMIS system.

Results from Supplemental Analyses

According to interviews with Department staff members from the Rates, Information Systems, and Business Analysis sections, the MMIS system was still in its early stage of testing and implementation at the time of this review. Staff members indicated that, historically, different sections handled separate encounter submission platforms (i.e., flat-file versus MMIS). This situation created challenges in sufficient communication, support, and coordination among the sections and resulted in an ineffective collaborative environment. Staff members also identified that decisions made for processing fee-for-service claims in the MMIS system may not address the unique qualities of behavioral health encounter data. One major issue pertinent to the use of the MMIS system was the challenge of balancing the need for functional system edits to verify the completeness and accuracy of submitted encounters with the need to allow flexibility in accommodating the service packages designed by BHOs.

The crosswalk reasonableness review showed that in general, the BHOs' crosswalks maintained a high degree of clinical reasonableness with several areas for improvement noted for a limited set of service codes. This was primarily related to local service codes being mapped to delete or non-compliant HIPAA codes, lack of details and guidelines for determining specific time-based service units, and unclear service descriptions.

Findings from the inconsistent coding analysis suggested that the issue of units being reported inconsistently or unreasonably was not widespread. Less than 1 percent of the outpatient (0.8 percent) and professional (0.4 percent) encounters contained duplicated detail lines. Less than 5 percent of outpatient and professional encounter detail lines were reported with questionable units for submitted procedures. Although there were some variations among BHOs in the proportion of encounters submitted with duplicated detail lines or bundled dates of services, the encounter data did not appear to have major issues associated with inconsistent coding between the procedure codes and the unit submitted in the encounters.

Nonetheless, about 7 of 10 outpatient and professional encounters appeared to be submitted repeatedly to the MMIS system. Because only two BHOs (BHI and NBH) were found to have a much higher proportion of encounters with repeated submission, it may be the result of the MMIS accepting both paid and denied encounters and how BHOs communicate to their contracted providers in terms of submitting claims/encounters. This finding has major implication to the study of encounter data validation in that the repeated submission of an encounter potentially impacted the overall unit accuracy rates. Based on HSAG's findings from the behavioral health record review, statewide BHO performance on the unit accuracy (51.6 percent) was much lower than diagnosis (87.9 percent) and procedure code (81.6 percent) accuracy. Submitting encounters

multiple times to the MMIS would likely inflate client group utilization rates and impact the ability to set accurate capitation rates.

Conclusions and Recommendations

Overall, the quality of the encounters submitted by the participating BHOs to the MMIS system was good. In terms of encounter data omissions, fewer than 6 percent of dates of services, 7 percent of diagnosis codes, and 10 percent of procedure codes were omitted from the behavioral health documentation. Encouraging results were also found in the accuracy of data elements submitted in the encounters. For dates of birth, more than 96 percent of the evaluated cases were accurate. Among those encounters with behavioral health record documentation, a high proportion of cases illustrated that accurate diagnosis and procedure codes were being submitted to the MMIS system. Overall, the diagnosis code accuracy rate was 87.9 percent and the procedure rate was 81.6 percent. A notable proportion of the invalid procedure codes was likely related to the appropriateness of mapping of the internal service codes to CPT/HCPCS codes by some BHOs. Although the accuracy rate for units of service was much lower than either diagnosis or procedure codes (51.6 percent), the results may be related to the repeated submission of encounters in the MMIS system. Because the inconsistent coding analysis suggests that very few encounters have issues related to larger-than-expected units of service, the relatively lower accuracy rate for units across BHOs will likely be improved once the MMIS system is modified to account for adjusted encounters.

Based on the findings from this study, HSAG proposed the following recommendations to the State:

- The Department should take a leadership role in maintaining good encounter data quality. The Department should organize encounter data work groups to discuss policies and procedures that will ensure high-quality data. A primary function of these work groups could focus on prioritizing and addressing issues identified by staff members from different data user sections and organizing regular meetings with BHOs and information system staff members to address data quality issues and encounter data submission issues. In addition, these work groups could also serve as a collaboration opportunity for the Department and BHOs to develop encounter data quality standards. Developed with short-term and long-term benchmarks, these standards can be used to assess whether submitted encounter data are of sufficient quality for State reporting and rate-setting. The Department should also consider implementing strategies, including corrective action plans, financial incentives, or penalties to motivate the BHOs to meet these benchmarks. Furthermore, the Department should develop guidelines for BHOs to perform ongoing reviews of encounter data quality as well as a periodic review of the clinical relevance and thoroughness of the BHOs' crosswalks. Ongoing reporting could include additional targeted reviews of coding accuracy and other administrative, data-based analyses (i.e., age/gender coding discrepancies, field accuracy reviews, utilization measures, and encounter timeliness and volume).
- The Department should consider conducting an in-depth information systems review of the MMIS encounter data system and internal processes. The focus of this review would go beyond the staff interviews conducted in this study and should evaluate internal systems responsible for acquiring, processing, and storing encounter data submitted by the BHOs. As part of this review, the Department should investigate, in collaboration with the BHOs, whether system-based barriers impact the accurate and complete submission of encounter data. Specifically, the

Department should work with BHOs to identify the root cause for the repeated submission issue. If the issue is shown to be related to how BHOs' providers submit claims/encounters, the Department should require BHOs to provide clear language within their provider contracts outlining the submission of claims and adjudicated claims. The Department should require BHOs to initiate internal processes to evaluate the submission of duplicated claims. This modification can be achieved by submitting the same transaction control numbers (TCNs) on submitted encounters to ensure the appropriate overlay of the original encounter in the MMIS system. Concurrently, the Department should also ensure that either Business Objects Application (BOA) or COGNOS decision support systems can accept the BHOs' unique TCNs.

- The Department should consider developing a robust set of data quality measures and methods to help guide and evaluate the BHOs' ability to submit appropriate data, since the detection of incomplete data fields, questionable data values, or abnormal fluctuations in encounter volume by service type at the initial submission stage may help the BHOs more quickly correct issues dealing with completeness and accuracy. The Department should also work with BHOs to ensure State requirements regarding the submission of complete and accurate encounter data are understood and integrated into the BHOs' internal processing of encounters. This will include clarifying how different service types are identified and encouraging BHOs to work with provider networks to ensure complete and accurate submission of encounters, including documentation of time and duration information in members' behavioral health records.

Overall Performance Related to Quality, Timeliness, and Access for the Encounter Data Validation

Although encounter data validation does not bear direct relevance to the quality of care provided to the members, the State relies on accurate and complete encounters to make a significant number of quality/program-related decisions. In addition, as part of their contractual requirements, the BHOs must submit accurate and complete encounters to demonstrate the quality of their services. Hence, findings from this study are generally related to the quality domain of care.

6. Assessment of BHO Follow-up on Prior Recommendations

Introduction

The Department required each BHO to address the recommendations and required actions the BHO had following the EQR activities conducted in FY 2007–2008. In this section of the report, HSAG assesses the degree to which the BHOs effectively addressed the improvement recommendations or required actions from the previous year.

Access Behavioral Care

Compliance Monitoring Site Reviews

As a result of the FY 2007–2008 compliance site review process, ABC was required to submit a plan of correction that addressed deficiencies in the areas of access to care and oversight and monitoring of providers. Additionally, ABC had four elements that required follow-up from the FY 2006–2007 review. ABC worked diligently with Department and HSAG staff and successfully completed all required actions prior to the FY 2008–2009 site review.

