2009–2010 External Quality Review Technical Report

for

Colorado Medicaid

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This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016

Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

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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 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:

- 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 Partners, LLC (FBHP)
- Northeast Behavioral Health Partnership, LLC (NBHP)

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.

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 [PMV], PIP validation, and CAHPS) 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

Statewide performance on compliance standards in the domain of quality of care and services was mixed. The fiscal year (FY) 2009–2010 compliance site review standards that assessed quality were Coordination and Continuity of Care, Member Rights and Protections, Member Information, Grievance System, and Quality Assessment and Performance Improvement. Statewide results for Quality Assessment and Performance Improvement were outstanding; both health plans achieved scores of 100 percent. Overall performance in Coordination and Continuity of Care was also a strength with a statewide average of 94 percent. Performance on the Member Information standard presented opportunities for improvement. Both health plans received corrective action recommendations related to providing members with clear, complete, and accurate information. The statewide average for Member Information was 76 percent. The lowest statewide performance was for the Grievance System standard, which had a statewide average of 63 percent. Corrective action is required to revise member materials, policies, and provider information materials.

Comparable performance measures, those that were validated in the current and prior year, demonstrated a statewide strength. All of the child measures related to quality demonstrated improvement close to or more than 5 percentage points. Most notably, the *Well-Child Visits in the First 15 Months of Life* measure showed an increase of more than 23 percentage points while all submeasures related to the *Children's and Adolescents' Access to PCPs* measure showed an improvement of at least 10 percentage points. And, although none of the adult measures with two-year comparisons showed statistically significant change, two first-time reported measures scored the top 10 percent of HEDIS 2009 national performance.

HSAG assigned all PIPs to the quality domain. All three of the PIPs reviewed by HSAG earned a validation status of *Met*, with scores of 100 percent for critical elements *Met*, and scores ranging from 91 percent to 100 percent for all evaluation elements *Met*. Colorado physical health plans have demonstrated a strong understanding and implementation of the CMS protocols.

All of the measures within the CAHPS survey addressed quality. Results from the survey were evenly divided, with half of the measures showing slight increases and half showing slight decreases. The only measure that had a statistically significant change was the adult measure, *Rating of Specialist Seen Most Often*, which showed a 6.1 percent decrease.

Quality—Behavioral Health

HSAG assigned five of the seven compliance standards to the quality domain: Emergency and Poststabilization Services, Member Rights and Protections, Grievance System, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. Statewide averages for these standards were outstanding. The only standard assigned to the quality domain that did not receive a statewide score of 100 percent was Grievance System, and the issues associated with this standard were related to timeliness. In relation to compliance monitoring, the BHOs demonstrated outstanding performance in the quality domain.

The *Hospital Recidivism* measure was the only quality measure validated in FY 2009–2010, and statewide performance was relatively unchanged. While three of the six submeasures reported a decline in rate (denoting an improvement in performance), the other three submeasures showed a slight increase (denoting a decline in performance). However, no change—whether an increase or decrease—was statistically significant.

PIPs were assigned to the quality domain and all seven of the PIPs validated by HSAG received a validation status of *Met*, with 100 percent of the critical elements also receiving a score of *Met*. The overall percentage of elements *Met* ranged from 91 percent to 100 percent. These scores demonstrated a comprehensive understanding and accurate implementation of CMS protocols.

Timeliness—Physical Health

HSAG assigned Coordination and Continuity of Care and Grievance System to the quality domain. While the health plans scored very well on Coordination and Continuity of Care, both plans struggled with the requirements of the Grievance System standard. Materials from both health plans contained incomplete or inaccurate information regarding time frames and requirements related to the grievance system.

Results from the review of validation of performance measures related to timeliness were very good. While the two adult measures related to timeliness did not show any significant changes, all child measures related to timeliness showed an increase of close to or more than 5 percent. Furthermore, Colorado scores for *Childhood Immunization Status—Combo #2* and *Combo #*3 ranked in the top 10th percentile of HEDIS 2009 national performance.

Timeliness—Behavioral Health

The five compliance monitoring components that addressed timeliness were Emergency and Poststabilization Services, Grievance System, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. Statewide averages were 100 percent for three of the five standards and 98 percent for a fourth standard. The Grievance System received the lowest score of 89 percent. As with the quality domain, statewide performance by the BHOs related to timeliness was very good.

Only one performance measure reported in FY 2008–2009 addressed timeliness: *Follow-up After Hospitalization for Mental Illness*. Statewide performance remained stable compared with last

year's performance. Of the six submeasures, the most significant change in rates over last year was the 1.1 percent improvement in *30-Day Follow-up* for non-state hospitals. While BHO variations in rates for most of the submeasures decreased since last year, the variation for the *90-Day Follow-up* measure remained greater than 10 percent. 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 Coordination and Continuity of Care, Member Information, Member Rights, and Grievance System. Again, both plans scored very well on the Coordination and Continuity of Care standard. The plans also performed fairly well on Member Information. The issues the plans had related to incorrect and incomplete information had a relatively big impact on their scores. HSAG is confident that the health plans will address these issues.

Except for the *Timeliness of Prenatal Care* measure, all adult and child measures related to access exhibited an improvement from last year's rates.

Access—Behavioral Health

The five standards HSAG assigned to the access domain were: Emergency and Poststabilization Services, Member Rights and Protections, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. Statewide performance on these standards was exceptional, with overall compliance of 100 percent for four of the five standards and 98 percent compliance on the fifth standard.

Six of the eight performance measures validated by HSAG were related to the access domain. Statewide, BHO performance was similar to last year's performance. None of the measures showed statistically significant rate changes. Three measures (*Penetration Rate—Adult, Overall Penetration Rate*, and *Ambulatory Care*) demonstrated variations between the BHOs of more than 10 percentage points. Wide variations suggested areas in need of improvement.

Table 1-1—Assignment of Activities to Performance Domains for Physical Health Plans

Physical Health Compliance Review Standards	Quality	Timeliness	Access
Standard III. Coordination and Continuity of Care	✓	✓	✓
Standard IV. Member Rights and Protections	✓		✓
Standard V. Member Information	✓		✓
Standard VI. The Grievance System	✓	✓	✓
Standard X. Quality Assessment and Performance Improvement	✓		

Table 1-1—Assignment of Activities to Performance Domains for Physical Health Plans			
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	✓	✓	
Children's and Adolescents' Access to Primary Care Providers (PCPs)			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Prenatal Care and *Postpartum Care*	✓	✓	✓
Antibiotic Utilization			✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Nutrition and Physical Activity for Children/Adolescents	✓		
Annual Monitoring for Patients on Persistent Medications	✓		
Frequency of Selected Procedures			✓
Ambulatory Care			✓
Inpatient Utilization—General Hospital/Acute Care			✓
Adult BMI Assessment	✓		
Chlamydia Screening in Women	✓		
Use of Imaging Studies for Low Back Pain	✓		
Controlling High Blood Pressure	✓		
Pharmacotherapy Management of COPD Exacerbation	✓		
Antidepressant Medication Management	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
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**
Standard I. Emergency and Poststabilization Services	✓	✓	✓
Standard IV. Member Rights and Protections	✓		✓
Standard VI. The Grievance System (Grievances Only)	✓	✓	
Standard VII. Provider Participation and Program Integrity		✓	✓
Standard VIII. Credentialing and Recredentialing	✓		
Standard IX. Subcontracts and Delegation		✓	✓
Standard X. Quality Assessment and Performance Improvement	✓	✓	✓
Performance Measures	**Quality**	**Timeliness**	**Access**
Inpatient Utilization			✓
Hospital Average Length of Stay			✓
Follow-up After Hospitalization for Mental Illness (7- and 30-Day Follow-up)		✓	
Emergency Department Utilization			✓
Hospital Recidivism	✓		
Overall Penetration Rates			✓
Penetration Rates by Service Category			✓
Penetration Rates by Age Category			✓
PIPs	**Quality**	**Timeliness**	**Access**
Performance Improvement Projects	✓		

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 second year that HSAG performed compliance monitoring reviews of the physical health plans. For the FY 2009–2010 site review process, the Department requested review of five areas of performance: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, and Standard X—Quality Assessment and Performance Improvement. HSAG developed a review strategy that corresponded with the five 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.

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 standards 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 III—Coordination and Continuity of Care	X	X	X
Standard IV—Member Rights and Protections	X		X
Standard V—Member Information	X		X
Standard VI—Grievance System	X	X	X
Standard X—Quality Assessment and Performance Improvement	X		

Denver Health Medicaid Choice

Findings

Table 3-2 presents the number of elements for each of the five 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 2009–2010).

Table 3-2—Summary of Scores for the Standards for FY 2009–2010 *for* Denver Health								
Standard #	**Description of Standard**	**# of Elements**	**# of Applicable Elements**	**# *Met***	**# *Partially Met***	**# *Not Met***	**# *Not Applicable***	**Score (% of *Met* Elements)**
III	Coordination and Continuity of Care	10	9	9	0	0	1	100%
IV	Member Rights and Protections	7	7	5	2	0	0	71%
V	Member Information	28	28	21	5	2	0	75%
VI	Grievance System	35	35	22	11	2	0	63%
X	Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
	Totals	**94**	**93**	**71**	**18**	**4**	**1**	**76%***

*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

HSAG's review of Standard III—Coordination and Continuity of Care, found that DHMC had an organizational structure that provided systemwide coordination of services to its members. The Medical Management Department's care management team and the inpatient, outpatient, and pharmacy case management teams collaborated to provide member education, improve the member's ability to follow a treatment plan, help members cope with their health problem, coordinate services with other providers, obtain medications or medical equipment, and transition between levels of care. HSAG also found evidence that DHMC coordinated services with other medical and behavioral health care organizations.

While reviewing Standard IV—Member Rights and Protections, HSAG found that DHMC had a program called "The Denver Health Dozen" that distributed reminders to improve the work place and "perfect the patient experience." The program reminded employees to "treat each other, our patients, and their families with courtesy, empathy, and respect. Be a Denver Health ambassador."

HSAG found that DHMC consistently used readability guides in the preparation of member materials. The health plan and member services staff were focused on serving members. DHMC had a well-designed intranet for exchanging and posting information that was useful to member service representatives in responding to questions posed by members calling DHMC for information or with inquiries or complaints.

DHMC also demonstrated strong performance on Standard X—Quality Assessment and Performance Improvement. DHMC had a highly functional quality assessment and performance improvement (QAPI) program. DHMC integrated its quality improvement activities throughout the health plan; quality improvement was a core focus of the organization. DHMC's documentation demonstrated extensive analysis of utilization and assessment of the quality and appropriateness of care.

Recommendations

Based on the findings from the review activities, DHMC was required to submit a corrective action plan (CAP) to address the following required actions:

Member Rights and Protections

- Remove language in its member handbook stating that a member is responsible for paying for emergency care without a referral and ensure that its policies are congruent with BBA emergency and poststabilization requirements.
- Develop a mechanism to demonstrate that it requires compliance with federal and State laws, including the Age Discrimination Act and the Rehabilitation Act.

Member Information

- Develop a policy and internal protocols to document and guide the distribution of member handbooks.

- Ensure that appointment standards are complete, correct, and consistent within the member handbook.
- Clarify information in the member handbook regarding the grievance system, including the correct time frames and process for requesting a State fair hearing and continuation of benefits, and a member's right to access the local appeal process and a State fair hearing simultaneously.
- Develop an MCO policy on advance directives that includes the requirement to notify members of any changes to State law relevant to advance directives within 90 days following the change in the law.
- Provide members with information about the MCO's advance directive policy (for example, that DHMC will honor all legally prepared advance directives).
- Include information in the member handbook regarding the rights available to providers to challenge DHMC's failure to cover a service.

Grievance System

- Clarify in **both** member and provider materials that a provider may, with the member's written consent, file a grievance or appeal, request a State fair hearing, and act as the member's authorized representative at a State fair hearing.
- Develop and implement a process to ensure that oral requests to file an appeal are followed with a written, signed appeal.
- Clarify in policy and member materials information regarding timely filing of an appeal for termination, suspension, or reduction of previously authorized services.
- Ensure that its claims process is compliant with BBA emergency and poststabilization service requirements.
- Ensure that its policy and practice are compliant with the requirements when sending written notice of a decision to extend the time frame for an authorization decision.
- Ensure that grievances are logged on the actual date of receipt of the grievance.
- Ensure that appeal resolution letters for appeals not resolved wholly in favor of the member include all pertinent information about requesting a State fair hearing and continuation of benefits.
- Provide information about the grievance system to all providers and subcontractors at the time they enter into a contract, including the requirements and time frames for filing appeals, requesting continuation of benefits, and requesting a State fair hearing.
- Inform providers of their right to appeal the failure of the contractor to cover a service.
- Ensure that the process to designate a client representative is not unnecessarily burdensome.
- Evaluate its processes for recording and responding to feedback from members and providers from various contact points within the system to identify any possible barriers to members or providers wishing to exercise the right to appeal an action or express a complaint.
- Ensure that its internal documents and member materials clearly identify the conditions and time frames under which benefits can continue during the appeal or State fair hearing processes.
- Ensure that its policy contains clear conditions under which reinstated benefits will occur.

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. Instances of inaccurate or unclear information in member materials negatively affected scores in all three domains.

Quality

Each of the five standards reviewed contained requirements that assessed quality. DHMC earned scores of 100 percent for the Coordination and Continuity of Care and the Quality Assessment and Performance Improvement standards, representing clear strengths in these areas. For the remaining three standards—Member Rights and Protections, Member Information, and Grievance System—DHMC achieved scores of 71 percent, 75 percent, and 63 percent, respectively. The overall score for the quality domain was 76 percent.

Timeliness

The standards that addressed the timeliness domain were the Coordination and Continuity of Care and the Grievance System standards. DHMC earned a score of 100 percent for the Coordination and Continuity of Care standard, representing a clear strength. While DHMC's score for the Grievance System standard was 63 percent, the specific requirements in that standard related to DHMC meeting timeliness requirements were all scored as met.

Access

The standards that assessed the access domain were Coordination and Continuity of Care, Member Rights and Protections, Member Information, and Grievance System. For these standards, DHMC earned scores of 100 percent, 71 percent, 75 percent, and 63 percent, respectively, for an average weighted access domain score of 72 percent.

Rocky Mountain Health Plans

Findings

Table 3-3 presents the number of elements for each of the five 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 2009–2010).

Table 3-3—Summary of Scores for the Standards for FY 2009–2010 *for* RMHP

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III	Coordination and Continuity of Care	10	9	8	1	0	1	89%
IV	Member Rights and Protections	7	7	7	0	0	0	100%
V	Member Information	28	27	21	5	1	1	78%
VI	Grievance System	35	35	22	12	1	0	63%
X	Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
	Totals	**94**	**92**	**72**	**18**	**2**	**2**	**78%**

*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

For Standard III—Coordination and Continuity of Care, RMHP demonstrated that it had a variety of mechanisms in place to provide each member with an ongoing source of primary care appropriate to his or her needs. RMHP employed numerous methods of identifying members with special health care needs (SHCN) and had procedures in place to ensure that those members received assistance in coordinating services with other organizations to prevent duplication of activities and to arrange necessary services.

While reviewing Standard IV—Member Rights and Protections, HSAG found that RMHP had thorough policies and procedures that addressed the confidentiality and physical security of protected health information (PHI). Methods employed by RMHP included a confidentiality agreement signed annually by all staff, restricted access to areas where PHI was stored, and periodic audits to confirm that providers had adequate procedures to protect PHI.

HSAG found that RMHP's member handbook included a list of covered services, noncovered services, and wrap-around services. The amount, scope, and duration of the services were described where applicable, and members were given instructions for obtaining benefits. The RMHP member handbook included a comprehensive list of member rights and responsibilities and included information about grievances, appeals, and State fair hearings. RMHP also had written policies and procedures that thoroughly addressed advance directives. Information about advance directives was included in RMHP's member handbook and in a special attachment to the member handbook called, "Your Right to Make Health Care Decisions." Information regarding advance directives was also included in the provider manual.

RMHP demonstrated that it provided members with information about the grievance system. In addition, RMHP ensured that individuals who made decisions on grievances were not involved in any previous level of review or decision making and had the appropriate clinical expertise.

While reviewing Standard X—Quality Assessment and Performance Improvement, HSAG found that RMHP had a well-organized, effective QAPI system with appropriate review and oversight by the medical director. RMHP demonstrated widespread physician/provider input in the system of care through the work of its Medical Practice Review Committee, New Technologies Assessment Committee, and Pharmacy and Therapeutics Committee.

Recommendations

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

Coordination and Continuity of Care

- Ensure that it informs all new members of the circumstances under which a member who has SHCN may continue to receive covered services from his or her non-network provider and the time frames within which those services may continue.

Member Information

- Notify all members at least once a year of their right to request and obtain certain required information as specified in the BBA.
- Ensure that its providers offer Early and Preventive Screening, Diagnosis, and Treatment (EPSDT) appointments within two weeks of a request.
- Ensure that the member handbook includes all pertinent information about State fair hearings, information regarding a request for continuation of benefits/services, appeal rights available to providers to challenge the failure of the contractor to cover a service, and definitions and descriptions of poststabilization services.

Grievance System

- Ensure that policies and procedures regarding member grievances and appeals include all elements of the definition of an action.

- Develop and implement a process to ensure that oral requests to file an appeal are accepted to establish the earliest possible filing date and are followed by a written, signed appeal.
- Clarify information regarding timely filing of appeals in member materials and policy.
- Ensure that notice of action letters provide clear information that providers can file an appeal on the member's behalf and include accurate information regarding continuation of services.
- Ensure that grievances are acknowledged in writing within 2 working days of receipt and that a written notice of disposition is provided within 15 working days.
- Ensure that its notices of appeal resolution contain all BBA-required elements, including correct information regarding State fair hearing requests.
- Provide information about the grievance system to all providers and subcontractors at the time they enter into a contract.
- Ensure that its policy, process, and member materials correctly specify the time frames and requirements to continue member benefits.

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. Instances of inaccurate or unclear communication in member materials negatively affected scores in all three domains.

Quality

Each of the five standards reviewed contained requirements related to quality. RMHP earned scores of 100 percent for the Member Rights and Protections and the Quality Assessment and Performance Improvement standards, representing a clear strength for RMHP. The other three standards (Coordination and Continuity of Care, Member Information, and Grievance System) received scores of 89 percent, 78 percent, and 63 percent, respectively. The overall weighted score for the quality domain was 78 percent.

Timeliness

The standards that addressed the timeliness domain were the Coordination and Continuity of Care and Grievance System standards. RMHP earned a score of 89 percent for the Coordination and Continuity of Care standard and a score of 63 percent for the Grievance System standard for an overall weighted average score of 68 percent for the timeliness domain.

Access

The standards that assessed the access domain were Coordination and Continuity of Care, Member Rights and Protections, Member Information, and Grievance System. RMHP earned a score of 100 percent for the Member Rights and Protections standard. The other standards in the access domain (Coordination and Continuity of Care, Member Information, and Grievance System) received scores of 89 percent, 78 percent, and 63 percent. The overall weighted average score for the access domain was 74 percent.

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

Table 3-4 shows the overall statewide average for each standard followed by overall recommendations drawn from the results of the compliance monitoring activity. Appendix E contains summary tables showing the detailed site review scores for the standards by health plan as well as the statewide average.

Table 3-4—Summary of Data From the Review of Standards

Standards	FY 2009–2010 Statewide Average*
Standard III—Coordination and Continuity of Care	94%
Standard IV—Member Rights and Protections	86%
Standard V—Member Information	76%
Standard VI—Grievance System	63%
Standard X—Quality Assessment and Performance Improvement	100%
Total	**77%**

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

Statewide recommendations (i.e., those in common for both plans) include:

- Both health plans must revise information in the member handbook related to appointment standards and time frames for requesting a State fair hearing.
- Both health plans must revise member materials pertaining to the grievance system, including revisions to the member handbook and member letters and notices.

Validation of Performance Measures

The Department elected to use HEDIS methodology to satisfy the CMS validation of performance measure protocol requirements, which also included an assessment of information systems. 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. Although HSAG did not audit DHMC and RMHP, 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 performance measures to one or more of the three domains as depicted in Table 3-5. Appendix B contains further details about the NCQA audit process and the methodology used to conduct the EQR validation of performance measure activities.

Table 3-5—FY 2008–2009 Performance Measures Required for Validation

Measure	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	✓	✓	
Children's and Adolescents' Access to Primary Care Providers (PCPs)			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Prenatal Care and *Postpartum Care*	✓	✓	✓
Antibiotic Utilization			✓
*Weight Assessment and Counseling for Nutrition and Physical Activity for Nutrition and Physical Activity for Children/Adolescents**	✓		
Annual Monitoring for Patients on Persistent Medications	✓		
Frequency of Selected Procedures			✓
Ambulatory Care			✓
Inpatient Utilization—General Hospital/Acute Care			✓
*Adult BMI Assessment**	✓		
*Chlamydia Screening in Women**	✓		
*Use of Imaging Studies for Low Back Pain**	✓		
*Controlling High Blood Pressure**	✓		
*Pharmacotherapy Management of COPD Exacerbation**	✓		

Table 3-5—FY 2008–2009 Performance Measures Required for Validation			
Measure	Quality	Timeliness	Access
*Antidepressant Medication Management**	✓		
*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis**	✓		

*Denotes new measures required for validation in FY 2009–2010

The Department required that 20 performance measures based on HEDIS 2010 specifications be validated in FY 2009–2010. Twelve of the measures also were validated in FY 2008–2009, allowing comparisons between the previous year's and the current year's results. With the exception of the Antibiotic Utilization measure, 11 of the measures reported last year had minor coding or other revisions. However, HSAG determined that the impact on yearly comparisons would be minimal at most. One exception to this is the *Childhood Immunization Status—Pneumococcal Conjugate Vaccine (PCV)* and *Combo #3* rates. The requirements for the PCV were revised, and now PCV antigens administered prior to 42 days after birth are no longer counted as numerator-compliant. This could result in a decrease (although probably small) to the *Childhood Immunization Status—Combo # 3* rate. This change does not impact the *Childhood Immunization Status—Combo #2* rate. An additional exception is the revision made to the *Prenatal* and *Postpartum Care* measures. Logical Observation Identifiers Names and Codes (LOINC®) codes for lab panels previously allowed as numerator-compliant for prenatal care services (along with a visit to an obstetric provider) were removed and could decrease numerator compliance for the *Timeliness of Prenatal Care* measure. However, plans do not ordinarily receive large volumes of LOINC codes. Among the eight measures newly required for this year, seven were specific to the adult population.

Denver Health Medicaid Choice (DHMC)

Compliance with Information Systems (IS) Standards

HSAG reviewed and evaluated all data sources, including the plan's Final 2010 HEDIS Compliance Audit Report and Interactive Data Submission System (IDSS) used to report the performance measures as a component of the validation process.

DHMC was fully compliant with all NCQA-defined IS standards relevant to the scope of the performance measure validation. The auditor mentioned "commendable practices" related to revision of data translation files sent to the NCQA-certified software vendor. In addition, the auditor noted that DHMC demonstrated significant improvements to processes that helped improve the overall quality of the membership data. The auditor also noted the impact of the quality assurance programming that was ongoing at the organization and that is reflected in the measure results.[3-1]

[3-1] HEDIS Compliance Audit, Final Audit Report, Denver Health Medical Plan, Inc., July 2010

Children's Performance Measures

Table 3-6 displays the DHMC rates and audit designations for each performance measure for children.

Table 3-6—Review Results and Audit Designation for Children's Performance Measures *for* DHMC

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Childhood Immunization Status and Well-Child Visits					
Childhood Immunization Status (Combo #2)	87.6%	86.1%	≥90th	R	R
Childhood Immunization Status (Combo #3)	87.1%	85.2%	≥90th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	56.2%	86.1%	≥90th	R	R
Well-Child Visits 3–6 Years of Life	63.0%	63.3%	10th–24th	R	R
Adolescent Well-Care Visits	41.8%	46.0%	50th–74th	R	R
Children's & Adolescents' Access to PCPs					
12–24 months	90.6%	93.6%	10th–24th	R	R
25 months–6 years	77.6%	79.2%	10th–24th	R	R
7–11 years	81.9%	85.1%	25th–49th	R	R
12–19 years	83.6%	85.8%	25th–49th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)					
3–11 Years	—	77.6%	≥90th	—	R
12–17 Years	—	75.3%	≥90th	—	R
Total	—	77.1%	≥90th	—	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)					
3–11 Years	—	73.3%	≥90th	—	R
12–17 Years	—	66.3%	≥90th	—	R
Total	—	71.8%	≥90th	—	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)					
3–11 Years	—	46.0%	≥90th	—	R
12–17 Years	—	56.2%	≥90th	—	R
Total	—	48.2%	75th–89th	—	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.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, DHMC showed strong results for performance measures. All DHMC performance measures received an audit result of *Reportable* (R) for the current measurement cycle. Among those measures with both previous and current year's rates, all but two measures (*Childhood Immunization Status Combo #2* and *#3)* demonstrated improvement. DHMC's FY 2009–2010 showed exceptional improvement on its performance for the *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure. The rate improved by almost 30 percentage points. This measure, along with the two *Childhood Immunization Status* measures (*Combo #2* and *#3*) also ranked above the 90th percentile of HEDIS 2009 national rates, demonstrating DHMC's strength.

DHMC's strength was also noted in the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, which was reported for the first-time in FY 2009–2010. The plan's performance was within the top 10 percent in HEDIS 2009 national performance for all but one *Weight Assessment and Counseling* submeasure.

Recommendations

Results of DHMC's performance measures yielded several opportunities for improvement. Although three measures (*Well-Child Visits 3–6 Years of Life, Children's and Adolescents' Access to Primary Care Providers—12–24 months* and *25 months–6 years*) demonstrated improvement in their rates from FY 2008–2009, these measures ranked within the national 10th and 25th percentiles.

Based on the results of this year's performance measure validation findings, HSAG recommends targeting the lower-performing measures, namely *Well-Child Visits 3–6 Years of Life* and *Children's and Adolescents' Access to Primary Care Providers (Ages 12 Months to 6 Years).* DHMC should consider implementing some of the following improvement efforts:

Improve Access

Open access appointments can increase compliance by expanding provider availability.[3-2] Evening or weekend clinic hours for providers can accommodate parents who cannot take time off from work. For example, one Saturday a month could be set aside for children and adolescents, with clinicians designated to perform well visits on that day. Visits on certain days could be made available on a walk-in, first-come, first-served basis. Additionally, parents should be encouraged to schedule their next visit before leaving the clinic.

Providing improved access to transportation would likely increase well-visit compliance. One method to improve transportation issues would be to coordinate with community volunteers and other outreach services to provide transportation to and from doctors' offices and clinics.

[3-2] O'Connor ME, Matthews BS, Gao D. Effect of Open Access Scheduling on Missed Appointments, Immunizations, and Continuity of Care for Infant Well-Child Care Visits. *Archives of Pediatrics & Adolescent Medicine.* 2006; 160: 889-893.

Reminder Systems

Postcards are an easy and effective tool to increase well visits. They can be sent to parents as a reminder to schedule their child's well visit. To be most effective, postcards should include contact information for either doctors' offices near the member's address or the member's assigned PCP. In addition, age-specific forms that detail what services should be provided and why they are important to the well-being of the child can help educate parents.

Physician Education

Quarterly provider reports that highlight children and adolescents in need of well visits are useful for promoting visit reminders and helping providers track their performance. Members who saw a doctor but did not have a well visit can be flagged as missed opportunities. To make this information pertinent to providers, their performance may be tied to a recognition program for providers who display outstanding performance. An additional practice that can improve well-visit compliance is educating providers on proper billing codes for well-child visits, which can reduce missed opportunities.

Adult's Performance Measures

Table 3-7 shows the DHMC rates and audit designations for each performance measure for adults.

Table 3-7—Review Results and Audit Designation for Adult's Performance Measures *for* DHMC

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Adult BMI Assessment	—	83.7%	≥90th	—	R
Annual Monitoring for Patients on Persistent Medications	80.8%	84.7%	50th–74th	R	R
Use of Imaging for Low Back Pain	—	79.4%	50th–74th	—	R
Controlling High Blood Pressure	—	64.7%	75th–89th	—	R
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	—	64.6%	≥90th	—	R
Timeliness of Prenatal Care	86.1%	83.5%	25th–49th	R	R
Postpartum Care	59.1%	58.4%	25th–49th	R	R
Chlamydia Screening in Women					
16–20 years	—	77.2%	≥90th	—	R
21–24 years	—	80.0%	≥90th	—	R
Total	—	78.5%	≥90th	—	R
Adult's Access to Preventive/Ambulatory Health Services					
20–44 years	68.8%	74.9%	10th–24th	R	R
45–64 years	70.7%	78.7%	10th–24th	R	R
65+ years	59.9%	69.5%	<10th	R	R
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	—	49.6%	10th–24th	—	R
Bronchodilator	—	55.6%	<10th	—	R
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	51.2%	—	—	R
Effective Continuation Phase Treatment	—	38.0%	—	—	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.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, DHMC showed strong results for the adult performance measures. All DHMC performance measures received an audit designation of *Reportable* (R) for the current measurement cycle. Among the measures with both previous and current measurement results, all but two measures (*Timeliness of Prenatal Care* and *Timeliness of Postpartum Care*) demonstrated improvement. DHMC's FY 2009–2010 performance on all of the *Adults' Access to Preventive/Ambulatory Health Services* measures improved by more than 5 percentage points. Among the first-time reported measures, three (*Adult BMI Assessment*, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, and *Chlamydia Screening in Women*) ranked among the top 10 percent in HEDIS 2009 national performance.

Recommendations

Results of DHMC's performance measures yielded a few opportunities for improvement. Although the *Adults' Access to Preventive/Ambulatory Health Services* measure demonstrated notable improvement from the previous year, DHMC's performance was among the bottom 10th percentile of HEDIS 2009 national performance. The rate of one first-time reported measure (*Pharmacotherapy management of COPD exacerbation—Bronchodilator)* was also among the bottom 10th percentile of HEDIS 2009 national performance.

HSAG recommends targeting the lower-performing measures, namely *Adults' Access to Preventive/Ambulatory Health Services* and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*. DHMC should consider implementing some of the following improvement efforts:

Geographic Availability

Geographic availability is an important determinant that affects access to care. Members living in counties with fewer PCPs are more likely to use EDs as their usual source of acute care. Many rural and inner-city urban areas still have fewer PCPs than demand necessitates. Improving access to PCPs will be successful if there are adequate physician levels to meet demand.

Administrators can use geographic information system applications to manage the geographic distribution of doctors and nurses based on maps of members' residences. Types of visits can be mapped in relation to patient distributions in order to determine if certain regions, for instance, have proportionately higher emergency department utilization for nonemergent conditions than other regions. Correlations between region, inappropriate utilization, and availability of PCPs can indicate where lower access rates are unduly influenced by physical barriers to care.[3-3]

[3-3] Centers for Disease Control and Prevention. GIS: Linking Public Health Data and Geography. 2007. Available at: http://www.cdc.gov/Features/GIS/. Accessed on: September 20, 2010.

