2010–2011 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.

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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. 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 three areas (i.e., 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 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] The Centers for Medicare & Medicaid Services (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. Statewide averages for all activities are located in Appendix E.

Quality—Physical Health

The fiscal year (FY) 2010–2011 compliance site review standards for which quality was assessed were (1) Coverage and Authorization of Services and (2) Credentialing and Recredentialing. Statewide performance was fair, with averages of 83 percent and 89 percent, respectively. Both health plans integrated care management processes with utilization management processes. Both health plans received recommendations to develop organizational provider assessment criteria and to implement a process to evaluate and ensure that nonaccredited facilities credential practitioners.

Statewide rates on children's performance measures assigned to the quality domain indicated stable performance. *Childhood Immunization Status (Combo #3)* and all measures involving BMI percentile ranked in the top 10th percentile for the HEDIS 2010 national performance. Statewide, nine adults' measures reported increases in rates; four (*Adult BMI Assessment*, *Postpartum Care*, *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*) showed improvement of more than 5 percentage points. *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* ranked in the top 10 percent of HEDIS 2010 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 89 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. For the statewide adult Medicaid population, the rates for all reportable measures increased slightly from the prior year. The Colorado child Medicaid population experienced slight increases for five measures and decreases for two. For this population, the *Getting Needed Care* measure had a substantial decrease of 6.4 percentage points.

Quality—Behavioral Health

HSAG assigned two of the three compliance standards to the quality domain: (1) Coverage and Authorization of Services and (2) Coordination and Continuity of Care. The BHOs demonstrated a strong understanding and implementation of State and federal regulations associated with these standards as shown by statewide averages of 95 percent and 97 percent, respectively.

The *Hospital Recidivism* measure was the only performance measure assigned to the quality domain. Performance across all BHOs 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, none of the changes—whether an increase or decrease—were statistically significant.

PIPs were assigned to the quality domain and all nine 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*. HSAG found that all BHOs were effectively using the CMS protocols to conduct valid PIPs.

Timeliness—Physical Health

HSAG assigned the two compliance standards (1) Coverage and Authorization of Services and (2) Access and Availability to the quality domain. Statewide performance was fair to strong, with averages of 83 percent and 92 percent, respectively. Materials from both health plans contained inconsistencies in documents regarding time frames for making expedited authorization decisions and providing notification to the member.

Statewide results on the timeliness performance measures were consistent with last year's results, with most of the measures showing changes of less than 5 percentage points. The *Postpartum Care* measure exhibited a more than 5 percentage point improvement. The *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure showed a decline for more than 10 percentage points, suggesting opportunities for improvement.

HSAG assigned the *Getting Care Quickly* CAHPS measure to the timeliness domain. While this measure experienced increases of 1.6 percentage points for the adult and 3.2 percentage points for the child populations, these increases were not statistically significant.

Timeliness—Behavioral Health

HSAG assigned all three compliance standards, Coverage and Authorization of Services, Access and Availability, and Coordination and Continuity of Care, to the timeliness domain. The BHOs demonstrated very strong performance with statewide averages of 95 percent, 100 percent, and 97 percent, respectively. All five BHOs achieved a score of 100 percent for Access and Availability, and four of the five BHOs scored 100 percent for Coordination and Continuity of Care.

Only one behavioral health performance measure was assigned to the timeliness domain, *Follow-up After Hospitalization for Mental Illness*. Statewide performance remained stable compared with last year's performance. For the *Follow Up After Hospitalization for Mental Illness* measure, the

categories *Non-State Hospitals—7 days* and *Non-State Hospitals—30-days* demonstrated the greatest statewide improvement, with increases of 1.7 and 1.9 percentage points over the previous year, respectively.

Access—Physical Health

The two compliance monitoring standards associated with the access domain were (1) Coverage and Authorization of Services and (2) Access and Availability. Both health plans monitored timely access to services and had mechanisms in place to improve performance. Both analyzed information from member grievances, member satisfaction surveys and HEDIS performance measures. Both health plans exhibited inconsistencies between documents regarding the time frame for making expedited authorization decisions and providing notification to the member.

Statewide results for performance measures assigned to the timeliness domain were consistent with last year's results, with most of the measures showing changes of less than 5 percentage points. The *Postpartum Care* measure exhibited a more than 5 percentage point improvement. The *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure showed a decline for more than 10 percentage points, suggesting opportunities for improvement.

HSAG assigned only one CAHPS survey measure to the access domain—*Getting Needed Care*. While the adult Medicaid population experienced an increase of 1.6 percentage points, the child population reported a statistically significant decrease of 6.4 percentage points from the prior year. HSAG recommended that the health plans continue to direct quality improvement activities toward this measure.

Access—Behavioral Health

HSAG assigned the compliance standards of (1) Coverage and Authorization of Services and (2) Access and Availability to the access domain. Statewide performance on these standards was exceptional, with overall compliance of 95 percent and 100 percent, respectively. The BHOs demonstrated strong provider oversight and ensured that standards for access were known by members and adhered to by providers.

Statewide results for performance measures assigned to the access domain were very similar to last year. Five of the eight comparable submeasures for the Penetration Rate measure showed a slight increase, and two demonstrated a slight decline. None reported changes in rate of more than 1 percentage point. The BHOs' performance on the utilization-based measures was characterized by a slight increase in *Inpatient Utilization—Non-State Hospitals* but a slight decline in *Inpatient Utilization—All Hospitals*, *Emergency Room Utilization* and *Hospital Average Length of Stay*.

Table 1-1—Assignment of Activities to Performance Domains for Physical Health Plans			
Physical Health Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard I—Coverage and Authorization of Services	✓	✓	✓
Standard II—Access and Availability		✓	✓
Standard VIII—Credentialing and Recredentialing	✓		
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)			✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Nutrition and Physical Activity for Children/Adolescents	✓		
Adult BMI Assessment	✓		
Annual Monitoring for Patients on Persistent Medications	✓		
Use of Imaging Studies for Low Back Pain	✓		
Controlling High Blood Pressure	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Prenatal Care and *Postpartum Care*	✓	✓	✓
Chlamydia Screening in Women	✓		
Adults' Access to Preventive/Ambulatory Health Services			✓
Pharmacotherapy Management of COPD Exacerbation	✓		
Antibiotic Utilization			✓
Inpatient Utilization—General Hospital/Acute Care			✓
Ambulatory Care			✓
Frequency of Selected Procedures			✓
PIPs	**Quality**	**Timeliness**	**Access**
Performance Improvement Projects	✓		
CAHPS Topics	**Quality**	**Timeliness**	**Access**
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Shared Decision Making	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

Table 1-2—Assignment of Activities to Performance Domains for Behavioral Health			
Behavioral Health Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard I—Coverage and Authorization of Services	✓	✓	✓
Standard II—Access and Availability		✓	✓
Standard III—Coordination and Continuity of Care	✓	✓	
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 third year that HSAG performed compliance monitoring reviews of the physical health plans. For the FY 2010–2011 site review process, the Department requested review of three areas of performance: Coverage and Authorization of Services, Access and Availability, and Standard Credentialing and Recredentialing. HSAG developed a review strategy that corresponded with the three 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. As part of Coverage and Authorization of Services, HSAG conducted a record review of 20 denials. HSAG also conducted a review of 10 credentialing files and 10 recredentialing files as part of its review of Credentialing and Recredentialing. While HSAG incorporated the findings for particular elements of the record review into the score for the applicable standard, the record review score was also calculated separately.