Performance Measures

ABC successfully followed up on and addressed most of the previous year's required actions related to performance measure validation. Since the BHO did not perform an internal ("411" Department-mandated) audit, ABC's efforts to follow up on the recommendation regarding improving medical record review related to this activity was not evaluated. Nonetheless, ABC addressed the recommendation concerning its oversight of all delegated functions to DST Healthcare Solutions. During this year's validation, the auditors noted that the BHO's transition to DST for adjudication was successfully accomplished and the oversight processes in place at ABC met standards.

In reviewing last year's rates for performance measures below the statewide average, several measures such as *Consumer Perception of Access*, *Consumer Satisfaction*, and *Consumer Perception of Participation* were found this year to have rates higher than the statewide average. Improved rates for these measures this past year may suggest that the BHO revised its interventions.

Performance Improvement Projects

For the FY 2007–2008 validation cycle, ABC completed two PIPs. HSAG reviewed and validated Steps I through IV for ABC's *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP and Steps I through V for its *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP.

After validating the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG recommended that the BHO include plan-specific data that supported the selection of the study topic in Activity I of the PIP Summary Form. Additionally, HSAG recommended that the information regarding the basis on which the study indicators were adopted be provided in Activity III.

For the *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP, HSAG recommended that the BHO provide information about the eligible study population in Activity I of the PIP Summary Form. Additionally, the BHO should update the numerator and denominator of the study indicator in Activity III to accurately reflect the formula that was provided.

After reviewing the FY 2008-2009 PIP submissions, HSAG found that for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, the BHO addressed both opportunities for improvement. For the *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP, the BHO addressed one of the two opportunities for improvement by updating the numerator and denominator of the study indicator in Activity III.

Behavioral Healthcare, Inc.

Compliance Monitoring Site Reviews

BHI scored 100 percent on the FY 2007–2008 site review and did not have any required actions.

Performance Measures

BHI successfully followed up on and addressed most of the previous year's required actions related to performance measure validation. Since the BHO did not perform an internal ("411" Department-mandated) audit, BHI's efforts to follow up on the recommendation related to including comparative results from audit activities from year to year was not evaluated. The BHO also acknowledged that resolving issues related to 837 submission required collaboration with the Department because the BHO alone could not mitigate the issue. Nonetheless, BHI had followed up on the recommendations regarding eligibility errors by using the State's portal and the eligibility file downloaded daily by InNET (BHI's administrative services organization) to confirm consumer enrollment.

In reviewing last year's rates for those performance measures that were below the statewide average, some measures such as *Penetration Rate—Adults* and *Consumer Perception of Quality/Appropriateness* exhibited improvement over last year's results. Improved rates for these measures this past year may suggest that the BHO revised its interventions.

Performance Improvement Projects

For the FY 2007–2008 validation cycle, BHI completed three PIPs. HSAG reviewed and validated Steps I through IX for its *Screening for Bipolar Disorder* PIP, Steps I through X for its *Access to Initial Medication Evaluations* PIP, and Steps I through IV for its *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

After validating the *Screening for Bipolar Disorder* PIP, HSAG recommended that the BHO update the effective date for all new admissions in Activity IV to reflect the current year. Additionally, the BHO should correct the result for Study Indicator 3B in Activity III.

For the *Access to Initial Medication Evaluations* PIP, HSAG recommended that the BHO conduct an additional causal/barrier analysis to determine if a change or addition of interventions is needed. For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG recommended that the BHO include the rationale for each study indicator in Activity III of the PIP Summary Form.

For FY 2008–2009, only the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP was submitted for validation. HSAG found that the BHO did not address the opportunity for improvement identified in FY 2007–2008.

Colorado Health Partnerships

Compliance Monitoring Site Reviews

As a result of the FY 2007–2008 site review, CHP was required to revise its Medical Necessity Determination, Lack of Information, and Notification Timeliness policy to ensure that the policy is in compliance with all Medicaid managed care regulations and the Colorado BHO Medicaid contract. CHP successfully completed all required actions prior to the FY 2008–2009 site review.

Performance Measures

CHP successfully followed up on and addressed most of the previous year's required actions related to performance measure validation. Since the BHO did not perform an internal ("411" Department-mandated) audit, CHP's efforts to follow up on the recommendation regarding an improvement on the 411 audit spreadsheet was not evaluated. The BHO did, however, follow up on other recommendations. To continue its monitoring of duplicate encounter reporting, CHP created data log reports and sent them to the community mental health centers to identify errors in data and potential duplicate records. In addition, CHP had begun its work on documenting the 837 transition process.

In reviewing last year's rates for performance measures below the statewide average, one measure (*Consumers Linked to Primary Care*) exhibited improvement over last year's results. Improvement in this measure's rate this past year may suggest that the BHO revised its interventions.

Performance Improvement Projects

For the FY 2007–2008 validation cycle, CHP conducted two PIPs. HSAG reviewed and validated Steps I through X for its *Identification and Use of Alternative and/or Crisis Services to Ensure Treatment at the Least Restrictive Level of Care for Medicaid Children and Adolescents* PIP and Steps I through IV for its *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

After validating 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* PIP, HSAG recommended that a causal/barrier analysis be completed to determine if new interventions could be developed to achieve the desired outcomes for the PIP.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG recommended that the BHO include plan-specific data that supported the selection of the study topic in Activity I of the PIP Summary Form. Additionally, HSAG recommended that the information regarding the basis on which the study indicators were adopted be provided in Activity III of the PIP Summary Form.

For FY 2008–2009, only the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP was submitted for validation. HSAG found that the BHO addressed the opportunity for improvement in Activity I; however, the opportunity for improvement in Activity III was not addressed.

Foothills Behavioral Health

Compliance Monitoring Site Reviews

As a result of the FY 2007–2008 site review, FBH was required to review its access policies and procedures and evaluate how the FBH network CMHCs' staff members have been implementing policies regarding services for Medicaid members who reside in nursing facilities. FBH was required to clarify Medicaid managed care regulations regarding access to services with the CMHCs and ensure that when CMHCs respond to requests from nursing facilities, they do not require processes that delay access to services.

FBH successfully completed the FY 2007–2008 required actions.

Performance Measures

FBH successfully followed up on and addressed the previous year's required actions related to performance measure validation. The BHO continued to improve the validation of its encounter data and worked toward the completion of its crosswalk revisions. The plan monitored encounter data submission volume and accuracy on an ongoing basis, providing detail on mental health center errors in encounter file submissions to ensure that corrective actions are taken. During the audit, the

BHO documented and demonstrated actions taken as a result of the previous year's performance measure validation audit findings. The auditors considered this a best practice.

In reviewing last year's rates, one measure (*Consumer Perception of Participation*) that demonstrated a decrease of 8.5 percentage points from FY 2005–2006 to FY 2006–2007 was found to exhibit improvements between FY 2006–2007 and FY 2007–2008. Improvement in this measure's rate this past year may suggest that the BHO revised its interventions.

Performance Improvement Projects

FBH conducted three PIPs during the FY 2007–2008 validation cycle. HSAG reviewed and validated Steps I through X for FBH's *Improving Use and Documentation of Clinical Guidelines* and *Supporting Recovery* PIPs and Steps I through IV for its *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

After validating the *Improving Use and Documentation of Clinical Guidelines* PIP, HSAG recommended that future submissions clearly specify which interventions had been revised, including when they were revised. The BHO should include a discussion about how the interventions were standardized and monitored for success on an on-going basis. Additionally, HSAG made recommendations regarding the use of a Chi-square test between each measurement period and further assessment and/or intervention changes based on the results for Study Indicator 2, Item 12.