Open Access Scheduling

When scheduling systems lead to poor access at the practice level, they affect the appropriate utilization of primary care services.[3-4] The most common reason that patients give for seeking care in urgent care centers is the failure to obtain a timely appointment with a PCP. High no-show rates are also associated with longer delays for appointments. Open access scheduling is designed to address several flaws in existing scheduling systems through the implementation of three key changes:

- Patients are offered same-day access to an appointment regardless of the nature of their problem (routine, preventive, or acute).
- Patients' appointments are scheduled with their PCPs as often as possible (versus being seen by the first available doctor).
- Practices attempt to minimize waiting time within the office.

Improving Physician-Patient Relationships

The physician-patient relationship is integral to the successful delivery of primary health care. Studies have shown that continuity of care between patients and physicians is associated with improved use of health services, preventive care, and satisfaction with care.[3-5] Positive physician-patient relationships also result in better compliance and improved self-care. As often as possible, patients should be matched with their primary clinicians.

Identifying Members for Targeted Interventions

It is important to effectively identify members who should be targeted for an intervention prior to the implementation of any quality improvement initiatives. Members with chronic obstructive pulmonary disease (COPD), for example, can be identified through claims data, encounter data, pharmacy data, collaborating with other health plans to build regional registries, searching durable equipment claims for COPD-related devices (e.g., peak flow meter), performing medical record reviews, and implementing a process to identify newly enrolled members with COPD (e.g., a health screen risk assessment during new member welcome calls).

Furthermore, registries are an effective mechanism to identify and manage many chronic diseases such as asthma or COPD. A COPD registry can be created that contains information about members diagnosed with COPD. The registries can be used to support reporting needs such as the identification of newly diagnosed members, stratifying by selected variables, and monitoring of COPD care.[3-6]

[3-4] Randolph GD, Murray M, Swanson JA, et al. Behind Schedule: Improving Access to Care for Children One Practice at a Time. *Pediatrics*. 2004; 113(3): e320-e327. Available at: http://pediatrics.aappublications.org/cgi/content/full/113/3/e230. Accessed on: May 24, 2010.

[3-5] Kerse N, Buetow S, Mainous AG, et al. Physician-Patient Relationship and Medication Compliance: A Primary Care Investigation. *Annals of Family Medicine*. 2004; 2(5): 455-460.

[3-6] Center for Health Care Strategies, Inc. *Achieving Better Care for Asthma: A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans*. CHCS; 2002.

Utilization Performance Measures

Table 3-8 shows the DHMC rates and audit designations for the utilization performance measures.

Table 3-8—Review Results and Audit Designation for Utilization Performance Measures *for* DHMC

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Antibiotic Utilization					
Average Scrips PMPY for All Antibiotics	0.39	0.41	<10th	R	R
Average Scrips PMPY for Antibiotics of Concern	0.10	0.11	<10th	R	R
Percentage of Antibiotics of Concerns of all Antibiotics Scrips	25.6%	26.3%	<10th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	5.68	12.85	≥90th	R	R
Average Length of Stay	3.82	5.40	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	2.47	8.55	≥90th	R	R
Average Length of Stay	3.81	4.88	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	0.93	1.27	25th–49th	R	R
Average Length of Stay	6.83	15.33	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months aged 10–64 years)	5.03	6.62	50th–74th	R	R
Average Length of Stay	2.58	2.74	50th–74th	R	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	219.95	296.80	10th–24th	R	R
ED Visits	9.43	63.06	50th–74th	R	R
Ambulatory Surgery/Procedures	16.46	22.53	≥90th	R	R
Observation Room Stays Resulting in Discharge	0.81	1.01	25th–49th	R	R
Frequency of Selected Procedures					
Myringotomy (0–4 Male & Female)	0.02	0.52	10th–24th	R	R
Myringotomy (5–19 Male & Female)	0.00	0.23	10th–24th	R	R
Tonsillectomy (0–9 Male & Female)	0.04	0.30	10th–24th	R	R
Tonsillectomy (10–19 Male & Female)	0.00	0.28	25th–49th	R	R
Dilation & Curettage (15–44 Female)	0.03	0.02	<10th	R	R
Dilation & Curettage (45–64 Female)	0.00	0.00	10th–24th	R	R
Hysterectomy, Abdominal (15–44 Female)	0.09	0.07	<10th	R	R
Hysterectomy, Abdominal (45–64 Female)	0.17	0.20	10th–24th	R	R
Hysterectomy, Vaginal (15–44 Female)	0.06	0.03	<50th	R	R
Hysterectomy, Vaginal (45–64 Female)	0.08	0.16	25th–50th	R	R
Cholecystectomy, Open (30–64 Male)	0.03	0.06	<75th	R	R

Table 3-8—Review Results and Audit Designation for Utilization Performance Measures *for* DHMC					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Cholecystectomy, Open (15–44 Female)	0.01	0.01	†	R	R
Cholecystectomy, Open (45–64 Female)	0.04	0.04	<50th	R	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.06	0.09	10th–24th	R	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	0.25	0.58	25th–49th	R	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	0.12	0.33	10th–24th	R	R
Back Surgery (20–44 Male)	0.17	0.05	10th–24th	R	R
Back Surgery (20–44 Female)	0.05	0.08	10th–24th	R	R
Back Surgery (45–64 Male)	0.15	0.10	10th–24th	R	R
Back Surgery (45–64 Female)	0.29	0.20	10th–24th	R	R
Mastectomy (15–44 Female)	0.00	0.00	†	R	R
Mastectomy (45–64 Female)	0.08	0.00	10th–24th	R	R
Lumpectomy (15–44 Female)	0.03	0.03	<10th	R	R
Lumpectomy (45–64 Female)	0.04	0.37	10th–24th	R	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.

† All percentiles were 0.00 for this indicator; therefore, percentile ranking is not applicable.

[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Utilization Observations

HSAG noted that overall, DHMC experienced increases for a majority of the utilization measures. There was a large increase in the *Inpatient Utilization—General Hospital Acute Care (Medicine) Discharges (Per 1,000 member months)* that also impacted the *Total Inpatient* rate. DHMC also experienced large increases in the *Ambulatory Care* measure. The *Emergency Department (ED) Visits (Per 1,000 member months)* rate climbed from 9.43 to 63.06. Rates for *Outpatient Visits* and *Ambulatory Surgery/Procedures* experienced large increases as well.

It is important to assess utilization based on the characteristics of the plan's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics each plan's results provide additional information that the plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions. Given the dramatic increase in the ED utilization, HSAG recommends that the Department require DHMC to address the increase formally. DHMC should provide utilization information on the top reasons/diagnoses seen, an explanation of what they believe led to the increase, and a summary of efforts implemented to decrease inappropriate ED utilization.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, DHMC improved on a majority of the measures reported for both previous and current measurement cycles. Several measures reported the first time for the current measurement year attained the 2009 HEDIS national Medicaid top 10 percent in performance. The following is a summary assessment of DHMC's performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** DHMC's overall performance in the quality domain was similar to last year, with some measures related to quality showing improvement and others demonstrating a slight decline. With the exception of the two *Childhood Immunization Status* measures, all children's performance measures related to quality demonstrated some improvement in rates from last year. In particular, the measure *Well-Child Visits in the First 15 Months of Life, 6+ Visits* showed major improvement (close to 30 percentage points) from last year's rate. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* was ranked within the top 10 percent in HEDIS 2009 national performance. DHMC's performance on quality among the adults' measures, with rates reported for both years, was similar to last year's performance. The *Annual Monitoring for Patients on Persistent Medications* measure showed a slight improvement from last year's rate, but the two *Prenatal* and *Postpartum Care* measures exhibited a slight decline. The plan's performance on the four first-time reported adult measures was mixed. Three measures, *Adult BMI Assessment*, *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, and *Chlamydia Screening in Women*, ranked within the top 10 percent in HEDIS 2009 national performance and one, *Pharmacotherapy Management of COPD Exacerbation*, ranked below the 25th percentiles. Overall, opportunities for improvement were noted for the measures *Well-Child Visits 3–6 Years of Life* and the *Pharmacotherapy management of COPD Exacerbation—Bronchodilator*.
- **Timeliness:** DHMC demonstrated consistent performance for the timeliness measures. All but two children's performance measures demonstrated some improvement in rates from last year. The measure *Well-Child Visits in the First 15 Months of Life, 6+ Visits* showed close to a 30 percentage-point improvement when compared to last year's rate. Although the two *Childhood Immunization Status* measures showed a slight decline in their rates, they still maintained the top 10th percentile ranking according to the HEDIS 2009 national performance. The only adult timeliness measures, *Prenatal* and *Postpartum Care*, also exhibited a slight decline in rates. Overall, opportunities for improvement were noted for the *Well-Child Visits 3–6 Years of Life* measure, where its ranking was below the 25th percentile, based on the HEDIS 2009 national performance.
- **Access:** DHMC had mixed performance in the access domain. The MCO exhibited improvements in two of the three measures reported with previous and current year's rates (*Children's and Adolescents' Access to Primary Care Providers (PCPs)* and *Adults' Access to Preventive/Ambulatory Health Services*), but had a slight decline in the two *Prenatal* and *Postpartum Care* measures. Nonetheless, the performance of these measures was ranked below the 2009 HEDIS national median (50th) percentiles. The MCO also demonstrated an increase in usage on all utilization-based performance measures (*Antibiotic Utilization, Inpatient Utilization, Ambulatory Care,* and *Frequency of Selected Procedures*) from last year. Opportunities for improvement among measures in the access domain were noted in the *Children's and Adolescents' Access to Primary Care Provides (PCPs)* and *Adults' Access to Preventive/Ambulatory Health Services* measures.

Rocky Mountain Health Plans (RMHP)

Compliance with Information Systems Standards

HSAG reviewed and evaluated all data sources—including the plan's Final 2010 HEDIS Compliance Audit Report and IDSS—that were used to report the performance measures as a component of the validation process.

RMHP was fully compliant with the applicable NCQA-defined IS standards, with the exception of the following:

- IS 1.0—The plan was considered to be substantially compliant with IS Standard 1.0 due to its limited system ability to capture more than eight diagnosis codes. In addition, the rendering physician was not captured but was loaded into a separate memo field. The auditor determined that these concerns had a minimal impact on HEDIS reporting.[3-7]

Children's Performance Measures

Table 3-9 shows the RMHP rates and audit designations for each performance measure for children.

Table 3-9—Review Results and Audit Designation for Children's Performance Measures *for* RMHP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Childhood Immunization Status and Well-Child Visits					
Childhood Immunization Status (Combo #2)	78.3%	89.3%	≥ 90th	R	R
Childhood Immunization Status (Combo #3)	73.7%	85.9%	≥ 90th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	77.3%	72.6%	75th–89th	R	R
Well-Child Visits 3–6 Years of Life	63.5%	70.5%	50th–74th	R	R
Adolescent Well-Care Visits	45.5%	48.2%	50th–74th	R	R
Children's & Adolescents' Access to PCPs					
12–24 months	98.3%	98.8%	≥ 90th	R	R
25 months–6 years	89.1%	91.8%	75th–89th	R	R
7–11 years	92.3%	91.7%	50th–74th	R	R
12–19 years	91.9%	92.7%	≥ 90th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)					
3–11 Years	—	58.6%	≥ 90th	—	R
12–17 Years	—	57.0%	≥ 90th	—	R
Total	—	58.2%	≥ 90th	—	R

[3-7] 2010 Compliance Audit, Final Audit Report, HEDIS, Rocky Mountain Health Plans, 6/30/2010.

Table 3-9—Review Results and Audit Designation for Children's Performance Measures *for* RMHP					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)					
3–11 Years	—	62.6%	75th–89th	—	R
12–17 Years	—	53.5%	75th–89th	—	R
Total	—	60.1%	75th–89th	—	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)					
3–11 Years	—	54.9%	≥ 90th	—	R
12–17 Years	—	48.2%	75th–89th	—	R
Total	—	53.0%	≥ 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.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, RMHP showed strong results for the performance measures. All RMHP's performance measures received an audit designation of *Reportable* (R) for the current measurement cycle. Among those measures with both previous and current rates, all but two submeasures demonstrated improvement, with the two *Childhood Immunization Status* measures exhibiting an improvement of more than 10 percentage points. In addition, four of the nine submeasures (two *Childhood Immunization Status* measures and two *Children's and Adolescents Access to Primary Care Providers (PCPs)* measures) were ranked within the top 10 percent in the HEDIS 2009 national performance.

RMHP's strength was also noted in the measure, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,* which was reported for the first time in FY 2009–2010. The plan's performance was within the top 10 percent in HEDIS 2009 national performance for five of the nine *Weight Assessment and Counseling* submeasures.

Recommendations

Results of RMHP's performance measures yielded several opportunities for improvement. Two of the nine submeasures with last year's rate exhibited a slight decline in performance in the current year. In particular, *Well-Child Visits in the First 15 Months of Life, 6+ Visits* had a 4.7 percentage-point decrease.

HSAG recommends targeting the *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure. RMHP should consider implementing some of the following improvement efforts:

Improve Access

Open access appointments can increase compliance by expanding provider availability.[3-8] Evening or weekend clinic hours for providers can accommodate parents who cannot take time off from work. For example, one Saturday a month could be set aside for children and adolescents, with clinicians designated to perform well visits on that day. Visits on certain days could be made available on a walk-in, first-come, first-served basis. Additionally, parents should be encouraged to schedule their next visit before leaving the clinic.

Providing improved access to transportation would likely increase well-visit compliance. One method to improve transportation issues would be to coordinate with community volunteers and other outreach services to provide transportation to and from doctors' offices and clinics.

Reminder Systems

Postcards are an easy and effective tool to increase well-visits. They can be sent to parents as a reminder to schedule their child's well visit. To be most effective, postcards should include contact information for either doctors' offices near the member's address or the member's assigned PCP. In addition, age-specific forms that detail what services should be provided and why they are important to the well-being of the child can help educate parents.

Physician Education

Quarterly provider reports that highlight children and adolescents in need of well visits are useful for promoting visit reminders and helping providers track their performance. Members who saw a doctor but did not have a well-visit can be flagged as missed opportunities. To make this information pertinent to providers, their performance may be tied to a recognition program for providers who display outstanding performance. An additional practice that can improve well visit compliance is educating providers on proper billing codes for well-child visits, which can reduce missed opportunities.

[3-8] O'Connor ME, Matthews BS, Gao D. Effect of Open Access Scheduling on Missed Appointments, Immunizations, and Continuity of Care for Infant Well-Child Care Visits. *Archives of Pediatrics & Adolescent Medicine.* 2006; 160: 889-893.

Adult's Performance Measures

Table 3-10 shows the RMHP rates and audit designations for each performance measure for adults.

Table 3-10—Review Results and Audit Designation for Adult's Performance Measures *for* RMHP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Adult BMI Assessment	—	48.7%	75th–89th	—	R
Annual Monitoring for Patients on Persistent Medications	71.4%	75.3%	<10th	R	R
Use of Imaging for Low Back Pain	—	72.6%	10th–24th	—	R
Controlling High Blood Pressure	—	74.1%	≥90th	—	R
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	—	35.9%	≥90th	—	R
Timeliness of Prenatal Care	95.2%	95.0%	≥90th	R	R
Postpartum Care	71.9%	73.7%	≥90th	R	R
Chlamydia Screening in Women					
16–20 years	—	45.2%	10th–24th	—	R
21–24 years	—	45.8%	<10th	—	R
Total	—	45.5%	10th–24th	—	R
Adult's Access to Preventive/Ambulatory Health Services					
20–44 years	86.1%	87.7%	75th–89h	R	R
45–64 years	87.6%	90.4%	75th–89th	R	R
65+ years	95.2%	95.6%	≥90th	R	R
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	—	34.3%	<10th	—	R
Bronchodilator	—	62.9%	<10th	—	R
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	NB	—	—	R
Effective Continuation Phase Treatment	—	NB	—	—	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 required benefit is not offered.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, RMHP showed strong results for the adult performance measures. All of RMHP's applicable performance measures received an audit result of *Reportable* (R) for the current measurement cycle (RMHP does not provide a mental health benefit and therefore is not required to report the *Antidepressant Medication Management* measure). Among the measures with both previous and current measurement results, all but one measure, *Timeliness of Prenatal Care,*

demonstrated improvement. Additionally, the measures *Prenatal* and *Care* and the *Adult's Access to Preventive/Ambulatory Health Services—65+ year* measure were ranked among the top 10 percent in HEDIS 2009 national performance. Among the first-time reported measures, two of them, *Controlling High Blood Pressure* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* ranked among the top 10 percent in HEDIS 2009 national performance.

Recommendations

Results of RMHP's performance measures yielded a few opportunities for improvement. Although the *Annual Monitoring for Patients on Persistent Medications* measure demonstrated an improvement of close to 4 percentage points from the previous year, RMHP's performance was among the bottom 10 percent in HEDIS 2009 national performance. The rates of three first-time reported measures (*Chlamydia Screening in Women—21–24 years* and the two *Pharmacotherapy Management of COPD Exacerbation* submeasures) were also among the bottom 10 percent in HEDIS 2009 national performance.

Based on the results of this year's performance measure validation findings, HSAG recommends targeting the lower-performing measures, namely *Annual Monitoring for Patients on Persistent Medications, Chlamydia Screening in Women—21–24 Years,* and *Pharmacotherapy Management of COPD Exacerbation*. RMHP should consider implementing some of the following improvement efforts:

For Chlamydia Screening:

Physician Reminders

Providing PCPs and OB/GYNs with a list of missed screening opportunities is an effective practice that has shown to increase screening rates. By giving providers a list of patients who were identified as not having received a screening within the specified time frame, providers can contact members and encourage them to come in for important screenings. Sending the lists to both PCPs and OB/GYNs makes it more difficult for women to evade or ignore promptings from their physicians.[3-9]

Patient Reminders

Members are more responsive to reminders when a clinician calls (i.e., physicians or their support staff).[3-10] However, other reminder methods, such as direct mailings (e.g., postcards and letters) and small media (e.g., brochures, pamphlets, flyers, and newsletters) have also been effective. Reminders should be eye-catching, timely, and personalized. One method to accomplish this is to send colorful birthday cards with enclosed reminders. Reminders can also be used to provide additional information on locations of screening facilities with business hours.

3-9 National Committee for Quality Assurance. Breast Cancer Screening: Raising Member and Physician Awareness. *Quality Profiles*. 2008. Available at: http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/1_14.asp. Accessed on: May 6, 2010.

3-10 Task Force on Community Preventive Services. Recommendations for Client- and Provider-Directed Interventions to Increase Breast, Cervical, and Colorectal Cancer Screening. *American Journal of Preventive Medicine.* 2008; 35(1 Supplement): S21-S25.

Improving Access and Awareness

It is important for a plan to determine if proper resources are in place to allow members to obtain screenings. Plans may contract with more OB/GYNs and/or increase the number of sites that perform screenings. At each stage, plans must keep members informed of the changes in procedures and additional resources.[3-11] Other methods to improve awareness include articles in a member newsletter, educational materials for members, and information on locations and business hours of screening facilities.

Physician Communication

If a physician is able to properly communicate with his or her patient about various topics such as birth control, STDs, pregnancy, underage sex, and the importance of getting routine Pap Smears, there is a higher chance the patient will be compliant with regular screenings.

Many health plans and medical groups are now giving practitioners formal training in communication skills. This training can be completed either by in-house programs or communications programs offered by outside organizations. Most of the time this type of training is optional; however, some organizations have made the classes a requirement. In other organizations, the training is only required for doctors who consistently receive low scores in the area of communication.[3-12]

The purpose of the training programs is to improve providers' effectiveness as both managers of health and as educators of patients. It is also thought that trained physicians will allocate a greater percentage of the clinic-visit time to patient education, which leads to greater patient knowledge, better compliance with treatment, and improved health outcomes.

The most effective and efficient way to offer physician-patient communication training is through a workshop or a seminar. The result is that many strategies to improve communication can be covered in a short period. Workshops also have the advantage of using case studies to illustrate the importance of communication and suggest approaches to improving the relationship between the physician and patient.[3-13]

Physician Tools and Resources

Providers often need reminders about screening guidelines. Clarifying and reinforcing guidelines, reinforcing the importance of screening, and creating tools to facilitate screening are three methods that improve HEDIS screening rates by reaching out to providers.

[3-11] National Committee for Quality Assurance. Breast Cancer Screening – Hitting the Road with Screening Programs. *Quality Profiles*. 2010. Available at: http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/1_15.asp. Accessed on: May 27, 2010.

[3-12] Agency for Healthcare Research and Quality. The CAHPS Improvement Guide. Available at: https://www.cahps.ahrq.gov/QIGuide/content/interventions/Training2AdvanceSkills.aspx. Accessed on: April 26, 2010.

[3-13] Ibid.

NCQA further recommends the following tools to help facilitate screening:

- Patient registry of females who had screenings.
- Copies of reminder letters sent to patients who are due for screenings.
- List of patients, with contact information, who have not received screenings.[3-14]

For medication management/chronic care:

Identifying Members for Targeted Interventions

It is important to effectively identify members who should be targeted for an intervention prior to implementing any quality improvement initiatives. Members with COPD, for example, can be identified through claims data, encounter data, pharmacy data, collaborating with other health plans to build regional registries, searching durable equipment claims for COPD-related devices (e.g., peak flow meter), performing medical record reviews, and implementing a process to identify newly enrolled members with COPD (e.g., a health screen risk assessment during new member welcome calls).

Furthermore, registries are an effective mechanism to identify and manage many chronic diseases such as asthma or COPD. A COPD registry can contain information about members diagnosed with COPD. The registries can be used to support reporting needs, such as the identification of newly diagnosed members, stratifying by selected variables, and monitoring COPD care.[3-15]

Physician Reminders

Certain medications require monitoring for therapeutic blood levels or a specific lab test to assess crucial organ functions (liver, kidney, etc.). By using pharmacy prescription data, plans may provide physicians with current listings of key medications that require routine lab monitoring, coupled with any lab results data that are available. Practice guidelines for appropriate lab monitoring of patients on targeted medications would also be beneficial for providers.

[3-14] National Committee for Quality Assurance. Improving Chlamydia Screening: Strategies From Top Performing Health plans. 2007. Available at: http://www.ncqa.org/Portals/0/Publications/Resource%20Library/Improving_Chlamydia_Screening_08.pdf. Accessed on: May 28, 2010.

[3-15] Center for Health Care Strategies, Inc. *Achieving Better Care for Asthma: A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans*. CHCS; 2002.

Utilization Performance Measures

Table 3-11 shows the RMHP rates and audit designations for the utilization performance measures.

Table 3-11—Review Results and Audit Designation for Utilization Performance Measures *for* RMHP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Antibiotic Utilization					
Average Scrips PMPY for All Antibiotics	1.13	1.06	25th–49th	R	R
Average Scrips PMPY for Antibiotics of Concern	0.44	0.39	10th–24th	R	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips	38.8%	37.1%	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	13.9	12.12	≥90th	R	R
Average Length of Stay	3.34	2.76	<10th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	5.05	3.97	50th–74th	R	R
Average Length of Stay	3.68	2.97	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	2.92	2.45	≥90th	R	R
Average Length of Stay	5.58	4.60	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months aged 10–64 years)	12.23	11.63	≥90th	R	R
Average Length of Stay	1.94	1.83	<10th	R	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	461.34	470.45	≥90th	R	R
ED Visits	59.16	63.33	50th–74th	R	R
Ambulatory Surgery/Procedures	13.60	14.51	≥90th	R	R
Observation Room Stays Resulting in Discharge	1.25	1.84	50th–74th	R	R
Frequency of Selected Procedures					
Myringotomy (0–4 Male & Female)	3.88	3.52	50th–74th	R	R
Myringotomy (5–19 Male & Female)	0.48	0.73	75th–89th	R	R
Tonsillectomy (0–9 Male & Female)	0.96	1.24	≥90th	R	R
Tonsillectomy (10–19 Male & Female)	0.92	1.51	≥90th	R	R
Dilation & Curettage (15–44 Female)	0.16	0.28	50th–74th	R	R
Dilation & Curettage (45–64 Female)	0.42	0.00	10th	R	R
Hysterectomy, Abdominal (15–44 Female)	0.33	0.33	75th–89th	R	R
Hysterectomy, Abdominal (45–64 Female)	0.42	0.30	25th–49th	R	R
Hysterectomy, Vaginal (15–44 Female)	0.85	1.11	≥90th	R	R
Hysterectomy, Vaginal (45–64 Female)	0.42	0.49	≥90th	R	R
Cholecystectomy, Open (30–64 Male)	0.00	0.00	<75th	R	R
Cholecystectomy, Open (15–44 Female)	0.03	0.00	†	R	R

Table 3-11—Review Results and Audit Designation for Utilization Performance Measures *for* RMHP					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Cholecystectomy, Open (45–64 Female)	0.21	0.00	<50th	R	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.33	0.50	≥90th	R	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	1.54	1.50	≥90th	R	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	1.27	1.48	≥90th	R	R
Back Surgery (20–44 Male)	1.32	0.71	≥90th	R	R
Back Surgery (20–44 Female)	0.56	0.36	75th–89th	R	R
Back Surgery (45–64 Male)	0.37	1.51	≥90th	R	R
Back Surgery (45–64 Female)	1.38	1.28	≥90th	R	R
Mastectomy (15–44 Female)	0.10	0.00	†	R	R
Mastectomy (45–64 Female)	0.21	0.39	75th–89th	R	R
Lumpectomy (15–44 Female)	0.29	0.36	≥90th	R	R
Lumpectomy (45–64 Female)	0.74	1.08	≥90th	R	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.

† All percentiles were 0.00 for this indicator; therefore, percentile ranking is not applicable.

[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Utilization Observations

HSAG noted that overall rates for RMHP's utilization were fairly stable when compared to last year. RMHP experienced minor decreases in the *Discharges (Per 1,000 Member Months)* for all of the *Inpatient Utilization—General Hospital Acute Care* types: Total Inpatient, Medicine, Surgery, and Maternity. There were small decreases noted for all of the *Antibiotic Utilization* submeasures. RMHP experienced increases in all of the rates for the *Ambulatory Care* measures, although the rates for *Ambulatory Surgery/Procedures* and *Observation Room Stays Resulting in Discharge* were minor.

It is important to assess utilization based on the characteristics of the plan's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics each plan's results provide additional information the plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, RMHP 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 2009 HEDIS national Medicaid top 10 percent in performance. 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. The two *Childhood Immunization Status* measures demonstrated improvement in rates by more than 10 percentage points from last year. These measures also ranked among the top 10 percent in HEDIS 2009 national performance. On the other hand, the measure *Well-Child Visits in the First 15 Months of Life, 6+ Visits* showed close to a 5 percentage-point decline. Rates for five of the nine first-time reported children's submeasures for the measure *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* were ranked within the top 10 percent in HEDIS 2009 national performance. Among the adults' measures with rates reported for both years, RMHP's performance was mixed. Two measures reported last year (*Postpartum Care* and *Annual Monitoring for Patients on Persistent Medications*) showed an improvement. Two first-time reported measures, *Controlling High Blood Pressure* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* ranked among the top 10 percent, but four ranked at the bottom 10 percent of their respective HEDIS 2009 performance rates. These four first-time reported measures, *Annual Monitoring for Patients on Persistent Medications, Chlamydia Screening in Women—21–24 years*, and the two *Pharmacotherapy Management of COPD Exacerbation* submeasures, together with the *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure, presented opportunities for improvement.
- **Timeliness:** RMHP demonstrated mixed performance in timeliness, with some measures showing an improvement and others a slight decline in rates. The two *Childhood Immunization Status* measures demonstrated improvement in rates by more than 10 percentage points from last year. These measures also ranked among the top 10 percent in HEDIS 2009 national performance. On the other hand, the measure *Well-Child Visits in the First 15 Months of Life, 6+ Visits* showed close to a 5 percentage point decline. Overall, opportunity for improvement was noted in *Well-Child Visits in the First 15 Months of Life, 6+ Visits*.
- **Access:** RMHP had overall good performance in the access domain. The MCO exhibited improvements in a majority of the measures reported with previous and current year's rates (*Children's and Adolescents' Access to Primary Care Providers (PCPs), Adults' Access to Preventive/Ambulatory Health Services,* and *Postpartum Care*) but had a slight decline in the *Timeliness of Prenatal Care* measure. The MCO also demonstrated an increase in the use of ambulatory care services and a decrease in antibiotic utilization and the use of inpatient services.

Primary Care Physician Program (PCPP)

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 3-12 displays the key types of data sources used in the validation of performance measures and the time period to which the data applied.

Table 3-12—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
HEDIS Record of Administration, Data Management and Processes (Roadmap)	CY 2009
Certified Software Report	CY 2009
Performance Measure Reports	CY 2009
Supporting Documentation	CY 2009
On-site Interviews and Information Systems Demonstrations	CY 2009

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.

Compliance with Information Systems Standards

HSAG reviewed and evaluated all data sources (including the plan's Final 2010 HEDIS Audit Report and IDSS) used to report the performance measures as a component of the validation process.

PCPP was fully compliant with all NCQA-defined IS standards relevant to the scope of the performance measure validation, except the following:

- IS 1.0—PCPP was considered to be substantially compliant with IS Standard 1.0 due to possible data completeness concerns. PCPP does not get complete medical service data from Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). The auditor recommended that PCPP continue to work with FQHCs and RHCs to obtain complete claims information. This concern has an impact on HEDIS reporting, since medical services could be underreported.[3-16]
- IS 4.0—PCPP was considered to be substantially compliant with IS Standard 4.0, since practitioner data are limited when identifying primary care physicians who provide services to clients at multispecialty clinics. There were numerous clinics where no specialty code existed for the associated providers.[3-17]

[3-16] HEDIS 2010 Compliance Audit, Final Report of Findings for Department of Health Care Policy & Financing, July 2010
[3-17] Ibid.

Children's Performance Measures

Table 3-13 shows the PCPP rates and audit designations for each performance measure for children.

Table 3-13—Review Results and Audit Designation for Children's Performance Measures *for* PCPP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Childhood Immunization Status and Well-Child Visits					
Childhood Immunization Status (Combo #2)	70.1%	81.1%	50th–74th	R	R
Childhood Immunization Status (Combo #3)	65.5%	78.0%	75th–89th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	15.9%	62.2%	50th–74th	R	R
Well-Child Visits 3–6 Years of Life	46.2%	63.5%	10th–24th	R	R
Adolescent Well-Care Visits	28.0%	50.1%	50th–74th	R	R
Children's & Adolescents' Access to PCPs					
12–24 months	14.9%	97.5%	50th–74th	R	R
25 months–6 years	22.8%	85.8%	25th–49th	R	R
7–11 years	33.7%	86.9%	25th–49th	R	R
12–19 years	38.7%	88.2%	50th–74th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)					
3–11 Years	—	40.6%	75th–89th	—	R
12–17 Years	—	27.5%	50th–74th	—	R
Total	—	35.5%	75th–89th	—	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)					
3–11 Years	—	51.4%	50th–74th	—	R
12–17 Years	—	33.8%	25th–49th	—	R
Total	—	44.5%	50th–74th	—	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)					
3–11 Years	—	41.0%	75th–89th	—	R
12–17 Years	—	33.1%	50th–74th	—	R
Total	—	38.0%	50th–74th	—	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.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, PCPP showed strong results for the performance measures. All of PCPP's performance measures received an audit result of *Reportable* (R) for the current measurement cycle. Measures with both previous and current year's rates demonstrated improvement by at least 10 percentage

points from the previous year's results. Of note were significant increases in the rates for *Well-Child Visits in the First 15 Months of Life, 6+ Visits*, *Well-Child Visits 3–6 Years of Life, Adolescent Well Care Visits,* and *Children's and Adolescents' Access to Primary Care Providers (PCPs)*. These increases can be attributed to efforts to more thoroughly identify provider types. In addition, PCPP's performance on three of the nine first-time submeasures related to *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* ranked between the 75th and 90th percentiles of HEDIS 2009 national performance.