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 I—Coverage and Authorization of Services	X	X	X
Standard II—Access and Availability		X	X
Standard VII—Credentialing and Recredentialing	X		

Denver Health Medicaid Choice

Findings

Table 3-2 and Table 3-3 present the number of elements for each of the three standards and record reviews, the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*, and the overall compliance score for the current year (FY 2010–2011).

Table 3-2—Summary of Scores for the Standards for FY 2010–2011 *for* DHMC							
Standard	**# of Elements**	**# of Applicable Elements**	**# *Met***	**# *Partially Met***	**# *Not Met***	**# *Not Applicable***	**Score (% of *Met* Elements)**
Standard I—Coverage and Authorization of Services	27	27	23	4	0	0	85%
Standard II—Access and Availability	13	13	11	2	0	0	85%
Standard VII—Credentialing and Recredentialing	47	37	34	3	0	10	92%
Totals	**87**	**77**	**68**	**9**	**0**	**10**	**88%***

*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.

Table 3-3—Summary of Scores for DHMC's Record Reviews							
Record Review	**# of Elements**	**# of Applicable Elements**	**# *Met***	**# *Partially Met***	**# *Not Met***	**# *Not Applicable***	**Score (% of *Met* Elements)**
Denials	120	84	82	0	2	36	98%
Credentialing	79	68	68	0	0	11	100%
Recredentialing	79	58	58	0	0	21	100%
Totals	**278**	**210**	**208**	**0**	**2**	**68**	**99%***

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

Strengths

DHMC's care management and case management processes were integrated with utilization management (UM) processes, and staff members met routinely to discuss complex cases, provide referrals to service providers outside of DHMC's system, and assist with level of care transitions.

DHMC, through its various quality improvement initiatives, monitored timely access to services and began implementing mechanisms to improve performance. This included analyzing information from member grievances, member satisfaction surveys, HEDIS performance measures, and appointment availability data. DHMC began improving scheduling processes by handling appointment requests via a centralized appointment center. Although not all DHMC provider sites were participating at the time of the review, DHMC noted that the six sites that were fully participating had decreased call abandonment rates and improved the percentage of accurately scheduled appointments. Additional physicians were hired to meet increased demand for services.

The credentialing and recredentialing record reviews demonstrated that DHMC implemented its policies and procedures as written. Credentialing and recredentialing files were well organized. Primary source verification was completed as required and within the required time frames.

Recommendations

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

Coverage and Authorization of Services

- DHMC policies, procedures, and manuals must have consistent use of time period references to three working days, three calendar days, or 72 hours. DHMC must have a policy requirement to notify a member of an expedited authorization decision as quickly as the member's health condition requires but no later than three working days after receipt of the request for service.
- DHMC must ensure that its policy does not require written follow-up to oral expedited appeal requests.
- DHMC must ensure that its policies include extension time frames for standard and expedited authorization decisions and that its policies and manuals are consistent with each other.
- DHMC must ensure that its policies are consistent in stating that there are no incentives for denial, limitation, or discontinuation of medically necessary services for any individual involved in utilization management (UM) activities.
- DHMC should ensure that its policies and claims payment processes are congruent with the Code of Federal Regulations regarding poststabilization care (CFR) at 42 CFR 438.114(e) regarding the circumstances in which DHMC will be financially responsible for poststabilization care services obtained within or outside its network.

Access and Availability

- DHMC's grievance analysis indicated that the access and availability category had the highest percentage of grievances. These grievances were related to appointment delay and wait time to obtain appointments.
- There were inconsistencies between DHMC documents regarding appointment standards. DHMC must ensure that its policies, procedures, manuals, and member materials provide consistent information regarding appointment standards.

Credentialing and Recredentialing

- DHMC must develop a process for conducting on-site quality assessments of organizational providers, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed. DHMC must develop its own criteria for organizational provider assessment for each type of organizational provider and determine if State or CMS site visits evaluate each of DHMC's assessment and site visit standards. In addition, DHMC must have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners, as applicable.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality

Both Coverage and Authorization of Services, and Credentialing and Recredentialing contained requirements that assessed quality. DHMC earned a score of 85 percent for Coverage and Authorization of Services with a denials record review score of 98 percent. DHMC achieved a score of 92 percent for Credentialing and Recredentialing, and both credentialing and recredentialing record reviews scored 100 percent. DHMC's overall score for the quality domain was 97 percent, indicating some clear strengths in this area.

Timeliness

Both Coverage and Authorization of Services, and Access and Availability contained requirements that assessed timeliness. DHMC earned a score of 85 percent for both of these standards, and a score of 98 percent for the denials record review. DHMC's overall score for the timeliness domain was 94 percent indicating mixed results with some clear strengths and some opportunities for improvement within the timeliness domain.

Access

Both Coverage and Authorization of Services, and Access and Availability contained requirements that assessed access. DHMC earned a score of 85 percent for both of these standards, and a score of 98 percent for the denials record review. DHMC's overall score for the access domain was 94 percent.

Rocky Mountain Health Plans

Findings

Table 3-4 and Table 3-5 present the number of elements for each of the three standards and record reviews, the number of elements assigned a score of *Met*, *Partially Met, Not Met, and NA*, and the overall compliance score for the current year (FY 2010–2011).

Table 3-4—Summary of Scores for the Standards for FY 2010–2011 *for* RMHP

	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	27	27	22	5	0	0	81%
Standard II—Access and Availability	13	13	13	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	47	45	39	4	2	2	87%
Totals	**87**	**85**	**74**	**9**	**2**	**2**	**87%***

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

Table 3-5—Summary of Scores for RMHP's Record Reviews

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	120	82	46	0	36	38	56%
Credentialing	80	78	78	0	0	2	100%
Recredentialing	80	69	69	0	0	11	100%
Totals	**280**	**229**	**193**	**0**	**36**	**51**	**84%***

*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

During its review of Coverage and Authorization of Services, HSAG found that RMHP's definition of medical necessity was consistent across policies and with the federal Medicaid managed care definition. RMHP's definitions of emergency medical condition, emergency medical services, and poststabilization services were also congruent with federal requirements. RMHP included definitions for these terms in the member handbook at the required readability level.

RMHP earned a score of 100 percent for the Access and Availability standard, representing a clear strength for the health plan. Through its various quality improvement initiatives, RMHP monitored timely access to services and had mechanisms in place to improve performance. This included analyzing information from member grievances, member satisfaction surveys, and Healthcare

Effectiveness Data and Information Set (HEDIS) performance measures. An on-site review of 10 credentialing and 10 recredentialing records demonstrated that RMHP completed primary source verification and processed credentialing and recredentialing applications within the prescribed time frames. The on-site record reviews also demonstrated that RMHP completed primary source verification using NCQA-approved sources. The credentialing and recredentialing records contained all of the required documentation and were well organized.