For the *Supporting Recovery* PIP, HSAG recommended that future submissions of the PIP provide an explanation as to why there was a 13-month gap from baseline to Remeasurement 1. Additionally, HSAG recommended that the BHO monitor data internally for a longer period of time to determine if intervention efforts result in improvement across all study indicators.

For the *Coordination of Care Between Medical, Physical, and Behavioral Health Providers* PIP, HSAG recommended that the BHO include plan-specific data that supported the selection of the study topic in Activity I. Additionally, in Activity IV, the BHO should modify the study population definition to include "and enrolled" for members who were Medicaid-eligible for at least 10 months with FBH.

For FY 2008–2009, only the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* and *Supporting Recovery* PIPs were submitted for validation. HSAG found that the BHO addressed all of the opportunities for improvement identified for both of the PIPs in FY 2007–2008.

Northeast Behavioral Health

Compliance Monitoring Site Reviews

As a result of the FY 2007–2008 site review, NBH was required to complete several corrective actions related to reporting instances of possible Medicaid fraud. NBH revised all applicable policies and procedures and worked diligently with the Department and HSAG to successfully complete all required actions.

Performance Measures

NBH successfully followed up on and addressed most of the previous year's required actions related to performance measure validation. The BHO's Financial Information Technology (FIT) Committee implemented activities that helped mitigate internal data issues and inconsistencies. During the past year, a quality improvement coordinator position was added to help ensure effective organizational communication. This effort addressed HSAG's recommendations regarding regular reasonability and edit checks to identify potential data errors. Since the BHO did not perform an internal ("411" Department-mandated) audit, NBH's effort to follow up on the recommendation regarding data completeness and accuracy for required fields mandated for this audit was not evaluated; however, the FIT Committee performed oversight to ensure overall data were complete and accurate.

In reviewing this year's rates, one measure (*Consumer Satisfaction*) was found to have improvements from last year's results. Although the *Consumers Linked to Primary Care* measure continued to exhibit a decline from last year's results, the decline was less than 5 percentage points. Relative improvements on these measures may suggest that the BHO revised its interventions.

Performance Improvement Projects

NBH conducted three PIPs during the FY 2007–2008 validation cycle. HSAG reviewed and validated Steps I through X for its *Increase NBH Center Provider Communication/Coordination With Primary Care Physicians and Other Health Providers* PIP, Steps I through VIII for its *Therapy with Children and Adolescents: Increasing Caregiver Involvement* PIP, and Steps I through IV for its *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

There were no recommendations for either the *Increase NBH Center Provider Communication/Coordination With Primary Care Physicians and Other Health Providers* or the *Therapy with Children and Adolescents: Increasing Caregiver Involvement* PIPs. For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG recommended that the BHO provide the basis for each study indicator in Activity III of the PIP Summary Form.

For FY 2008–2009, HSAG found that the BHO addressed the opportunity for improvement in the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

Focused Studies

Introduction

For FY 2008–2009, the Department offered each behavioral and physical health plan the option of conducting two PIPs or one PIP and one focused study with an intervention. BHI and Colorado Access opted to conduct one PIP and one focused study. The following are summaries of the focused studies.

Colorado Access

Study Topic and Goal: The focused study was designed to evaluate the effect of a telephonic contact after inpatient discharge on the incidence of post-hospital follow-up visits. The goal of the study was to form a link between inpatient and outpatient care by making certain that the post-hospital visit with the appropriate physician occurred.

Methodology: Beginning in June 2008, members of the Access Health Plan (Colorado Access' Medicaid health plan) Enhanced Care Management Program who were in the Medicaid aid categories of Old Age Pension or Blind and Disabled were enrolled in the study. Within these categories were enrollees with multiple diagnoses and complex medical/social needs. The focus of the study was the specified subpopulation of enrollees age 18 or older with a recent inpatient admission. Members who had been discharged to home care or another acute care facility were excluded. Members of the study population were contacted telephonically within seven days of discharge by health plan care coordinators who administered a questionnaire.

Summary and Findings: Study findings were not yet available.

Behavioral HealthCare, Inc.

Study Topic and Goal: The intent of the focus study was to identify and address barriers to coordination of care between behavioral health and primary care providers for Medicaid consumers receiving BHI services.

Methodology: Three surveys, each specifically tailored to consumers, clinicians, and primary care providers, were developed to identify barriers to coordination of care. BHI identified a random sample of consumers and PCPs. All clinicians in the population were included in the survey mailing. Survey mailing dates were staggered, with the first set of surveys sent February 1, 2009, and the second set mailed March 11, 2009. The data collection period ran through April 15, 2009, and resulted in 350 returned and completed surveys. Study indicators were calculated as percentages with specifically defined numerators and denominators.

Summary and Findings: There was a trend indicating that consumers' opinions about care coordination were slightly more positive than those of the clinicians and primary care physicians (PCPs) who identified several barriers and dissatisfaction with the coordination-of-care process. These differences in perception might indicate a need for consumer education regarding physical health issues, the importance of obtaining medical care, and what consumers might expect in terms of quality and efficiency of coordination of care. The study findings indicated there are opportunities for improvement, including clarification of confidentiality requirements, the specific kinds of information to be exchanged between medical and behavioral health providers, and communication issues between systems of care. Education and training for both behavioral and medical providers is necessary to improve care coordination.

Conclusion and Recommendations: BHI will address barriers identified in the focus study through the new Care Coordination Model to ensure a continuum of care between behavioral and medical health providers. BHI's wellness committee will develop education and training materials to increase consumer awareness of the need to obtain medical care, and for clinicians to focus on specific details of coordination of care. A BHI mental health center (MHC) has designated a phone line for PCPs to access a nurse at the MHC to discuss medical and mental health issues. BHI will monitor the success of this intervention. BHI will continue discussions with medical MCOs and the Department on issues specific to education and training, communication and information exchange between providers, as well as specific issues such as reimbursement rates.

Other State Initiatives

Presumptive Eligibility

Effective January 2008, Colorado implemented presumptive eligibility (PE) for children who appeared to be eligible for either Medicaid or the State's Children's Health Insurance Program (CHIP), Child Health Plan *Plus* (CHP+). PE allows children who appear to be eligible, but who are not yet enrolled in the program, the opportunity to seek health care immediately while eligibility is determined. Within Colorado, there are 89 sites where PE determinations can occur.

Medical Homes

As of March 1, 2009, 88,000 Colorado Medicaid children were enrolled in a medical home. A medical home is a family-centered team approach to providing quality, cost-effective health care that is culturally competent, comprehensive, coordinated, and provided with compassion. There are 97 practices representing 310 physicians designated as medical home providers.

Colorado Regional Integrated Care Collaborative (CRICC)

Colorado participates in a national collaborative sponsored by the Center for Health Care Strategies (CHCS) to partner with local health plans, providers, consumer organizations, and other stakeholders to improve the quality of care received by high-need, high-cost, fee-for-service Medicaid individuals through improved coordination of services. The program is being

implemented in select counties. Medicaid clients may be eligible to receive case management, care coordination, and supplemental benefits if they are: (1) 21 years of age or older, (2) in the Medicaid categories of Aid to the Needy Disabled/Aid to Blind (AND/AB-SSI) or Old Age Pensioners—Under Age 65 (OAP) and not eligible for Medicare, and (3) a resident of one of the targeted counties.

Transforming Care for Dual Eligibles

Colorado was one of seven states chosen to participate in Transforming Care for Dual Eligibles, a national initiative to test innovative models for individuals who are dually eligible for Medicaid and Medicare. To address the elimination of barriers to integrating Medicaid- and Medicare-covered services, Colorado will receive technical assistance addressing program design, care models, financing mechanisms, contracting strategies, and working with CMS.