Recommendations

Although a majority of the measures exhibited a noticeable improvement from last year, results of PCPP's performance measures yielded some opportunities for improvement. In particular, the *Well-Child Visits 3–6 Years of Life* measure ranked between the 10th and 25th percentiles of the HEDIS 2009 national performance.

HSAG recommends targeting the *Well-Child Visits 3–6 Years of Life* measure. PCPP should consider implementing some of the following improvement efforts:

Improve Access

Open access appointments can increase compliance by expanding provider availability.[3-18] Evening or weekend clinic hours for providers can accommodate parents who cannot take time off from work. For example, one Saturday a month could be set aside for children and adolescents, with clinicians designated to perform well visits on that day. Visits on certain days could be made available on a walk-in, first-come, first-served basis. Additionally, parents should be encouraged to schedule their next visit before leaving the clinic.

Providing improved access to transportation would likely increase well-visit compliance. One method to improve transportation issues would be to coordinate with community volunteers and other outreach services to provide transportation to and from doctors' offices and clinics.

Reminder Systems

Postcards are an easy and effective tool to increase well visits. They can be sent to parents as a reminder to schedule their child's well visit. To be most effective, postcards should include contact information for either doctors' offices near the member's address or the member's assigned PCP. In addition, age-specific forms that detail what services should be provided and why they are important to the well-being of the child can help educate parents.

Physician Education

Quarterly provider reports that highlight children and adolescents in need of well visits are useful for promoting visit reminders and helping providers track performance. Members who saw a doctor but did not have a well visit can be flagged as missed opportunities. To make this information

[3-18] O'Connor ME, Matthews BS, Gao D. Effect of Open Access Scheduling on Missed Appointments, Immunizations, and Continuity of Care for Infant Well-Child Care Visits. *Archives of Pediatrics & Adolescent Medicine.* 2006; 160: 889-893.

pertinent to providers, their performance may be tied to a recognition program for providers who display outstanding performance. Another practice to improve well-visit compliance is to educate providers on proper billing codes for well-child visits, which can reduce missed opportunities.

Adult's Performance Measures

Table 3-14 shows the PCPP rates and audit designations for each performance measure for adults.

Table 3-14—Review Results and Audit Designation for Adult's Performance Measures *for* PCPP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Adult BMI Assessment	—	28.5%	50th–74th	—	R
Annual Monitoring for Patients on Persistent Medications	82.2%	82.0%	25th–49th	R	R
Use of Imaging for Low Back Pain	—	81.8%	≥90th	—	R
Controlling Blood Pressure	—	41.1%	10th–24th	—	R
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	—	50.2%	≥90th	—	R
Timeliness of Prenatal Care	70.2%	66.9%	<10th	R	R
Postpartum Care	58.2%	57.0%	10th–24th	R	R
Chlamydia Screening in Women					
16–20 years	—	33.6%	<10th	—	R
21–24 years	—	34.3%	<10th	—	R
Total	—	33.9%	<10th	—	R
Adult's Access to Preventive/Ambulatory Health Services					
20– 44 years	81.8%	83.8%	50th–74th	R	R
45–64 years	86.7%	88.1%	50th–74th	R	R
65+ years	81.9%	85.4%	25th–49th	R	R
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	—	27.8%	<10th	—	R
Bronchodilator	—	31.6%	<10th	—	R
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	55.4%	75th–89th	—	R
Effective Continuation Phase Treatment	—	37.8%	75th–89th	—	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.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, PCPP showed moderately strong results for the adult performance measures. All of PCPP's performance measures received an audit result of *Reportable* (R) for the current measurement cycle. Among the measures with both previous and current measurement results, the *Adults' Access to Preventive/Ambulatory Health Services* measures demonstrated improvement from last year. Among the first-time measures, two—*Use of Imaging for Low Back Pain* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*—ranked among the top 10 percent in HEDIS 2009 national performance.

Recommendations

Results of PCPP's performance measures yielded a few opportunities for improvement. PCPP's performance on the *Annual Monitoring for Patients on Persistent Medications* and on the *Prenatal* and *Postpartum Care* measures demonstrated a slight decline from last year's results. For the *Timeliness of Prenatal Care* measure, the current rate (66.9 percent) was ranked within the bottom 10 percent in HEDIS 2009 national performance. Among the first-time reported measures, all submeasures related to the *Chlamydia Screening in Women* and *Pharmacotherapy Management of COPD Exacerbation* measures ranked below the 10th percentile of HEDIS 2009 national performance.

Based on the results of this year's performance measure validation findings, HSAG recommends targeting the lower-performing measures, namely *Timeliness of Prenatal Care, Chlamydia Screening in Women,* and *Pharmacotherapy Management of COPD Exacerbation*. The PCPP should consider implementing some of the following improvement efforts:

For Chlamydia Screening:

Physician Reminders

Providing PCPs and OB/GYNs with a list of missed screening opportunities is an effective practice that has shown to increase screening rates. By providing providers with a list of patients who were identified as not having received a screening within the specified time frame, providers can contact those members and encourage them to come in for important screenings. Sending the lists to both PCPs and OB/GYNs makes it more difficult for women to evade or ignore promptings from their physicians.[3-19]

Patient Reminders

Members are more responsive to reminders when a clinician calls (i.e., physicians or their support staff).[3-20] However, other reminder methods, such as direct mailings (e.g., postcards and letters) and

[3-19] National Committee for Quality Assurance. Breast Cancer Screening: Raising Member and Physician Awareness. *Quality Profiles*. 2008. Available at: http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/1_14.asp. Accessed on: May 6, 2010.

[3-20] Task Force on Community Preventive Services. Recommendations for Client- and Provider-Directed Interventions to Increase Breast, Cervical, and Colorectal Cancer Screening. *American Journal of Preventive Medicine.* 2008; 35(1 Supplement): S21-S25.

small media (e.g., brochures, pamphlets, flyers, and newsletters) have also been effective. Reminders should be eye-catching, timely, and personalized. One method to accomplish this is to send colorful birthday cards with enclosed reminders. Reminders can also be used to provide additional information on locations of screening facilities with business hours.

Improving Access and Awareness

It is important for a plan to determine if proper resources are in place to allow members to obtain screenings. Plans may contract with more OB/GYNs and/or increase the number of sites that perform screenings. At each stage, plans must keep members informed of the changes in procedures and additional resources.[3-21] Other methods to improve awareness include articles in a member newsletter, educational materials for members, and information on locations and business hours of screening facilities

Physician Communication

If a physician is able to properly communicate with his or her patient about various topics such as birth control, STDs, pregnancy, underage sex, and the importance of getting routine Pap Smears, there is a higher chance the patient will be compliant with regular screenings.

Many health plans and medical groups are now giving practitioners formal training in communication skills. This training can be completed either by in-house programs or communications programs offered by outside organizations. Most of the time this type of training is optional; however, some organizations have made the classes a requirement. In other organizations, the training is only required for doctors who consistently receive low scores in the area of communication.[3-22]

The purpose of the training programs is to improve providers' effectiveness as both managers of health and as educators of patients. Trained physicians, it is thought, will allocate a greater percentage of the clinic-visit time to patient education, which leads to greater patient knowledge, better compliance with treatment, and improved health outcomes.

The most effective and efficient way to offer physician-patient communication training is through a workshop or a seminar. The result is that many strategies to improve communication can be covered in a short period. Workshops also have the advantage of using case studies to illustrate the importance of communication and suggest approaches to improve the relationship between the physician and patient.[3-23]

[3-21] National Committee for Quality Assurance. Breast Cancer Screening – Hitting the Road with Screening Programs. *Quality Profiles*. 2010. Available at: http://www.qualityprofiles.org/quality_profiles/case_studies/Womens_Health/1_15.asp. Accessed on: May 27, 2010.

[3-22] Agency for Healthcare Research and Quality. The CAHPS Improvement Guide. Available at: https://www.cahps.ahrq.gov/QIGuide/content/interventions/Training2AdvanceSkills.aspx. Accessed on: April 26, 2010.

[3-23] Ibid.

Physician Tools and Resources

Providers often need reminders about screening guidelines. Clarifying and reinforcing guidelines, reinforcing the importance of screening, and creating tools to facilitate screening are three methods to improve HEDIS screening rates by reaching out to providers.

NCQA further recommends the following tools to help facilitate screening:

- Patient registry of females who had screenings.
- Copies of reminder letters sent to patients who are due for screenings.
- List of patients, with contact information, who have not received screenings.[3-24]

For medication management/chronic care:

Identifying Members for Targeted Interventions

It is important to effectively identify members who should be targeted for an intervention prior to implementing any quality improvement initiatives. Members with COPD, for example, can be identified through claims data, encounter data, pharmacy data, collaborating with other health plans to build regional registries, searching durable equipment claims for COPD-related devices (e.g., peak flow meter), performing medical record reviews, and implementing a process to identify newly enrolled members with COPD (e.g., a health screen risk assessment during new member welcome calls).

Furthermore, registries are an effective mechanism to identify and manage many chronic diseases such as asthma or COPD. A COPD registry can be created to contain information about members diagnosed with COPD. The registries can be used to support reporting needs such as the identification of newly diagnosed members, stratifying by selected variables, and the monitoring of COPD care.[3-25]

Physician Reminders

Certain medications require monitoring for therapeutic blood levels or specific lab test to assess crucial organ functions (liver, kidney, etc.). By using pharmacy prescription data, plans may provide physicians with current listings of key medications that require routine lab monitoring, coupled with any lab results data that are available. Practice guidelines for appropriate lab monitoring of patients on targeted medications would also be beneficial for providers.

[3-24] National Committee for Quality Assurance. Improving Chlamydia Screening: Strategies From Top Performing Health plans. 2007. Available at: http://www.ncqa.org/Portals/0/Publications/Resource%20Library/Improving_Chlamydia_Screening_08.pdf. Accessed on: May 28, 2010.

[3-25] Center for Health Care Strategies, Inc. *Achieving Better Care for Asthma: A Best Clinical and Administrative Practices Toolkit for Medicaid Health Plans*. CHCS; 2002.

For prenatal care improvements:

Education on Proper Coding

Health plans should educate and ensure that providers are accurately capturing prenatal and postpartum care visits through the use of CPT and CPT Category II codes. The use of these codes will help to facilitate the administrative capture of prenatal and postpartum visits and subsequently increase rates. One study revealed that 94 percent of members received prenatal care in the first trimester based on medical record review; however, HEDIS rates based on administrative data reflected that 75 percent of women received a timely prenatal care visit for the same time period evaluated. This difference in the rates suggests a lack of accurate and complete administrative data.[3-26] Working with providers to ensure that accurate and complete data are captured may help to increase rates.

Coordination of Care

Plans that coordinate care and validate practice guidelines between internists, family practitioners, and OB/GYNs can positively affect maternal health. Incorporating into the care delivery process alternative types of providers such as nurses and midwives has been associated with increased member satisfaction.

Educational Outreach Programs

Educational outreach programs aimed at educating women who are pregnant or who recently had a baby about the importance of timely prenatal care and postpartum care could be developed and implemented. Educational programs can be administered throughout the community in various settings. Media campaigns can also be employed to further publicize the importance of receiving adequate care. Health plans should ensure that educational materials meet the language, literacy levels, and cultural needs of its Medicaid members.[3-27]

Informational mailings can also be sent to members who are of childbearing age and who have been identified through administrative data. These mailings can include information on women's health, including prenatal and postpartum health care visits.

Resource Lists

A barrier to care can be that women simply do not know where to receive health care. A solution is to ensure that a resource list that includes provider contact information is readily available to women. For example, a list of resources could be made available to women at the time and place where pregnancy tests are performed. In addition, resource lists could be disseminated to providers to ensure that their patients are receiving necessary care.[3-28]

[3-26] Green D, Koplan J, Cutler C. Prenatal Care In the First Trimester: Misleading Findings from HEDIS. *International Journal for Quality in Health Care*. 1999; 11(6): 465-473.

[3-27] Center for Health Improvement. *Improving Access to and Use of Prenatal Care in San Joaquin County*. January 2004. Available at: http://www.co.san-joaquin.ca.us/FirstFive/base/documents/prenatalReport.pdf. Accessed on: May 5, 2010.

[3-28] Tough S, Siever J, Johnson D. Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning. *BMC Public Health.* 2007; 7: 148.

Provide Transportation

One potential barrier to care is the member's inability to obtain access to consistent transportation. Plans can work with stakeholder and policy makers to increase funding for transportation programs.[3-29] This best practice would likely result in an increase in prenatal and postpartum visit rates, particularly in rural areas with less public transportation. Another option is to provide bus tokens or taxi vouchers for transportation.

Utilization Performance Measures

Table 3-15 shows the PCPP rates and audit designations for utilization performance measures and submeasures.

Table 3-15—Review Results and Audit Designation for Utilization Performance Measures *for* PCPP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Antibiotic Utilization					
Average Scrips PMPY for All Antibiotics	1.14	1.20	50th–74th	R	R
Average Scrips PMPY for Antibiotics of Concern	0.47	0.49	50th–74th	R	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips	41.3%	40.7%	25th–49th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	9.02	11.46	75th–89th	R	R
Average Length of Stay	5.39	4.94	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	5.39	6.95	≥90th	R	R
Average Length of Stay	4.84	4.13	75th–89th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	2.38	3.16	≥90th	R	R
Average Length of Stay	8.05	7.71	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months aged 10–64 years)	2.25	2.39	<10th	R	R
Average Length of Stay	2.67	2.61	10th–24th	R	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	434.21	461.64	≥90th	R	R
ED Visits	63.78	66.44	50th–74th	R	R
Ambulatory Surgery/Procedures	14.47	15.35	≥90th	R	R
Observation Room Stays Resulting in Discharge	1.57	1.10	25th–49th	R	R

[3-29] Tough S, Siever J, Johnson D. Retaining Women in a Prenatal care Randomized Controlled Trial in Canada: Implications for Program Planning. *BMC Public Health.* 2007; 7: 148.

Table 3-15—Review Results and Audit Designation for Utilization Performance Measures *for* PCPP					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Frequency of Selected Procedures					
Myringotomy (0–4 Male & Female)	2.95	3.00	50th–74th	R	R
Myringotomy (5–19 Male & Female)	0.68	0.74	75th–89th	R	R
Tonsillectomy (0–9 Male & Female)	0.90	1.10	≥90th	R	R
Tonsillectomy (10–19 Male & Female)	0.63	0.64	≥90th	R	R
Dilation & Curettage (15–44 Female)	0.15	0.16	25th–49th	R	R
Dilation & Curettage (45–64 Female)	0.16	0.07	<25th	R	R
Hysterectomy, Abdominal (15–44 Female)	0.32	0.43	≥90th	R	R
Hysterectomy, Abdominal (45–64 Female)	0.38	0.36	25th–49th	R	R
Hysterectomy, Vaginal (15–44 Female)	0.41	0.18	50th–74th	R	R
Hysterectomy, Vaginal (45–64 Female)	0.19	0.11	25th–49th	R	R
Cholecystectomy, Open (30–64 Male)	0.00	0.07	<75th	R	R
Cholecystectomy, Open (15–44 Female)	0.04	0.09	≥90th	R	R
Cholecystectomy, Open (45–64 Female)	0.19	0.00	<50th	R	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.62	0.47	75th–89th	R	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	1.03	0.79	50th–74th	R	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	1.01	0.61	50th–74th	R	R
Back Surgery (20–44 Male)	0.36	0.28	25th–49th	R	R
Back Surgery (20–44 Female)	0.29	0.43	≥90th	R	R
Back Surgery (45–64 Male)	0.61	0.92	75th–89th	R	R
Back Surgery (45–64 Female)	1.11	1.04	≥90th	R	R
Mastectomy (15–44 Female)	0.04	0.07	≥90th	R	R
Mastectomy (45–64 Female)	0.03	0.29	75th–89th	R	R
Lumpectomy (15–44 Female)	0.11	0.20	50th–74th	R	R
Lumpectomy (45–64 Female)	0.38	0.54	50th–74th	R	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.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Utilization Observations

HSAG noted that overall rates for PCPP were fairly stable when compared to last year. For the *Antibiotic Utilization* measure, PCPP experienced small increases in the *Average Scripts PMPY for All Antibiotics* and *Antibiotics of Concern*, but a decrease in *the Percentage of Antibiotics of Concern of All Antibiotic Scripts*. For the current year, PCPP showed an increase in both inpatient and ambulatory care services but a decline in the average length of stay for inpatient utilization.

It is important to assess utilization based on the characteristics of the plan's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each plan's results provide additional information that the plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

Overall, PCPP performance was relatively strong on the majority of measures. Several measures reported the first time for the current measurement year attained the 2009 HEDIS national Medicaid top 10th percentile 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 overall performance in the quality domain was mixed. All children's measures reported with both years' rates demonstrated improvement of at least 10 percentage points. Nonetheless, the ranking of the *Well-Child Visits 3–6 Years of Life* was between the 10th and 25th percentiles of HEDIS 2009 national performance. The adult measures (*Annual Monitoring for Patients on Persistent Medications* and *Prenatal* and *Postpartum Care*) showed a slight decline from last year's rates. Among measures reported for the first time in the current year, the variations in ranking relative to the HEDIS 2009 national performance reflected mixed performance. In particular, two of the adult measures—*Use of Imaging for Low Back Pain* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*—ranked among the top 10 percent in HEDIS 2009 national performance, and yet all submeasures related to *Chlamydia Screening in Women* and *Pharmacotherapy management of COPD Exacerbation* ranked in the bottom 10 percent. Opportunities for improvement were noted in the measures *Well-Child Visits 3–6 Years of Life*, *Timeliness of Prenatal Care*, *Pharmacotherapy management of COPD Exacerbation*, and *Chlamydia Screening in Women*.
- **Timeliness:** PCPP demonstrated mixed performance in its timeliness measures. All children's measures demonstrated improvement by at least 10 percentage points. Nonetheless, the ranking of the *Well-Child Visits 3–6 Years of Life* was between the 10th and 25th percentiles of HEDIS 2009 national performance. The *Prenatal* and *Postpartum Care* measures showed slight declines from last year's rates and ranked below the 25th percentile of HEDIS 2009 national performance. Opportunities for improvement, therefore, were noted for *Well-Child Visits 3–6 Years of Life* and for *Timeliness of Prenatal Care.*
- **Access:** PCPP had overall good performance in the access domain, although some measures exhibited a slight decline from last year's results. Improvements were present in a majority of the measures reported with previous and current year's rates (*Children's and Adolescents' Access to Primary Care Providers (PCPs)* and *Adults' Access to Preventive/Ambulatory Health Services*), but had a slight decline in the *Prenatal* and *Postpartum Care* measures. PCPP also demonstrated an increase in the use of ambulatory care services and inpatient services, with decreases noted for the average length of stay for inpatient services. An opportunity for improvement was noted for the *Timeliness of Prenatal Care* measures, where the ranking was below the 10th percentile, based on the HEDIS 2009 national performance.

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

Table 3-16 shows the statewide weighted averages and audit designations for each performance measure for children.

Table 3-16—Statewide Summary of Rates for the Children's Performance Measures

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		FY 2008–2009	FY 2009–2010
Childhood Immunization Status and Well-Child Visits					
Childhood Immunization Status (Combo #2)	81.7%	86.0%	≥90th	R	R
Childhood Immunization Status (Combo #3)	79.5%	84.1%	≥90th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	57.3%	80.7%	≥90th	R	R
Well-Child Visits 3–6 Years of Life	58.7%	64.7%	25th–49th	R	R
Adolescent Well-Care Visits	36.9%	47.9%	50th–74th	R	R
Children's & Adolescents' Access to PCPs					
12–24 months	80.6%	95.2%	25th–49th	R	R
25 months–6 years	65.5%	83.0%	10th–24th	R	R
7–11 years	60.7%	86.9%	25th–49th	R	R
12–19 years	62.9%	88.0%	50th–4th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)					
3–11 Years	58.0%	66.8%	≥90th	—	R
12–17 Years	46.1%	58.9%	≥90th	—	R
Total	54.9%	64.6%	≥90th	—	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)					
3–11 Years	63.1%	67.0%	≥90th	—	R
12–17 Years	47.6%	55.0%	75th–89th	—	R
Total	58.9%	63.7%	75th–89th	—	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)					
3–11 Years	48.0%	47.1%	75th–89th	—	R
12–17 Years	43.9%	48.5%	75th–89th	—	R
Total	46.9%	47.3%	75th–89th	—	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.

[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, statewide rates on the children's measures demonstrated strong performance. All performance measures received an audit result of *Reportable* (R) for the current measurement cycle. All measures with both previous and current rates demonstrated improvement for close to or more than 5 percentage points from the previous year's results. In particular, the *Well-Child Visits in the First 15 Months of Life, 6+ Visits*, *Adolescent Well-Care Visits*, and all submeasures related to the *Children's and Adolescents' Access to Primary Care Providers (PCP),* showed at least a 10 percentage point improvement. The two *Childhood Immunization Status* measures and the *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure also ranked in the top 10 percentile of HEDIS 2009 national performance. Among the first-time reported children's measures, statewide performance on four of the nine submeasures under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* were ranked among the top 10 percent in HEDIS 2009 national performance.

Recommendations

Statewide performance on a few children's measures yielded some opportunities for improvement. Although the measure *Children's and Adolescents' Access to Primary Care Providers (PCPs)—25 months–6 years* demonstrated an improvement of more than 15 percentage points, its ranking according to the HEDIS 2009 national performance was between the 10th and 25th percentiles. Based on the results of this year's performance measure validation findings, recommendations for improving statewide performance include:

- Implementing quality strategies to improve the rate for *Children's and Adolescents' Access to Primary Care Providers (PCPs)—25 months–6 years*.

Adult's Performance Measures

Table 3-17 displays the statewide weighted averages and audit designations for each performance measure for adults.

Table 3-17—Statewide Summary of Rates for the Adult's Performance Measures

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Adult BMI Assessment	—	51.0%	≥90th	—	R
Annual Monitoring for Patients on Persistent Medications	79.8%	82.2%	25th–49th	R	R
Use of Imaging for Low Back Pain	—	78.5%	50th–74th	—	R
Controlling High Blood Pressure	—	56.2%	25th–49th	—	R
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	—	49.8%	≥90th	—	R
Timeliness of Prenatal Care	87.0%	85.6%	50th–74th	R	R
Postpartum Care	63.9%	64.1%	50th–74th	R	R

Table 3-17—Statewide Summary of Rates for the Adult's Performance Measures					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Chlamydia Screening in Women					
16–20 years	—	57.3%	50th–74th	—	R
21–24 years	—	61.8%	50th–74th	—	R
Total	—	59.3%	50th–74th	—	R
Adult's Access to Preventive/Ambulatory Health Services					
20–44 years	77.3%	80.8%	25th–49th	R	R
45–64 years	80.9%	84.7%	25th–49th	R	R
65+ years	76.5%	81.4%	25th–49th	R	R
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	—	40.6%	<10th	—	R
Bronchodilator	—	49.0%	<10th	—	R
Antidepressant Medication Management					
Effective Acute Phase Treatment	—	52.8%	75th–89th	—	R
Effective Continuation Phase Treatment	—	37.9%	75th–89th	—	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.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Strengths

Statewide results on the adults' measures showed strong performance in the current year. All performance measures received an audit result of *Reportable* (R) for the current measurement cycle. Statewide strengths were noted in some of the first-time reported measures where current year's rates were among the top 10 percent of HEDIS 2009 national performance. These measures included *Adult BMI Assessment* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*.

Recommendations

Statewide results from some of the adult's performance measures suggested a few opportunities for improvement. A slight decline was noted in the *Timeliness of Prenatal Care* measure (1.4 percentage points). Among the first-time reported measures, all submeasures related to the *Pharmacotherapy Management of COPD Exacerbation* measure ranked below the 10th percentile of HEDIS 2009 national performance.

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

- Implementing quality improvement strategies to improve the rates for *Pharmacotherapy management of COPD Exacerbation*.

Utilization Performance Measures

Table 3-18 shows the statewide weighted averages and audit designations for each utilization performance measure.

Table 3-18—Statewide Summary of Rate for the Utilization Performance Measures

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Antibiotic Utilization					
Average Scrips PMPY for All Antibiotics	0.76	0.76	10th–24th	R	R
Average Scrips PMPY for Antibiotics of Concern	0.28	0.27	10th–24th	R	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips	36.6%	35.7%	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	8.13	12.31	≥90th	R	R
Average Length of Stay	4.26	4.80	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	3.85	7.25	≥90th	R	R
Average Length of Stay	4.26	4.48	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	1.73	2.03	≥90th	R	R
Average Length of Stay	7.03	9.52	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months aged 10–64 years)	5.18	6.14	50th–74th	R	R
Average Length of Stay	2.35	2.41	10th–24th	R	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	329.96	376.48	50th–74th	R	R
ED Visits	35.44	64.09	50th–74th	R	R
Ambulatory Surgery/Procedures	15.33	18.98	≥90th	R	R
Observation Room Stays Resulting in Discharge	1.13	1.19	25th–49th	R	R
Frequency of Selected Procedures					
Myringotomy (0–4 Male & Female)	1.26	1.55	10th–24th	R	R
Myringotomy (5–19 Male & Female)	0.30	0.46	50th–74th	R	R
Tonsillectomy (0–9 Male & Female)	0.40	0.64	25th–49th	R	R
Tonsillectomy (10–19 Male & Female)	0.37	0.62	≥90th	R	R
Dilation & Curettage (15–44 Female)	0.09	0.11	10th–24th	R	R
Dilation & Curettage (45–64 Female)	0.14	0.03	10th–24th	R	R
Hysterectomy, Abdominal (15–44 Female)	0.20	0.22	25th–49th	R	R
Hysterectomy, Abdominal (45–64 Female)	0.31	0.29	10th–24th	R	R
Hysterectomy, Vaginal (15–44 Female)	0.32	0.31	≥90th	R	R
Hysterectomy, Vaginal (45–64 Female)	0.18	0.19	25th–49th	R	R
Cholecystectomy, Open (30–64 Male)	0.01	0.06	<75th	R	R
Cholecystectomy, Open (15–44 Female)	0.03	0.03	†	R	R

Table 3-18—Statewide Summary of Rate for the Utilization Performance Measures					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2009	HEDIS 2010		HEDIS 2009	HEDIS 2010
Cholecystectomy, Open (45–64 Female)	0.14	0.02	<50th	R	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.34	0.30	50th–74th	R	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	0.73	0.83	50th–74th	R	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	0.72	0.64	50th–74th	R	R
Back Surgery (20–44 Male)	0.41	0.25	25th–49th	R	R
Back Surgery (20–44 Female)	0.22	0.23	50th–74th	R	R
Back Surgery (45–64 Male)	0.37	0.62	50th–74th	R	R
Back Surgery (45–64 Female)	0.84	0.75	75th–89th	R	R
Mastectomy (15–44 Female)	0.03	0.02	†	R	R
Mastectomy (45–64 Female)	0.08	0.19	50th–74th	R	R
Lumpectomy (15–44 Female)	0.10	0.15	25th–49th	R	R
Lumpectomy (45–64 Female)	0.31	0.56	50th–74th	R	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.
† All percentiles were 0.00 for this indicator; therefore, percentile ranking is not applicable.
[1] Percentile ratings were assigned to the HEDIS 2010 reported rates based on HEDIS 2009 Ratios and Percentiles for Medicaid populations.

Utilization Observations

There has been a great deal of research in methods to measure patterns of high- and low-utilization in health care. Utilization measures are difficult to measure for a number of reasons, since utilization can vary greatly depending on the population. Methods used to measure utilization include analyzing the costs associated with the population being studied. One popular method of analyzing utilization is to use an ordinary least squares (OLS) regression analysis. Research using OLS has found that, typically, young children have high utilization, and males and females have similar utilization until puberty. After puberty, however, women tend to have higher utilization rates during child-bearing age, while men typically have lower utilization until around age 40.

Another proposed method is to use a Cox proportional hazards model for cost analysis. This method has been shown to be beneficial for identifying costs if the data are not censored. Censoring in health care data occurs when there are issues in estimating the average lifetime cost for treating a particular disease, cost until cure, or cost in a specific time frame. There are times when complete costs for some patients cannot be observed due to patients being lost to follow-up or they are still alive, not cured, discharged, or have not been enrolled for a specific time frame.

HSAG noted that statewide performance for *Antibiotic Utilization* was very similar to last year's performance. The rate for *Average Scrips PMPY for All Antibiotics* was the same as last year and small decreases were noted for the *Average Scrips PMPY for Antibiotics of Concern* and for *Percentage of Antibiotics of Concern of All Antibiotic Scrips*. All of the rates for *Discharges (Per 1,000 Member Months)* for *Inpatient Utilization—General Hospital Acute Care* increased, with

Medicine and Total Inpatient services experiencing large increases. The rates for all of the *Ambulatory Care* measures increased, with large increases noted for both *Outpatient* and *ED Visits.*

Summary Assessment Related to Quality, Timeliness, and Access

Statewide performance on the comparable measures with previous and current years' results was consistent with last year's performance, with some improvement on a majority of measures and a slight decline for a few measures. The following is a summary assessment of statewide performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** Statewide performance in the quality domain was mixed, with some measures related to quality showing great improvement and others a slight decline. All children's measures reported with both years' rates demonstrated improvement, especially the *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure, where the improvement was at least 15 percentage points. Adult's measures with both years' rates reported a modest increase except the *Timeliness of Prenatal Care* measure (1.4 percentage point decline), which could be attributed (at least in part) to the change in specifications. Several first-time measures were ranked at the top 10 percentile of HEDIS 2009 national performance, including four submeasures under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, *Adult BMI Assessment*, and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*. At the same time, the *Pharmacotherapy Management of COPD Exacerbation* measure ranked at the bottom 10 percent of national performance. An opportunity for improvement, therefore, was noted in the *Pharmacotherapy Management of COPD Exacerbation* measure.
- **Timeliness:** Statewide results on timeliness measures demonstrated overall good performance in the current year. All children's timeliness measures showed improvement, especially the *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure, where the improvement was at least 15 percentage points. One of the *Prenatal and Postpartum Care* measures (*Timeliness of Prenatal Care*) exhibited a slight decline of 1.4 percentage points. None of the timeliness performance measures ranked below the 25th percentile of the HEDIS 2009 national performance.
- **Access**: Statewide results on the access measures showed a mixed performance in the current year. With the exception of the *Timeliness of Prenatal Care* measure, all exhibited an improvement from last year's rates. Nonetheless, one submeasure under *Children's and Adolescents' Access to Primary Care Providers—25 months–6 years,* ranked below the 25th percentile of the HEDIS 2009 national performance. As for the utilization-based performance measures, antibiotic utilization was generally consistent with last year's performance. However, the use of inpatient services and ambulatory care has increased since last year.

Validation of Performance Improvement Projects

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

For FY 2009–2010, the Department offered each health plan the option of conducting two PIPs or one PIP and one focused study with an intervention. DHMC conducted one PIP and one focused study and RMHP conducted two PIPs. HSAG performed validation activities on one PIP for DHMC and two PIPs for RMHP. Focused study summaries are located in Section 7.