Recommendations

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

Coverage and Authorization of Services

- RMHP must ensure that it adheres to its policy that denial decisions must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease and that it makes authorization decisions within the required time frames.
- RMHP must ensure that notices of action are provided to members and to providers and that notices to members include information indicating that the provider can file an appeal on the member's behalf. Letters to members should not state that the member may have to pay for the services.
- RMHP must ensure that policies, procedures, and manuals are consistent in their use of three working days, three calendar days, or 72 hours.
- RMHP must ensure that its written policies, procedures, and processes adhere to federal Medicaid managed care regulations—specifically, that extensions of time frames for authorization decisions are only allowed up to 14 calendar days for both standard and expedited authorization decisions.
- RMHP must ensure that it does not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms for Medicaid members.
- RMHP must ensure that it does not refuse to cover emergency services based on a notification requirement for the emergency room provider, hospital, or fiscal agent to notify the member's PCP, the contractor, or the State agency of the member's screening and treatment.

Credentialing and Recredentialing

- RMHP must develop a process to report any actions taken against nonphysician practitioners for quality reasons to the appropriate authorities, including the Colorado Department of Regulatory Agencies (DORA) for nonphysician practitioners.
- RMHP must maintain documentation to demonstrate that its medical practice review committees function as the credentialing committees, use a peer review process, and include representation from a range of participating providers.
- RMHP must develop a process for conducting on-site quality assessments of organizational providers, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed. RMHP must develop its own criteria for organizational provider assessment for each type of organizational provider and

determine if State or CMS site visits evaluate each of RMHP's assessment and site visit standards. In addition, RMHP must have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners, as applicable.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality

Both Coverage and Authorization of Services and Credentialing and Recredentialing standards contained requirements that assessed quality. RMHP earned a score of 81 percent for Coverage and Authorization of Services with a denials record review score of 56 percent. RMHP received a score of 87 percent for Credentialing and Recredentialing, and both credentialing and recredentialing record reviews scored. RMHP's overall score for the quality domain was 84 percent, indicating mixed results within this area.

Timeliness

Both Coverage and Authorization of Services and Access and Availability standards contained requirements that assessed timeliness. RMHP earned a score of 81 percent for Coverage and Authorization of Services, with a denials record review score of 56 percent, and a score of 100 percent for the Access and Availability standard. RMHP's overall timeliness score was 66 percent, indicating mixed results with both strengths and opportunities for improvement within the timeliness domain.

Access

Both Coverage and Authorization of Services and Access and Availability standards contained requirements that assessed timeliness. RMHP earned a score of 81 percent for Coverage and Authorization of Services, a denials record review score of 56 percent, and a score of 100 percent for the Access and Availability standard, indicating mixed results within the access domain.

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

Table 3-6 and Table 3-7 show the overall statewide average for each standard and record reviews 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 and record reviews by health plan as well as the statewide average.

Table 3-6—Summary of Data From the Review of Standards and Record Reviews	
Standards	**FY 2010–2011 Statewide Average***
Standard I—Coverage and Authorization of Services	83%
Standard II—Access and Availability	92%
Standard VII—Credentialing and Recredentialing	89%
Total	**88%**

* Statewide average rates are weighted averages calculated by dividing the sum of the individual numerators by the sum of the individual denominators for both the standard scores and the record review scores.

Table 3-7—Summary of Data From the Review of Standards and Record Reviews	
Standards	**FY 2010–2011 Statewide Average***
Denials	77%
Credentialing	100%
Recredentialing	100%
Total	**91%**

* Statewide average rates are weighted averages calculated by dividing the sum of the individual numerators by the sum of the individual denominators for both the standard scores and the record review scores.

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

- Both health plans had inconsistencies between their respective documents regarding the timeframe for making expedited authorization decisions and providing notification to the member. Both health plans must ensure that members receive notices of action within three working days if services are denied following an expedited request for services. Policies, procedures, and manuals must reflect this timeline consistently.
- Both health plans must develop their own criteria for organizational provider assessment for each type of organizational provider and determine if State or CMS site visits evaluate each of the health plan's assessment and site visit standards. In addition, both health plans must have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners, as applicable.

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 3-8. Appendix B contains further details about the NCQA audit process and the methodology used to conduct the EQR validation of performance measure activities.

Table 3-8—FY 2010–2011 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)			✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Nutrition and Physical Activity for Children/Adolescents	✓		
Adult BMI Assessment	✓		
Annual Monitoring for Patients on Persistent Medications	✓		
Use of Imaging Studies for Low Back Pain	✓		
Controlling High Blood Pressure	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Prenatal Care and *Postpartum Care*	✓	✓	✓
Chlamydia Screening in Women	✓		
Adults' Access to Preventive/Ambulatory Health Services			✓
Pharmacotherapy Management of COPD Exacerbation	✓		
Antibiotic Utilization			✓

Table 3-8—FY 2010–2011 Performance Measures Required for Validation			
Measure	**Quality**	**Timeliness**	**Access**
Inpatient Utilization—General Hospital/Acute Care			✓
Ambulatory Care			✓
Frequency of Selected Procedures			✓

The Department required that 19 performance measures be validated in FY 2010–2011 based on HEDIS 2011 specifications. All measures also were validated in FY 2009–2010, allowing comparisons between the previous year's and the current year's results.

Denver Health Medicaid Choice (DHMC)

Compliance with Information Systems (IS) Standards

HSAG reviewed and evaluated all data sources, including the plan's final 2011 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 identified DHMC's continuing efforts to reach members to provide for their care needs as a commendable practice. In addition, the auditor noted that DHMC continued to evaluate measures that did not meet its expectations and implemented programs and remedies to improve the care and overall HEDIS results.

Children's Performance Measures

Table 3-9 displays the DHMC rates and audit designations for each performance measure for children.

Table 3-9—Review Results and Audit Designation for Children's Performance Measures *for* DHMC					
Performance Measures	**Rate**		**Percentile Ratings[1]**	**Audit Designation**	
	HEDIS 2010	**HEDIS 2011**		**HEDIS 2010**	**HEDIS 2011**
Childhood Immunization Status and Well-Child Visits					
Childhood Immunization Status (Combo #2)[2]	86.1%	86.1%	≥90th	R	R
Childhood Immunization Status (Combo #3)[2]	85.2%	85.6%	≥90th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	86.1%	67.7%	50th–74th	R	R
Well-Child Visits 3–6 Years of Life	63.3%	68.4%	25th–49th	R	R
Adolescent Well-Care Visits	46.0%	49.1%	50t–-74th	R	R

Table 3-9—Review Results and Audit Designation for Children's Performance Measures *for* DHMC					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Children's and Adolescents' Access to Primary Care Providers (PCPs)					
12–24 Months	93.6%	93.9%	10th–24th	R	R
25 Months–6 Years	79.2%	80.0%	<10th	R	R
7–11 Years	85.1%	81.5%	<10th	R	R
12–19 Years	85.8%	85.3%	10th–24th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)					
3–11 Years	77.6%	78.6%	≥90th	R	R
12–17 Years	75.3%	75.5%	≥90th	R	R
Total	77.1%	77.9%	≥90th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)					
3–11 Years	73.3%	79.2%	≥90th	R	R
12–17 Years	66.3%	66.3%	≥90th	R	R
Total	71.8%	76.2%	≥90th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)					
3–11 Years	46.0%	55.3%	≥90th	R	R
12–17 Years	56.2%	57.1%	75th–89th	R	R
Total	48.2%	55.7%	75th–89th	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 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.
[2] The dosage for Haemophilus influenza Type b vaccine (HiB) was changed from 2 to 3 in the HEDIS 2011 specification. Nonetheless, the change does not substantially impact trending from HEDIS 2010 to HEDIS 2011 results.