Appendix A. EQR Activities—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.

This was the first year that HSAG had performed compliance monitoring reviews of the physical health plans. For the FY 2008–2009 site review process, the Department requested a focused review of four areas of performance. For Colorado Access, a newly contracted MCO for FY 2008–2009, a fifth standard area was reviewed. HSAG developed a review strategy, which corresponded with the five areas identified by the Department. These were: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care (Colorado Access only), Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with federal regulations and contract requirements was evaluated through review of the five standards.

This was the fifth year that HSAG had performed compliance monitoring reviews of the BHOs. For the FY 2008–2009 site review process, the Department requested a focused review of four areas of performance. HSAG developed a review strategy consisting of four components for review that corresponded with the four performance areas identified by the Department. These were: Member Information (Component 1), Notices of Action (Component 2), Appeals (Component 3), and Underutilization (Component 4). Compliance with federal regulations and contract requirements was evaluated through review of the four components.

In developing the data collection tools and in reviewing the components, HSAG used the health plans' contract requirements and regulations specified by the BBA with revisions that were issued June 14, 2002, and effective August 13, 2002. The site review processes were consistent with the February 11, 2003, CMS final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs).*

Objectives

Private accreditation organizations, state licensing agencies, 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 three physical health plans and five BHOs with which the State contracts.

The objective of each site review was to provide meaningful information to the Department and the health plans regarding:

- The plan's compliance with federal regulations and contract requirements in each area of review.
- The quality and timeliness of, and access to, health care furnished by the plan, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the plan's services related to the area reviewed.
- Activities to sustain and enhance performance processes.

Technical Methods of Data Collection

For both the physical health plans and the behavioral health organizations, HSAG performed the seven compliance monitoring activities described in the February 11, 2003, CMS final protocol. These activities were: planning for monitoring activities, obtaining background information from the State Medicaid agency (the Department), reviewing documents, conducting interviews, collecting accessory information, analyzing/compiling findings, and reporting results to the Department.

Pre-on-site review activities consisted of scheduling and developing timelines for the site reviews and report development; developing data collection tools, report templates, and on-site agendas; and review of the health plans' and BHO's documents prior to the on-site portion of the review.

On-site review activities included review of additional documents, policies, and committee minutes to determine compliance with health care regulations and implementation of the organizations' policies. For the Department's newest contractor (Colorado Access), a record review of medical and administrative records to evaluate evidence of care coordination activities was also conducted.

Also during the on-site portion of the review, HSAG conducted an opening conference to review the agenda and objectives of the site review and to allow the health plans or BHOs to present any important information to assist the reviewers in understanding the unique attributes of each organization. HSAG used the on-site interviews to provide clarity and perspective to the documents reviewed both prior to the site review and on-site. HSAG then conducted a closing conference to summarize preliminary findings and anticipated required actions and opportunities for improvement.

Table A-1 describes the tasks performed for each activity in the CMS final protocol for monitoring compliance during FY 2008-2009.

Table A-1—Compliance Monitoring Review Activities Performed	
For this step,	
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department, the health plans, and the BHOs to set the dates of the reviews. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the data collection tools, review and approval of the report templates, and timeliness for conducting other review activities. ◆ HSAG staff provided an orientation for the health plans, the BHOs, and the Department to preview the FY 2008–2009 compliance monitoring review process and to allow the health plans and the BHOs to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ HSAG provided a presentation to the Department, the health plans, and the BHOs titled, "Developing and Implementing Corrective Action Plans." In this presentation, HSAG reviewed the timeline and requirements for the corrective action plan process. ◆ HSAG representatives responded to questions from the health plans and the BHOs related to the process and federal managed care regulations to ensure that the health plans and BHOs were prepared for the compliance monitoring review. HSAG maintained contact with the health plans and BHOs as needed throughout the process and provided information to the health plans'/BHOs' key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the BBA regulations and the health plans' and BHOs' current contracts to develop the monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.

Table A-1—Compliance Monitoring Review Activities Performed	
For this step,	
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review for each organization, HSAG notified the health plans and the BHOs in writing of the desk audit request and sent a documentation request form and an on-site agenda. The health plans and BHOs were provided 30 days to submit all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the four components (five for Colorado Access). ◆ Documents requested included applicable policies and procedures, minutes of key health plan/BHO committee or other group meetings, reports, logs, and other documentation. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the health plans'/BHOs' key staff members to obtain a complete picture of the organizations' compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the organizations' performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with each health plan and BHO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2008–2009 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement and required actions based on the review findings.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft of each health plan-/BHO-specific report to the health plans and BHOs for review and comment. ◆ HSAG coordinated with the Department to incorporate the health plans'/BHOs' comments and finalize the reports. ◆ HSAG distributed the health plan-/BHO-specific final report to the applicable health plan or BHO and the Department.

Description of Data Sources

For both the physical health plans and the BHOs, the following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and handouts
- Policies and procedures
- The QAPI program plan, work plan, and annual evaluation
- Quality studies and reports
- Management/monitoring reports
- Quarterly reports (i.e. grievances, appeals)
- Provider 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 care coordination
- Interviews with key health plan/BHO staff members conducted on-site

Data Aggregation, Analysis, and How Conclusions Were Drawn

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. For the coordination of care record review (Colorado Access only), scores were not assigned. A narrative format was used to describe evidence found and that evidence was analyzed for the presence of coordinating care for members of that health plan. Each health plan or BHO was given an overall percentage-of-compliance score. This score represented the percentage of the applicable elements met by the health plan or 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 performance.

Appendix B. EQR Activities—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 was one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of performance measure data collected by the health plan.
- Determine the extent to which the specific performance measures calculated by the health plan (or on behalf of the health plan) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection—Physical Health

DHMC and RMHP had existing business relationships with licensed organizations that conducted HEDIS audits for their other lines of business. The Department allowed the health plans to use their existing auditors. The Department mandated that HSAG conduct the NCQA HEDIS Compliance Audit for PCPP. The NCQA HEDIS Compliance Audit followed NCQA audit methodology and encompassed a more in-depth examination of the health plan's processes than the requirements for validating performance measures as set forth by CMS. Therefore, using this audit methodology complied with both NCQA and CMS specifications and allowed for a complete and reliable evaluation of the health plans.

The following process describes the standard practice for HEDIS audits regardless of the auditing firm. HSAG used a number of different methods and information sources to conduct the audit assessment, including:

- Teleconference calls with Department personnel and vendor representatives, as necessary.
- Detailed review of the Department's completed responses to the Record of Administration, Data Management and Processes (Roadmap)—published by NCQA as Appendix 2 to the *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*—and updated information communicated by NCQA to the audit team directly.

- On-site meetings at the Department's offices, including:
  - Staff interviews.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary HEDIS data source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS measures.
- Reabstraction of a sample of medical records selected by the auditors, with a comparison of results to the Department's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the Department's HEDIS data collection and reporting processes, as well as data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates as presented within the NCQA-published Interactive Data Submission System (IDSS)—2009 completed by the Department or its contractor.
- Interviews by auditors, as part of the on-site visit, of a variety of individuals whose job functions or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS coordinator, information systems director, medical records staff, claims processing staff, enrollment and provider data manager, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors or contractors who provided or processed HEDIS 2009 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

The Department was responsible for preparing and providing the performance report for PCPP, and the health plans were responsible for their respective reports. The auditor's responsibility was to express an opinion on the performance report based on the auditor's examination, using procedures NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the health plans, HSAG did review the audit reports produced by the other licensed organizations. HSAG did not discover any questionable findings or inaccuracies in the reports; therefore, HSAG agreed that these reports were an accurate representation of the health plans.