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. HSAG scored the evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)* and included *Points of Clarification* when applicable. A *Point of Clarification* was used for elements with a *Met* score when documentation for an evaluation element included 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 health plans had an opportunity to resubmit additional documentation after the initial HSAG review to improve their scores prior to finalization of the FY 2009–2010 PIP Validation Report.

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 additional details about the EQR validation of PIP activities.

Denver Health Medicaid Choice (DHMC)

Findings

DHMC conducted the State-mandated collaborative PIP: *Coordination of Care between Physical and Behavioral Health*. This was the first validation cycle for this PIP. HSAG reviewed Activities I through IV. Table 3-19 and Table 3-20 show DHMC's scores based on HSAG's evaluation. HSAG reviewed and scored each activity according to HSAG's validation methodology.

Table 3-19—PIP Validation Scores
***for* Coordination of Care between Physical and Behavioral Health**
***for* DHMC**

Review Activity	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. Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Use Sound Sampling Techniques	6	Not Assessed				1	Not Assessed			
VI. Reliably Collect Data	11	Not Assessed				1	Not Assessed			
VII. Implement Intervention and Improvement Strategies	4	Not Assessed				1	Not Assessed			
VIII. Analyze Data and Interpret Results	9	Not Assessed				2	Not Assessed			
IX. Assess for Real Improvement	4	Not Assessed				No Critical Elements				
X. Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**15**	**0**	**0**	**3**	**13**	**8**	**0**	**0**	**0**

Table 3-20—FY 2009–2010 Overall PIP Validation Scores and Validation Status *for* Coordination of Care between Physical and Behavioral Health *for* DHMC	
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

DHMC demonstrated strength in its study design (Activities I–IV) by receiving an overall score of 100 percent for all evaluation elements *Met,* a score of 100 percent for critical elements *Met*, and a *Met* validation status.

Recommendations

HSAG determined recommendations based on evaluation elements that received a *Partially Met* or a *Not Met* score. Because DHMC received *Met* scores for all elements evaluated, there were no recommendations.

However, HSAG identified *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 *Coordination of Care Between Physical and Behavioral Health* PIP:

- HSAG noted that all the codes used for Study Indicator 3 were seven-digit codes except for one. HSAG suggested that DHMC ensure all codes are accurate prior to the next annual submission.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of *Coordination of Care Between Physical and Behavioral Health* was to improve both the quality of, and access to, care and services, the external quality review (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 was related to the domain of quality.

Overall, DHMC's processes for conducting a valid PIP were strong. DHMC's PIP received a validation status of *Met*, with HSAG having confidence that DHMC built a strong foundation in which to move forward.

Rocky Mountain Health Plans (RMHP)

Findings

RMHP conducted two PIPs: *Improving Well-Care Rates for Adolescents*, which was a plan-selected topic, and *Improving Coordination of Care for Members With Behavioral Health Conditions*, the State-mandated collaborative PIP. Both were continued from FY 2008–2009. 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 Activities I through IX. Table 3-21 and Table 3-22 show RMHP's scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3-21—PIP Validation Scores *for* Improving Well-Care Rates for Adolescents *for* RMHP

Review Activity	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. Select the Study Topic(s)	6	6	0	0	0	1	1	0	0	0
II. Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the Study Indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Use Sound Sampling Techniques	6	6	0	0	0	1	1	0	0	0
VI. Reliably Collect Data	11	10	0	0	1	1	1	0	0	0
VII. Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII. Analyze Data and Interpret Results	9	7	1	0	1	2	1	0	0	1
IX. Assess for Real Improvement	4	4	0	0	0	No Critical Elements				
X. Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**47**	**1**	**0**	**4**	**13**	**12**	**0**	**0**	**1**

Table 3-22—FY 2008–2009 and FY 2009–2010 Overall PIP Validation Scores and Validation Status for *Improving Well-Care Rates for Adolescents* *for* RMHP		
	FY 2008–2009	**FY 2009–2010**
Percentage Score of Evaluation Elements *Met**	**100%**	**98%**
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

In reviewing RMHP's *Improving Well-Care Rates for Adolescents* PIP, HSAG found that RMHP demonstrated strength in its study design (Activities I–IV) and study implementation (Activities V–VII) phases, as evidenced by its score of 100 percent and its *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. The plan also demonstrated statistically significant improvement from baseline to the first remeasurement.

Recommendations

As a *Point of Clarification* HSAG recommended 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 Activities I through IX. Table 3-23 and Table 3-24 show RMHP's scores based on HSAG's evaluation. HSAG reviewed and scored each activity according to HSAG's validation methodology.

Table 3-23—PIP Validation Scores
***for* Improving Coordination of Care for Members With Behavioral Health Conditions**
***for* RMHP**

Review Activity	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. Select the Study Topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the Study Question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the Study Indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Use a Representative and Generalizable Study Population	3	3	0	0	0	2	2	0	0	0
V. Use Sound Sampling Techniques	6	0	0	0	6	1	0	0	0	1
VI. Reliably Collect Data	11	5	0	0	6	1	0	0	0	1
VII. Implement Intervention and Improvement Strategies	4	3	0	0	1	1	1	0	0	0
VIII. Analyze Data and Interpret Results	9	8	0	0	1	2	1	0	0	1
IX. Assess for Real Improvement	4	1	2	1	0	No Critical Elements				
X. Assess for Sustained Improvement	1	Not Assessed				No Critical Elements				
Totals for All Activities	**53**	**32**	**2**	**1**	**17**	**13**	**10**	**0**	**0**	**3**

Table 3-24—FY 2008–2009 and FY 2009–2010 Overall PIP Validation Scores and Validation Status *for* Improving Coordination of Care for Members With Behavioral Health Conditions *for* RMHP		
	FY 2008–2009	**FY 2009–2010**
Percentage Score of Evaluation Elements *Met**	**87%**	**91%**
Percentage Score of Critical Elements *Met***	**88%**	**100%**
Validation Status***	***Partially 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

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 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 had required actions for RMHP's *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP. RMHP received *Partially Met* scores in Activity III, Selected Study Indicators. HSAG recommended that RMHP revise Study Indicator 2 to clarify what the study indicator is intended to measure.

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 it received for the *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 3-25 shows the health plans' overall performance based on HSAG's validation of the FY 2009–2010 PIPs that were submitted for validation.

Table 3-25—Summary of Each MCO's PIP Validation Scores and Validation Status

MCO	PIP Study	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
DHMC	*Coordination of Care between Physical and Behavioral Health*	100%	100%	*Met*
RMHP	*Improving Well-Care Rates for Adolescents*	98%	100%	*Met*
RMHP	*Improving Coordination of Care for Members With Behavioral Health Conditions*	91%	100%	*Met*

Overall, the health plans' PIPs demonstrated strong performance. All three of the PIPs reviewed received a validation status of *Met*, with scores of 100 percent for critical elements *Met* and scores ranging from 91 percent to 100 percent for all evaluation elements *Met*.

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 that the plans will achieve the desired health outcomes for their members.

Table 3-26—Summary of Data From Validation of Performance Improvement Projects

Validation Activity	Number of PIPs Meeting All Evaluation Elements/Number Reviewed		Number of PIPs Meeting All Critical Elements/Number Reviewed	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
I. Select the Study Topic(s)	5/5	3/3	5/5	3/3
II. Define the Study Question(s)	5/5	3/3	5/5	3/3
III. Select the Study Indicator(s)	4/5	3/3	4/5	3/3
IV. Use a Representative and Generalizable Study Population	5/5	3/3	5/5	3/3
V. Use Sound Sampling Techniques	3/3	2/2	3/3	2/2
VI. Reliably Collect Data	3/3	2/2	3/3	2/2
VII. Implement Intervention and Improvement Strategies	3/3	2/2	3/3	2/2
VIII. Analyze Data and Interpret Results	3/3	1/2	3/3	2/2

Table 3-26—Summary of Data From Validation of Performance Improvement Projects				
Validation Activity	Number of PIPs Meeting All Evaluation Elements/Number Reviewed		Number of PIPs Meeting All Critical Elements/Number Reviewed	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
IX. Assess for Real Improvement	0/2	1/2	No Critical Elements	
X. Assess for Sustained Improvement	1/2	0/0	No Critical Elements	

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

Table 3-26 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 activity. In both years, all PIPs that were submitted received scores of *Met* for all evaluation elements and for all critical elements for Activities I through VII. In FY 2009–2010, two PIPs had progressed to Activity IX 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 received a *Met* score for all evaluation elements in that activity, represented in the table as 1/2.

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.

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 D contains additional details about the technical methods of data collection and analysis of survey data and the 2009 NCQA CAHPS national averages.

For all of the health plan 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 (DHMC)

Findings

Table 3-27 shows the child Medicaid results achieved by DHMC for the current year (FY 2009–2010) and the prior year (FY 2008–2009).

Table 3-27—Child Medicaid Question Summary Rates and Global Proportions *for* DHMC

Measure	FY 2008–2009 Rate	FY 2009–2010 Rate
Getting Needed Care	NA	NA
Getting Care Quickly	52.9%	44.5%
How Well Doctors Communicate	69.2%	71.0%
Customer Service	NA	NA
Shared Decision Making	NA	60.6%
Rating of Personal Doctor	64.4%	74.3%
Rating of Specialist Seen Most Often	NA	NA
Rating of All Health Care	50.5%	55.4%
Rating of Health Plan	57.8%	63.9%

NA indicates that the measure had fewer than 100 respondents.

Table 3-28 shows the adult Medicaid results achieved by DHMC during the current year (FY 2009–2010) and the prior year (FY 2008–2009).

Table 3-28—Adult Medicaid Question Summary Rates and Global Proportions *for* DHMC

Measure	FY 2008–2009 Rate	FY 2009–2010 Rate
Getting Needed Care	30.6%	33.4%
Getting Care Quickly	40.6%	39.1%
How Well Doctors Communicate	69.8%	67.0%
Customer Service	NA	NA
Shared Decision Making	53.0%	54.6%
Rating of Personal Doctor	68.8%	65.7%
Rating of Specialist Seen Most Often	NA	57.1%
Rating of All Health Care	42.4%	36.8%
Rating of Health Plan	47.6%	46.0%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

The child Medicaid survey results showed a substantial increase for two measures: *Rating of Personal Doctor* and *Rating of Health Plan*. DHMC showed a substantial decrease for one of the five comparable measures: *Getting Care Quickly*. DHMC should continue to direct quality improvement activities toward this measure.

The adult Medicaid survey results showed a substantial decrease for one of the seven comparable measures: *Rating of All Health Care*. Additionally, the results showed slight decreases for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *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.

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, two of the five comparable measures' rates increased substantially: *Rating of Personal Doctor* (9.9 percentage points) and *Rating of Health Plan* (6.1 percentage points). One measure, *Getting Care Quickly*, had a substantial rate decrease of 8.4 percentage points. DHMC had the lowest rates among the health plans in FY 2009–2010 for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of All Health Care*. DHMC did not have the highest rates among the health plans in FY 2009–2010 for any measures.

For the adult Medicaid population, the rates of one of the comparable measures—*Rating of All Health Care*—decreased substantially, by 5.6 percentage points. Additionally, the rates decreased

slightly for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. None of the measures increased substantially; however, two of the measures—*Getting Needed Care* and *Shared Decision Making*—had slight rate increases. Seven of the measures for the adult Medicaid population had the lowest rates among the health plans in FY 2009–2010. These were *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*. One measure—*Rating of Personal Doctor*—had the highest rates among the health plans in FY 2009–2010.

Rocky Mountain Health Plans (RMHP)

Findings

Table 3-29 shows the child Medicaid results achieved by RMHP for the current year (FY 2009–2010) and the prior year (FY 2008–2009).

Table 3-29—Child Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2008–2009 Rate	FY 2009–2010 Rate
Getting Needed Care	63.2%	64.1%
Getting Care Quickly	74.8%	75.3%
How Well Doctors Communicate	76.7%	80.0%
Customer Service	NA	NA
Shared Decision Making	69.2%	72.6%
Rating of Personal Doctor	70.4%	78.0%
Rating of Specialist Seen Most Often	NA	NA
Rating of All Health Care	56.6%	64.6%
Rating of Health Plan	65.5%	66.9%

NA indicates that the measure had fewer than 100 respondents.

Table 3-30 displays the adult Medicaid results achieved by RMHP during the current year (FY 2009–2010) and the prior year (FY 2008–2009).

Table 3-30—Adult Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2008–2009 Rate	FY 2009–2010 Rate
Getting Needed Care	59.1%	58.4%
Getting Care Quickly	58.6%	61.4%
How Well Doctors Communicate	70.7%	68.3%
Customer Service	61.8%	68.7%
Shared Decision Making	63.8%	66.0%
Rating of Personal Doctor	66.3%	64.7%
Rating of Specialist Seen Most Often	66.1%	60.9%

Table 3-30—Adult Medicaid Question Summary Rates and Global Proportions *for* RMHP		
Measure	**FY 2008–2009 Rate**	**FY 2009–2010 Rate**
Rating of All Health Care	50.9%	54.2%
Rating of Health Plan	58.9%	60.3%

Recommendations

RMHP did not have any decreases in measure rates for the child population. For the adult Medicaid population, RMHP had four measures with decreasing rates; however, only one of the measures decreased substantially. This was *Rating of Specialist Seen Most Often*. Additionally, rates dropped slightly for *Getting Needed Care*, *How Well Doctors Communicate*, and *Rating of Personal Doctor*. 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.

For the child Medicaid population, RMHP had the highest rates among the health plans in FY 2009–2010 for seven 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*. Two of these measures increased substantially: *Rating of Personal Doctor* (7.6 percentage points) and *Rating of All Health Care* (8.0 percentage points).

For the adult Medicaid population, rates increased for five of RMHP measures: *Getting Care Quickly* (2.8 percentage points), *Customer Service* (6.9 percentage points), *Shared Decision Making* (2.2 percentage points), *Rating of All Health Care* (3.3 percentage points), and *Rating of Health Plan* (1.4 percentage points). Furthermore, RMHP had the highest rates among the health plans in FY 2009–2010 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*. However, RMHP had the lowest rates among the health plans in FY 2009–2010 for one measure: *Rating of Personal Doctor*.

Primary Care Physician Program (PCPP)

Findings

Table 3-31 shows the child Medicaid results achieved by PCPP during the current year (FY 2009–2010) and the prior year (FY 2008–2009).

Table 3-31—Child Medicaid Question Summary Rates and Global Proportions *for* PCPP		
Measure	**FY 2008–2009 Rate**	**FY 2009–2010 Rate**
Getting Needed Care	54.9%	52.4%
Getting Care Quickly	74.7%	69.0%
How Well Doctors Communicate	76.6%	75.7%
Customer Service	49.6%	55.8%
Shared Decision Making	67.1%	70.7%
Rating of Personal Doctor	73.0%	69.8%
Rating of Specialist Seen Most Often	66.5%	69.0%
Rating of All Health Care	65.2%	59.3%
Rating of Health Plan	62.5%	62.6%

NA indicates that the measure had fewer than 100 respondents.

Table 3-32 shows the adult Medicaid results achieved by PCPP during the current year (FY 2009–2010) and the prior year (FY 2008–2009).

Table 3-32—Adult Medicaid Question Summary Rates and Global Proportions *for* PCPP		
Measure	**FY 2008–2009 Rate**	**FY 2009–2010 Rate**
Getting Needed Care	51.5%	53.3%
Getting Care Quickly	54.5%	58.7%
How Well Doctors Communicate	63.0%	68.5%
Customer Service	NA	NA
Shared Decision Making	59.9%	63.3%
Rating of Personal Doctor	61.7%	65.4%
Rating of Specialist Seen Most Often	65.9%	61.6%
Rating of All Health Care	50.1%	51.1%
Rating of Health Plan	51.2%	54.9%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

The child Medicaid survey rates increased on four measures: *Customer Service*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. Additionally, the increase was substantial for one of these measures, *Customer Service*. Substantial decreases occurred on two measures: *Getting Care Quickly* and *Rating of All Health Care.* Furthermore, rates dropped slightly for three measures: *Getting Needed Care, How Well Doctors Communicate*, and *Rating of Personal Doctor*. PCPP should continue to direct quality improvement activities toward these measures.

The adult Medicaid survey rates increased on seven 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*. Additionally, these increases were substantial for one measure, *How Well Doctors Communicate*. The adult Medicaid survey results showed a slight decrease for one measure: *Rating of Specialist Seen Most Often*. Therefore, PCPP should continue to direct quality improvement activities toward this measure.

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, four measures' rates increased. The rates for one of these measures, *Customer Service,* increased substantially, by 6.2 percentage points. Five of the measures' rates decreased between FY 2008–2009 to FY 2009–2010. These were *Getting Needed Care* (2.5 percentage points), *Getting Care Quickly* (5.7 percentage points), *How Well Doctors Communicate* (0.9 percent), *Rating of Personal Doctor* (3.2 percentage points), and *Rating of All Health Care* (5.9 percentage points). PCPP had the lowest rates among the health plans in FY 2009–2010 for three measures: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. None of PCPP's rates were the highest among the health plans for the child population in FY 2009–2010.

For the adult Medicaid population, the rates for seven of the measures increased from FY 2008–2009: *Getting Needed Care* (1.8 percentage points), *Getting Care Quickly* (4.2 percentage points), *How Well Doctors Communicate* (5.5 percentage points), *Shared Decision Making* (3.4 percentage points), *Rating of Personal Doctor* (3.7 percentage points), *Rating of All Health Care* (1.0 percentage points), and *Rating of Health Plan* (3.7 percentage points). One of the measures—*Rating of Specialist Seen Most Often*—decreased; however, this decrease was not substantial. PCPP had the highest rates among the health plans in FY 2009–2010 for two measures: *How Well Doctors Communicate* and *Rating of Specialist Seen Most Often*. None of PCPP's rates were the lowest among the health plans for the adult population in FY 2009–2010.

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

Table 3-33 shows the child Medicaid statewide averages for the current year (FY 2009–2010) and the prior year (FY 2008–2009).

Table 3-33—Child Medicaid Statewide Averages		
Measure	**FY 2008–2009 Rate**	**FY 2009–2010 Rate**
Getting Needed Care	59.1%	58.3%
Getting Care Quickly	67.5%	62.9%
How Well Doctors Communicate	74.2%	75.6%
Customer Service	*	*
Shared Decision Making	68.2%	68.0%
Rating of Personal Doctor	69.3%	74.0%
Rating of Specialist Seen Most Often	*	*
Rating of All Health Care	57.4%	59.8%
Rating of Health Plan	61.9%	64.5%

* Only one health plan was able to report a rate; therefore, a State average was not calculated for either measure.

Table 3-34 shows the adult Medicaid statewide averages during the current year (FY 2009–2010) and the prior year (FY 2008–2009).

Table 3-34—Adult Medicaid Statewide Averages		
Measure	**FY 2008–2009 Rate**	**FY 2009–2010 Rate**
Getting Needed Care	47.1%	48.4%
Getting Care Quickly	51.2%	53.1%
How Well Doctors Communicate	67.8%	67.9%
Customer Service	*	*
Shared Decision Making	58.9%	61.3%
Rating of Personal Doctor	65.6%	65.3%
Rating of Specialist Seen Most Often	66.0%	59.9%
Rating of All Health Care	47.8%	47.4%
Rating of Health Plan	52.6%	53.7%

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

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, the rates for four measures increased slightly from FY 2008–2009 to FY 2009–2010: *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan*. The statewide child Medicaid survey results

decreased slightly for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Shared Decision Making*. The State should continue to direct quality improvement activities toward these measures.

For the statewide adult Medicaid population, the rates for five measures increased slightly from FY 2008–2009 to FY 2009–2010: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of Health Plan*. There was a substantial decrease in the rates of one of the adult population measures: *Rating of Specialist Seen Most Often* (6.1 percentage points). Additionally, there was a slight decrease in the rates of two measures: *Rating of Personal Doctor* and *Rating of All Health Care*. The State should continue to direct quality improvement activities toward these measures.

Recommendations

Recommendations for improvement were made for each health plan based on its performance on the measures. Specific recommendations regarding these measures include:

- ***Getting Needed Care***—Quality Improvement (QI) activities should target the following areas: (1) Creating enhanced, updated provider directories and posting them on the health plan's Web site to assist members in choosing a provider who meets their needs; (2) Streamlining the referral process to allow members to more readily obtain care; (3) Implementing a referral expert to track and manage each health plan's referral requirements to save time and energy obtaining approvals; (4) Simplifying patient flow to decrease wait times; (5) Ensuring patients are receiving care from physicians most appropriate to treat their condition; (6) Implementing reminder systems to notify patients before their appointment and a recall system to contact patients to reschedule missed appointments; and (7) Using physician reminder systems such as concurrent reports.
- ***Getting Care Quickly***—QI activities should target the following areas: (1) Implementing a scheduling model that allows appointment flexibility for patients making same day appointments; (2) Simplifying patient flow to limit bottlenecks and redundancies in the care process; (3) Increasing electronic communications that allow for prompt care to patients who may not require an appointment; (4) Using e-mail and electronic forms of communication to alleviate the demand for in-person visits; and (5) Improving access to health care information via the Internet to provide patients with instant feedback and education.
- ***How Well Doctors Communicate***—QI activities should target the following areas: (1) Enhancing communication skills with patients through specialized workshops for clinicians; (2) Providing patients with tools for communicating with physicians, such as prestructured question lists; (3) Providing educational literature to patients before, during and after a visit in order for patients to educate themselves on medical conditions; (4) Following up with patients after visits to ensure they understand all information from the appointment; and (5) Discussing approaches to implement a shared decision-making model so patients and physicians can communicate more effectively.
- ***Rating of Personal Doctor***—QI activities should target the following areas: (1) Increasing communication between physicians and patients; (2) Identifying and resolving bottlenecks and redundancies in the patient-flow process to decrease the time between the point that care is

needed and when it is received; and (3) Eliminating barriers that prohibit patients from receiving prompt, adequate care.

- ***Rating of Specialist Seen Most Often***—QI activities should target the following areas: (1) Increasing availability of a specialist to allow patients to receive timely care, and (2) Streamlining the referral process so it allows for members to more readily obtain the care they need.
- ***Rating of All Health Care***—QI activities should target the following areas: (1) Increasing access to care by identifying barriers, and (2) Improving overall patient satisfaction with patient health care and health plan experiences.
- ***Rating of Health Plan***—QI activities should target the following areas: (1) Increasing the distribution of information about the plan; (2) Improving customer service and client satisfaction with physicians; (3) Simplifying the process of choosing a provider; and (4) Evaluating the efficiency and ease of scheduling appointments.

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 2008–2009. This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations from the previous year.

Denver Health Medicaid Choice (DHMC)

Compliance Monitoring Site Reviews

As a result of the FY 2008–2009 review, DHMC was required to address six components of the Coverage and Authorization of Services, Access and Availability, and Provider Participation and Program Integrity standards. DHMC submitted its CAP to HSAG and the Department in May 2009. After careful review, HSAG and the Department determined that if implemented as written, the plan submitted by DHMC would adequately address all required actions. In September 2009, DHMC implemented its plan and submitted documents demonstrating compliance to HSAG and the Department. By October 2009, HSAG and the Department had reviewed all documentation submitted by DHMC and determined that DHMC successfully addressed all required actions. There were no required actions continued from FY 2008–2009.

Validation of Performance Measures

In FY 2008–2009, DHMC had three HEDIS 2009 measures (*Well-Child Visits in the First 15 Months of Life*, *6+ Visits*, *Annual Dental Visits*, and *Adults' Access to Preventive/Ambulatory Health Services—40 to 64 years*) with either decreased performance from the previous year or being ranked below the national HEDIS Medicaid 10th percentile. HSAG recommended that DHMC implement quality strategies to improve rates for these measures. Performance for the *Well-Child Visits* and *Adult's Access* measures improved in FY 2009–2010 by more than 5 percentage points. These improvements may suggest the MCO followed up on HSAG's recommendations. HSAG could not determine whether DHMC followed up on recommendations related to the *Annual Dental Visits* measure because the measure was not reported for FY 2009–2010.

Validation of Performance Improvement Projects

Because this was DHMC's first submission of its *Coordination of Care Between Physical and Behavioral Health* PIP, there were no prior requirements or recommendations.

Consumer Assessment of Healthcare Providers and Systems

For the adult population measures between FY 2007–2008 and FY 2008–2009, HSAG did note that DHMC showed substantial declines in the summary rate and global proportions reported for *Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*. For this reason, HSAG recommended that DHMC direct quality improvement activities toward these areas. Two of these measures, *Getting Needed Care* and *Shared Decision Making*, showed improvement between FY 2008–2009 and FY 2009–2010. These increases indicate an improvement in consumer satisfaction in these domains. Nonetheless, three of the measures continued to decline: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan*. Additionally, the decline for the measure *Rating of All Health Care* was substantial.

For the comparable child population measures between FY 2007–2008 and FY 2008–2009, HSAG did note that DHMC showed a substantial decline in the global proportions reported for *Rating of All Health Care*. Additionally, declining rates were observed in *Rating of Personal Doctor* and *Rating of Health Plan*, even though these were not substantial decreases. For this reason, HSAG recommended that DHMC direct quality improvement activities toward these areas. DHMC experienced an increase between FY 2008–2009 and FY 2009–2010 for all of these measures. Additionally, DHMC experienced a substantial increase in *Rating of Personal Doctor* and *Rating of Health Plan* between FY 2008–2009 and FY 2009–2010. These increases indicate an improvement in consumer satisfaction in these domains.

Rocky Mountain Health Plans (RMHP)

Compliance Monitoring Site Reviews

As a result of the FY 2008–2009 site review, RMHP was required to address a total of five elements related to coverage and authorization of services, access and availability, and subcontracts and delegation. RMHP submitted its CAP to HSAG and the Department in May 2009. In July 2009, HSAG and the Department determined that the plan submitted by RMHP would adequately address all required actions and asked that RMHP submit evidence that the CAP had been successfully implemented by August 31, 2009. In September 2009, HSAG and the Department reviewed all documentation submitted by RMHP and determined that RMHP had successfully completed the FY 2008–2009 required actions. There were no required actions continued from FY 2008–2009.

Validation of Performance Measures

In FY 2008–2009, RMHP had one measure that fell below the national HEDIS Medicaid 10th percentile (*Annual Monitoring for Patients on Persistent Medications*) and one measure with decreased performance (*LDL-C Control < 100 mg/dL under Cholesterol Management for People with CV Conditions)* from the previous year. HSAG recommended that RMHP implement quality strategies to improve rates for these measures. Performance for the *Annual Monitoring for Patients on Persistent Medications* measure improved in FY 2009–2010. The improvement may suggest that the MCO followed up on HSAG's recommendations. HSAG could not determine whether RMHP

followed up on recommendations related to the *LDL-C Control < 100 mg/dL under Cholesterol Management for People with CV Conditions* measure because the measure was not reported for FY 2009–2010.

Validation of Performance Improvement Projects

For the FY 2008–2009 validation cycle, HSAG identified a *Point of Clarification* in Step VIII of RMHP's *Improving Well-Care Rates for Adolescents.* This was to include a complete interpretation of the study results that included Baseline results. Although this *Point of Clarification* was not adequately addressed in the FY 2009–2010 submission, HSAG anticipates that RMHP will address all opportunities identified to strengthen the documentation of the study before the FY 2010–2011 submission.

HSAG's FY 2008–2009 review of RMHP's *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP resulted in two recommendations related to Activity III—Review the Selected Study Indicators. RMHP adequately addressed both of these recommendations in its FY 2009–2010 submission.

Consumer Assessment of Healthcare Providers and Systems

For the comparable adult population measures between FY 2007–2008 and FY 2008–2009, HSAG did note that RMHP showed slight declines in the summary rate and global proportions reported 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*. While these declines were not substantial, HSAG recommended that RMHP direct quality improvement activities toward these areas. The measures *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, and *Rating of Health Plan* showed improvements between FY 2008–2009 and FY 2009–2010, with a substantial increase for *Customer Service*. These increases indicate an improvement in consumer satisfaction in these domains. Nonetheless, *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* continued to decline. The measure *Rating of Specialist Seen Most Often* continued to decline substantially between FY 2008–2009 to FY 2009–2010.

The child population was not given recommendations in FY 2008–2009, since the survey was not administered in FY 2007–2008.

Primary Care Physician Program (PCPP)

Validation of Performance Measures

In FY 2008–2009, PCPP had several measures that fell below the national HEDIS Medicaid 10th percentile (*Well-Child Visits in the First 15 Months of Life, 6 + Visits, 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*), and three measure with decreased performance (*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)* from the previous year. HSAG recommended that PCPP implement quality strategies to improve rates for these measures. Performance for the two *Well-Child Visits* measures improved in FY 2009–2010. These improvements may suggest that PCPP followed up on HSAG's recommendations. However, current year's results for *Postpartum Care* did not show any improvements. Further, HSAG could not ascertain whether PCPP followed up on recommendations related to the *LDL-C Screening Performed under Cholesterol Management for People With CV Conditions and Comprehensive Diabetes Care* measure because the measure was not reported for FY 2009–2010.

Validation of Performance Improvement Projects

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

Consumer Assessment of Healthcare Providers and Systems

The PCPP adult Medicaid survey results showed slight decreases between FY 2007–2008 and FY 2008–2009 for two measures: *Getting Care Quickly* and *Shared Decision Making*. While these decreases were not substantial, HSAG recommended that PCPP direct quality improvement activities toward these measures. Both of these areas experienced increases between FY 2008–2009 and FY 2009–2010. These increases, although not substantial (more than 5 percent), do indicate improvement in consumer satisfaction in these domains.

For the comparable child population measures between FY 2007–2008 and FY 2008–2009, HSAG did note that PCPP received a slight decline in the child summary rates and global proportions for two measures: *Rating of All Health Care* and *Rating of Health Plan*. While these decreases were not substantial, HSAG recommended that PCPP direct quality improvement activities toward these measures. One of these measures, *Rating of Health Plan*, experienced a slight increase between FY 2008–2009 and FY 2009–2010. This increase, although not substantial, does indicate improvement in consumer satisfaction in this domain. As for the measure *Rating of All Health Care*, it experienced a continued decline between FY 2008–2009 and FY 2009–2010, and this decline was substantial. The observed rate decrease reflects a decline in consumer satisfaction.

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 behavioral health organization (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

This is the sixth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the FY 2009–2010 site review process, the Department requested a review of seven areas of performance that it had not reviewed within the previous two fiscal years. These were Standard I—Emergency and Poststabilization Services (a subset of Standard I—Coverage and Authorization of Services); Standard IV—Member Rights and Protections; Standard VI—The Grievance System (grievances only); Standard VII—Provider Participation and Program Integrity; Standard VIII—Credentialing and Recredentialing; Standard IX—Subcontracts and Delegation; and Standard X—Quality Assessment and Performance Improvement.

In developing the data collection tools and in reviewing the seven standards, HSAG used the BHO's contract requirements and regulations specified by the Balanced Budget Act of 1997 (BBA), with revisions that were issued June 14, 2002, and were effective August 13, 2002. To determine compliance, HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Recognizing the interdependence of quality, timeliness, and access, HSAG assigned each of the standards to one or more of these three domains, as shown in Table 5-1. 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 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**
Standard I—Emergency and Poststabilization Services	X	X	X
Standard IV—Member Rights and Protections	X		X
Standard VI—The Grievance System (Grievances Only)	X	X	
Standard VII—Provider Participation and Program Integrity		X	X
Standard VIII—Credentialing and Recredentialing	X		
Standard IX—Subcontracts and Delegation		X	X
Standard X—Quality Assessment and Performance Improvement	X	X	X

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

Access Behavioral Care (ABC)

Findings

Table 5-2 presents the number of elements for each of the seven 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 2009–2010).