Strengths

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, most have minor changes from last year's rates (i.e., within a 5-percentage-point difference). Four measures (*Well-Child Visits 3-6 Years of Life*, *Counseling for Nutrition 3-11 Years*, *Counseling for Physical Activity 3-11 Years* and *Counseling for Physical Activity Total*) reported notable improvement (i.e., 5 percentage points greater than last year's rates). Additionally, the two *Childhood Immunization Status* measures (*Combo #2 and #3*), the *BMI Percentile* and *Counseling for Nutrition* measures under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, as well as the *Counseling for Physical Activity 3-11 Years* measure ranked within the top 10 percent in the HEDIS 2010 national performance.

Recommendations

Results of DHMC's performance measures yielded several opportunities for improvement. The *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure rate reported a decline of nearly 20 percentage points. In addition to improving on this measure, DHMC should also focus on low-performing measures (e.g., two measures under *Children's & Adolescents' Access to Primary Care Providers (PCPs)—25 Months–6 Years* and *7–11 Years*) where the HEDIS 2011 rates ranked below the national 10th percentiles.

Based on the results of this year's performance measure validation findings, HSAG recommends targeting the lower-performing measures, namely *Well-Child Visits in the First 15 Months of Life, 6+ Visits* and *Children's and Adolescents' Access to Primary Care Providers (Ages 25 Months to 6 Years* and *7–11 Years).* DHMC should conduct a barrier analysis to help identify the source of the declines and design and implement interventions to target them. DHMC could consider some of the following improvement efforts.

Improve Access

Open access appointments can increase compliance by expanding provider availability.[3-1] 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.

Reminder Systems

Post cards 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 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.

Data Mining

For under-performing measures such as *Well-Child Visits in the First 15 Months of Life* and *Children's Access to Primary Care Providers (PCPs) 12–24 Months)*, that share a similar population with higher-performing measures such as *Children's Immunization Status (Combo #2 and #3)*, DHMC should conduct data mining activities to determine where and when children are receiving immunizations. If children are receiving immunizations from their PCP, then it is possible that the PCP is either not performing a Well-Child Visit or the PCP is not appropriately documenting the visit. Both of these incidents yield an opportunity to educate the PCP on services available to the population and proper coding of the visit. If the immunizations are forwarded by a registry and they are not performed at a PCP office, the MCO should identify the most common

[3-1] 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.

places that the immunizations are performed and target parent education activities at immunization locations to inform parents about the importance of well-child visits for children.

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.

Adults' Performance Measures

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

Table 3-10—Review Results and Audit Designation for Adults' Performance Measures *for* DHMC

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Adult BMI Assessment	83.7%	82.2%	≥90th	R	R
Annual Monitoring for Patients on Persistent Medications	84.7%	84.7%	50th–74th	R	R
Use of Imaging for Low Back Pain	79.4%	75.5%	25th–49th	R	R
Controlling High Blood Pressure	64.7%	66.2%	75th–89th	R	R
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	64.6%	44.4%	≥90th	R	R
Timeliness of Prenatal Care	83.5%	82.9%	25th–49th	R	R
Postpartum Care	58.4%	61.0%	25th–49th	R	R
Chlamydia Screening in Women					
16–20 Years	77.2%	73.1%	≥90th	R	R
21–24 Years	80.0%	72.8%	75th–89th	R	R
Total	78.5%	73.0%	≥90th	R	R
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	74.9%	73.2%	10th–24th	R	R
45–64 Years	78.7%	78.7%	10th–24th	R	R
65+ Years	69.5%	70.2%	<10th	R	R
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	49.6%	60.9%	25th–49th	R	R
Bronchodilator	55.6%	71.0%	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.
[1] Percentile ratings were assigned to the HEDIS 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, DHMC showed mixed results for the adult performance measures. All DHMC performance measures received an audit designation of *Reportable* (R) for the current measurement cycle. All measures for *Pharmacotherapy Management of COPD Exacerbation* improved by more than 10 percentage points. Additionally, *Adult BMI Assessment, Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis,* as well as C*hlamydia Screening in Women (16–20 Years and Total)* ranked among the top 10 percent in HEDIS 2010 national performance.

Recommendations

Results of DHMC's performance measures yielded a few opportunities for improvement. Overall, DHMC should focus efforts on measures that performed below the 50th percentile, even more specifically those that fell below the 10th percentile.

Physician Reminders

Providing PCPs and OB/GYNs with a list of missed screening opportunities/preventive health services 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.[3-2]

Patient Reminders

Members are more responsive to reminders when a clinician calls (i.e., physicians or their support staff).[3-3] 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 screening facility locations, including business hours.

[3-2] 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.

[3-3] 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 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.[3-4] 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.

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 providing practitioners with 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.[3-5]

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.[3-6]

[3-4] 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.

[3-5] 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.

[3-6] Ibid.

Utilization Performance Measures

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

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

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Antibiotic Utilization					
Average Scrips PMPY for All Antibiotics	0.41	0.48	<10th	R	R
Average Scrips PMPY for Antibiotics of Concern	0.11	0.12	<10th	R	R
Percentage of Antibiotics of Concerns of all Antibiotics Scrips	26.3%	25.8%	<10th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	12.85	9.93	75th–89th	R	R
Average Length of Stay	5.40	3.75	50th–74th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	8.55	5.87	75th–89th	R	R
Average Length of Stay	4.88	3.14	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	1.27	1.53	50th–74th	R	R
Average Length of Stay	15.33	8.13	75th–89th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months aged 10–64 Years)	6.62	5.28	25th–49th	R	R
Average Length of Stay	2.74	2.52	25th–49th	R	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	296.80	264.51	10th–24th	R	R
ED Visits	63.06	47.30	<10th	R	R
Frequency of Selected Procedures					
Bariatric Weight Loss Surgery (0-19 Male & Female)	—	0.00	—	—	R
Bariatric Weight Loss Surgery (20-44 Male & Female)	—	0.08	—	—	R
Bariatric Weight Loss Surgery (45-64 Male & Female)	—	0.08	—	—	R
Tonsillectomy (0–9 Male & Female)	0.30	0.39	10th–24th	R	R
Tonsillectomy (10–19 Male & Female)	0.28	0.17	10th–24th	R	R
Hysterectomy, Abdominal (15–44 Female)	0.07	0.08	<10th	R	R
Hysterectomy, Abdominal (45–64 Female)	0.20	0.19	<10th	R	R
Hysterectomy, Vaginal (15–44 Female)	0.03	0.08	10th–24th	R	R
Hysterectomy, Vaginal (45–64 Female)	0.16	0.19	25th–49th	R	R
Cholecystectomy, Open (30–64 Male)	0.06	0.05	50th–74th	R	R
Cholecystectomy, Open (15–44 Female)	0.01	0.01	≥90th	R	R
Cholecystectomy, Open (45–64 Female)	0.04	0.08	50th–74th	R	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.09	0.21	25th–49th	R	R