Technical Methods of Data Collection—Behavioral Health

The Department identified 14 performance measures for validation by the BHOs. Some of these measures were calculated by the Department using data submitted by the BHOs; other measures were calculated by the BHOs. The measures came from a number of sources, including claims/encounter data and Mental Health Statistics Improvement Program (MHSIP) consumer surveys.

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.

HSAG followed the same process for each performance measure validation it conducted for each BHO. The process 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' information systems, 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.
  - Prior to the on-site reviews, HSAG asked each BHO and the Department to complete the ISCAT. HSAG prepared two different versions of the ISCAT: one that was customized for completion by the BHOs and another that was customized for completion by the Department. 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 and calculate performance measure data (using encounter data) and a site visit to the Department to validate the performance measure calculation process for the penetration rate and survey-based measures. 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 key BHO and Department staff members, allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews 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 an information systems demonstration, as well as discussion and observation of source code logic with 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—Physical Health

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

- **Record of Administration, Data Management and Processes (Roadmap)**. The completed Roadmap provided background information on the Department's and health plans' policies, processes, and data in preparation for the on-site validation activities.
- **Certified Software Report**. The vendor's certified software report was reviewed to confirm that all of the required measures for reporting had a *Pass* status.
- **Previous Performance Measure Reports**. Previous performance measure reports were reviewed to determine trending patterns and rate reasonability.
- **Supporting Documentation**. This additional information assisted reviewers with completing 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.
- **On-site Interviews and Demonstrations**. This information was obtained through interaction, discussion, and formal interviews with key health plan and State 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**
Roadmap	CY 2008
Certified Software Report	CY 2008
Performance Measure Reports	CY 2008
Supporting Documentation	CY 2008
On-site Interviews and Demonstrations	CY 2008

Note: CY stands for calendar year.

Description of Data Obtained—Behavioral Health

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data 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' information systems, 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:** HSAG obtained the calculated results from the Department for each of the BHOs.
- **On-site Interviews and Demonstrations:** HSAG obtained information through interaction, discussion, and formal interviews with key BHO and Department staff members as well as through system demonstrations.

Table B-2 displays the data sources used in the validation of performance measures and the time period to which the data applied.

Table B-2—Description of Data Sources	
Data Obtained	**Time Period to Which the Data Applied**
ISCAT (from BHOs and the Department)	FY 2007–2008
Source code (programming language) for performance measures (from the Department)	FY 2007–2008
Previous year's performance measure reports	FY 2006–2007
Current performance measure results (from BHOs and the Department)	See note*
Supporting documentation (from BHOs and the Department)	FY 2007–2008
On-site interviews and demonstrations (from BHOs and the Department)	FY 2007–2008
***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 was sent to consumers receiving services between July 1, 2006, and June 30, 2007.	

Data Aggregation, Analysis, and How Conclusions Were Drawn—Physical Health

The following process describes the standard practice for HEDIS audits regardless of the auditing firm.

HSAG determined results for each performance measure based on the validation activities previously described. After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for PCPP. HSAG forwarded this report to the Department and PCPP. Health plan auditors forwarded reports to the Department and the health plans.

The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate the domains of quality, timeliness, and access. HSAG recognized the interdependence of quality, timeliness, and access and has assigned each of the performance measures to one or more of the three domains. Using this framework, Table B-3 shows HSAG's assignment of performance measures to these domains.

Table B-3—FY 2008–2009 Performance Measures Required for Validation			
Measure	**Quality**	**Timeliness**	**Access**
Childhood Immunization Status	X	X	
Well-Child Visits in the First 15 Months of Life	X	X	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	X	X	
Adolescent Well-Care Visits	X	X	
Annual Dental Visits			X

Table B-3—FY 2008–2009 Performance Measures Required for Validation			
Measure	**Quality**	**Timeliness**	**Access**
Children's & Adolescents' Access to Primary Care Providers			X
Adults' Access to Preventive/Ambulatory Health Services			X
Prenatal Care		X	X
Postpartum Care		X	X
Use of Services: Inpatient Utilization—General Hospital Acute Care			X
Ambulatory Care			X
Cholesterol Management for Patients With CV Conditions	X		
Annual Monitoring for Patients on Persistent Medications	X		
Use of Appropriate Medications for People With Asthma	X		
Comprehensive Diabetes Care	X		
Antibiotic Utilization			X
Frequency of Selected Procedures			X

Data Aggregation, Analysis, and How Conclusions Were Drawn—Behavioral Health

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS protocol, HSAG gave a validation finding of *Fully Compliant*, *Substantially Compliant*, *Not Valid*, or *Not Applicable* to each performance measure. HSAG based each validation finding 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. HSAG forwarded these reports to the State and the appropriate BHO. Section 3 contains information about BHO-specific performance measure rates and validation status.

IS Findings

The section that follows provides a summary of the MCOs' and the PCPP's key findings for each IS standard as noted in their final audit report.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

PCPP, RMHP, and DHMC were fully compliant with the overall standard, indicating that each entity's processes related to medical service data capture, transfer, and entry were sufficient.

RMHP was considered substantially compliant with IS Standard 1.2 due to limited system ability to capture more than eight diagnosis codes.

IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry

PCPP, RMHP, and DHMC were fully compliant with this standard, indicating that there were sufficient processes in place related to enrollment data capture, transfer, and entry.

Previously, DHMC was found to be substantially compliant due to insufficient audit processes. In the past year, an audit program was implemented for the membership department, which mitigated any concern related to data quality.

IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry

PCPP, DHMC, and RMHP were found to be fully compliant with this standard, indicating that there were sufficient processes in place related to provider data capture, transfer, and entry.

IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight

PCPP, DHMC, and RMHP were all found to be fully compliant with this standard, indicating that there were sufficient processes in place related to medical record review, including training, sampling, abstraction, and oversight. Each entity passed medical record review validation by its respective audit firms at 100 percent.

IS 5.0—Supplemental Data—Capture, Transfer, and Entry

PCPP, DHMC, and RMHP were all found to be fully compliant with this standard, indicating that there were sufficient processes in place related to supplemental data capture, transfer, and entry.

DHMC used two supplemental databases: one internal non-standard and one external standard. An external standard database was also used for PCPP. The processes used by both entities related to these databases met standards.

RMHP's audit report did not provide details on supplemental databases used by the plan.

IS 6.0—Member Call Center Data—Capture, Transfer, and Entry

This standard was not applicable to the measures under the scope of the audit.

IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity

PCPP, DHMC, and RMHP all used NCQA-certified software to calculate the HEDIS rates, which helps ensure the integrity of the HEDIS calculations. Each entity was found to be fully compliant with data integration standards as they relate to the calculation of the HEDIS measures under the scope of the audit.

Appendix C. EQR Activities—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 QAPI program, each BHO and MCO was required by the Department to conduct PIPs in accordance with 42 CFR 438.240. The purpose of the PIPs was to achieve, through ongoing measurements and intervention, significant, sustained improvement in both clinical and nonclinical areas. This structured method of assessing and improving BHO and MCO processes was designed to have a favorable affect on health outcomes and consumer satisfaction. Additionally, as one of the mandatory EQR activities under the BBA, the State was 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 and each MCO'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.

HSAG performed validation activities on nine PIPs for the BHOs and five PIPs for the remaining MCOs. For the MCOs, HSAG performed validation activities on two PIPs for two of the MCOs and one PIP for the remaining MCO.

Technical Methods of Data Collection

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 and each MCO completed and submitted to HSAG for review and validation. The PIP Summary Form standardized the process for submitting information regarding PIPs and ensured that all CMS protocol requirements were addressed.