Table 5-2—Summary of Scores for ABC								
Standard #	**Description of Standard**	**# of Elements**	**# of Applicable Elements**	**# *Met***	**# *Partially Met***	**# *Not Met***	**# *Not Applicable***	**Score (% of *Met* Elements)**
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%
VI	The Grievance System (Grievances Only)	13	13	11	2	0	0	85%
VII	Provider Participation and Program Integrity	8	8	8	0	0	0	100%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	5	5	0	0	1	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
	Totals	**93**	**92**	**90**	**2**	**0**	**1**	**98%**

*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

For six of the seven standards that HSAG reviewed, ABC earned overall percentage-of-compliance scores of 100 percent, indicating a comprehensive understanding of the managed care requirements in the BBA. ABC's policies and procedures were comprehensive, easy to understand, and presented in an organized manner. During the on-site interviews, ABC staff members were able to clearly articulate the procedures followed, which corroborated the written policies and procedures.

ABC widely communicated information regarding member rights and protections through various print documents, including its Member and Family Handbook, Provider Manual, flyers, and newsletters. Information related to member rights was also frequently shared with members attending Member and Family Advisory Board (MFAB) meetings. ABC used data from multiple sources, including member satisfaction surveys, feedback from peer specialists, and grievances data to help identify member concerns related to rights violations.

The corporate compliance plan was very well organized and comprehensive. The corporate compliance training program and related presentations were comprehensive and included quizzes and refresher courses for existing staff members.

The evidence provided in the corporate compliance plan to demonstrate monitoring of delegated entities' credentialing programs was comprehensive and included credentialing and recredentialing file audits. The delegated credentialing and recredentialing audit tools were consistent with NCQA standards. Additionally, the ongoing delegated credentialing monitoring reports provided evidence of a comprehensive, ongoing monitoring structure. The Credentials Committee minutes were well-organized and provided clear evidence of the committee's review of credentialing files that did not meet credentialing or recredentialing standards.

Recommendations

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

The Grievance System

- Ensure that all grievances are acknowledged and resolved within the required time frames. Letters of disposition must contain the resolution of the disposition process and the correct date on which the grievance was resolved.

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 standards of the FY 2009–20010 compliance site review that assessed quality were Emergency and Poststabilization Services, Member Rights and Protections, the Grievance System, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. ABC's overall findings related to the quality domain were strong. ABC earned a score of 100 percent for the Emergency and Poststabilization, Member Rights and Protections Credentialing and Recredentialing, and Quality Assessment and Performance Improvement standards. ABC earned a score of 85 percent for the Grievance System standard, for an overall weighted quality score of 97 percent. ABC's most significant factor representing an opportunity for improvement was the lack of timeliness of grievance processing, as determined through a review of records. Requirements not related to timeliness within the Grievance System standard were all scored *Met*.

Timeliness

The standards that addressed the timeliness domain were Emergency and Poststabilization Services, the Grievance System, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. ABC earned a score of 100 percent for the Emergency and Poststabilization Services, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement standards, and a score of 85 percent for the Grievance System Standard, for an overall weighted timeliness score of 96 percent. Again, ABC's performance in the timeliness domain was negatively affected by its score related to the timeliness of processing grievances.

Access

The standards that assessed the access domain were the Emergency and Poststabilization Services, Member Rights and Protections, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement standards. ABC's performance in the access domain was very strong, having received 100 percent scores for all standards within the domain. Particular strengths in this domain were related to organization and clarity of ABC's policies and procedures, knowledge of ABC's staff regarding requirements and procedures, and its comprehensive corporate compliance and credentialing programs.

Behavioral HealthCare, Inc. (BHI)

Findings

Table 5-3 presents the number of elements for each of the seven 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 2009–2010).

Table 5-3—Summary of Scores for BHI

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%
VI	The Grievance System (Grievances Only)	13	13	11	2	0	0	85%
VII	Provider Participation and Program Integrity	8	8	7	1	0	0	88%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
	Totals	**93**	**93**	**90**	**3**	**0**	**0**	**97%**

*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

The overall compliance score of 97 percent demonstrated BHI's strong understanding and implementation of the BBA regulations. Areas of particular strength included Standards I—Emergency and Poststabilization Services, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

BHI had an effective mechanism in place to track the reason for a denial of an emergency room claim and consulted with the medical director in cases in which the decision to approve or deny a claim was in question. BHI reviewed all claims for emergency services to ensure that claims were not denied inappropriately.

BHI widely communicated information regarding member rights to both members and providers through policy, in-person trainings, the BHI provider manual, and written materials provided to members at the point of enrollment. BHI had advocates stationed at its partner community mental health centers (CMHCs) to answer questions and assist members if they encountered problems with needed services.

BHI's corporate compliance policies were written clearly and described the process for individuals to report potential fraud and abuse issues. The on-site audit provided evidence that compliance drop boxes were located throughout the facility for staff members to report potential issues of fraud or abuse anonymously.

Recommendations

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

The Grievance System

- Ensure that all grievances are acknowledged within two working days of receipt of the grievance and are resolved within 15 working days, and that resolution letters contain the results of the disposition process.

Provider Participation and Program Integrity

- Develop a method for informing providers that it does not prohibit or restrict health care professionals acting within the lawful scope of their practice from advising or advocating on behalf of members regarding treatments that may be self-administered, along with the risks, benefits, and consequences of treatment or nontreatment.

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 standards of the FY 2008–2009 compliance site review that assessed quality were Emergency and Poststabilization Services, Member Rights and Protections, the Grievance System, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. BHI's overall findings related to quality were strong. BHI earned a score of 100 percent for the standards Emergency and Poststabilization, Member Rights and Protections Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. BHI earned a score of 85 percent for the Grievance System standard, for an overall weighted quality score of 97 percent. BHI's most significant factor representing opportunity for improvement was the lack of timeliness of grievance processing, as determined through a review of records. Requirements not related to timeliness within the Grievance System standard were all scored *Met*.

Timeliness

The standards that addressed the timeliness domain were Emergency and Poststabilization Services, the Grievance System, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. BHI earned a score of 100 percent for Emergency and Poststabilization Services, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. BHI earned a score of 85 percent for the Grievance System standard and 88 percent for Provider Participation and Program Integrity, for an overall weighted timeliness score of 94 percent. BHI's performance in the timeliness domain was negatively affected by its score in both the timeliness of processing grievances and the lack of required notice to providers regarding provider-enrollee communications.

Access

The standards that assessed the access domain were the Emergency and Poststabilization Services, Member Rights and Protections, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement standards. BHI's performance in the access domain was mixed. BHI earned a score of 100 percent for the Emergency and Poststabilization Services, Member Rights and Protections, Subcontracts and Delegation, and Quality Assessment and Performance Improvement standards. Particular strengths in this domain were related to BHI's communication to members and providers and its strong corporate compliance program. One requirement related to provider enrollee communication negatively impacted BHI's overall score for the access domain.

Colorado Health Partnerships, LLC (CHP)

Findings

Table 5-4 presents the number of elements for each of the seven 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 2009–2010).

Table 5-4—Summary of Scores for CHP

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%
VI	The Grievance System (Grievances Only)	13	13	13	0	0	0	100%
VII	Provider Participation and Program Integrity	8	8	8	0	0	0	100%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
	Totals	**93**	**93**	**93**	**0**	**0**	**0**	**100%**

*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

For all seven of the standards that HSAG reviewed, CHP received percentage-of-compliance scores of 100 percent, indicating a comprehensive understanding of the managed care requirements of the BBA. CHP's policies and procedures were comprehensive and easy to understand, and were presented in an organized manner. During the on-site interviews, CHP staff members were able to clearly articulate the procedures followed, which corroborated the written policies and procedures.

CHP delegated utilization management to ValueOptions (VO), including the authorization and adjudication of emergency and poststabilization services. ValueOptions had comprehensive policies and procedures in place that were consistent with the BBA provisions. CHP demonstrated that its policies were in practice and effective in ensuring that members were not held liable for payment

for emergency behavioral health care. The CHP member handbook contained clear and concise verbiage pertaining to the availability of emergency and poststabilization services.

CHP closely monitored providers to ensure that they were trained in the area of member rights. CHP used diverse venues and presentation methods to ensure that members, providers, and the community at large were aware of member rights and protections. The CHP training program demonstrated a comprehensive and diverse set of materials.

The grievance policies detailed the comprehensive grievance system and the policies contained all of the required information. The grievance files reviewed were well-organized, contained all of the required content, and provided evidence that staff members adhered to the policies and associated time frames when processing grievances. CHP's grievance database captured all of the required elements, and database demonstrations provided by the staff provided evidence that staff members were able to retrieve grievance information quickly.

The CHP compliance education materials presented a comprehensive overview of the type of information used to educate and train CHP associates on the compliance program. The CHP compliance education materials included information regarding standards of conduct, designation of a compliance officer, lines of communication between the compliance officer and CHP associates, disciplinary guidelines, and CHP's provision for prompt response to detected offenses and corrective action initiatives related to the Medicaid managed care contract.

The on-site demonstration of the ValueOptions credentialing database showed the comprehensive organization and capabilities of the database, which allowed staff members to access provider credentialing and recredentialing information quickly. Meeting minutes of both the National Credentialing Committee and the Colorado Local Credentialing Committee were comprehensive and well-organized, and they provided evidence of thorough review of practitioner credentialing and recredentialing files by the two credentialing committees.

The CHP Agreement to Delegate and the Management Services Agreement were consistent with the applicable NCQA and BBA requirements. The agreements included a description of all delegated activities and detailed monitoring activities that CHP would conduct to ensure compliance. CHP demonstrated that it closely monitored performance of each delegated activity on an ongoing and annual basis.

CHP had an ongoing and comprehensive quality assessment and performance improvement program in place. The program included mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. CHP had data systems in place to collect, analyze, integrate, and report data in support of the program. CHP had processes in place to detect over- and under-utilization through innovative data integration and report development.

Recommendations

HSAG did not recommend any required actions for CHP as a result of the FY 2009–2010 compliance site reviews.

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 standards of the FY 2008–2009 compliance site review that assessed quality were Emergency and Poststabilization Services, Member Rights and Protections, the Grievance System, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. CHP's overall findings related to quality were very strong. CHP earned a score of 100 percent for each of the standards comprising the quality domain and an overall compliance score of 100 percent. The most significant factors that contributed to CHP's strong performance were its oversight of provider organizations to ensure training regarding member rights, its comprehensive grievance database, and its credentialing and QAPI programs.

Timeliness

The standards that addressed the timeliness domain were Emergency and Poststabilization Services, the Grievance System, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. CHP earned a score of 100 percent for each of the standards comprising the timeliness domain and an overall compliance score of 100 percent. Particular strengths in this area were CHP's oversight of provider and delegate organizations regarding timeliness of response to grievance and appeals, and member care.

Access

The standards that assessed the access domain were the Emergency and Poststabilization Services, Member Rights and Protections, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement standards. CHP's performance in the access domain was very strong, having earned 100 percent scores for each of the standards in the domain. Particular strengths were related to CHP's comprehensive QAPI program.

Foothills Behavioral Health Partners, LLC (FBHP)

Findings

Table 5-5 presents the number of elements for each of the seven 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 2009–2010).

Table 5-5—Summary of Scores for FBHP

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%
VI	The Grievance System (Grievances Only)	13	13	10	3	0	0	77%
VII	Provider Participation and Program Integrity	8	8	8	0	0	0	100%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
	Totals	**93**	**93**	**90**	**3**	**0**	**0**	**97%**

*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

FBHP earned an overall percentage-of-compliance score of 97 percent. HSAG identified three areas within the Grievance System (Grievances Only) standard that required follow-up corrective action, reflected by a score of 77 percent. However, for all six of the remaining standards that HSAG reviewed, FBHP earned overall scores of 100 percent, which indicates a comprehensive understanding of the managed care requirements set forth in the BBA. FBHP's policies and procedures were comprehensive, easily understood, and presented in an organized manner. During the on-site interviews, FBHP staff members were able to clearly articulate the procedures followed, which corroborated the policies and procedures.

FBHP communicated information regarding member rights and protections in easy-to-understand language in the FBHP Member Handbook, flyers, and posters. FBHP had a comprehensive member rights training program in place for staff members at its partner mental health centers.

FBHP's description of chart audits to detect fraud and abuse and its use of corrective action when provider billing discrepancies were detected provided a comprehensive overview of the types of actions FBHP took to ensure compliance with State and federal regulations by the BHO and its providers.

The Provider Data Sheet, which was generated from the ValueOptions NetworkConnect online provider credentialing and recredentialing database, demonstrated the BHO's clear and concise organization of provider credentialing and recredentialing information. This information came from primary source verification, verification of providers' responses on the credentialing and recredentialing application, and recommendations based on information collected during the credentialing or recredentialing process.

FBHP demonstrated that it closely monitored ValueOptions' performance under a delegation agreement through data reports, formal site reviews, and weekly meetings to address any challenges related to program implementation. The BHO also provided evidence that it actively followed up on deficiencies in delegate performance.

FBHP had an active Quality Improvement/Utilization Management Committee in place that reviewed data for a variety of performance improvement measures, identified opportunities for improvement, and made recommendations regarding strategies to further enhance performance. FBHP also had a substantial number of clinical practice guidelines in place, including several evidence-based practices. The BHO made member- and family-friendly "tip" documents related to the guidelines available to both members and families.

Recommendations

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

The Grievance System

- Ensure that it acknowledges all grievances within two working days of receipt and that the individuals who make decisions on grievances involving clinical issues have the appropriate level of expertise in treating the member's condition.
- Ensure that it investigates and resolves all grievances and provides notice of disposition to the member within 15 working days of receipt, and that all grievance notices include the results of the disposition process.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality

The standards of the FY 2008–2009 compliance site review that assessed quality were Emergency and Poststabilization Services, Member Rights and Protections, the Grievance System, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. FBHP's overall findings related to quality were mixed. FBHP earned a score of 100 percent for Emergency and Poststabilization Services, Member Rights and Protections, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. FBHP earned a score of 77 percent for the Grievance System standard, for an overall weighted score of 96 percent for the quality domain. Particular strengths in the quality domain were related to FBHP's clear communication with provider organizations regarding member rights and protections, its strong credentialing program through its delegate, ValueOptions, and FBHP's active QAPI program.

Timeliness

The standards that addressed the timeliness domain were Emergency and Poststabilization Services, the Grievance System, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. FBHP earned a score of 100 percent for the Emergency and Poststabilization Services, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. FBHP's performance in the timeliness domain was negatively affected by its score in the Grievance System standard area (77 percent). Specifically related to timeliness, in the Grievance System standard, FBHP did have deficiencies regarding timeliness of acknowledgement letters and grievance resolutions. Required actions in this domain as well were issues of having staff members with the appropriate level of expertise making decisions on grievances involving clinical issues, and the content of the grievance resolution notices.

Access

The standards that assessed the access domain were the Emergency and Poststabilization Services, Member Rights and Protections, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement standards. FBHP's performance in the access domain was very strong, having earned 100 percent scores for each of the standards in the access domain. Particular strengths in this domain were related to FBHP's strengths related to member rights and protections and its active QAPI program.

Northeast Behavioral Health Partnership, LLC (NBHP)

Findings

Table 5-6 presents the number of elements for each of the seven 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 2009–2010).

Table 5-6—Summary of Scores for NBHP

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%
VI	The Grievance System (Grievances Only)	13	13	13	0	0	0	100%
VII	Provider Participation and Program Integrity	8	8	8	0	0	0	100%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
	Totals	**93**	**93**	**93**	**0**	**0**	**0**	**100%**

*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

NBHP received overall percentage-of-compliance scores of 100 percent for each of the seven standards reviewed, which demonstrated a comprehensive understanding of the managed care requirements set forth in the BBA. NBHP's policies and procedures were comprehensive and easily understood, and were presented in an organized manner. During the on-site interviews, NBHP staff members were able to clearly articulate procedures followed, which corroborated the written policies and procedures.

ValueOptions (as NBHP's delegate) had comprehensive policies in place to provide staff guidance regarding the provision of emergency and poststabilization services. ValueOptions took steps to closely monitor the appropriateness of any denied emergency claims. One strategy used by

ValueOptions, for example, was to conduct a second-level physician review of denied emergency claims to ensure that claims were approved for any member with a psychiatric diagnosis. In addition, NBHP made user-friendly information regarding how to access crisis care available to members as part of the NBHP Member Handbook.

NBHP had comprehensive training in place for providers, the NBHP staff, and the ValueOptions Service Center staff in the area of member rights and protections. NBHP considered grievances and appeals data as part of its overall quality assessment and performance improvement (QAPI) process.

NBHP, through its delegate ValueOptions, had well-defined grievance policies and procedures in place that detailed the grievance system, and the policies contained all the required information. The grievance database captured all the required elements, and database demonstrations provided by the staff provided evidence that staff members were able to retrieve grievance information quickly.

The NBHP compliance program education PowerPoint provided a comprehensive overview of the type of information used to educate and train NBHP associates on the compliance program, and it included information regarding standards of conduct, designation of a compliance officer, lines of communication between the compliance officer and NBHP associates, disciplinary guidelines, and NBHP's provision for prompt response to detected offenses and corrective action initiatives related to the Medicaid managed care contract.

NBHP had delegation agreements in place with each of its delegates. The NBHP agreements included a description of all delegated functions and detailed monitoring activities to be conducted by NBHP to ensure compliance with the terms of the agreement. NBHP demonstrated that it closely monitored the performance of each of its delegates through on-site compliance reviews, clinical chart review, and a review of grievance reports and other deliverables.

Recommendations

HSAG did not recommend any required actions for NBHP as a result of the FY 2009–2010 compliance site reviews.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality

The standards of the FY 2008–2009 compliance site review that assessed quality were Emergency and Poststabilization Services, Member Rights and Protections, the Grievance System, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement. NBHP's overall findings related to quality were very strong. NBHP earned a score of 100 percent for each of the standards in the quality domain, and an overall score of 100 percent. Particular strengths in the quality domain were related to staff training regarding member rights and protections, NBHP's strong credentialing program through its delegate, ValueOptions, and member and provider representation in the QAPI program.

Timeliness

The standards that addressed the timeliness domain were Emergency and Poststabilization Services, the Grievance System, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. NBHP earned a score of 100 percent for each of the standards in the timeliness domain and an overall score of 100 percent. Particular strengths in the timeliness domain were related to NBHP's effective procedures in processing grievances in a timely manner, mechanisms for prompt response related to NBHP's corporate compliance, and timeliness of processing credentialing and recredentialing applications.

Access

The standards that assessed the access domain were Emergency and Poststabilization Services, Member Rights and Protections, Provider Participation and Program Integrity, Subcontracts and Delegation, and Quality Assessment and Performance Improvement. NBHP earned 100 percent scores for each of the standards in the access domain and an overall score of 100 percent. Particular strengths in the access domain were related to NBHP's mechanisms for reviewing denied emergency room claims for validity, and its comprehensive oversight and monitoring of provider organizations.

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 standard followed by conclusions drawn from the results of the compliance monitoring activity. Appendix E contains summary tables showing the detailed site review scores for the site review standards, by BHO, and the statewide average.

Table 5-7—Statewide Averages

Standards	FY 2009–2010 Statewide Average*
Standard I—Emergency and Poststabilization Services	**100%**
Standard IV—Member Rights and Protections	**100%**
Standard VI—The Grievance System (Grievances Only)	**89%**
Standard VII—Provider Participation and Program Integrity	**98%**
Standard VIII—Credentialing and Recredentialing	**100%**
Standard IX—Subcontracts and Delegation	**100%**
Standard X—Quality Assessment and Performance Improvement	**100%**
Overall Statewide Compliance Score	**98%**

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

As for statewide recommendations, two of the five BHOs were required to ensure that all grievances were acknowledged and resolved within the required time frames and that letters of

disposition contained the resolution of the disposition process and the correct date on which the grievance was resolved.

Quality, Timeliness, and Access

Overall statewide performance for Quality, Timeliness, and Access was very strong. Two of the five BHOs earned 100 percent overall scores, for an overall statewide performance rating of 98 percent. The overall statewide weighted score for the quality domain was 98 percent. For the timeliness domain it was 97 percent and for the access domain it was 99.5 percent. All five BHOs earned a 100 percent score for the Emergency and Poststabilization, Member Rights and Protections, Credentialing and Recredentialing, Subcontracts and Delegation, and Quality Assessment and Performance Improvement standards. For the Provider Participation and Program Integrity standard, one BHO received a score of *Partially Met* for one of the eight requirements in that standard. Each of the other BHOs received overall scores of 100 percent for the Provider Participation and Program Integrity standard. There was somewhat of a trend related to the Grievance System standard. Three of the five BHOs received *Partially Met* scores in this standard. For all three, the *Partially Met* scores were related to timeliness issues, as evidenced by the findings in the grievance record reviews. One of the BHOs had an additional *Partially Met* score related to the appropriateness of the clinical expertise of staff members making decisions on grievances. The statewide scores on the Grievance System standard negatively impacted both the quality and timeliness domains.

Validation of Performance Measures

The Department required the collection and reporting of eight performance measures for the FY 2009–2010 validation process: five were HEDIS-like measures and three were measures developed by the Department. Some of these measures have subcategory measures (e.g., *Hospital Average Length of Stay* has two submeasures: *Non-State Hospitals* and *All Hospitals*). Counting all subcategory measures yielded a total of 23. All measures originated from claims/encounter data. FY 2009–2010 is the second consecutive year that all eight measures were validated and reported; therefore, comparisons with last year's results are 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)		✓	

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

Access Behavioral Care (ABC)

Findings—System and Reporting Capabilities

HSAG evaluated the systems ABC used to report the performance measures as a component of the validation process.

Claims and Encounters: HSAG identified no issues related to claims and encounter data processing. ABC had adequate oversight of its vendor to ensure claims and encounters were processed accurately. Monitoring of encounter data volume for Mental Health Center of Denver (MHCD) was also performed and it appeared to be an improvement in the oversight process since last year. Although encounter data submission to the State was not an issue for flat file submissions, there were still some issues for the 837 format. The State and ABC continue to work on these issues.

Eligibility: HSAG had no concerns with the eligibility data system. ABC had processes in place to reconcile enrollment data with State enrollment and capitation files.

Findings—Performance Measure Results

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 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Age Category				
Children 12 years of age and younger	5.9%	6.8%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 through 17 years of age	18.1%	18.1%	*Fully Compliant*	*Fully Compliant*
Adults 18 through 64 years of age	23.0%	23.6%	*Fully Compliant*	*Fully Compliant*
Adults 65 years of age or older	9.0%	8.2%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	1.1%	0.9%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.1%	0.1%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	11.1%	11.2%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rates	12.7%	13.3%	*Fully Compliant*	*Fully Compliant*
Hospital Recidivism[1]				
Non-State Hospitals—7 days	5.5%	4.6%	*Fully Compliant*	*Fully Compliant*
30 days	13.4%	12.4%	*Fully Compliant*	*Fully Compliant*
90 days	21.2%	23.0%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	6.4%	5.0%	*Fully Compliant*	*Fully Compliant*
30 days	16.5%	13.0%	*Fully Compliant*	*Fully Compliant*
90 days	24.2%	24.1%	*Fully Compliant*	*Fully Compliant*
Hospital Average Length of Stay				
Non-State Hospitals	8.70	9.20	*Fully Compliant*	*Fully Compliant*
All Hospitals	14.17	12.15	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	11.35	11.10	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	7.77	7.08	*Fully Compliant*	*Fully Compliant*
All Hospitals	10.86	8.59	*Fully Compliant*	*Fully Compliant*

Table 5-9—Review Results and Audit Designation *for* ABC				
Performance Measures	Rate		Audit Designation	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 days	30.8%	38.1%	*Fully Compliant*	*Fully Compliant*
30 days	72.5%	58.8%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	31.5%	40.4%	*Fully Compliant*	*Fully Compliant*
30 days	73.1%	61.4%	*Fully Compliant*	*Fully Compliant*
[1] For the Hospital Recidivism measure, an increase in rates from last year's suggested poorer performance.				

Strengths

HSAG found that ABC had the systems in place to analyze and conduct reports that could be used to monitor and track performance, and to develop targeted interventions for improving rates. The encounter data work group helped to ensure that ABC's encounter data were complete and accurate on an ongoing basis. ABC continued to work collaboratively with the Department regarding submission of 837 data files. HSAG also found that ABC's use of vendor software helped ensure that the HEDIS-like measures were pulled in a consistent way, with good quality assurance checks prior to reporting. ABC also demonstrated good oversight of its vendor.

ABC received a *Fully Compliant* status in its audit for all eight performance measures. HSAG observed improvement in all but one submeasure under *Hospital Recidivism*, and two 7-day follow-up submeasures under *Follow-Up After Hospitalization for Mental Illness*. The two submeasures under Follow-*Up After Hospitalization for Mental Illness*, in particular, reported an at least 5 percentage points of improvement over last year. Utilization increased for *Penetration Rate—Children 12 years of age and younger*, *Penetration Rate—Adults 18 through 64 years of age*, *Penetration Rate—Ambulatory Care*, and *Overall Penetration Rate*. Among these measures, ABC's rates for *Penetration Rate—Adults 18 through 64 years of age* and for *Overall Penetration Rate* were also higher than the statewide weighted average.

Recommendations

The ABC performance measure validation results present some opportunities for improvement. Five submeasures showed a decline in the rates from the prior measurement year, with the most notable decline in the two *30-day Follow-Up After Hospitalization for Mental Illness* submeasures. The decrease in rates was greater than 10 percentage points. One submeasure under *Hospital Recidivism* and all submeasures under *Follow-Up After Hospitalization for Mental Illness* also reflected performance that was below the statewide performance by at least 5 percentage points.[5-1]

[5-1] As an inverse measure, when the rates of the *Hospital Recidivism* measures are higher than the statewide weighted averages, it actually suggested below-statewide-average performance.

HSAG noted that ABC was working to implement the new coding manual changes. ABC indicated it expected to have that implementation completed by April 2010. ABC should continue to monitor provider submissions to ensure that accurate and complete coding is performed.

ABC noted that it was looking at targeting high-volume providers for specific interventions. HSAG recommended moving forward with development of targeted interventions and encouraged ABC to provide specific feedback (rates) to providers demonstrating their individual performance.

HSAG recommended that ABC continue working with the Department and the other BHOs to modify and update the scope document, as necessary; for example, by including the covered mental health diagnosis codes or reference to an official contract listing.

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:** *Hospital Recidivism* was the only quality measure reported for this year. ABC's performance on this measure has improved from the previous year. Although all but one submeasure showed slight improvement (as reflected in the decline in rates from FY 2008–2009), ABC's performance was below the statewide average performance. In particular, the 90-day recidivism rates for non-state hospitals and all hospitals were 4.7 percentage points and 6.2 percentage points below the statewide performance.
- **Timeliness:** *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported for this year. ABC's performance on this measure was mixed. Although the seven-day follow-up rates increased from the previous year more than 5 percentage points, its 30-day follow-up rates decreased by more than 10 percentage points. Additionally, all rates were below the statewide weighted average performances by more than 5 percentage points. Once again this year, an opportunity for improvement exists, because the rates continue to fall below the statewide weighted average, and performance was mixed for the two indicators.
- **Access**: ABC's performance in the domain of quality was also mixed, with some measures reflecting the BHO's strength or improvement since last year. Four of the eight penetration-related submeasures demonstrated a slight improvement from the previous year, two had the same performance, and two exhibited a decline. For utilization-based measures, it is important to assess utilization based on the characteristics of the BHO's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Behavioral HealthCare, Inc. (BHI)

Findings—System and Reporting Capabilities

HSAG evaluated the systems BHI used to report the performance measures as a component of the validation process.

Claims and Encounters: HSAG had no concerns with BHI's processing of claims data. Data for FY 2009 were processed by InNET. The majority of service data come in as encounters and were submitted to InNET and processed accordingly. InNET provided a monthly encounter validation report to the CMHCs to work errors or issues on encounter data submission prior to submitting the file to the State. This process minimized file rejections from the State and ensured data were complete and accurate.

As of July 1, 2009, service data were processed by Colorado Access. BHI and Colorado Access worked out the encounter and claims data processes. A review of data demonstrated that there was no data loss in the transition from one administrative services organization (ASO) to the next.

Eligibility: HSAG auditors found no concerns with the processing of eligibility data. InNET received and processed enrollment files for FY 2009. This process was sufficient to capture Medicaid-eligible members assigned to BHI. As of July 1, 2009, Colorado Access began processing the enrollment files. The CMHCs verified and worked enrollment issues, and also verified eligibility for consumers prior to delivering services.

Findings—Performance Measure Results

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 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Age Category				
Children 12 years of age and younger	4.9%	5.0%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 through 17 years of age	18.6%	17.8%	*Fully Compliant*	*Fully Compliant*
Adults 18 through 64 years of age	18.5%	18.1%	*Fully Compliant*	*Fully Compliant*
Adults 65 years of age or older	3.6%	3.6%	*Fully Compliant*	*Fully Compliant*

Table 5-10—Review Results and Audit Designation *for* BHI				
Performance Measures	Rate		Audit Designation	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Service Category				
Inpatient Care	0.7%	0.5%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.1%	0.2%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	9.9%	8.9%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rate	10.0%	9.9%	*Fully Compliant*	*Fully Compliant*
***Hospital Recidivism*[1]**				
Non-State Hospitals—7 days	3.4%	5.5%	*Fully Compliant*	*Fully Compliant*
30 days	10.5%	11.0%	*Fully Compliant*	*Fully Compliant*
90 days	16.0%	15.4%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	3.5%	5.0%	*Fully Compliant*	*Fully Compliant*
30 days	12.7%	12.7%	*Fully Compliant*	*Fully Compliant*
90 days	19.2%	19.9%	*Fully Compliant*	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	7.16	7.63	*Fully Compliant*	*Fully Compliant*
All Hospitals	13.00	17.75	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	7.60	6.79	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	2.56	1.77	*Fully Compliant*	*Fully Compliant*
All Hospitals	5.84	5.44	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 days	51.4%	38.9%	*Fully Compliant*	*Fully Compliant*
30 days	62.7%	58.0%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	56.3%	49.3%	*Fully Compliant*	*Fully Compliant*
30 days	68.8%	64.0%	*Fully Compliant*	*Fully Compliant*

[1] For the Hospital Recidivism measure, an increase in rates from last year's suggested poorer performance.

Strengths

BHI was extremely thorough in its approach to the transition process from InNET to Colorado Access. The transition began in April 2009 and was completed July 1, 2009. BHI acquired two staff members from InNET, which helped with the continuity of programming and data management. BHI rewrote the source code for the performance measures to make it more streamlined. The process of verifying the new code to the previous year's data to ensure the code generated accurate rates was a good practice. The cross-checks between tables and measures were a good verification process that was implemented.