Table 3-11—Review Results and Audit Designation for Utilization Performance Measures *for* DHMC					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	0.58	0.59	10th-24th	R	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	0.33	0.41	10th-24th	R	R
Back Surgery (20–44 Male)	0.05	0.13	10th-24th	R	R
Back Surgery (20–44 Female)	0.08	0.04	10th-24th	R	R
Back Surgery (45–64 Male)	0.10	0.26	10th-24th	R	R
Back Surgery (45–64 Female)	0.20	0.34	25th-49th	R	R
Mastectomy (15–44 Female)	0.00	0.00	≥90th	R	R
Mastectomy (45–64 Female)	0.00	0.15	50th-74th	R	R
Lumpectomy (15–44 Female)	0.03	0.01	<10th	R	R
Lumpectomy (45–64 Female)	0.37	0.26	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 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.

Utilization Observations

Compared to last year, DHMC reported minor changes in the *Antibiotic Utilization* measures but showed a decline for some of the *Inpatient Utilization* and *Ambulatory Care* indicators. 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

- **Quality:** DHMC performed consistently for most of the children and adult quality-related measures, For children measures, one rate (*Well-Child Visits in the First 15 Months of Life, 6+ Visits*) declined more than 18 percentage points from last year and one rate (*Well-Child Visits 3–6 Years of Life*) improved more than 5 percentage points. For adult measures, two rates (*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Chlamydia Screening in Women*) declined at least 5 percentage points and one rate (*Pharmacotherapy Management of COPD Exacerbation*) improved by at least 10 percentage points. Overall, opportunities for improvement were noted for measures where performance had declined or was below the 50th percentile.
- **Timeliness:** DHMC's performance on most of the timeliness measures was consistent with that of last year, with a few children and adult measures exhibiting notable changes. Although the *Well-Child Visits 3–6 Years of Life* measure reported an increase of 5 percentage points, the measure

Well-Child Visits in the First 15 Months of Life, 6+ Visits showed a decline of at least 10 percentage points. Opportunities for improvement were noted for the *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure.

- **Access:** DHMC demonstrated consistent performance in all the access measures. Although there were no notable improvement or decline for any of the measures, opportunities for improvement were noted for the *Children's & Adolescents' Access to Primary Care Providers* and *Adults' Access to Preventive/Ambulatory Health Services* measures, which DHMC's ranking was below the national HEDIS 25th percentile. The MCO also demonstrated a slight decline in usage on the *Inpatient Utilization* and *Ambulatory Care* measures.

Rocky Mountain Health Plans (RMHP)

Compliance with Information Systems Standards

HSAG reviewed and evaluated all data sources—including the plan's final 2011 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, except for the following:

- IS 1.0—RMHP 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 name of 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]
- IS 7.0—RMHP was considered to be substantially compliant with IS Standard 1.0 due to its limited system ability to capture more than eight diagnosis codes. The auditor determined that these concerns had a minimal impact on HEDIS reporting.[3-8]

[3-7] 2011 Compliance Audit, Final Audit Report, HEDIS, Rocky Mountain Health Plans, June 30, 2011.
[3-8] Ibid.

Children's Performance Measures

Table 3-12 shows the RMHP rates and audit designations for each performance measure for children.

Table 3-12—Review Results and Audit Designation for Children's Performance Measures *for* RMHP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Childhood Immunization Status and Well-Child Visits					
Childhood Immunization Status (Combo #2)[2]	89.3%	82.2%	75th–89th	R	R
Childhood Immunization Status (Combo #3)[2]	85.9%	78.6%	75th–89th	R	R
Well-Child Visits in the First 15 Months of Life, 6+ Visits	72.6%	81.2%	≥90th	R	R
Well-Child Visits 3–6 Years of Life	70.5%	68.1%	25th–49th	R	R
Adolescent Well-Care Visits	48.2%	49.9%	50th–74th	R	R
Children's and Adolescents' Access to Primary Care Providers (PCPs)					
12–24 Months	98.8%	99.3%	≥90th	R	R
25 Months–6 Years	91.8%	90.0%	50th–74th	R	R
7–11 Years	91.7%	92.4%	50th–74th	R	R
12–19 Years	92.7%	93.4%	75th–89th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)					
3–11 Years	58.6%	64.8%	75th–89th	R	R
12–17 Years	57.0%	56.1%	75th–89th	R	R
Total	58.2%	62.5%	75th–89th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)					
3–11 Years	62.6%	61.5%	75th–89th	R	R
12–17 Years	53.5%	54.2%	75th–89th	R	R
Total	60.1%	59.6%	75th–89th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)					
3–11 Years	54.9%	48.0%	75th–89th	R	R
12–17 Years	48.2%	55.1%	75th–89th	R	R
Total	53.0%	49.9%	75th–89th	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 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.

[2] The dosage for Haemophilus influenza Type b vaccine (HiB) was changed from 2 to 3 in the HEDIS 2011 specification. Nonetheless, the change does not substantially impact trending from HEDIS 2010 to HEDIS 2011 results.

Strengths

All RMHP's performance measures received an audit designation of *Reportable* (R) for the current measurement cycle. Three measures (*Well Child Visits in the First 15 Months of Life, 6+ Visits, BMI Percentile 3–11 Years,* and *Counseling for Physical Activity 12–17 Years)* showed an improvement of more than 5 percentage points. Additionally, *Children's and Adolescents' Access to PCPs 12–24 Months* and *Well Child Visits in the First 15 Months of Life, 6+ Visits* ranked within top 10 percent in the HEDIS 2010 national performance.

Recommendations

Results of RMHP's performance measures yielded several opportunities for improvement. Three measures (*Counseling for Physical Activity 3–11 Years,* and the two combo *Childhood Immunization Status* measures) showed a decline of more than 5 percentage points when compared with the previous year, but ranked above the 75th percentile. RMHP should consider implementing some of the following improvement efforts.

Reminder Systems

Postcards are an easy and effective tool to increase well-visits (widely accepted as the time when immunizations are administered). 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 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 (e.g., immunizations) 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 who are behind on their immunizations are useful for promoting visit reminders and helping providers track their performance. Members who saw a doctor but did not get the recommended immunization 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.

Adults' Performance Measures

Table 3-13 shows the RMHP rates and audit designations for each performance measure for adults.