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 steps:

- Step I. Review the Selected Study Topic(s)
- Step II. Review the Study Question(s)
- Step III. Review the Selected Study Indicator(s)
- Step IV. Review the Identified Study Population
- Step V. Review Sampling Methods
- Step VI. Review Data Collection Procedures
- Step VII. Assess Improvement Strategies
- Step VIII Review Data Analysis and Study Results
- Step IX. Assess for Real Improvement
- Step X. Assess for Sustained Improvement

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the BHOs' and the MCOs' PIP Summary Form. This form provided detailed information about each BHO's and MCO's PIP as it related to the 10 CMS protocol steps reviewed and evaluated. HSAG validates PIPs only as far as the PIP has progressed. Activities in the PIP Summary Form that have not been completed are scored *Not Assessed* by the HSAG PIP Review Team.

Table C-1—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
PIP Summary Form (completed by each BHO and MCO)	FY 2008–2009

[C-1] U.S. 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.

Data Aggregation, Analysis, and How Conclusions Were Drawn

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

Additionally, some of the evaluation elements may include a *Point of Clarification*. A *Point of Clarification* indicates that while an evaluation element may have the basic components described in the narrative of the PIP to meet the evaluation element, enhanced documentation would demonstrate a stronger understanding of the CMS protocol.

The scoring methodology used for all PIPs is 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 (NA)*: Elements that were *NA* were removed from all scoring (including critical elements if they were not assessed).

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 validity and reliability of the results as follows:

- *Met*: High confidence/confidence in the reported PIP results.
- *Partially Met*: Low confidence in the reported PIP results.
- *Not Met*: Reported PIP results that were not credible.

The BHOs and MCOs had an opportunity to resubmit additional documentation after the initial HSAG review to improve their scores prior to the finalization of the FY 2008–2009 PIP Validation Report.

After completing the validation re-review, HSAG prepared a report of the findings with requirements and recommendations for each validated PIP. HSAG forwarded these reports to the Department and the appropriate BHO or MCO.

Appendix D. EQR Activities—Consumer Assessment of Healthcare Providers and Systems (CAHPS) (Physical Health Plans Only)

Introduction

This appendix describes the manner in which CAHPS data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the health plans.

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on the level of satisfaction members have with their health care experiences.

Technical Methods of Data Collection

The technical method of data collection was through the administration of the CAHPS 4.0H Adult Medicaid Health Plan Survey for the adult population and the CAHPS 4.0H Child Medicaid Health Plan Survey (without the children with chronic conditions measurement set) for the child population. The surveys include a set of standardized items (51 items for the CAHPS 4.0H Adult Medicaid Health Plan Survey and 47 items for the CAHPS 4.0H Child Medicaid Health Plan Survey) that assess patient perspectives on care. The surveys were administered in both English and Spanish. Clients identified as Spanish-speaking were administered the Spanish instrument. All other clients received an English version of the survey. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed for the selection of members and the distribution of surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). If a minimum of 100 responses for a measure was not achieved, the result of the measure was "Not Applicable" (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the

sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the adult and child Medicaid surveys fell into one of the following two categories: 1) "Never," "Sometimes," "Usually," and "Always" or 2) "Definitely No," "Somewhat No," "Somewhat Yes," and "Definitely Yes."

A positive or top-box response for the composites was defined as a response of "Always" or "Definitely Yes." The percentage of top-box responses was referred to as a global proportion for the composite scores.

Description of Data Obtained

Table D-1 and Table D-2 present the question summary rates (i.e., the percentage of respondents offering a positive response) for the 2009 global ratings for the adult and child populations, respectively. DHMC and RMHP provided HSAG with the data presented in the following tables. Synovate and the Center for the Study of Services (CSS) administered the CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys for DHMC and RMHP, respectively. The health plans reported that NCQA methodology was followed in calculating these results. Measures at or above the NCQA national averages are highlighted in yellow.

Table D-1—NCQA National Averages and Question Summary Rates for Global Ratings

Measure of Member Satisfaction	Adult Medicaid 2009			
	2008 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	60.5%	68.8%	66.3%	61.7%
Rating of Specialist Seen Most Often	60.9%	NA	66.1%	65.9%
Rating of All Health Care	46.9%	42.4%	50.9%	50.1%
Rating of Health Plan	53.4%	47.6%	58.9%	51.2%

A question summary rate is the percentage of respondents offering a positive response (a value of 9 or 10).

A minimum of 100 responses is required for a global rating to be reported as a CAHPS survey result. Global ratings that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Indicates a rate that is at or above the 2008 NCQA CAHPS national average.

Table D-2—NCQA National Averages and Question Summary Rates for Global Ratings				
Measure of Member Satisfaction	Child Medicaid 2009			
	2008 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	64.8%	64.4%	70.4%	73.0%
Rating of Specialist Seen Most Often	64.2%	NA	NA	66.5%
Rating of All Health Care	65.1%	50.5%	56.6%	65.2%
Rating of Health Plan	62.2%	57.8%	65.5%	62.5%

A question summary rate is the percentage of respondents offering a positive response (values of 9 or 10).

A minimum of 100 responses is required for a global rating to be reported as a CAHPS survey result. Global ratings that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Indicates a rate that is at or above the 2008 NCQA CAHPS national average.

Table D-3 and Table D-4 present the global proportions (i.e., the percentage of respondents offering a positive response) for the 2009 composite scores for the adult and child populations, respectively. DHMC and RMHP provided HSAG with the data presented in the following tables. Synovate and the Center for the Study of Services (CSS) administered the CAHPS 4.0H Adult and Child Medicaid Health Plan Surveys for DHMC and RMHP, respectively. The health plans reported that NCQA methodology was followed in calculating these results. Measures at or above the NCQA national averages are highlighted in yellow.

Table D-3—NCQA National Averages and Global Proportions for Composite Scores				
Measure of Member Satisfaction	Adult Medicaid 2009			
	2008 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	48.9%	30.6%	59.1%	51.5%
Getting Care Quickly	55.7%	40.6%	58.6%	54.5%
How Well Doctors Communicate	67.7%	69.8%	70.7%	63.0%
Customer Service	57.3%	NA	61.8%	NA
Shared Decision Making	58.7%	53.0%	63.8%	59.9%

A global proportion is the percentage of respondents offering a positive response ("Always" or "Definitely Yes").

A minimum of 100 responses is required for a composite score to be reported as a CAHPS survey result. Composite scores that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Indicates a rate that is at or above the 2008 NCQA CAHPS national average.

Table D-4—NCQA National Averages and Global Proportions for Composite Scores				
Measure of Member Satisfaction	Child Medicaid 2009			
	2008 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	*	NA	63.2%	54.9%
Getting Care Quickly	*	52.9%	74.8%	74.7%
How Well Doctors Communicate	69.2%	69.2%	76.7%	76.6%
Customer Service	*	NA	NA	49.6%
Shared Decision Making	**	NA	69.2%	67.1%

A global proportion is the percentage of respondents offering a positive response ("Always" or "Definitely Yes").

A minimum of 100 responses is required for a composite score to be reported as a CAHPS survey result. Composite scores that do not meet the minimum number of responses are denoted as Not Applicable (NA).

* The results for these measures are not comparable to the 2008 NCQA CAHPS national averages due to the transition to the CAHPS 4.0H Child Medicaid Health Plan Survey.

** The *Shared Decision Making* composite was added as a new measure upon implementation of the CAHPS 4.0H Health Plan Surveys; therefore, national data do not exist.