As in the previous year, BHI received a *Fully Compliant* status in its audit for all performance measures. HSAG noted slightly improved performance for the three submeasures (i.e., *Penetration Rate—Child 12 years of age and younger*, *Penetration Rate—Intensive Outpatient/Partial*

Hospitalization, and *Non-State Hospital Recidivism—90 days)* from the previous year. Additionally, the rate for *Penetration Rate—Intensive Outpatient/Partial Hospitalization* was also above the statewide weighted average.

Recommendations

Some areas for improvement were noted for BHI. Two seven-day submeasures under *Follow-Up After Hospitalization for Mental Illness* showed a decline in rates of more than 5 percentage points from the previous measurement year. For the non-state hospitals, the decline was 12.5 percentage points; for the state hospitals, it was 7 percentage points. The two *Follow-Up After Hospitalization for Mental Illness* measures for non-state hospitals (both seven-day and 30-day) were also below the statewide weighted averages for more than 5 percentage points.

HSAG had no recommendations for the measure period under review, since the processes audited were performed under the InNET contract. The current processes, as of July 1, 2009, were performed by the new ASO, Colorado Access. Next year's review will focus on the transition and how processes changed and were monitored.

The BHOs should continue to work with the State on issues related to the 837 file submission and ensure the handling of any aspect of the file submission process that can be impacted by the BHO.

During on-site discussions, it was noted that BHI should continue to work with the Department and the other BHOs to modify and update the scope document as necessary; for example, by including the covered mental health diagnosis codes or referencing an official contract listing.

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**: *Hospital Recidivism* was the only quality measure reported for this year. BHI's performance in this measure was mixed, with a majority of the submeasures showing a decline in performance. Only one submeasure (*Non-State Hospitals—90 days*) demonstrated an improvement and one (*All Hospitals—30 days*) had the same performance from last year. The 90-day hospital recidivism for the non-state hospitals submeasure was also the only one above the statewide weighted average.

- **Timeliness**: The *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported for this year. BHI's performance on this measure suggests areas for improvement. All submeasures demonstrated a decline from the previous year. The two seven-day follow-up submeasures decline more than 5 percentage points from last year. All submeasures were also below the current year's statewide averages. In particular, the seven-day and 30-day submeasures for non-state hospitals were also below the current year's statewide averages.

- **Access**: BHI's performance in the domain of access was consistent with last year's performance and was mixed. An increase was noted in two of the *Penetration Rate* submeasures (*Children 12 years of age and younger* and *Intensive Outpatient/Partial Hospitalization*), one submeasure

(*Adults 65 years of age or older*) had the same performance and all others had a slight decline. Nonetheless, all the changes from last year did not exceed 1 percentage-point increase or decrease. The majority of the submeasures were below the current year's statewide averages. For the utilization-based access measures (i.e., *Hospital Average Length of Stay*, *Emergency Room Utilization*, and *Inpatient Utilization*), all measures except the *Hospital Average Length of Stay* experienced a decline in the rate. It is important to assess utilization based on the characteristics of the BHO's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Colorado Health Partnerships, LLC (CHP)

Findings—System and Reporting Capabilities

HSAG evaluated the systems CHP used to report the performance measures as a component of the validation process.

Claims and Encounters: HSAG identified no issues with systems or processes related to claims and encounter data. HSAG found excellent monitoring practices in place to monitor encounter submission volumes. The use of optical character recognition (OCR) technology for paper claims data mitigates any concerns regarding data entry accuracy.

Eligibility: HSAG auditors had no concerns with CHP's eligibility data system or processes. Real-time eligibility could be verified via the State's Web-based portal. CHP's finance department monitored and pulled files once per month and kept files in a local archive. CHP continued working toward utilization of the 834 eligibility file and the 820 caption file as sources for eligibility data.

Findings—Performance Measure Results

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 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Age Category				
Children 12 years of age and younger	7.5%	6.7%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 through 17 years of age	21.2%	18.9%	*Fully Compliant*	*Fully Compliant*
Adults 18 through 64 years of age	21.7%	20.2%	*Fully Compliant*	*Fully Compliant*
Adults 65 years of age or older	6.0%	6.8%	*Fully Compliant*	*Fully Compliant*

Table 5-11—Review Results and Audit Designation *for* CHP				
Performance Measures	Rate		Audit Designation	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Service Category				
Inpatient Care	0.8%	0.7%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.1%	0.1%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	13.5%	12.5%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rate	13.7%	12.8%	*Fully Compliant*	*Fully Compliant*
***Hospital Recidivism*[1]**				
Non-State Hospitals—7 days	2.9%	3.3%	*Fully Compliant*	*Fully Compliant*
30 days	8.7%	9.8%	*Fully Compliant*	*Fully Compliant*
90 days	15.2%	17.8%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	2.3%	2.4%	*Fully Compliant*	*Fully Compliant*
30 days	6.8%	8.1%	*Fully Compliant*	*Fully Compliant*
90 days	12.4%	14.2%	*Fully Compliant*	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	7.05	8.32	*Fully Compliant*	*Fully Compliant*
All Hospitals	14.56	16.78	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	8.93	11.38	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	3.22	2.55	*Fully Compliant*	*Fully Compliant*
All Hospitals	5.63	4.85	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 days	41.7%	47.7%	*Fully Compliant*	*Fully Compliant*
30–day	64.3%	69.2%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	45.0%	49.8%	*Fully Compliant*	*Fully Compliant*
30–day	66.3%	68.9%	*Fully Compliant*	*Fully Compliant*

[1] For the Hospital Recidivism measure, an increase in rates from last year's suggested poorer performance.

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 2008–2009. CHP supplied thorough documentation pre-on-site, facilitating the review process. Numerous processes were implemented to increase encounter data accuracy, including additional encounter edits, and the CMHCs were given comprehensive information regarding their encounter submissions. CHP staff members continued to demonstrate commitment to data quality and data completeness by implementing new processes to monitor these data, and continue to keep CMHCs accountable and involved in this endeavor.

HSAG scored all of CHP's performance measures as *Fully Compliant.* All submeasures under *Follow-Up After Hospitalization for Mental Illness* showed improved performance from last year and performed above the current year's statewide averages. Three sub-measures (seven-day and 30-day follow-up for non-state hospitals and seven-day follow-up for state hospitals) improved more than 4 percentage points. In additional, although the rates for *Hospital Recidivism* declined from last year, CHP's performance was still above the current year's statewide averages. Additionally, although only one of the *Penetration Rate by Age Category* submeasures (*Adults 65 years of age or older*) showed a slight improvement in performance from last year, the current year's performance was above the statewide weighted average.

Recommendations

This year's CHP performance results highlighted several areas for improvement. The majority of the performance measures declined from last year's rates. However, none of these changes were more than 5 percentage points.

Based on the results of performance measure validation findings for FY 2008–2009, HSAG suggested that CHP continue to develop the documentation related to its encounter file submission process. CHP should also continue working toward preparing for ICD-10 implementation; discussions internally and with the Department should be considered in order to successfully migrate to this code set. Also, CHP should continue efforts to move toward using 834 eligibility files and 820 capitation files as sources for eligibility data.

The BHO should continue to collaborate with the other BHOs and the Department to update the scope document to include reference to the covered mental health diagnosis codes. The BHO should work with the other BHOs and the Department to consider updating the exclusion criteria for the follow-up measure to exclude nonacute readmissions within 30 days in order to mirror HEDIS more closely. In addition, the BHO should work with the other BHOs and the Department to consider revising the document so that Attachments A and B are either incorporated into the main document or Attachment A contains all penetration rate criteria, and Attachment B contains all follow-up criteria.

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**: *Hospital Recidivism* was the only quality measure reported for this year. CHP's performance in the domain of quality was consistent with that of last year. Although all *Hospital Recidivism* measures demonstrated a decline in performance, none decreased for more than 5 percentage points. In addition, despite the decline, CHP's performance was still above the statewide weighted averages.

- **Timeliness**: CHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) demonstrated a strength. All submeasures improved from last year; three had increases for more than 4 percentage points. In addition, all submeasures performed above the current year's statewide averages.

- **Access**: CHP's performance in the domain of access was also consistent with the previous year. All but two *Penetration Rate* submeasures (*Adults 65 years of age or older* and *Intensive Outpatient/Partial Hospitalization*) showed a decline from last year. Most had a decrease in rate of less than 1 percentage point, with the exception of the *Penetration Rate* for two age groups (*Adolescents 13 through 17 years of age* and *Adults 18 through 64 years of age*). For these two measures, the decline was at least 1.5 percentage points. For utilization-based measures, HSAG observed that *Hospital Average Length of Stay* and *Emergency Room Utilization* measures had an increase in rates over last year and was higher than statewide averages. It is important to assess utilization based on the characteristics of the BHO's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Foothills Behavioral Health Partners, LLC (FBHP)

Findings— System and Reporting Capabilities

HSAG evaluated the systems FBHP used to report the performance measures as a component of the validation process.

Claims and Encounters: HSAG identified no issues related to claims and encounter data processing. The claims and encounter data processing during this measurement period was performed by InNET and the FBHP staff. FBHP appeared to have adequate systems in place for monitoring InNET for accuracy and completeness of claims. However, as of July 1, 2009, the claims processing was transitioned to Value Options. This transition process was well-documented.

Eligibility: HSAG had no concerns with FBHP's eligibility data system. FBHP had processes in place to reconcile enrollment data with State enrollment and capitation files.

Findings – Performance Measure Results

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

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

Performance Measures	Rate		Audit Designation	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Age Category				
Children 12 years of age and younger	10.5%	12.4%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 through 17 years of age	28.2%	28.9%	*Fully Compliant*	*Fully Compliant*
Adults 18 through 64 years of age	26.9%	29.1%	*Fully Compliant*	*Fully Compliant*
Adults 65 years of age or older	8.8%	9.9%	*Fully Compliant*	*Fully Compliant*

Table 5-12—Review Results and Audit Designation *for* FBHP				
Performance Measures	Rate		Audit Designation	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Service Category				
Inpatient Care	0.9%	0.8%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.2%	0.2%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	17.4%	18.7%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rate	17.5%	19.5%	*Fully Compliant*	*Fully Compliant*
Hospital Recidivism[1]				
Non-State Hospitals—7 days	3.3%	6.3%	*Fully Compliant*	*Fully Compliant*
30 days	8.9%	8.0%	*Fully Compliant*	*Fully Compliant*
90 days	16.3%	21.4%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	2.4%	3.3%	*Fully Compliant*	*Fully Compliant*
30 days	6.9%	6.6%	*Fully Compliant*	*Fully Compliant*
90 days	14.8%	16.6%	*Fully Compliant*	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	6.28	6.40	*Fully Compliant*	*Fully Compliant*
All Hospitals	15.73	20.32	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	9.19	8.14	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	2.70	2.24	*Fully Compliant*	*Fully Compliant*
All Hospitals	6.40	6.04	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 days	58.2%	77.3%	*Fully Compliant*	*Fully Compliant*
30 days	73.4%	84.1%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	58.7%	77.7%	*Fully Compliant*	*Fully Compliant*
30 days	75.0%	87.3%	*Fully Compliant*	*Fully Compliant*

[1] For the Hospital Recidivism measure, an increase in rates from last year's suggested poorer performance.

Strengths

FBHP'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 2008–2009. FBHP's cohesive team provided a good knowledge base in all aspects of reporting. FBHP did an excellent job documenting the transition process. HSAG auditors felt the control and capture of the data from the transition was handled well, despite the complexity of the multiple systems and entities involved.

HSAG scored all of FBHP's performance measures as *Fully Compliant.* FBHP's Performance improved from the previous year for six submeasures under *Penetration Rate,* two submeasures under *Hospital Recidivism,* and all submeasures under *Follow-Up After Hospitalization for Mental*

Illness. In particular, the performance for the *Follow-Up After Hospitalization for Mental Illness* measures reflected at least a 10 percentage point improvement. These measures and five submeasures under *Penetration Rate* also performed at least 5 percentage points above the current year's statewide averages.

Although some submeasures under *Penetration Rate* or *Hospital Recidivism* demonstrated a slight decline in performance from last year's rates, FBHP's performance was still above the statewide averages.

Recommendations

An area for improvement is the *Hospital Recidivism—90 days Non-State Hospitals* submeasure. This submeasure reported a 5.1 percentage point increase in rate from last year. Since for this measure a higher rate suggests poorer performance, the increased rate represented a decline in performance, presenting an opportunity for improvement.

HSAG had no recommendations regarding claims and encounter data processing and monitoring, since the review period covered the time frame under InNET as the ASO. HSAG recognized that next year will focus on new processes in place with the partnership between FBHP and ValueOptions. However, HSAG recommended that FBHP conduct more thorough checks on data (e.g., inspect data to ensure data fields are complete) prior to submission to the State and auditors. HSAG also recommended that FBHP continue working with the State on submission of the 837 files.

During on-site discussions, it was noted that FBHP should continue working with the Department and the other BHOs to modify and update the scope document, as necessary; for example, by including the covered mental health diagnosis codes or reference to an official contract listing.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of FBHP's validation of performance measure results related to the domains of quality, timeliness, and access.

- **Quality**: FBHP's performance on the only quality measure (*Hospital Recidivism*) was mixed. The 90 days submeasure for non-state hospitals showed a decline of at least 5 percentage points in performance. Nonetheless, the 30-day submeasures for both non-state hospitals and all hospitals reported a slight improvement. Four of the six submeasures under *Hospital Recidivism* performed better than the statewide weighted averages.

- **Timeliness**: FBHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) suggested a strength. All submeasures had a rate above the statewide average performance of at least 15 percentage points and reported at least a 10 percentage point improvement from last year. FBHP's *7-day Follow-Up* performance for both non-state and state hospitals continued to demonstrate strength—close to a 20 percentage point improvement from last year and at least 25 percentage points better than the statewide average.

- **Access**: FBHP's performance in the domain of access was consistent with that of last year. Six of the eight *Penetration Rate* submeasures showed increases while one submeasure had the

same performance and one exhibited a decline. However, none of these changes from last year's rates were greater than 5 percentage points. In addition, all *Penetration Rate* measures performed above the statewide averages. For the utilization-based measures, *Hospital Average Length of Stay* reported an increase in rate while the *Emergency Room Utilization* and *Inpatient Utilization* measures reported a decline. It is important to assess utilization based on the characteristics of the BHO's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the health plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Northeast Behavioral Health Partnership, LLC (NBHP)

Findings—System and Reporting Capabilities

HSAG evaluated the systems NBHP used to report the performance measures as a component of the validation process.

Claims and Encounters: HSAG had no concerns with NBHP's claims and encounter data systems or processes. HSAG found evidence that an issue identified during the previous year's review had been addressed immediately. Like other BHOs, NBHP also transitioned to a new ASO, ValueOptions, as of July 1, 2009. Although NBHP's former ASO during the review period was out of business at the time of the FY 2008–2009 site review, NBHP provided evidence that sufficient checks and balances were in place during the review period to ensure claims and encounter data were complete and accurate. A small number of run-out claims were processed manually by NBHP staff members and entered into an Excel spreadsheet, which was provided to ValueOptions.

Eligibility: HSAG had no concerns with NBHP's eligibility data systems or processes. Although NBHP's ASO was no longer in business at the time of the site review, NBHP provided documentation that sufficient checks and balances were in place during the review period to ensure eligibility data were complete, accurate, and available to providers at the time of service.

Findings – Performance Measure Results

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

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

Performance Measures	Rate		Audit Designation	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Age Category				
Children 12 years of age and younger	8.5%	8.0%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 through 17 years of age	23.8%	23.6%	*Fully Compliant*	*Fully Compliant*
Adults 18 through 64 years of age	21.5%	21.6%	*Fully Compliant*	*Fully Compliant*
Adults 65 years of age or older	4.5%	5.0%	*Fully Compliant*	*Fully Compliant*

Table 5-13—Review Results and Audit Designation *for* NBHP				
Performance Measures	Rate		Audit Designation	
	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rate by Service Category				
Inpatient Care	0.9%	0.8%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.02%	0.03%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	13.7%	13.3%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rate	13.8%	13.7%	*Fully Compliant*	*Fully Compliant*
***Hospital Recidivism*[1]**				
Non-State Hospitals—7 days	2.0%	3.5%	*Fully Compliant*	*Fully Compliant*
30 days	6.3%	6.2%	*Fully Compliant*	*Fully Compliant*
90 days	14.5%	10.4%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	2.3%	3.6%	*Fully Compliant*	*Fully Compliant*
30 days	8.7%	6.9%	*Fully Compliant*	*Fully Compliant*
90 days	16.3%	12.7%	*Fully Compliant*	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	5.23	4.91	*Fully Compliant*	*Fully Compliant*
All Hospitals	10.23	11.02	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	6.06	6.38	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	5.17	5.21	*Fully Compliant*	*Fully Compliant*
All Hospitals	7.20	7.10	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 days	37.5%	46.0%	*Fully Compliant*	*Fully Compliant*
30–day	62.5%	63.6%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 days	38.1%	48.1%	*Fully Compliant*	*Fully Compliant*
30 days	61.3%	66.7%	*Fully Compliant*	*Fully Compliant*

[1] For the Hospital Recidivism measure, an increase in rates from last year's suggested poorer performance.

Strengths

NBHP'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 2008–2009. NBHP provided thorough documentation of the transition from InNET to ValueOptions, which was effective July 1, 2009. The effort was well-coordinated and the overall result was that the data collected for the measurement period were able to be used to calculate the performance measures without any data loss concerns. The measures were calculated using InNET's programming code, ensuring consistency with the previous year's data.

HSAG scored all of NBHP's performance measures as *Fully Compliant.* Performance improved from the previous year for 11 submeasures (*Penetration Rate—Adults 18 through 64 years of age,*

Penetration Rate—Adults 65 years of age or older, *Penetration Rate—Intensive Outpatient/Partial Hospitalization*, *30-day and 90-day Hospital Recidivism for Non-State and All Hospitals*, and all submeasures under *Follow-Up After Hospitalization for Mental Illness*). Three of the submeasures under *Follow-Up After Hospitalization for Mental Illness* showed at least a 5 percentage point improvement over last year's results. The majority of the performance measures were also above the current year's statewide averages. In particular, NBHP's performance for the 90-day *Hospital Recidivism* for non-state and all hospitals were at least 5 percentage points better than the statewide averages.

Recommendations

Compared to last year's results, several submeasures reported a slight decrease in rate of no more than 1 percentage points. The *Hospital Recidivism—Non-State Hospitals—7 days* and *Hospital Recidivism—All Hospitals—7 days* declined over 1 percentage point and represents an opportunity for improvement. All measures were relatively static. NBHP should evaluate utilization trends routinely and monitor utilization patterns and performance improvement opportunities.

During the on-site review, it was discovered that run-out claims data (claims received after the ASO was no longer in business) were not included in the preliminary performance measure calculations. Queries were run to determine how many claims were involved, and the BHO was advised to ensure these claims were included in the final rate submission, documenting the process thoroughly. Also, during the on-site review, it was discovered that discharges in June 2009 with a follow-up visit occurring in July 2009 were not being counted appropriately for performance measure reporting purposes. The programming code was corrected post-on-site.

The BHO should continue to collaborate with the other BHOs and the Department to update the scope document to include reference to the covered mental health diagnosis codes. The BHO should work with the other BHOs and the Department to consider updating the exclusion criteria for the follow-up measure to exclude nonacute readmissions within 30 days to mirror HEDIS more closely. In addition, the BHO should work with the other BHOs and the Department to consider revising the document so that Attachments A and B are either incorporated into the main document, or Attachment A contains all penetration rate criteria and Attachment B contains all follow-up criteria. It was recommended that the North Range and Larimer CMHCs should implement a more formal process to manually track appointments that were kept to ensure that each resulted in an encounter, until their new electronic medical record went live (March 2010).

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of NBHP's validation of performance measure results related to the domains of quality, timeliness, and access.

- **Quality**: NBHP's performance on the only quality measure (*Hospital Recidivism*) was mixed but was consistent with last year's results. Four of the six submeasures reported an improvement in performance and two a decline. Nonetheless, the changes in rates for all the submeasures were below 5 percentage points. In addition, all submeasures performed better than the current year's statewide averages. In particular, two (90 days for non-state hospitals and for all hospitals) reported a rate of at least 5 percentage points better than the statewide performance.

- **Timeliness**: NBHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) suggested a strength. All submeasures reported an improvement in performance, with three exhibiting an increase in rate by at least 5 percentage points. One submeasure (*Non-State Hospitals—7 days*) also performed above the statewide average.
- **Access**: NBHP's performance in the domain of access was mixed and was consistent with the previous year. Three of the eight submeasures under *Penetration Rate* demonstrated a slight increase over last year's results. The decline in rates observed in five submeasures was also slight (i.e., less than 1 percentage point). Five submeasures performed slightly above the statewide average and two performed slightly below. For the utilization-based measures, *Hospital Average Length of Stay* for all hospital, *Emergency Room Utilization*, and *Inpatient Utilization* for non-state hospitals showed an increase in rate. It is important to assess utilization based on the characteristics of the BHO's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

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 2009–2010 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

	Fully Compliant		Substantially Compliant		Not Valid	
Performance Measures	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010	FY 2008–2009	FY 2009–2010
Penetration Rates by Age Category	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Penetration Rates by Service Category	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Overall Penetration Rates	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Hospital Recidivism	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Hospital Average Length of Stay	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Emergency Department Utilization	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Inpatient Utilization	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%
Follow-up After Hospitalization for Mental Illness (7 and 30-day follow up)	5/100%	5/100%	0/0%	0/0%	0/0%	0/0%

Table 5-15 provides a summary of the statewide weighted averages for the performance measure rates for FY 2009–2010 and the prior year. In general, Table 5-15 shows that statewide use of inpatient services, emergency room services, and hospital length of stay increased over last year.

Table 5-15—Statewide Weighted Average Rates for the Performance Measures			
Performance Measures	Rate		BHO FY 2009-2010 Rate Variations
	FY 2008–2009	FY 2009–2010	
Penetration Rate by Age Category			
Children 12 years of age and younger	7.0%	7.1%	5.0%–12.4%
Adolescents 13 through 17 years of age	21.1%	20.2%	17.8%–28.9%
Adults 18 through 64 years of age	21.9%	21.6%	18.1%–29.1%
Adults 65 years of age or older	6.3%	6.6%	3.6%–9.9%
Penetration Rate by Service Category			
Inpatient Care	0.8%	0.7%	0.5%–0.9%
Intensive Outpatient/Partial Hospitalization	0.1%	0.1%	0.03%–0.2%
Ambulatory Care	12.7%	12.2%	8.9%–18.7%
Overall Penetration Rate	13.1%	13.1%	9.9%–19.5%
Hospital Recidivism[1]			
Non-State Hospitals—7 days	3.8%	4.3%	3.3%–6.3%
30 days	10.2%	10.1%	6.2%–12.4%
90 days	17.4%	18.3%	10.4%–23.0%
All Hospitals—7 days	3.7%	3.9%	2.4%–5.0%
30 days	11.0%	9.9%	6.6%–13.0%
90 days	18.0%	17.9%	12.7%–24.1%
Hospital Average Length of Stay			
Non-State Hospitals	7.29	7.78	4.91–9.20
All Hospitals	13.72	15.36	11.02–20.32
Emergency Room Utilization (Rate/1000 Members, All Ages)	8.73	9.28	6.38–11.38
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	4.06	3.48	1.77–7.08
All Hospitals	6.89	6.07	4.85–8.59
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 days	38.9%	45.1%	38.1%–77.3%
30 days	67.5%	64.2%	58.0%–84.1%
All Hospitals—7 days	42.5%	49.7%	40.4%–77.7%
30 days	68.9%	67.3%	61.4%–87.3%

[1] For the Hospital Recidivism measure, an increase in rates from last year's suggested poorer performance.

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

As noted in previous years, overall statewide BHO performance for safeguarding data integrity and quality and for reporting performance measures continued to improve. Once again, all the BHOs continued to exert satisfactory efforts to ensure that their eligibility and claims/encounter data systems were solid to process data used for performance measure reporting. Similarly, 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*. Seven of the 18 nonutilization measures demonstrated an improvement in performance from the previous year. In particular, the two seven-day *Follow-Up After Hospitalization for Mental Illness* measures reported at least a 5 percentage points improvement. For non-state hospitals, the improvement was 6.2 percentage points and for state hospitals, it was 7.2 percentage points.

Quality

The *Hospital Recidivism* measure was the only quality measure for this year. Statewide BHO performance on the *Hospital Recidivism* measures was mixed. Three of the six submeasures reported a decline in rate (hence an improvement in performance) and the other three reported an increase in rate (hence a decline). However, none of these rates declined more than 5 percentage points. Rates for *Hospital Recidivism* ranged from 2.4 percent for seven-day recidivism to about 24.1 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 seven-day *Hospital Recidivism* (3 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* measure was the only timeliness measure this year. The rates for the *7-day Follow-Up* submeasures for non-state and state hospitals (45.1 percent and 49.7 percent, respectively) reflected a notable improvement from last year. However, these rates were still below the *30-day Follow-Up* submeasures for at least 15 percentage points. 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 BHO variations. Wide BHO performance variations were observed for both *7-day Follow-Up* measures: for non-state hospitals the variation was 39.2 percent and for state hospitals the variation was 37.3 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 similar to last year. Two of the eight submeasures under *Penetration Rate* showed a slight increase; one had the same performance and all the others had a slight decline. None reported changes in rate for more

than 5 percentage points. The greatest variations in rates among the BHOs were noted in the *Penetration Rate—Adolescents 13 through 17 years of age* and *Penetration Rate—Adults 18 through 64 years of age* measures, where a 10 percentage-point difference was observed. For the utilization-based measures, statewide performance on the utilization-based measures was characterized by a slight decline in inpatient utilization but a slight increase in emergency room utilization and hospital average length of stay.

Statewide Recommendations

HSAG offers the following recommendations:

- The Department should work with the BHOs to update the scope document to include the covered mental health diagnosis codes or a reference to an official contract listing. In addition, the Department and the BHOs should consider revising the scope document so that Attachment B is either incorporated into the main document or it contains all follow-up criteria.
- The Department and BHOs may wish to consider updating the exclusion criteria for the follow-up measure to exclude nonacute readmissions within 30 days to mirror HEDIS more closely.
- The Department should work with the BHOs to refine the scope document as it relates to penetration-rate calculation, incorporating all steps necessary for this calculation within the main document or adding all steps into Attachment A. This would make reviewing and updating this document much more straightforward.

Validation of Performance Improvement Projects

For FY 2009–2010, 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.

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 Activities reviewed and evaluated. The HSAG PIP Review Team scored the evaluation elements within each activity 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 *Met* (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 2009–2010 PIP Validation Report.

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 (ABC)

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 Activities I through IX. 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 activity 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 Activity	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. Choose the study topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a representative and generalizable study population	3	2	0	0	1	2	2	0	0	0
V. Use sound sampling methods	6	0	0	0	6	1	0	0	0	1
VI. Use valid and reliable data collection procedures	11	5	0	0	6	1	0	0	0	1
VII. Implement intervention and improvement strategies	4	3	0	0	1	1	1	0	0	0
VIII. Data analysis and interpretation of study results	9	8	0	0	1	2	1	0	0	1

Table 5-16—PIP Validation Scores *for* Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment *for* ABC										
Review Activity	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*
IX. Report improvement	4	1	0	3	0	0	No Critical Elements			
X. Describe sustained improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Activities	**53**	**32**	**0**	**3**	**17**	**13**	**10**	**0**	**0**	**3**

Table 5-17—FY 2008–2009 and FY 2009–2010 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment *for* ABC		
	Prior Year FY 2008–2009	FY 2009–2010
Percentage Score of Evaluation Elements *Met**	**96%**	**91%**
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

ABC demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII. 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 a *Point of Clarification* as an opportunity 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:

- Include a comparison of the baseline results to the baseline goals in the interpretation of the findings.

In addition to the *Point of Clarification*, ABC received three *Not Met* scores in Activity IX because the study indicators demonstrated an increase. For this PIP, a decrease indicates improvement.

ABC's second PIP was the State-mandated collaborative PIP. HSAG reviewed Activities I through IX. 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 activity 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 Activity	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. Choose the study topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a representative and generalizable study population	3	3	0	0	0	2	2	0	0	0
V. Use sound sampling methods	6	0	0	0	6	1	0	0	0	1
VI. Use valid and reliable data collection procedures	11	7	0	0	4	1	1	0	0	0
VII. Implement intervention and improvement strategies	4	3	0	0	1	1	1	0	0	0
VIII. Data analysis and interpretation of study results	9	8	0	0	1	2	1	0	0	1
IX. Report improvement	4	1	2	1	0	0	No Critical Elements			
X. Describe sustained improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Activities	**53**	**35**	**2**	**1**	**14**	**13**	**11**	**0**	**0**	**2**

Table 5-19—FY 2008–2009 and FY 2009–2010 PIP Overall Validation Scores and Validation Status
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* ABC**

	Prior Year FY 2008–2009	FY 2009–2010
Percentage Score of Evaluation Elements *Met**	**93%**	**92%**
Percentage Score of Critical Elements *Met***	**82%**	**100%**
Validation Status***	***Not 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, ABC demonstrated strength in its study design and study implementation phase by receiving *Met* scores for all applicable evaluation elements for Activities I through VIII. In addition, ABC demonstrated improvement in one study indicator.

Recommendations

There were no required actions for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. HSAG provided *Point of Clarifications* as opportunities for improvement. HSAG recommended that ABC:

- Provide the date ranges for the remeasurement periods in Activity III.
- Clearly identify factors that could affect the ability to compare measurements.

In addition to the Point *of Clarifications,* ABC received two *Partially Met* and one *Not Met* scores in Activity IX because only one of the study indicators demonstrated improvement.

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 3): 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 Activities 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.

  For the FY 2009–2010 validation cycle, HSAG validated the PIP through Activity IX. ABC addressed all *Points of Clarification* and the *Partially Met* score from last year's validation. For this year's validation, HSAG identified a new *Point of Clarification* in Activity VIII. Additionally, the PIP received three *Not Met* scores in Activity IX because neither of the study indicators showed improvement.

- *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* (Year 1 through Year 3): 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. For 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 of these related to critical evaluation elements in Activities VII and VIII.

  For the FY 2009–2010 validation cycle, ABC completed Activities I through IX. In this year's submission, ABC did not address the *Points of Clarification* in Activities III and VI. However, it did address the *Partially Met* and *Not Met* scores in Activities VII and VIII and improved the overall validation status from *Not Met* to *Met*. Not all of the study indicators demonstrated improvement and none of the study indicators demonstrated statistically significant improvement; therefore, new opportunities for improvement were identified in Activity IX.

Behavioral HealthCare, Inc. (BHI)

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 previous year.

HSAG reviewed Activities I through IX. 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 activity 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 Activity	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. Choose the study topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a representative and generalizable study population	3	3	0	0	0	2	2	0	0	0
V. Use sound sampling methods	6	6	0	0	0	1	1	0	0	0
VI. Use valid and reliable data collection procedures	11	8	1	0	2	1	1	0	0	0
VII. Implement intervention and improvement strategies	4	2	1	0	1	1	1	0	0	0
VIII. Data analysis and interpretation of study results	9	9	0	0	0	2	2	0	0	0
IX. Report improvement	4	4	0	0	0	0	No Critical Elements			
X. Describe sustained improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Activities	**53**	**45**	**2**	**0**	**5**	**13**	**13**	**0**	**0**	**0**

Table 5-21—FY 2008–2009 and FY 2009–2010 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers *for* BHI		
	Prior Year FY 2008–2009	FY 2009–2010
Percentage Score of Evaluation Elements *Met**	**97%**	**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

BHI demonstrated strength in its study design by receiving *Met* scores for all applicable evaluation elements in Activities I through V. In addition, BHI specified a defined and systematic process for collecting data, implemented interventions that were related to causes/barriers identified through quality improvement processes, and performed the data analysis according to the data analysis plan in the study. All study indicators demonstrated improvement.