Table 3-13—Review Results and Audit Designation for Adults' Performance Measures *for* RMHP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Adult BMI Assessment	48.7%	60.1%	75th–89th	R	R
Annual Monitoring for Patients on Persistent Medications	75.3%	84.1%	25th–49th	R	R
Use of Imaging for Low Back Pain	72.6%	66.9%	<10th	R	R
Controlling High Blood Pressure	74.1%	80.1%	≥90th	R	R
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	35.9%	48.6%	≥90th	R	R
Timeliness of Prenatal Care	95.0%	97.0%	≥90th	R	R
Postpartum Care	73.7%	77.4%	≥90th	R	R
Chlamydia Screening in Women					
16–20 Years	45.2%	47.4%	10th–24th	R	R
21–24 Years	45.8%	46.5%	<10th	R	R
Total	45.5%	47.0%	10th–24th	R	R
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	87.7%	87.7%	75th–89th	R	R
45–64 Years	90.4%	91.8%	≥90th	R	R
65+ Years	95.6%	96.1%	≥90th	R	R
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	34.3%	39.0%	<10th	R	R
Bronchodilator	62.9%	65.9%	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.
NB is shown when the required benefit is not offered.
[1] Percentile ratings were assigned to the HEDIS 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.

Strengths

All RMHP's performance measures received an audit designation of *Reportable* (R) for the current measurement cycle. Two measures (*Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* and *Adult BMI Assessment*) exhibited greater than 10-percentage-point improvements; two other measures (*Controlling High Blood Pressure* and *Annual Monitoring for Patients on Persistent Medications*) demonstrated greater than 5-percentage-point improvements over last year. Two *Prenatal and Postpartum Care* measures and two *Adults' Access to Preventive/Ambulatory Health Services* measures demonstrated rates that were ranked within the top 10 percent of the HEDIS 2010 national percentiles.

Recommendations

RMHP's performance on a few measures yielded some opportunities for improvement. One particular measure, *Use of Imaging for Low Back Pain*, had a decrease of nearly 6 percentage points from last year and ranked within the bottom 10 percent of the HEDIS 2010 national percentiles. Each of the measures within *Chlamydia Screening in Women* and *Pharmacotherapy Management of COPD Exacerbation* categories ranked below the 25th percentile within the HEDIS 2010 national performance. RMHP could consider implementing some of the following improvement efforts.

Meet Patient Expectations Through Education

Information about why an imaging test is not indicated is generally sufficient for most patients.[3-9] Providing patients with evidence-based information regarding the natural history of low back pain (i.e., its expected course), advising them to remain active, and providing them with information about effective self-care options and how to prevent future episodes can help ensure patients' expectations are met.

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 screening facility locations, including 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.[3-11] Other methods to improve awareness include articles in a member newsletter, educational materials for members, and information on screening facility locations, including business hours.

[3-9] Atlas SJ, Deyo RA. Evaluating and Managing Acute Low Back Pain in the Primary Care Setting. *Journal of General Internal Medicine*. 2001; 16: 120-131.

[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.

[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.

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.

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.[3-12]

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 and can be used to support reporting needs, such as the identification of newly-diagnosed members, stratifying by selected variables, and monitoring COPD care.[3-13]

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 available lab results data. Practice guidelines for appropriate lab monitoring of patients on targeted medications would also be beneficial for providers.

[3-12] 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.

[3-13] 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 3-14 shows the RMHP rates and audit designations for the utilization performance measures.

Table 3-14—Review Results and Audit Designation for Utilization Performance Measures *for* RMHP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Antibiotic Utilization					
Average Scrips PMPY for All Antibiotics	1.06	1.09	25th–49th	R	R
Average Scrips PMPY for Antibiotics of Concern	0.39	0.40	10th–24th	R	R
Percentage of Antibiotics of Concern of All Antibiotic Scrips	37.1%	36.7%	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	12.12	11.57	75th–89th	R	R
Average Length of Stay	2.76	2.92	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	3.97	3.80	50th–74th	R	R
Average Length of Stay	2.97	3.02	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	2.45	2.64	≥90th	R	R
Average Length of Stay	4.60	4.73	10th–24th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months Aged 10–64 Years)	11.63	10.29	75th–89th	R	R
Average Length of Stay	1.83	1.91	<10th	R	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	470.45	437.76	75th–89th	R	R
ED Visits	63.33	56.89	10th–24th	R	R
Frequency of Selected Procedures					
Bariatric Weight Loss Surgery (0-19 Male & Female)	—	0.00	—	—	R
Bariatric Weight Loss Surgery (20-44 Male & Female)	—	0.23	—	—	R
Bariatric Weight Loss Surgery (45-64 Male & Female)	—	0.11	—	—	R
Tonsillectomy (0–9 Male & Female)	1.24	1.36	≥90th	R	R
Tonsillectomy (10–19 Male & Female)	1.51	1.09	≥90th	R	R
Hysterectomy, Abdominal (15–44 Female)	0.33	0.20	10th–24th	R	R
Hysterectomy, Abdominal (45–64 Female)	0.30	0.27	10th–24th	R	R
Hysterectomy, Vaginal (15–44 Female)	1.11	1.26	≥90th	R	R
Hysterectomy, Vaginal (45–64 Female)	0.49	0.62	≥90th	R	R
Cholecystectomy, Open (30–64 Male)	0.00	0.00	50th–74th	R	R
Cholecystectomy, Open (15–44 Female)	0.00	0.00	≥90th	R	R
Cholecystectomy, Open (45–64 Female)	0.00	0.18	75th–89th	R	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.50	0.81	≥90th	R	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	1.50	1.59	≥90th	R	R

Table 3-14—Review Results and Audit Designation for Utilization Performance Measures *for* RMHP					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	1.48	1.43	≥90th	R	R
Back Surgery (20–44 Male)	0.71	0.75	≥90th	R	R
Back Surgery (20–44 Female)	0.36	0.49	≥90th	R	R
Back Surgery (45–64 Male)	1.51	0.74	50th–74th	R	R
Back Surgery (45–64 Female)	1.28	1.16	≥90th	R	R
Mastectomy (15–44 Female)	0.00	0.04	≥90th	R	R
Mastectomy (45–64 Female)	0.39	0.27	75th–89th	R	R
Lumpectomy (15–44 Female)	0.36	0.20	25th–49th	R	R
Lumpectomy (45–64 Female)	1.08	0.45	25th–49th	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 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.

Utilization Observations

HSAG noted that overall rates for RMHP's utilization were fairly stable when compared to the previous year. RMHP experienced minor decreases for the *Inpatient Utilization—General Hospital Acute Care*, *Discharges (Per 1,000 Member Months)* submeasure for all types except *Surgery* and slight increases in the *Average Length of Stay* for all types. There were small increases in the *Average Scrips PMPY for All Antibiotics* and *Average Scrips PMPY for Antibiotics of Concern* measures but a slight decline in the *Percentage of Antibiotics of Concern of All Antibiotic Scrips* measure. RMHP also reported decreases in the use of *Ambulatory Care* (for both *Outpatient* and *Emergency Department Visits*).