Indicates a rate that is at or above the 2008 NCQA CAHPS national average.

Data Aggregation, Analysis, and How Conclusions Were Drawn

Overall perceptions of the quality of medical care and services received can be assessed from both criterion and normative frames of reference. A normative frame of reference was used to compare the responses within each health plan.

The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate quality, timeliness, and access. HSAG recognized the interdependence of quality, timeliness, and access and has assigned each of the CAHPS survey measures to one or more of the three domains. Using this framework, Table D-5 shows HSAG's assignment of the CAHPS measures to these performance domains.

Table D-5—Assignment of CAHPS Measures to Performance Domains			
CAHPS Measures	Quality	Timeliness	Access
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Shared Decision Making	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

Appendix E. Summary Tables of EQR Activity Results—All Plans

Introduction

This appendix presents tables with the detailed findings for all physical and behavioral health plans for each EQR activity performed in FY 2008–2009.

Results from the Compliance Monitoring Site Reviews

Table E-1 shows the compliance summary scores for each physical health plan as well as the statewide average. Statewide average scores were calculated by dividing the total number of met elements across all three plans by the total number of applicable elements across all three plans.

Table E-1—FY 2008–2009 Compliance Scores for the Physical Health Plans

Description of Standard	Colorado Access	DHMC	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services	96%	84%	88%	89%
Standard II—Access and Availability	93%	93%	93%	93%
Standard III—Coordination and Continuity of Care*	100%	—	—	100%
Standard VII—Provider Participation and Program Integrity	100%	94%	100%	98%
Standard IX—Subcontracts and Delegation	88%	NA	88%	88%
Totals	**96%**	**89%**	**92%**	**93%**

* Standard III was reviewed for Colorado Access only.

Table E-2 displays the summary compliance monitoring scores for each BHO and the statewide average. Statewide average scores were calculated by dividing the total number of met elements across all three plans by the total number of applicable elements across all three plans.

Table E-2—FY 2008–2009 Compliance Scores for the BHOs

Description of Component	ABC	BHI	CHP	FBH	NBH	Statewide Average
Member Information	100%	100%	100%	100%	100%	100%
Notices of Action	67%	78%	50%	56%	67%	64%
Notices of Action Record Review	95%	88%	95%	82%	75%	90%
Appeals	91%	95%	73%	82%	82%	85%
Appeals Record Review	90%	100%	100%	96%	86%	96%
Underutilization	100%	100%	100%	100%	100%	100%
Totals	**92%**	**94%**	**90%**	**87%**	**86%**	**90%**

Results from the Validation of Performance Measures

Table E-3 presents scores for each physical health plan and the statewide average.

Table E-3—Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Childhood Immunization Status				
Combo #2	87.59%	78.32%	70.07%	78.66%
Combo #3	87.10%	73.71%	65.45%	75.42%
Well-Child Visits in the First 15 Months of Life, 6+ Visits	56.20%	77.32%	15.94%	49.82%
Well-Child Visits 3–6 Years of Life	63.02%	63.47%	46.23%	57.57%
Adolescent Well-Care Visits	41.85%	45.50%	27.98%	38.44%
Annual Dental Visits	0.02%	NB	61.90%	30.96%
Children's & Adolescents' Access to PCPs				
12–24 months	90.63%	98.29%	14.88%	67.93%
25 months–6 years	77.64%	89.06%	22.77%	63.16%
7–11 years	81.91%	92.33%	33.67%	69.30%
12–19 years	83.64%	91.88%	38.71%	71.41%
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	68.87%	86.08%	81.76%	78.90%
45–64 Years	70.69%	87.64%	86.73%	81.69%
65+ Years	59.91%	95.22%	81.92%	79.02%
Timeliness of Prenatal Care	86.13%	95.22%	70.21%	83.85%
Postpartum Care	59.12%	71.94%	58.22%	63.09%
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)				
Discharges (Per 1,000 Member Months)	5.68	13.9	9.02	9.53
Days (Per 1,000 Member Months)	21.73	46.48	48.62	38.94
Average Length of Stay	3.82	3.34	5.39	4.18
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)				
Discharges (Per 1,000 Member Months)	2.47	5.05	5.39	4.30
Days (Per 1,000 Member Months)	9.40	18.60	26.10	18.03
Average Length of Stay	3.81	6.68	4.84	4.11
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)				
Discharges (Per 1,000 Member Months)	0.93	2.92	2.38	2.08
Days (Per 1,000 Member Months)	6.32	16.31	19.19	13.94
Average Length of Stay	6.83	5.58	8.05	6.82
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)				
Discharges (Per 1,000 Member Months aged 10–64 years)	5.03	12.23	2.25	6.50
Days (Per 1,000 Member Months aged 10–64 years)	13.01	23.76	6.00	14.26

Table E-3—Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Average Length of Stay	2.58	1.94	2.67	2.40
Use of Services: Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	219.95	461.34	434.21	371.83
ED Visits	9.43	59.16	63.78	44.12
Ambulatory Surgery/Procedures	16.46	13.60	14.47	14.84
Observation Room Stays Resulting in Discharge	0.81	1.25	1.57	1.21
Cholesterol Management for People With CV Conditions				
LDL-C Screening Performed	85.19%	69.88%	58.61%	71.23%
LDL-C Control (< 100 mg/dL)	75.93%	45.78%	24.54%	48.75%
Annual Monitoring for Patients on Persistent Medications	80.84%	71.38%	82.24%	78.15%
Use of Appropriate Medications for People With Asthma	86.35%	88.97%	87.81%	87.71%
Comprehensive Diabetes Care				
HbA1c Testing	88.33%	85.69%	66.91%	80.31%
HbA1c Poor Control (> 9.0%)	25.83%	25.77%	64.96%	38.85%
HbA1c Control (<8.0%)	47.78%	64.42%	29.20%	47.13%
Eye Exam	50.69%	61.96%	37.96%	50.20%
LDL-C Screening	75.97%	70.14%	57.66%	67.92%
LDL-C Level < 100 mg/dl	52.08%	43.76%	23.60%	39.81%
Medical Attention for Nephropathy	83.06%	76.07%	55.47%	71.53%
Blood Pressure Controlled <130/80 mmHg	42.22%	47.03%	24.09%	37.78%
Blood Pressure Controlled <140/90 mmHg	66.81%	79.14%	36.74%	60.90%
Antibiotic Utilization				
Average Scrips PMPY for Antibiotics	0.39	1.13	1.14	0.89
Percentage of Antibiotics of Concern of all Antibiotic Scrips	25.59%	38.77%	41.33%	35.23%
Frequency of Selected Procedures				
Myringotomy (0–4 Male & Female)	0.02	3.88	2.95	2.28
Myringotomy (5–19 Male & Female)	0.00	0.48	0.68	0.39
Tonsillectomy (0–9 Male & Female)	0.04	0.96	0.90	0.63
Tonsillectomy (10–19 Male & Female)	0.00	0.92	0.63	0.52
Dilation & Curettage (15–44 Female)	0.03	0.16	0.15	0.11
Dilation & Curettage (45–64 Female)	0.00	0.42	0.16	0.19
Hysterectomy, Abdominal (15–44 Female)	0.09	0.33	0.32	0.25
Hysterectomy, Abdominal (45–64 Female)	0.17	0.42	0.38	0.32
Hysterectomy, Vaginal (15–44 Female)	0.06	0.85	0.41	0.44
Hysterectomy, Vaginal (45–64 Female)	0.08	0.42	0.19	0.23
Cholecystectomy, Open (30–64 Male)	0.03	0.00	0.00	0.01
Cholecystectomy, Open (15–44 Female)	0.01	0.03	0.04	0.03

Table E-3—Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	DHMC	RMHP	PCPP	Statewide Average
Cholecystectomy, Open (45–64 Female)	0.04	0.21	0.19	0.15
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.06	0.33	0.62	0.34
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	0.25	1.54	1.03	0.94
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	0.12	1.27	1.01	0.80
Back Surgery (20–44 Male)	0.17	1.32	0.36	0.62
Back Surgery (20–44 Female)	0.05	0.56	0.29	0.30
Back Surgery (45–64 Male)	0.15	0.37	0.61	0.38
Back Surgery (45–64 Female)	0.29	1.38	1.11	0.93
Mastectomy (15–44 Female)	0.00	0.10	0.04	0.05
Mastectomy (45–64 Female)	0.08	0.21	0.03	0.11
Lumpectomy (15–44 Female)	0.03	0.29	0.11	0.14
Lumpectomy (45–64 Female)	0.04	0.74	0.38	0.39

NB is shown when the organization did not offer the health benefits required by the measure.