Recommendations

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

- Place information regarding the inclusion of consumers with special health care needs in Activity I.
- Provide complete and consistent date ranges for all measurement periods in Activities III, VI, and IX.
- Provide the rationale for the study indicators in Activity III instead of Activity I.
- Establish a goal for each study indicator for every measurement period; the interpretation of the findings should discuss the rates in comparison to the goals.

In addition to the *Points of Clarification*, BHI received two *Partially Met* scores. The PIP did not document the date range for Remeasurement 2 and did not discuss the standardization and monitoring of the interventions based on the success of the study.

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 3): 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 Activity 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 the FY 2009–2010 validation cycle, BHI completed Activities I through IX. BHI addressed the *Not Met* evaluation element in Activity VI from last year's validation; however, it did not address any of the *Points of Clarification*. HSAG identified new opportunities for improvement in Activities VII and VIII.

Colorado Health Partnerships, LLC (CHP)

Findings

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

For the first PIP, HSAG reviewed Activities I through IX. 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 activity 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 Activity	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. Choose the study topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a representative and generalizable study population	3	3	0	0	0	2	2	0	0	0
V. Use sound sampling methods	6	6	0	0	0	1	1	0	0	0
VI. Use valid and reliable data collection procedures	11	9	0	0	2	1	1	0	0	0
VII. Implement intervention and improvement strategies	4	3	0	0	1	1	1	0	0	0
VIII. Data analysis and interpretation of study results	9	9	0	0	0	2	2	0	0	0
IX. Report improvement	4	1	3	0	0	0	No Critical Elements			
X. Describe sustained improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Activities	**53**	**44**	**3**	**0**	**5**	**13**	**13**	**0**	**0**	**0**

Table 5-23—FY 2008–2009 and FY 2009–2010 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers *for* CHP		
	Prior Year FY 2008–2009	FY 2009–2010
Percentage Score of Evaluation Elements *Met**	**100%**	**94%**
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 Activities I through VIII. CHP developed its interventions based on causes/barriers, and the interventions were system changes likely to have a long-term effect on study outcomes. CHP conducted the data analysis according to the data analysis plan in the study and one study indicator demonstrated statistically significant improvement.

Recommendations

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

- Include the year of HEDIS technical specifications used to identify the preventive or ambulatory medical visit codes.
- Remove the sampling technique from the denominator for Study Indicator 2 since it is not necessary to define the study indicator.
- Document the complete date ranges in Activity IX.
- Include information about the interrater reliability process.
- Update the written instructions for the manual data collection tool with the due dates for the current measurement period.
- Include a comparison to goals in the data analysis plan.
- Include a comparison of the results to the goals for each study indicator for every measurement period.
- Document the *p* values to four decimal places and correctly document the increase as a percentage-point increase.

CHP also received three *Partially Met* scores in Activity IX because only one study indicator demonstrated improvement.

For the second PIP, HSAG reviewed Activities I through IX. 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 activity 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 Activity	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. Choose the study topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Use a representative and generalizable study population	3	3	0	0	0	2	2	0	0	0
V. Use sound sampling methods	6	0	0	0	6	1	0	0	0	1
VI. Use valid and reliable data collection procedures	11	5	0	0	6	1	0	0	0	1
VII. Implement intervention and improvement strategies	4	2	0	0	2	1	1	0	0	0
VIII. Data analysis and interpretation of study results	9	8	0	0	1	2	1	0	0	1
IX. Report improvement	4	1	3	0	0	0	No Critical Elements			
X. Describe sustained improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Activities	**53**	**31**	**3**	**0**	**18**	**13**	**10**	**0**	**0**	**3**

Table 5-25—FY 2008–2009 and FY 2009–2010 PIP Overall Validation Scores and Validation Status *for* Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+ *for* CHP

	Prior Year FY 2008–2009	FY 2009–2010
Percentage Score of Evaluation Elements *Met**	**100%**	**91%**
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 *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP, CHP demonstrated a solid study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII. The interventions were related to causes/barriers and the PIP completed data analysis according to the data analysis plan. One study indicator demonstrated statistically significant improvement.

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 include an interpretation of the baseline results in comparison to the baseline goals. CHP also received three *Partially Met* scores in Activity IX because not all of the study indicators demonstrated improvement.

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 3): 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 Activity 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 the FY 2009–2010 validation cycle, CHP completed Activities I through IX. For this year's submission, CHP addressed some of the *Points of Clarification* from the previous year but did not make all of the requested changes in Activities III and IX. Additional opportunities for improvement were identified in Activities VIII and IX.

- *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* (Year 1 through Year 2): For the FY 2008–2009 validation cycle, the PIP progressed through Activity IV. HSAG identified one opportunity for improvement in Activity I. The opportunity for

improvement was included as a *Point of Clarification*. Plan-specific data were included in Activity I of the original PIP submission; however, the resubmission did not include the data. HSAG recommended that future submissions of the PIP include the plan-specific data in Activity I of the PIP Summary Form.

For FY 2009–2010, the PIP was submitted for the second annual submission. The PIP reported baseline and Remeasurement 1 results and progressed through Activity IX. CHP addressed the *Point of Clarification* in Activity I from the previous year's validation. For this year's submission, CHP had new opportunities for improvement identified in Activities VII, VIII, and IX.

Foothills Behavioral Health Partners (FBHP)

Findings

FBHP conducted two PIPs. The *Reducing ED Utilization for Youth* PIP was selected by the BHO and the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP was State-mandated. *Reducing ED Utilization for Youth* was a new PIP for this year and the coordination of care PIP was continued from the prior year.

For the first PIP, HSAG reviewed Activities I through VIII. Table 5-26 and Table 5-27 show FBHP's scores based on HSAG's evaluation of *Reducing ED Utilization for Youth*. HSAG reviewed and scored each activity according to HSAG's validation methodology.

Table 5-26—PIP Validation Scores *for* Reducing ED Utilization for Youth *for* FBHP

Review Activity	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. Choose the study topic(s)	6	6	0	0	0	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	5	0	0	2	3	3	0	0	0
IV. Use a representative and generalizable study population	3	2	0	0	1	2	2	0	0	0
V. Use sound sampling methods	6	0	0	0	6	1	0	0	0	1
VI. Use valid and reliable data collection procedures	11	5	0	0	6	1	0	0	0	1

Table 5-26—PIP Validation Scores *for* Reducing ED Utilization for Youth *for* FBHP										
Review Activity	**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. Implement intervention and improvement strategies	4	2	0	0	2	1	1	0	0	0
VIII. Data analysis and interpretation of study results	9	4	0	0	5	2	1	0	0	1
IX. Report improvement	4	Not Assessed				No Critical Elements				
X. Describe sustained improvement	1	Not Assessed				No Critical Elements				
Totals for All Activity	**53**	**26**	**0**	**0**	**22**	**13**	**10**	**0**	**0**	**3**

Table 5-27—FY 2009–2010 PIP Overall Validation Scores and Validation Status *for* Reducing ED Utilization for Youth *for* FBHP	
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 *Reducing ED Utilization for Youth* PIP, FBHP developed a strong study design in compliance with the CMS PIP protocol. All applicable evaluation elements in Activities I through VIII received a *Met* score. FBHP's interventions were related to causes and barriers and included system changes that were likely to induce permanent change. Additionally, FBHP conducted an analysis of the timing of an outpatient visit before an ED visit. FBHP will trend these results with future remeasurements. Based on the results, FBHP will consider efforts to incorporate prescribers into the crisis prevention interventions.

Recommendations

There were no required actions for the *Reducing ED Utilization for Youth* PIP; however, HSAG recommended, as a *Point of Clarification*, that FBHP discuss the impact and resolutions to the identified factors that threaten the validity of the study and enter the results in the table in Activity IX.

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

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

Review Activity	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. Choose the study topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a representative and generalizable study population	3	3	0	0	0	2	2	0	0	0
V. Use sound sampling methods	6	6	0	0	0	1	1	0	0	0
VI. Use valid and reliable data collection procedures	11	9	0	0	2	1	1	0	0	0
VII. Implement intervention and improvement strategies	4	3	0	0	1	1	1	0	0	0
VIII. Data analysis and interpretation of study results	9	9	0	0	0	2	2	0	0	0
IX. Report improvement	4	3	1	0	0	0	No Critical Elements			
X. Describe sustained improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Activities	**53**	**46**	**1**	**0**	**5**	**13**	**13**	**0**	**0**	**0**

Table 5-29—FY 2008–2009 and FY 2009–2010 PIP Overall Validation Scores and Validation Status
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* FBHP**

	Prior Year FY 2008–2009	FY 2009–2010
Percentage Score of Evaluation Elements *Met**	**100%**	**98%**
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, FBHP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements for Activities I through VIII. All study indicators demonstrated improvement and one study indicator demonstrated a statistically significant increase.

Recommendations

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, there were no required actions. HSAG's recommendations presented as *Points of Clarification* to FBHP were:

- Include all of the measurement periods in Activities VI and IX.
- Document if updated medical record abstraction training was completed.
- Specify in the data analysis plan that the PIP will compare the results for each study indicator to the goal that was established.
- Discuss the result for each study indicator in comparison to the goal that was established for the measurement period.
- Document the results as percentages in the Activity IX results table.
- Document the correct *p* value for Study Indicator 2.

FBHP also received one *Partially Met* score in Activity IX because one study indicator demonstrated an increase that was not statistically significant.

Summary Assessment Related to Quality, Timeliness, and Access

As discussed previously, HSAG assigned all PIPs to the quality domain. Therefore, the summary assessment of FBHP's PIP validation results relate to the domain of quality. FBHP's PIPs addressed CMS' requirements related to quality outcomes—specifically, quality of care and services. By improving coordination of care and consumer satisfaction, FBHP will increase the likelihood of desired health outcomes for its consumers.

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

- *Reducing ED Utilization for Youth* (Year 1): The FY 2009–2010 submission was the first submission of the PIP. FBHP completed Activities I through VIII. The PIP provided baseline results and analysis. The next annual submission will provide the Remeasurement 1 results.
- *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* (Years 1 through 3): For the FY 2007–2008 validation cycle, FBHP 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 Activity I to document plan-specific information when it becomes available, and in Activity IV to include the wording "and enrolled" for consumers who were Medicaid-eligible for at least 10 months with FBHP.

For the FY 2008–2009 validation cycle, FBHP 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, FBHP reported baseline data and addressed the opportunities for improvement from FY 2007–2008. HSAG identified three additional opportunities for improvement in this submission.

For the FY 2009–2010 validation cycle, FBHP completed Activities I through IX. FBHP addressed the opportunities for improvement from last year's validation; however, new opportunities for improvement were identified in Activities VI, VIII, and IX. FBHP showed statistically significant improvement in one study indicator and a nonsignificant improvement in the other one. FBHP plans to continue with the implementation of interventions and monitoring to ensure all procedures are followed consistently. FBHP will also conduct an audit of its procedures to determine areas that may need additional automation or prompting.

Northeast Behavioral Health Partnership (NBHP)

Findings

NBHP 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 Activities I through IX. Table 5-30 and Table 5-31 show NBHP's scores based on HSAG's evaluation of *Therapy With Children and Adolescents: Increasing Caregiver Involvement*. HSAG reviewed and scored each activity according to HSAG's validation methodology.

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

Review Activity	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. Choose the study topic(s)	6	6	0	0	0	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a representative and generalizable study population	3	3	0	0	0	2	2	0	0	0
V. Use sound sampling methods	6	0	0	0	6	1	0	0	0	1
VI. Use valid and reliable data collection procedures	11	5	0	0	6	1	0	0	0	1
VII. Implement intervention and improvement strategies	4	2	0	0	2	1	1	0	0	0

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

Review Activity	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*
VIII. Data analysis and interpretation of study results	9	8	0	0	1	2	1	0	0	1
IX. Report improvement	4	1	2	1	0	0	No Critical Elements			
X. Describe sustained improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Activities	**53**	**33**	**2**	**1**	**16**	**13**	**10**	**0**	**0**	**3**

Table 5-31—FY 2008–2009 and FY 2009–2010 PIP Overall Validation Scores and Validation Status *for* Therapy With Children and Adolescents: Increasing Caregiver Involvement *for* NBHP

	Prior Year FY 2008–2009	FY 2009–2010
Percentage Score of Evaluation Elements *Met**	**97%**	**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 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, all applicable evaluation elements in Activities I through VIII received a *Met* score. The PIP provided Remeasurement 2 results, and all of the BHO's mental health centers continued the primary intervention, a standardized therapy contract. NBHP documented a change in data collection and the data analysis plan. Therefore, the BHO recalculated the Remeasurement 1 rate to include telephone case management contacts, reflected as Remeasurement 1b. From Remeasurement 1b to Remeasurement 2, NBHP's results improved for one study indicator; however, two of the study indicators declined. NBHP is completing a causal/barrier analysis to determine if systematic issues interfered with the process or if the declines were due to random year-to-year variation. NBHP plans to submit the findings in the next annual PIP submission.

Recommendations

There were no required actions for the *Therapy With Children and Adolescents*: *Increasing Caregiver Involvement* PIP. HSAG's recommendation as a *Point of Clarification* was as follows:

- Provide the details of the causal/barrier analysis, including how the interventions were revised based on the analysis.

NBHP also received two *Partially Met* scores and one *Not Met* score in Activity IX because not all of the study indicators demonstrated improvement and none of the study indicators demonstrated statistically significant improvement.

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

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

Review Activity	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. Choose the study topic(s)	6	5	0	0	1	1	1	0	0	0
II. Define the study question(s)	2	2	0	0	0	2	2	0	0	0
III. Select the study indicator(s)	7	6	0	0	1	3	3	0	0	0
IV. Use a representative and generalizable study population	3	3	0	0	0	2	2	0	0	0
V. Use sound sampling methods	6	0	0	0	6	1	0	0	0	1
VI. Use valid and reliable data collection procedures	11	9	0	0	2	1	1	0	0	0
VII. Implement intervention and improvement strategies	4	3	0	0	1	1	1	0	0	0
VIII. Data analysis and interpretation of study results	9	7	1	0	1	2	1	0	0	1
IX. Report improvement	4	4	0	0	0	0	No Critical Elements			
X. Describe sustained improvement	1	Not Assessed				0	No Critical Elements			
Totals for All Activities	**53**	**39**	**1**	**0**	**12**	**13**	**11**	**0**	**0**	**2**

Table 5-33—FY 2008–2009 and FY 2009–2010 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Psychiatric Providers and Physical Health Providers *for* NBHP		
	Prior Year FY 2008–2009	FY 2009–2010
Percentage Score of Evaluation Elements *Met**	100%	98%
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, NBHP demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements for Activities I through VII. The PIP also completed the data analysis according to the data analysis plan and one study indicator demonstrated an improvement that was statistically significant.

Recommendations

There were no required actions for the *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP. HSAG's recommendations as a *Point of Clarification* were as follows:

- Use State fiscal year measurement periods for all study indicators.
- Specify the year of the HEDIS technical specifications that was used to identify the preventive or ambulatory medical visit codes.
- Discuss current training for the medical record reviewers.
- Update the interrater reliability results.
- Include a comparison to goals in the data analysis plan.
- Include a comparison to the goal for every study indicator for each measurement period.
- Document the goals as a percentage.
- Label the current Remeasurement 1 results as "Baseline 2."
- Document that there were no factors that affected the ability to compare the Baseline and Remeasurement 1 results for Study Indicator 1.

Summary Assessment Related to Quality, Timeliness, and Access

As discussed previously, HSAG assigned all PIPs to the quality domain. Therefore, the summary assessment of NBHP's PIP validation results relate to the domain of quality. NBHP'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, NBHP will increase the likelihood of desired health outcomes for its consumers.

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

- *Therapy With Children and Adolescents*: *Increasing Caregiver Involvement* (Years 1 through 3): For the FY 2007–2008 validation cycle, NBHP's PIP received an overall score of 100 percent, a critical element score of 100 percent, and a *Met* validation status. NBHP 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 Activity IX. NBHP collected Remeasurement 1 data. All three study indicators showed statistically significant improvement. There was one *Partially Met* score in Activity VIII. Going forward, HSAG anticipates that NBHP will address the areas identified for improvement.

  For FY 2009–2010, the study methodology changed; therefore, HSAG validated the PIP through Activity IX again. NBHP addressed the *Partially Met* score in Activity VIII; however, HSAG identified new opportunities for improvement in Activities VII and IX. HSAG identified a *Point of Clarification* in Activity VII that NBHP should address in next year's annual submission. In Activity IX, not all of the study indicators showed improvement, and none of the study indicators demonstrated statistically significant improvement. For next year's submission, NBHP will submit Remeasurement 3 results and HSAG will validate the PIP through Activity X.

- *Coordination of Care Between Psychiatric Providers and Physical Health Providers* (Years 1 through 3): For the FY 2007–2008 validation cycle, NBHP 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 Activity 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, NBHP 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, NBHP reported baseline data and addressed the opportunity for improvement from FY 2007–2008. HSAG identified two additional opportunities for improvement.

  For the FY 2009–2010 validation cycle, NBHP completed Activities I through IX. NBHP provided complete date ranges for all measurement periods; however, it did not provide the year of HEDIS technical specifications used to identify the preventive or ambulatory medical visit codes for Study Indicator 1. HSAG identified additional opportunities for improvement in Activities VI and VIII.

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 2009–2010 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*	91%	100%	*Met*
ABC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	92%	100%	*Met*
BHI	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	96%	100%	*Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	94%	100%	*Met*
CHP	*Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+*	91%	100%	*Met*
FBHP	*Reducing ED Utilization for Youth*	100%	100%	*Met*
FBHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	98%	100%	*Met*
NBHP	*Therapy With Children and Adolescents: Increasing Caregiver Involvement*	92%	100%	*Met*
NBHP	*Coordination of Care Between Psychiatric Providers and Physical Health Providers*	98%	100%	*Met*

Overall, the BHOs' PIPs demonstrated strong performance. All nine PIPs received a validation status of *Met*, with scores of 100 percent for critical elements *Met* and scores ranging from 91 percent to 100 percent for all evaluation elements *Met*. The BHOs' performance improved from the previous year, when only eight out of nine PIPs received 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, FBHP, and NBHP to assist them in achieving their desired outcomes for their studies and meet all documentation requirements.

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 in Activities I through V. For FY 2009–2010 all PIPs received scores of *Met* for all critical evaluation elements. There were no PIPs validated through Activity X for FY 2009–2010.

Table 5-35—Summary of Data From Validation of Performance Improvement Projects					
	Validation Activity	Prior Year (FY 2008–2009) Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	FY 2009–2010 Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Prior Year (FY 2008–2009) Number of PIPs Meeting All Critical Elements/ Number Reviewed	FY 2009–2010 Number of PIPs Meeting All Critical Elements/ Number Reviewed
I.	Choose the study topic(s)	9/9	9/9	9/9	9/9
II.	Define the study question(s)	9/9	9/9	9/9	9/9
III.	Select the study indicator(s)	9/9	9/9	9/9	9/9
IV.	Use a representative and generalizable study population	9/9	9/9	9/9	9/9
V.	Use sound sampling methods	8/8	9/9	8/8	9/9
VI.	Use valid and reliable data collection procedures	7/8	8/9	8/8	9/9
VII.	Implement intervention and improvement strategies	7/8	8/9	7/8	9/9
VIII.	Data analysis and interpretation of study results	5/8	8/9	7/8	9/9
IX.	Report improvement	1/2	2/8	No Critical Elements	
X.	Describe sustained improvement	1/1	0/0	No Critical Elements	
The shaded areas represent those areas in which not all evaluation elements were *Met*.					

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 2008–2009. 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 2008–2009 site review, ABC was required to revise all applicable policies and related documents to include a definition of an action that was consistent with the BBA definition and was consistent across types of actions. ABC was required to ensure that notices of action and appeal resolution letters were easy to understand from a member perspective. ABC was also required to revise its applicable policies and related documents to accurately reflect the requirements and time frames for continuation of benefits during the appeal and State fair hearing processes.

ABC submitted a CAP to address all requirements in July 2009. After careful review, HSAG and the Department determined that, if implemented as written, ABC's CAP would adequately address all required actions. ABC submitted documents to HSAG and the Department that demonstrated implementation of its CAP in August 2009. After requiring ABC to make minor edits, HSAG and the Department determined that ABC successfully completed all FY 2008–2009 required actions. There were no required actions continued from FY 2008–2009.

Performance Measures

After the FY 2007–2008 PMV audit, HSAG recommended that ABC increase formal oversight of the Mental Health Center of Denver (MHCD) and work with the Department to reformat the Attachment A document and modify the Attachment B document.

During the FY 2009–2010 audits, HSAG found evidence that ABC monitored MHCD via a variety of reports produced monthly, quarterly, and annually. Encounter data volume was also checked monthly to ensure ABC was obtaining complete data from MHCD.

ABC continued to work collaboratively with the Department regarding submission of 837 data files, as well as the encounter data work group, to help ensure that data continued to be complete and accurate.

Performance Improvement Projects

For the FY 2008–2009 validation cycle, ABC completed two PIPs. HSAG reviewed and validated Activities I through VIII for both the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP and the *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 as required actions that the BHO provide a discussion about the causal/barrier analysis and quality improvement processes used in developing the interventions and provide a data analysis plan to explain how data analysis would occur.

In addition to the required actions, HSAG suggested as *Points of Clarification* 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 update the year annually as the study progresses.

For the *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP, there were no required actions. HSAG recommended that the BHO 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, and provide complete date ranges for all measurement periods, including future measurement periods.

After reviewing the FY 2009–2010 PIP submissions, HSAG found that for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, the BHO addressed the required actions in Activities VII and VIII; however, it did not address the *Points of Clarification* in Activities III and VI. For the *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP, the BHO addressed all of the opportunities for improvement.

Behavioral Healthcare, Inc.

Compliance Monitoring Site Reviews

As a result of the FY 2008–2009 compliance review, BHI was required to ensure that each notice of action was easy to understand and sent within the required time frames. BHI was required to revise any applicable policies and documents to include the time frame for mailing the notice of action for actions related to a denial, in whole or in part, of payment for a service. Furthermore, BHI was required to revise its 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.

BHI submitted a CAP to address all requirements in July 2009. After careful review, HSAG and the Department determined that, if implemented as written, BHI's CAP would adequately address all required actions. HSAG and the Department continued to work with BHI through February 2010 and determined that BHI had successfully completed all FY 2008–2009 required actions. There were no required actions continued from FY 2008–2009.

Performance Measures

Two of the FY 2008–2009 recommendations were not specific to BHI but were recommendations made across all of the BHOs (i.e., continue to work on the 837 file submission to the Department and reformat and modify Attachments A and B of the scope document). The BHOs continue to work on these activities. BHI addressed all recommendations from the previous year's audit that were specific to the BHO. Now that BHI is contracted with Colorado Access as the new ASO, weekly claims audits are being performed. Also, at Community Connections, a new time clock system was implemented that allows consumers to clock in for services. This system will allow BHI to better capture these encounter data. Education and training continues on this new system to ensure all consumers know how to use it and also know the importance of capturing these data.

Performance Improvement Projects

For the FY 2008–2009 validation cycle, BHI submitted one PIP. HSAG reviewed and validated Activities I through VIII for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

After validating the PIP, HSAG recommended that the BHO 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, and include an overview of the study in the written instructions for completing the manual data collection tool.

For FY 2009–2010, HSAG found that the BHO addressed the *Not Met* evaluation element in Activity VI; however, it did not address any of the *Points of Clarification*.

Colorado Health Partnerships

Compliance Monitoring Site Reviews

Based on the 2008–2009 compliance review, CHP was required to submit a CAP that addressed elements of noncompliance related to notices of action and appeals. Required actions included:

- Revising applicable policies and related materials to include an accurate and complete definition of an action.
- Ensuring that each notice of action sent to a member is easy to understand.
- Revising all applicable policies to ensure they contain accurate time frames for mailing notices of action and notices of appeal resolution and include the requirements and time frames for continuation of benefits during the appeal and State fair hearing process.
- Clarifying applicable policies to ensure member access to the State fair hearing process.
- Revising applicable policies to reflect compliance with BBA requirements regarding oral notice for expedited appeals and to be consistent with CHP's practices.

CHP submitted its CAP to HSAG and the Department in June 2009. After careful review, HSAG determined that the CAP was not specific enough to adequately address all required actions. HSAG and the Department participated in a conference call with CHP in August 2009 to answer CHP staff members' questions regarding requirements of the BBA and to outline the necessary components of a comprehensive plan. HSAG and the Department continued to work with CHP until HSAG determined that CHP had successfully completed all FY 2008–2009 required actions.

Performance Measures

HSAG found evidence that CHP worked with the other BHOs and the Department to refine the scope document. Although CHP did not complete the recommended action related to creating documentation of the encounter file submission process, it was a work in progress during the site review. CHP demonstrated sufficient oversight of the CMHCs transitioning to Unicare in the past year, holding regular meetings with the CMHCs during the transition process. CHP also ran encounter data volume comparison reports and performed other checks to ensure no data were lost during that time frame. These activities helped to ensure the transition was successful, and no data were lost.

Performance Improvement Projects

For the FY 2008–2009 validation cycle, CHP conducted two PIPs. HSAG reviewed and validated Activities I through IV for the *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP and Activities I through VIII for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

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.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, there were no required actions; however, HSAG recommended as *Points of Clarification* that the BHO provide complete date ranges for all measurement periods in Activities III, VI, and IX, include 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, and move the information regarding the rationale for the study indicators in Activity I to the section provided in Activity III.

For FY 2009–2010, the BHO addressed the recommendation in Activity I for the *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP. For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG found that the BHO addressed some of the *Points of Clarification* from the previous year; however, it did not make all of the requested changes in Activities III and IX.

Foothills Behavioral Health Partners

Compliance Monitoring Site Reviews

As a result of the FY 2008–2009 site review, Foothills Behavioral Health (FBH) was required to develop a plan of corrective action to address deficiencies in the areas of notices of action and appeals.

The definition of an action included in FBH's policies and member materials was incomplete. FBH was required to 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 results of the on-site review of notice of action records, FBH was required to:

- Ensure that it mails all notices of action within 10 days of receiving a request for services.
- Ensure that each notice 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 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.

Based on the results of the on-site review of appeal records, FBH was required to ensure that appeals were resolved and notification sent within the required time frames.

While FBH staff did use the extension process when it was in the interest of the member for standard appeals (as evidenced by the record review), FBH policies did not include an extension provision for appeals that were initially filed as expedited appeals. FBH was required to 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 best interest of the member.

FBH described an expedited review process in its policies and member materials; however, the process did not include the procedure for notifying members in writing if a request for expedited review is denied, or the procedure for FBH to determine that an expedited review process is needed. FBH was required to clarify its applicable policies and other materials to describe all the required processes related to the expedited review process for processing appeals.

The Grievance and Appeals policy, while it addressed all of the requirements, was incorrect regarding the time frame for filing an appeal and requesting continuation of benefits. FBH was required to revise applicable policies and other 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.

FBH submitted its CAP to HSAG and the Department in June 2009. After review of the proposed plan, HSAG and the Department determined that, if implemented as written, the plan would successfully address all required actions. HSAG and the Department approved FBH's CAP in July 2009 and asked that FBH submit evidence that the plan had been implemented by August 31, 2009.

In July 2009, FBH partnered with VO to form Foothills Behavioral Health Partners **(**FBHP**).** In August 2009, FBH/FBHP submitted documentation to demonstrate implementation of the proposed CAP. HSAG and the Department carefully reviewed all documentation and determined that FBHP successfully completed the FY 2008–2009 required actions. There were no required actions continued from FY 2008–2009.

Performance Measures

As a result of the FY 2008–2009 audit, HSAG recommended that FBHP work with the Department and other BHOs to reformat the Attachment A document and modify the Attachment B document. HSAG also recommended that FBHP work with the State on submitting encounter data via the 837 file format. FBHP complied with all of these recommendations and continues to work collaboratively with the Department regarding submission of 837 data files to help ensure the data are complete and accurate.

FBHP was in a transition period last year from using InNET to using VO. HSAG recommended that as FBH transitioned to FBHP (as the partnership) and used VO as its ASO, a comparative data analysis should be completed to ensure that the transition does not impact encounter data integrity or completeness. The documentation of the transition process was excellent. FBHP's control and capture of the data from the transition was also handled well, despite the complexity of the multiple systems and entities involved. The data appeared to be complete for claims and encounters processed under InNET, as well as the new claims and encounters processed via VO.

Performance Improvement Projects

FBHP submitted two PIPs during the FY 2008–2009 validation cycle. HSAG reviewed and validated Activities I through X for FBHP's *Supporting Recovery* PIP and Activities I through VIII for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

There were no required actions for the *Supporting Recovery* PIP; however, HSAG recommended as a *Point of Clarification* that FBHP add a standard deviation for the Remeasurement 4 result of Study Indicator 1. The final submission of the PIP was in FY 2008–2009.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, there were no required actions. HSAG recommended as *Points of Clarification* that the BHO specify that consumers with special health care needs were not excluded from the study, further define "statistically improve" as stated in the baseline goal, and clearly define all data sources.

For FY 2009–2010, the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP and a new study, the *Reducing ED Utilization for Youth* PIP were submitted for validation. HSAG found that the BHO addressed all of the opportunities for improvement identified

in FY 2008–2009 for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP.

Northeast Behavioral Health Partnership

Compliance Monitoring Site Reviews

As a result of the FY 2008–2009 site review, Northeast Behavioral Health (NBH) was required to revise all pertinent materials to include the correct definition of an action. NBH was also required to revise materials containing appeal resolution notification and time frames to reflect the BBA requirements and to address the 14-calendar day extension for expedited appeals. Furthermore, based on the on-site appeals record review, NBH was required to develop a mechanism to document reasonable efforts to provide oral notice of resolution for expedited appeals and to ensure that the notice of action accurately informs members of the conditions under which benefits may continue during the appeal and State fair hearing process.

NBH submitted its CAP to HSAG and the Department in June 2009. HSAG and the Department approved NBH's CAP in July 2009 and asked that NBH submit evidence that the plan had been successfully implemented by August 31, 2009.

In July 2009, NBH partnered with VO to form Northeast Behavioral Health Partnership **(**NBHP**)**. The CAP submitted by NBH/NBHP addressed how the NBH partnership with VO involved the revision of all utilization management policies and procedures. The new set of policies and procedures for NBHP contained consistent language throughout regarding the correct definition of an action and appropriately addressed all applicable time frames related to appeals. These new policies and procedures outlined how NBHP would document reasonable efforts to provide oral notice of resolution for expedited appeals and to ensure that notices of action accurately informed members of the conditions under which benefits may continue during the appeal and State fair hearing process.

NBHP submitted documentation supporting its CAP to HSAG and the Department. After careful review of all documents, HSAG and the Department found ample evidence that NBHP successfully completed the FY 2008–2009 required actions. There were no required actions continued from FY 2008–2009.