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

- **Quality:** Compared to last year, RMHP performed consistent for most of the children quality-related measures but showed notable changes for the adult measures. Two children measures (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile: 3–11 Years* and *Well-Child Visits in the First 15 Months of Life, 6+ Visits*) improved by more than 5 percentage points. However, the two *Childhood Immunization Status* measures reported a more than 5-percentage-point decline. For adult measures, four (*Adult BMI Assessment*, *Annual Monitoring for Patients on Persistent Medications*, *Controlling High Blood Pressure*, and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*) showed a notable improvement and one (*Use of Imaging for Low Back Pain*) reported a decline. Overall, opportunities for improvement were noted for those measures reporting a decline in performance of more than 5 percentage points (i.e., *Childhood Immunization Status—Combo #2 and Combo #3*, and *Use of Imaging for Low Back Pain*).
- **Timeliness:** With the exception of one measure, RMHP demonstrated either improvement or consistent performance in most of the children and adult measures. The MCO reported the *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure having an improvement of more than 5 percentage points from last year. While performance on the *Childhood Immunization Status* measure reported a decline of more than 5 percentage points, performance still ranks above the 75th percentile
- **Access:** RMHP maintained consistent performance in the access domain from last year. Current year's rates for all measures were within one percentage points from last year's rates. Additionally, the majority of the utilization-based access measures sustained similar rates as last year's. A slight decline for discharges and increases in average length of stay were noted for the *Inpatient Utilization—General Hospital Acute Care* measure. Although there were small increases in the two *Average Scrips PMPY Antibiotic Utilization* measures, the *Percentage of Antibiotics of Concern of All Antibiotic Scrips* measure exhibited a decline. RMHP also reported decreased utilization of *Ambulatory Care* 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 3-15 displays the key types of data sources used in the validation of performance measures and the time period to which the data applied.

Table 3-15—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
HEDIS Record of Administration, Data Management and Processes (Roadmap)	CY 2010
Certified Software Report	CY 2010
Performance Measure Reports	CY 2010
Supporting Documentation	CY 2010
On-site Interviews and Information Systems Demonstrations	CY 2010

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 2011 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 did not receive 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 impacts HEDIS reporting, since medical services could be underreported.[3-14]

[3-14] HEDIS 2011 Compliance Audit, Final Report of Findings for Department of Health Care Policy & Financing, July 2011

Children's Performance Measures

Table 3-16 shows the PCPP rates and audit designations for each performance measure for children.

Table 3-16—Review Results and Audit Designation for Children's Performance Measures *for* PCPP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Childhood Immunization Status and Well-Child Visits					
Childhood Immunization Status (Combo #2)[2]	81.1%	81.8%	75th–89th	R	R
Childhood Immunization Status (Combo #3)[2]	78.0%	80.8%	75th–89th	R	R
Well–Child Visits in the First 15 Months of Life, 6+ Visits	62.2%	57.1%	25th–49th	R	R
Well–Child Visits 3–6 Years of Life	63.5%	70.1%	25th–49th	R	R
Adolescent Well-Care Visits	50.1%	47.7%	50th–74th	R	R
Children's & Adolescents' Access to PCPs					
12–24 Months	97.5%	96.9%	50th–74th	R	R
25 Months–6 Years	85.8%	88.4%	25th–49th	R	R
7–11 Years	86.9%	90.4%	25th–49th	R	R
12–19 Years	88.2%	91.7%	50th–74th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)					
3–11 Years	40.6%	48.3%	75th–89th	R	R
12–17 Years	27.5%	44.4%	75th–89th	R	R
Total	35.5%	46.7%	75th–89th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)					
3–11 Years	51.4%	56.6%	50th–74th	R	R
12–17 Years	33.8%	44.4%	50th–74th	R	R
Total	44.5%	51.6%	50th–74th	R	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)					
3–11 Years	41.0%	45.5%	50th–74th	R	R
12–17 Years	33.1%	45.0%	50th–74th	R	R
Total	38.0%	45.3%	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 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.

[2] The dosage for Haemophilus influenza Type b vaccine (HiB) was changed from 2 to 3 in the HEDIS 2011 specification. Nonetheless, the change does not substantially impact trending from HEDIS 2010 to HEDIS 2011 results.

Strengths

All PCPP's performance measures received an audit designation of *Reportable* (R) for the current measurement cycle. Several measures showed notable improvement from last year. The *Well-Child Visits 3–6 Years of Life* measures and most measures under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* reported improvement of more than 5 percentage points, with two measures (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile and Counseling for Physical Activity)—12–17 Years*) reported increases in rates of more than 10 percentage points.

Recommendations

Since none of the measures ranked below the 25th percentile of the HEDIS 2010 national performance, PCPP should focus on improving rates for measures that reported a decline in performance. One measure, *Well-Child Visits in the First 15 Months of Life, 6+Visits*, had a decrease of slightly over 5 percentage points from last year. PCPP should consider implementing some of the following improvement efforts:

Improve Access

Open access appointments can increase compliance by expanding provider availability.[3-15] 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

Post cards 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 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.

Data Mining

For the under-performing measure, *Well-Child Visits in the First 15 Months of Life*, that shares a similar population with higher-performing measures such as *Children's Immunization Status (Combo #2 and #3)*, PCPP should conduct data mining activities to determine where and when children are receiving immunizations. If children are receiving immunizations from their PCP, then it is possible that the PCP is either not performing a Well-Child Visit or the PCP is not

[3-15] 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.

appropriately documenting the visit. Both of these incidents yield an opportunity to educate the PCP on services available to the population and proper coding of the visit. If the immunizations are forwarded by a registry and they are not performed at a PCP office, the PCPP should identify the most common places that the immunizations are performed and target parent education activities at immunization locations to inform parents about the importance of well-child visits for children.

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 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.

Adults' Performance Measures

Table 3-17 shows the PCPP rates and audit designations for each performance measure for adults.

Table 3-17—Review Results and Audit Designation for Adults' Performance Measures *for* PCPP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Adult BMI Assessment	28.5%	35.5%	50th–74th	R	R
Annual Monitoring for Patients on Persistent Medications	82.0%	83.2%	25th–49th	R	R
Use of Imaging for Low Back Pain	81.8%	71.1%	10th–24th	R	R
Controlling Blood Pressure	41.1%	43.3%	10th–24th	R	R
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	50.2%	40.1%	≥90th	R	R
Timeliness of Prenatal Care	66.9%	84.0%	25th–49th	R	R
Postpartum Care	57.0%	70.3%	75th–89th	R	R
Chlamydia Screening in Women					
16–20 Years	33.6%	30.5%	<10th	R	R
21–24 Years	34.3%	27.7%	<10th	R	R
Total	33.9%	29.4%	<10th	R	R
Adults' Access to Preventive/Ambulatory Health Services					
20– 44 Years	83.8%	83.6%	50th–74th	R	R
45–64 Years	88.1%	88.0%	25th–49th	R	R
65+ Years	85.4%	86.0%	25th–49th	R	R
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	27.8%	62.5%	25th–49th	R	R
Bronchodilator	31.6%	75.0%	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.