Table E-4 includes FY 2008–2009 performance measure results for each BHO as well as the statewide average.

Table E-4—2008–2009 Performance Measure Results for BHOs						
Performance Measures	ABC	BHI	CHP	FBH	NBH	Statewide Average
Penetration Rate by Age Category						
Children	8.0%	7.1%	10.1%	13.6%	11.2%	10.0%
Adults	19.5%	15.2%	18.4%	22.5%	17.6%	18.6%
Penetration Rate by Service Category						
Inpatient Care	1.1%	0.7%	0.08%	0.9%	0.9%	0.7%
Intensive Outpatient/Partial Hospitalization	0.1%	0.1%	0.1%	0.2%	0.2%	0.1%
Ambulatory Care	11.1%	9.9%	13.5%	17.4%	13.7%	13.1%
Overall Penetration Rate	12.7%	10.0%	13.7%	17.5%	13.8%	13.5%
Hospital Recidivism						
Non-State Hospitals – 7 days	6.0%	3.0%	3.0%	3.0%	2.0%	3.4%
30 days	13.0%	11.0%	9.0%	9.0%	6.0%	9.6%
90 days	21.0%	16.0%	15.0%	16.0%	15.0%	16.6%
All Hospitals – 7 days	6.0%	3.0%	2.0%	2.0%	2.0%	3.0%
30 days	16.0%	13.0%	7.0%	7.0%	9.0%	10.4%
90 days	24.0%	19.0%	12.0%	15.0%	16.0%	17.2%

Table E-4—2008–2009 Performance Measure Results for BHOs						
Performance Measures	**ABC**	**BHI**	**CHP**	**FBH**	**NBH**	**Statewide Average**
Hospital Average Length of Stay						
Non-State Hospitals	8.7	7.16	7.05	6.28	5.23	6.88
All Hospitals	14.17	13.00	14.56	15.73	10.23	13.54
Emergency Room Utilization (Rate/1000 Members, All Ages)	11.35	7.60	8.93	9.19	6.06	8.63
Inpatient Utilization (Rate/1000 Members, All Ages)						
Non-State Hospitals	7.77	2.56	3.22	2.70	5.17	4.28
All Hospitals	10.86	5.84	5.63	6.40	7.20	7.19
Follow-Up After Hospitalization for Mental Illness						
Non-State Hospitals – 7–day	30.8%	51.4%	41.7%	58.2%	37.5%	43.9%
30–day	7.26%	62.7%	64.3%	73.4%	62.5%	67.1%
State Hospitals – 7–day	31.5%	56.3%	45.0%	58.7%	38.1%	45.9%
30–day	73.1%	68.8%	66.3%	75.0%	61.3%	68.9%
Consumer Perception of Access	76.6%	78.2%	70.5%	70.8%	71.6%	73.5%
Consumer Perception of Quality	74.0%	74.0%	70.7%	66.7%	65.9%	70.3%
Consumer Perception of Outcome	62.2%	63.5%	59.6%	50.7%	65.9%	60.4%
Consumer Satisfaction	76.3%	79.4%	72.2%	69.4%	77.6%	75.0%
Consumer Perception of Participation	70.1%	66.0%	63.0%	60.3%	61.9%	64.3%
Consumers Linked to Primary Care	74.4%	77.1%	82.3%	83.3%	78.7%	79.2%

Results from the Validation of Performance Improvement Projects

Table E-5 lists the PIP study conducted by each physical health plan and the corresponding summary scores.

Table E-5—Summary of Physical Health Plans PIP Validation Scores and Validation Status				
MCO	**PIP Study**	**% of All Elements *Met***	**% of Critical Elements *Met***	**Validation Status**
Colorado Access	*Coordination of Care*	100%	100%	*Met*
DHMC	*Childhood Immunizations*	92%	100%	*Met*
DHMC	*Member Satisfaction With Access to Pharmacy Services Within Denver Health*	96%	100%	*Met*
RMHP	*Improving Well-Care Rates for Adolescents*	100%	100%	*Met*
RMHP	*Improving Coordination of Care for Members With Behavioral Health Conditions*	87%	88%	*Partially Met*

Table E-6 lists the PIP study conducted by each BHO and the corresponding summary scores.

Table E-6––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	*Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers*	96%	100%	*Met*
ABC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	93%	82%	*Not Met*
BHI	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	97%	100%	*Met*
CHP	*Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+*	100%	100%	*Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	100%	100%	*Met*
FBH	*Supporting Recovery*	93%	100%	*Met*
FBH	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	100%	100%	*Met*
NBH	*Therapy With Children and Adolescents: Increasing Caregiver Involvement*	97%	100%	*Met*
NBH	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	100%	100%	*Met*

Results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Table E-7 displays each physical health plan's summary rates and global proportions for the child CAHPS survey.

Table E-7—Child Medicaid Question Summary Rates and Global Proportions

Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	NA	63.2%	54.9%	59.1%
Getting Care Quickly	52.9%	74.8%	74.7%	67.5%
How Well Doctors Communicate	69.2%	76.7%	76.6%	74.2%
Customer Service	NA	NA	49.6%	*
Shared Decision Making	NA	69.2%	67.1%	68.2%
Rating of Personal Doctor	64.4%	70.4%	73.0%	69.3%
Rating of Specialist Seen Most Often	NA	NA	66.5%	*
Rating of All Health Care	50.5%	56.6%	65.2%	57.4%
Rating of Health Plan	57.8%	65.5%	62.5%	61.9%

NA indicates that the measure had fewer than 100 respondents.

* Only one health plan was able to report the *Customer Service* and *Rating of Specialist Seen Most Often* measures; therefore, a State average was not calculated for either measure.

Table E-8 displays each physical health plan's summary rates and global proportions for the adult CAHPS survey.

Table E-8—Adult Medicaid Question Summary Rates and Global Proportions

Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	30.6%	59.1%	51.5%	47.1%
Getting Care Quickly	40.6%	58.6%	54.5%	51.2%
How Well Doctors Communicate	69.8%	70.7%	63.0%	67.8%
Customer Service	NA	61.8%	NA	*
Shared Decision Making	53.0%	63.8%	59.9%	58.9%
Rating of Personal Doctor	68.8%	66.3%	61.7%	65.6%
Rating of Specialist Seen Most Often	NA	66.1%	65.9%	66.0%
Rating of All Health Care	42.4%	50.9%	50.1%	47.8%
Rating of Health Plan	47.6%	58.9%	51.2%	52.6%

NA indicates that the measure had fewer than 100 respondents.

* Only one health plan was able to report the *Customer Service* measure; therefore, a State average was not calculated.