Performance Measures

During the FY 2008–2009 site visit, HSAG identified an issue related to claims data entry audits. Again, although the BHO's ASO was not in business at the time of the FY 2009–2010 site review, NBHP provided ample evidence to demonstrate it had addressed the issue immediately following the FY 2008–2009 audit. Furthermore, NBHP provided documentation that showed sufficient checks and balances were in place during the review period to ensure claims and encounter data were complete and accurate. A small number of run-out claims were manually processed by a NBHP staff member and entered into an Excel spreadsheet, which was provided to VO.

CHP also continued working with the Department and other BHOs to modify the scope document. Last, the BHO's CMHCs, North Range and Larimer, had not yet converted to their new clinical record system at the time of the on-site review due to unforeseen delays, but this transition was expected to take place in March 2010.

Performance Improvement Projects

NBHP submitted two PIPs during the FY 2008–2009 validation cycle: *Therapy With Children and Adolescents: Increasing Caregiver Involvement* and *Coordination of Care Between Psychiatric Providers and Physical Health Providers.* HSAG reviewed and validated Activities I through IX for the *Therapy With Children and Adolescents: Increasing Caregiver Involvement* PIP and Activities I through VIII for the *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP.

There were no required actions for the *Therapy With Children and Adolescents: Increasing Caregiver Involvement* PIP. HSAG recommended that the BHO 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, and document factors that may affect the ability to compare measurements.

For the *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP, there were no required actions. 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; include the year of the HEDIS technical specifications that were used; and update the year as the study progresses.

For FY 2009–2010, HSAG found that the BHO addressed the opportunities for improvement in the *Therapy With Children and Adolescents: Increasing Caregiver Involvement PIP* and one of the recommendations for the *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP. The BHO provided complete date ranges for all measurement periods; however, it did not provide the year of the HEDIS technical specifications used to identify the preventive or ambulatory medical visit codes for Study Indicator 1.

Focused Studies

Introduction

For FY 2009–2010, the Department offered each behavioral and physical health plan the option of conducting two PIPs or one PIP and one focused study with intervention. Behavioral Health Care, Inc. (BHI) and Denver Health Medicaid Choice (DHMC) opted to conduct one PIP and one focused study. The Department evaluated the focused studies and those results are presented here.

Denver Health Medicaid Choice

Study Topic and Goal

DHMC selected its study topic based on the 2009 HEDIS and CAHPS results and member grievances related to access and availability. The focused study is designed to evaluate whether analysis of access/availability grievances and HEDIS Adults Access to Preventive/Ambulatory Health Services (AAP) data will help identify preventable barriers to care, and if so, whether the barriers to care are related to appointment availability with the community health clinics.

Methodology

Using HEDIS 2010 technical specifications, DHMC plans to identify the percentage of members ages 45 through 64 and ages 65 years and older who have a preventive/ambulatory visit, and the percentage of those who do not have a preventive/ambulatory visit but who accessed emergency department or urgent care for an acute care condition during the 2009 measurement year. Data will also be collected on any DHMC member who reports a grievance for 2010 related to access and availability.

Summary and Findings

Study findings are not yet available; the study period is January 1, 2009, through December 31, 2010.

Behavioral HealthCare, Inc.

Study Topic and Goal

The BHI focus study question was: Are BHI members who are prescribed atypical antipsychotics monitored for metabolic side effects in compliance with standards of practices, as suggested by American Psychiatric Association (APA) guidelines. The impetus for the study was the 2004 publication of a consensus statement by the American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity that identified a growing concern about the association of antipsychotic medications with obesity and diabetes mellitus. These national organizations developed a consensus position on how patients should be monitored for the development of significant weight gain, dyslipedemia, and diabetes, and how they should be treated if diabetes developed. Although monitoring guidelines were developed by the consensus panel, subsequent studies have shown that compliance with the guidelines has been poor. BHI developed a focus study to assess the level of monitoring within its affiliated mental health centers.

Methodology

The study assessed the current level of monitoring for metabolic side effects for BHI adult Medicaid members ages 18 and older with any diagnosis and who were prescribed an atypical antipsychotic medication at any point during the baseline or remeasurement periods (January 1 through March 31, 2009 [baseline], and 2010 [remeasurement]). The study included two sets of indicators. Clients who had initiated a new atypical antipsychotic within the last year were placed in the initiation group and information on five indicators was collected:

- Documentation of weight, height, blood levels within 30 days of initiation.
- Referral for fasting plasma glucose (FPG) and fasting lipid panel (FLP) within 30 days of initiation.
- Documentation of personal and family history of obesity, hypertension, diabetes, dyslipidemia, cardiovascular disease.
- Documented FPG and FLP lab results within 90 days of initiation.
- Referrals for follow-up FPG and FLP tests.

Clients who had been on the same atypical antipsychotic for over a year were placed in the maintenance group and data were collected on referral for and results of FPG and FLP tests.

Between the baseline and remeasurement, BHI developed and implemented a practice guideline on monitoring clients taking atypical antipsychotic medications. Therefore, some of the date ranges for baseline ran into the remeasurement period, and some of the date ranges for the remeasurement period included time before the practice guideline was implemented.

Summary of Findings

The primary goal for the study was met: establishing a baseline in monitoring clients prescribed atypical antipsychotics for metabolic side effects.

The results of the remeasurement demonstrated:

- There was a significant increase in the psychiatric staff asking clients specifically about their personal and family history of obesity, hypertension, diabetes, dyslipidemia, and cardiovascular disease.
- There was a significant increase in clinicians providing clients with medication education on the risks and benefits of taking atypical antipsychotics for the initiation group.
- For clients in the initiation group, the psychiatric staff considered a medication change 17.64 percent more often in the remeasurement than in the baseline.
- For the maintenance group, there was a 9.7 percent increase in referring for FPG labs and an 11.6 percent increase in referring for FLP labs between baseline and remeasurement.
- There was a 14.81 percent decrease in referral to the PCP when metabolic symptoms were present for the initiation group, but this was an insignificant change due to the small denominator—number of clients with metabolic symptoms present—for both the baseline and remeasurement.
- Psychiatric staff members referred for labs and documented the laboratory test results more often for clients in the maintenance group (baseline 46–49 percent; remeasurement 57–59 percent) than for the clients in the initiation group (baseline 28–33 percent; remeasurement 37 percent).
- For remeasurement, more clients in the maintenance group with metabolic symptoms were referred to a PCP than those in the initiation group (67.39 percent and 55.56 percent, respectively).
- For remeasurement, the psychiatric staff considered a medication change when metabolic symptoms were present more often for clients in the initiation group than in the maintenance group (61.76 percent and 45.83 percent, respectively). Medication changes could have been considered less often if prescribers felt the therapeutic effects outweighed the risks and side effects if the medication was effective for the client.
- Overall, results showed a trend toward improvement.

BHI established a baseline for monitoring clients prescribed an atypical antipsychotic. The indicators requiring the simplest level of intervention did show the highest impact in remeasurement. Trends toward improvement indicated that a change in psychiatric practices—improving monitoring and documentation on clients prescribed atypical antipsychotics—may take more time than was allowed for in this study.

Conclusion and Recommendations

BHI recommended that its practice guideline, Monitoring Clients Prescribed Atypical Antipsychotics for Metabolic Side Effects, be re-introduced with a desktop training package

outlining the importance of monitoring clients taking atypical antipsychotics. Individual community mental health centers were encouraged to hold their own trainings on how electronic medical records could be used to improve monitoring and documentation.

Other State Initiatives

Accountable Care Collaborative

The Accountable Care Collaborative is part of the Medicaid reform effort. It will consist of a statewide data and analytics organization and a number of regional care-coordination organizations. The regional organizations will offer care-coordination services to support local participating providers and clients in the regions. The Accountable Care Collaborative Request for Information (RFI) was posted in July 2009 to seek information from stakeholders to further develop the model. The request for proposals (RFP) was posted August 19, 2010, and the Department will implement the program starting with 60,000 clients. As the program demonstrates success, it will be expanded in later years. All aid categories will be eligible for enrollment in the program.

CHIPRA Grant to Evaluate School-Based Health Center Model

In February 2010, Colorado and New Mexico Medicaid programs were awarded a five-year grant from the U.S. Department of Health and Human Services through the Children's Health Insurance Program Reauthorization Act (CHIPRA) to evaluate the school-based health center model of comprehensive health care service delivery to determine if the model can be recommended for replication on a broader scale. School-based health centers address health concerns and enroll children in Medicaid and Child Health Plan Plus (CHP+); improve levels of immunization and well-child and adolescent care; reduce the inappropriate use of emergency room care; reduce behavioral health risks among vulnerable populations of students; engage a broad local community constituency in health planning for children; and involve local school and public health with the private sector, improving comprehensiveness, quality, and access to health care.

The grant will not provide direct service funds to the school-based health centers in Colorado or New Mexico, but will enable the Department to evaluate health care quality and implement new processes to enhance the function of centers in Colorado and New Mexico.

Health Care Affordability Act

The 2009 Colorado Health Care Affordability Act authorized the Department to collect a hospital provider fee to expand health care coverage to more than 100,000 Coloradans. When fully implemented, $600 million in fees will be matched by federal dollars for a total of $1.2 billion annually, which will support Medicaid and CHP+ expansion and improve hospital reimbursement rates. In May 2010, an estimated 44,000 parents who had a child on Medicaid became eligible for health care coverage as a result of the hospital provider fee. Parents with a child on Medicaid can earn up to 100 percent of the federal poverty level (FPL), an increase from 60 percent.

Comprehensive Health Access Modernization Program

The Department received five-year funding from the Health Resources and Services Administration's State Health Access Program (SHAP) for seven comprehensive and interrelated projects described as Colorado's Comprehensive Health Access Modernization Program (CO-CHAMP). CO-CHAMP reflects the Department's responsibility to "champion" policies that will lead to greater access to health care, increase positive health outcomes, and reduce cost-shifting. CO-CHAMP projects include investments in infrastructure and technology as well as implementation of new strategies around benefit design and cost-sharing. Some of the programs being implemented with CO-CHAMP funding include:

- **Maximum Outreach, Retention and Enrollment (MORE)** provides an opportunity to significantly increase health care coverage. A portion of the CO-CHAMP grant will be used to implement the MORE program to design, develop, and implement outreach for Medicaid and CHP+ populations. The focus of the MORE program for the first grant year is to provide outreach to enroll children and pregnant women qualifying for CHP+ up to 250 percent of the FPL and low-income parents qualifying for Medicaid up to 100 percent of the FPL. The Department is offering to grant funds to qualified entities to assist the Department's efforts to increase enrollment in the Colorado Medicaid and the CHP+ programs by conducting eligibility and enrollment outreach activities from October 1, 2010, through August 31, 2011.
- **Eligibility Modernization—Streamlining the Application Process** will streamline the application process by replacing paper documentation with electronic data where possible, develop Web-based services for clients, and create interfaces to other State and federal systems to ease data exchange for the expansion populations, making it easier for clients to apply for public health insurance programs.
- **Benefits for Adults without Dependent Children** and **Buy in Programs for People with Disabilities** are being developed as a result of the Colorado Health Care Affordability Act.

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 was implemented in select counties and enrolled more than 2,300 clients.

Medical Homes

The Department implemented a Medical Home program for low-income children enrolled in Medicaid and CHP+. Certified Medical Homes include safety-net and private providers across the state. A total of 504 providers are qualified to serve as medical homes, serving 236,000 publicly insured children. To be certified as a medical home, primary care providers must have 24 hour, seven-day-per-week access, convenient scheduling, and must provide care coordination. After becoming certified by the Department, providers are eligible for pay-for-performance payments based on the timely access of well-child care visits.

Health Information Technology

The Department contracts with Colorado Regional Health Information Organization (CORHIO), Colorado's state-designated entity charged with facilitating health information exchange (HIE) across Colorado. CORHIO operates Colorado Regional Extension Center (CO-REC), one of 70 regional extension centers around the country designated to offer health care providers technical assistance, guidance, and information on best practices to support and accelerate health care provider efforts to become meaningful users of electronic health records (EHRs). CO-REC is delivering services through strong collaborations with the following organizations that are committed to outstanding quality improvement and shared health information across the State:

- Colorado Community Managed Care Network
- Colorado Foundation for Medical Care
- Colorado Rural Health Centers
- ClinicNet
- Health Team Works (formally known as Colorado Clinical Guidelines Collaborative)
- Physician Health Partners
- Quality Health Network

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 established that eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified objectives. With the Department of Health and Human Services' July 2010 "meaningful use" definitions in place, CO-REC will be working with primary care providers and their practices to ensure that the EHR system they acquire will support achievement of "meaningful use" objectives.

CO-REC and its seven partner organizations will provide hands-on field support for all health care providers in Colorado to advance the rapid adoption and use of health information technology.

CO-REC's implementation strategy includes assisting providers to:

- Effectively select, implement, and meaningfully use an EHR.
- Negotiate the purchases of and pricing for EHRs, including standard interfaces.
- Progress toward meaningful use of an existing EHR.
- Optimize practice work flow to ensure improvements in quality of care.
- Understand and negotiate favorable, cost-effective EHR contracts to take full advantage of interoperability.
- Protect the integrity, privacy, and security of patients' health records.
- Meet the qualifications for incentive payments from Medicaid or Medicare.

Emergency Department Utilization

Under the auspices of the Colorado Behavioral Health Quality Improvement Committee (BQuIC), the BHOs are implementing a variety of strategies to decrease inappropriate mental health utilization of emergency departments. Performance will be assessed in January 2011 using data from the 2010 HEDIS-like measure, *Emergency Department Utilization*.

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 second year that HSAG had performed compliance monitoring reviews of the physical health plans. For the FY 2009–2010 site review process, the Department requested a review of five areas of performance. HSAG developed a review strategy that corresponded with the five areas identified by the Department. These were: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—The Grievance System, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal regulations and contract requirements was evaluated through review of the five standards.

This was the sixth year that HSAG had performed compliance monitoring reviews of the BHOs. For the FY 2009–2010 site review process, the Department requested a review of seven areas of performance. HSAG developed a review strategy that corresponded with the seven areas identified by the Department. These were: Standard I—Emergency and Poststabilization Services, Standard IV—Member Rights and Protections, Standard VI—The Grievance System (grievances only), Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, Standard X—Quality Assessment and Performance Improvement. Compliance with federal regulations and contract requirements was evaluated through review of the seven standards.

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 2009–2010.

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 2009–2010 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 2009–2010 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 2009–2010 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 grievances record review (BHOs only), scores were incorporated into Standard VI—The Grievance System. 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)—2010 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 2010 (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 2009
Certified Software Report	CY 2009
Performance Measure Reports	CY 2009
Supporting Documentation	CY 2009
On-site Interviews and Demonstrations	CY 2009

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 2008–2009
Source code (programming language) for performance measures (from the Department)	FY 2008–2009
Previous year's performance measure reports	FY 2007–2008
Current performance measure results (from BHOs and the Department)	FY 2008–2009
Supporting documentation (from BHOs and the Department)	FY 2008–2009
On-site interviews and demonstrations (from BHOs and the Department)	FY 2008–2009

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. The health plans forwarded their final audit reports and final IDSS to the Department. HSAG reviewed and evaluated all data sources to assess health plan compliance with the HEDIS Compliance Audit Standards. The information system (IS) standards are listed as follows:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry
- IS 6.0—Member Call Center Data—Capture, Transfer, and Entry (this standard is not applicable to the measures under the scope of the performance measure validation)
- IS 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support HEDIS Reporting Integrity.

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.

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 2009–2010

[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 2009–2010 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 (56 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.

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 2010 global ratings for the adult and child populations. DHMC and RMHP provided HSAG with the data presented in the following tables. Morpace 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 2010			
	2009 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	61.3%	65.7%	64.7%	65.4%
Rating of Specialist Seen Most Often	60.8%	57.1%	60.9%	61.6%
Rating of All Health Care	48.1%	36.8%	54.2%	51.1%
Rating of Health Plan	55.0%	46.0%	60.3%	54.9%

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 2009 NCQA CAHPS national average.

Table D-2—NCQA National Averages and Question Summary Rates for Global Ratings				
Measure of Member Satisfaction	Child Medicaid 2010			
	2009 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	69.6%	74.3%	78.0%	69.8%
Rating of Specialist Seen Most Often	66.8%	NA	NA	69.0%
Rating of All Health Care	60.5%	55.4%	64.6%	59.3%
Rating of Health Plan	65.4%	63.9%	66.9%	62.6%

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 2009 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 2010 composite scores for the adult and child populations. DHMC and RMHP provided HSAG with the data presented in the following tables. Morpace 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 2010			
	2009 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	49.7%	33.4%	58.4%	53.3%
Getting Care Quickly	56.1%	39.1%	61.4%	58.7%
How Well Doctors Communicate	68.2%	67.0%	68.3%	68.5%
Customer Service	58.7%	NA	68.7%	NA
Shared Decision Making	58.5%	54.6%	66.0%	63.3%

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 2009 NCQA CAHPS national average.

Table D-4—NCQA National Averages and Global Proportions for Composite Scores				
Measure of Member Satisfaction	Child Medicaid 2010			
	2009 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	55.8%	NA	64.1%	52.4%
Getting Care Quickly	70.9%	44.5%	75.3%	69.0%
How Well Doctors Communicate	74.3%	71.0%	80.0%	75.7%
Customer Service	60.3%	NA	NA	55.8%
Shared Decision Making	66.1%	60.6%	72.6%	70.7%

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 2009 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 2009–2010.

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 elements that were met across both plans by the total number of applicable elements across both plans.

Table E-1—FY 2009–2010 Compliance Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Standard III—Coordination and Continuity of Care	100%	89%	94%
Standard IV—Member Rights and Protections	71%	100%	86%
Standard V—Member Information	75%	78%	76%
Standard VI—The Grievance System	63%	63%	63%
Standard X—Quality Assessment and Performance Improvement	100%	100%	100%
Totals	**76%**	**78%**	**77%**

Table E-2 shows the summary compliance monitoring scores for each BHO and the statewide average. Statewide average scores were calculated by dividing the total number of elements that were met across all five plans by the total number of applicable elements across all five plans.

Table E-2—FY 2009–2010 Compliance Scores for the BHOs

Description of Component	ABC	BHI	CHP	FBH	NBH	Statewide Average
Standard I—Emergency and Poststabilization Services	100%	100%	100%	100%	100%	100%
Standard IV—Member Rights and Protections	100%	100%	100%	100%	100%	100%
Standard VI—The Grievance System (Grievances Only)	85%	85%	100%	77%	100%	89%
Standard VII—Provider Participation and Program Integrity	100%	88%	100%	100%	100%	98%
Standard VIII—Credentialing and Recredentialing	100%	100%	100%	100%	100%	100%
Standard IX—Subcontracts and Delegation	100%	100%	100%	100%	100%	100%

Table E-2—FY 2009–2010 Compliance Scores for the BHOs						
Description of Component	ABC	BHI	CHP	FBH	NBH	Statewide Average
Standard X—Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%
Totals	**98%**	**97%**	**100%**	**97%**	**100%**	**98%**

Results from the Validation of Performance Measures

Table E-3 presents children's performance measure results for each physical health plan and the statewide average.

Table E-3—Children's Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	DHMC	RMHP	PCPP	Statewide Average
Childhood Immunization Status and Well-Child Visits				
Childhood Immunization Status (Combo #2)	86.1%	89.3%	81.1%	86.0%
Childhood Immunization Status (Combo #3)	85.2%	85.9%	78.0%	84.1%
Well-Child Visits in the First 15 Months of Life, 6+ Visits	86.1%	72.6%	62.2%	80.7%
Well-Child Visits 3–6 Years of Life	63.3%	70.5%	63.5%	64.7%
Adolescent Well-Care Visits	46.0%	48.2%	50.1%	47.9%
Children's and Adolescents' Access to Primary Care Providers (PCPs)				
12–24 months	93.6%	98.8%	97.5%	95.2%
25 months–6 years	79.2%	91.8%	85.8%	83.0%
7–11 years	85.1%	91.7%	86.9%	86.9%
12–19 years	85.8%	92.7%	88.2%	88.0%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent (BMI Percentile)				
3–11 Years	77.6%	58.6%	40.6%	66.8%
12–17 Years	75.3%	57.0%	27.5%	58.9%
Total	77.1%	58.2%	35.5%	64.6%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent (Counseling for Nutrition)				
3–11 Years	73.3%	62.6%	51.4%	67.0%
12–17 Years	66.3%	53.5%	33.8%	55.0%
Total	71.8%	60.1%	44.5%	63.7%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent (Counseling for Physical Activity)				
3–11 Years	46.0%	54.9%	41.0%	47.1%
12–17 Years	56.2%	48.2%	33.1%	48.5%
Total	48.2%	53.0%	38.0%	47.3%

Table E-4 presents adult's performance scores for each physical health plan, and the statewide average.

Table E-4—Adult's Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Adult BMI Assessment	83.7%	48.7%	28.5%	51.0%
Annual Monitoring for Patients on Persistent Medications	84.7%	75.3%	82.0%	82.2%
Use of Imaging for Low Back Pain	79.4%	72.6%	81.8%	78.5%
Controlling Blood Pressure	64.7%	74.1%	41.1%	56.2%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	64.6%	35.9%	50.2%	49.8%
Timeliness of Prenatal Care	83.5%	95.0%	66.9%	85.6%
Postpartum Care	58.4%	73.7%	57.0%	64.1%
Chlamydia Screening in Women				
16–20 years	77.2%	45.2%	33.6%	57.3%
21–24 years	80.0%	45.8%	34.3%	61.8%
Total	78.5%	45.5%	33.9%	59.3%
Adult's Access to Preventive/Ambulatory Health Services				
20–44 years	74.9%	87.7%	83.8%	80.8%
45–64 years	78.7%	90.4%	88.1%	84.7%
65+ years	69.5%	95.6%	85.4%	81.4%
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	49.6%	34.3%	27.8%	40.6%
Bronchodilator	55.6%	62.9%	31.6%	49.0%
Antidepressant Medication Management				
Effective Acute Phase Treatment	51.2%	NB	55.4%	52.8%
Effective Continuation Phase Treatment	38.0%	NB	37.8%	37.9%
NB is shown when the required benefit is not offered.				

Table E-5 presents utilization performance scores for each physical health plan and the statewide average.

Table E-5—Adult's Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Antibiotic Utilization				
Average Scrips PMPY for All Antibiotics	0.41	1.06	1.20	0.76
Average Scrips PMPY for Antibiotics of Concern	0.11	0.39	0.49	0.27
Percentage of Antibiotics of Concern of all Antibiotic Scrips	26.3%	37.1%	40.7%	35.7%

Table E-5—Adult's Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)				
Discharges (Per 1,000 Member Months)	12.85	12.12	11.46	12.31
Average Length of Stay	5.40	2.76	4.94	4.80
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)				
Discharges (Per 1,000 Member Months)	8.55	3.97	6.95	7.25
Average Length of Stay	4.88	2.97	4.13	4.48
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)				
Discharges (Per 1,000 Member Months)	1.27	2.45	3.16	2.03
Average Length of Stay	15.33	4.60	7.71	9.52
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)				
Discharges (Per 1,000 Member Months aged 10–64 years)	6.62	11.63	2.39	6.14
Average Length of Stay	2.74	1.83	2.61	2.41
Use of Services: Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	296.80	470.45	461.64	376.48
ED Visits	63.06	63.33	66.44	64.09
Ambulatory Surgery/Procedures	22.53	14.51	15.35	18.98
Observation Room Stays Resulting in Discharge	1.01	1.84	1.10	1.19
Frequency of Selected Procedures				
Myringotomy (0–4 Male & Female)	0.52	3.52	3.00	1.55
Myringotomy (5–19 Male & Female)	0.23	0.73	0.74	0.46
Tonsillectomy (0–9 Male & Female)	0.30	1.24	1.10	0.64
Tonsillectomy (10–19 Male & Female)	0.28	1.51	0.64	0.62
Dilation & Curettage (15–44 Female)	0.02	0.28	0.16	0.11
Dilation & Curettage (45–64 Female)	0.00	0.00	0.07	0.03
Hysterectomy, Abdominal (15–44 Female)	0.07	0.33	0.43	0.22
Hysterectomy, Abdominal (45–64 Female)	0.20	0.30	0.36	0.29
Hysterectomy, Vaginal (15–44 Female)	0.03	1.11	0.18	0.31
Hysterectomy, Vaginal (45–64 Female)	0.16	0.49	0.11	0.19
Cholecystectomy, Open (30–64 Male)	0.06	0.00	0.07	0.06
Cholecystectomy, Open (15–44 Female)	0.01	0.00	0.09	0.03
Cholecystectomy, Open (45–64 Female)	0.04	0.00	0.00	0.02
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.09	0.50	0.47	0.30
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	0.58	1.50	0.79	0.83
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	0.33	1.48	0.61	0.64
Back Surgery (20–44 Male)	0.05	0.71	0.28	0.25
Back Surgery (20–44 Female)	0.08	0.36	0.43	0.23

Table E-5—Adult's Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	DHMC	RMHP	PCPP	Statewide Average
Back Surgery (45–64 Male)	0.10	1.51	0.92	0.62
Back Surgery (45–64 Female)	0.20	1.28	1.04	0.75
Mastectomy (15–44 Female)	0.00	0.00	0.07	0.02
Mastectomy (45–64 Female)	0.00	0.39	0.29	0.19
Lumpectomy (15–44 Female)	0.03	0.36	0.20	0.15
Lumpectomy (45–64 Female)	0.37	1.08	0.54	0.56

Table E-6 includes FY 2009–2010 performance measure results for each BHO as well as the statewide average.

Table E-6—2009–2010 Performance Measure Results for BHOs						
Performance Measures	ABC	BHI	CHP	FBH	NBH	Statewide Average
Penetration Rate by Age Category						
Children 12 years of age and younger	6.8%	5.0%	6.7%	12.4%	8.0%	7.1%
Adolescents 13 through 17 years of age	18.1%	17.8%	18.9%	28.9%	23.6%	20.2%
Adults 18 through 64 years of age	23.6%	18.1%	20.2%	29.1%	21.6%	21.6%
Adults 65 years of age or older	8.2%	3.6%	6.8%	9.9%	5.0%	6.6%
Penetration Rate by Service Category75.6%						
Inpatient Care	0.9%	0.5%	0.7%	0.8%	0.8%	0.7%
Intensive Outpatient/Partial Hospitalization	0.1%	0.2%	0.1%	0.2%	0.03%	0.1%
Ambulatory Care	11.2%	8.9%	12.5%	18.7%	13.3%	12.2%
Overall Penetration Rate	13.3%	9.9%	12.8%	19.5%	13.7%	13.1%
Hospital Recidivism						
Non-State Hospitals – 7 days	4.6%	5.5%	3.3%	6.3%	3.5%	4.3%
30 days	12.4%	11.0%	9.8%	8.0%	6.2%	10.1%
90 days	23.0%	15.4%	17.8%	21.4%	10.4%	18.3%
All Hospitals – 7 days	5.0.%	5.0%	2.4%	3.3%	3.6%	3.9%
30 days	13.0%	12.7%	8.1%	6.6%	6.9%	9.9%
90 days	24.1%	19.9%	14.2%	16.6%	12.7%	17.5%
Hospital Average Length of Stay						
Non-State Hospitals	9.20	7.63	8.32	6.40	4.91	7.78
All Hospitals	12.15	17.75	16.78	20.32	11.02	15.36
Emergency Room Utilization (Rate/1000 Members, All Ages)	11.10	6.79	11.38	8.14	6.38	9.28
Inpatient Utilization (Rate/1000 Members, All Ages)						
Non-State Hospitals	7.08	1.77	2.55	2.24	5.21	3.48
All Hospitals	8.59	5.44	4.85	6.04	7.10	6.07

Table E-6—2009–2010 Performance Measure Results for BHOs						
Performance Measures	**ABC**	**BHI**	**CHP**	**FBH**	**NBH**	**Statewide Average**
Follow-Up After Hospitalization for Mental Illness						
Non-State Hospitals—7 days	38.1%	38.9%	47.7%	77.3%	46.0%	45.1%
30 days	58.8%	58.0%	69.2%	84.1%	63.6%	64.2%
State Hospitals—7 days	40.4%	49.3%	49.8%	77.7%	48.1%	49.7%
30 days	61.4%	64.0%	68.9%	87.3%	66.7%	67.3%

Results from the Validation of Performance Improvement Projects

Table E-7 lists the PIP study conducted by each physical health plan and the corresponding summary scores.

Table E-7—Summary of Physical Health Plans PIP Validation Scores and Validation Status				
MCO	**PIP Study**	**% of All Elements *Met***	**% of Critical Elements *Met***	**Validation Status**
DHMC	*Coordination of Care Between Physical and Behavioral Health*	100%	100%	*Met*
RMHP	*Improving Well-Care Rates for Adolescents*	98%	100%	*Met*
RMHP	*Improving Coordination of Care for Members With Behavioral Health Conditions*	91%	100%	*Met*

Table E-8 lists the PIP study conducted by each BHO and the corresponding summary scores.

Table E-8––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*	91%	100%	*Met*
ABC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	92%	100%	*Met*
BHI	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	96%	100%	*Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	94%	100%	*Met*
CHP	*Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+*	91%	100%	*Met*
FBHP	*Reducing ED Utilization for Youth*	100%	100%	*Met*
FBHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	98%	100%	*Met*

Table E-8––Summary of Each BHO's PIP Validation Scores and Validation Status				
BHO	PIP Study	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
NBHP	*Therapy With Children and Adolescents: Increasing Caregiver Involvement*	92%	100%	*Met*
NBHP	*Coordination of Care Between Psychiatric Providers and Physical Health Providers*	98%	100%	*Met*

Results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Table E-9 shows each physical health plan's summary rates and global proportions for the child CAHPS survey.

Table E-9—Child Medicaid Question Summary Rates and Global Proportions				
Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	NA	64.1%	52.4%	58.3%
Getting Care Quickly	44.5%	75.3%	60.9%	62.9%
How Well Doctors Communicate	71.0%	80.0%	75.7%	75.6%
Customer Service	NA	NA	55.8%	*
Shared Decision Making	60.6%	72.6%	70.7%	68.0%
Rating of Personal Doctor	74.3%	78.0%	69.8%	74.0%
Rating of Specialist Seen Most Often	NA	NA	69.0%	*
Rating of All Health Care	55.4%	64.6%	59.3%	59.8%
Rating of Health Plan	63.9	66.9%	62.2%	64.5%

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-10 shows each physical health plan's summary rates and global proportions for the adult CAHPS survey.

Table E-10—Adult Medicaid Question Summary Rates and Global Proportions				
Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	33.4%	58.4%	53.3%	48.8%
Getting Care Quickly	39.1%	61.4%	58.7%	51.3%
How Well Doctors Communicate	67.0%	68.3%	68.5%	67.9%
Customer Service	NA	68.7%	NA	*
Shared Decision Making	64.6%	66.0%	63.3%	61.3%
Rating of Personal Doctor	65.7%	64.7%	65.4%	65.3%

Table E-10—Adult Medicaid Question Summary Rates and Global Proportions				
Measure	DHMC	RMHP	PCPP	Statewide Average
Rating of Specialist Seen Most Often	57.1%	60.9%	61.6%	59.9%
Rating of All Health Care	36.8%	54.2%	51.1%	47.4%
Rating of Health Plan	46.0%	60.3%	54.9%	53.7%

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.