[1] Percentile ratings were assigned to the HEDIS 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.

Strengths

Overall, PCPP showed very 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. Four measures (both measures in *Pharmacotherapy Management of COPD Exacerbation* and both measures in *Prenatal and Postpartum Care*) showed an increase of more than 10 percentage points over the prior year, with the *Pharmacotherapy Management of COPD Exacerbation* demonstrated an improvement over 30 percentage points. In addition, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* ranked among the top 10 percent in HEDIS 2010 national performance.

Recommendations

PCPP's performance on a few measures suggested opportunities for improvement. The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Use of Imaging for Low Back Pain* measures showed a decrease of more than 10 percentage points from the previous year. Additionally, the *Chlamydia Screening in Women 21–24 Years* measure reported a decrease in rate of more than 5 percentage points and all indicators performed below the 10th percentile. The PCPP should consider implementing some of the following improvement efforts.

Patient Reminders

Members are more responsive to reminders when a clinician calls (i.e., physicians or their support staff).[3-16] 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.

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.[3-17] Since the early detection and treatment of chlamydia can help prevent adverse health consequences such as pelvic inflammatory disease and infertility, the PCPP should employ targeted outreach strategies to women to educate them on the importance of gynecological preventive care. Other methods to improve awareness include articles in a member newsletter, educational materials for members, and information on screening facility locations, including business hours.

[3-16] 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.

[3-17] 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.

Physician Tools and Resources

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. The PCPP should also provide additional education to physicians on the importance of gynecological preventive screenings and remind physicians to include chlamydia screening in routine examinations.

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.[3-18]

Meet Patient Expectations Through Education

Information about why an imaging test is not indicated is generally sufficient for most patients.[3-19] Providing patients with evidence-based information on low back pain regarding the natural history of low back pain (i.e., its expected course), advising them to remain active, and providing them with information about effective self-care options, and how to prevent future episodes can help ensure patients' expectations are met.

Patient Education

There is a need to increase patient awareness about not only the dangers of antibiotic use for treating acute bronchitis but also the lack of effectiveness. Patient education should emphasize that the condition does not require antibiotic treatment and that antibiotic treatment is not recommended. Furthermore, the use of the term "chest cold" has been associated with a decrease in a patient's belief that he or she needs an antibiotic. In one study, 44 percent of patients thought that antibiotics were more important for acute bronchitis compared to 11 percent for chest colds. For those patients whose acute bronchitis may be associated with smoking, smoking cessation advise/tools can help to reduce the symptoms of acute bronchitis caused by smoking.[3-20]

[3-18] 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.

[3-19] Atlas SJ, Deyo RA. Evaluating and Managing Acute Low Back Pain in the Primary Care Setting. *Journal of General Internal Medicine*. 2001; 16: 120-131.

[3-20] Braman SS. Chornic Cough Due to Acute Bronchitis: ACCP Evidence-Based Clinical Practice Guidelines. *Chest*. 2006; 129: 95S-103S.

Delayed Prescribing Practices

Delayed prescribing includes the delay in prescribing antibiotics unless a patient has continuing, severe symptoms for a specified time after an initial visit with a provider. Delayed prescribing practices rationalizes antibiotic use and results in a reduction of overall use of antibiotic, a change in consulting patterns, and allows for the adequate control of symptoms. Studies recommend delaying prescribing antibiotics from 48 to 72 hours. In one study, delaying the prescribing of antibiotics for 48 hours resulted in 62 percent of patients not using antibiotics. [3-21]

Utilization Performance Measures

Table 3-18 shows the PCPP rates and audit designations for utilization performance measures and submeasures.

Table 3-18—Review Results and Audit Designation for Utilization Performance Measures *for* PCPP

Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Antibiotic Utilization					
Average Scrips PMPY for All Antibiotics	1.20	1.25	50th–74th	R	R
Average Scrips PMPY for Antibiotics of Concern	0.49	0.47	25th–49th	R	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips	40.7%	37.9%	25th–49th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)					
Discharges (Per 1,000 Member Months)	11.46	11.51	75th–89th	R	R
Average Length of Stay	4.94	4.90	≥90th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)					
Discharges (Per 1,000 Member Months)	6.95	6.97	≥90th	R	R
Average Length of Stay	4.13	4.19	75th–89th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)					
Discharges (Per 1,000 Member Months)	3.16	3.02	≥90th	R	R
Average Length of Stay	7.71	7.68	75th–89th	R	R
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)					
Discharges (Per 1,000 Member Months Aged 10–64 Years)	2.39	2.62	<10th	R	R
Average Length of Stay	2.61	2.63	25th–49th	R	R
Use of Services: Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	461.64	409.99	50th–74th	R	R
ED Visits	66.44	63.92	25th–49th	R	R
Frequency of Selected Procedures					
Bariatric Weight Loss Surgery (0–19 Male & Female)	—	0.01	—	—	R
Bariatric Weight Loss Surgery (20–44 Male & Female)	—	0.08	—	—	R
Bariatric Weight Loss Surgery (45–64 Male & Female)	—	0.09	—	—	R

[3-21] Little P. Delayed Prescribing—A Sensible Approach to the Management of Acute Otitis Media" *JAMA*. 2006; 296(10): 1290-1291.

Table 3-18—Review Results and Audit Designation for Utilization Performance Measures *for* PCPP					
Performance Measures	Rate		Percentile Ratings[1]	Audit Designation	
	HEDIS 2010	HEDIS 2011		HEDIS 2010	HEDIS 2011
Tonsillectomy (0–9 Male & Female)	1.10	1.02	75th–89th	R	R
Tonsillectomy (10–19 Male & Female)	0.64	0.73	≥90th	R	R
Hysterectomy, Abdominal (15–44 Female)	0.43	0.40	75th–89th	R	R
Hysterectomy, Abdominal (45–64 Female)	0.36	0.21	10th–24th	R	R
Hysterectomy, Vaginal (15–44 Female)	0.18	0.30	75th–89th	R	R
Hysterectomy, Vaginal (45–64 Female)	0.11	0.07	10th–24th	R	R
Cholecystectomy, Open (30–64 Male)	0.07	0.03	50th–74th	R	R
Cholecystectomy, Open (15–44 Female)	0.09	0.06	≥90th	R	R
Cholecystectomy, Open (45–64 Female)	0.00	0.00	50th–74th	R	R
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.47	0.29	25th–49th	R	R
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	0.79	1.07	75th–89th	R	R
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	0.61	0.71	50th–74th	R	R
Back Surgery (20–44 Male)	0.28	0.19	10th–24th	R	R
Back Surgery (20–44 Female)	0.43	0.21	50th–74th	R	R
Back Surgery (45–64 Male)	0.92	0.57	25th–49th	R	R
Back Surgery (45–64 Female)	1.04	0.67	50th–74th	R	R
Mastectomy (15–44 Female)	0.07	0.02	≥90th	R	R
Mastectomy (45–64 Female)	0.29	0.11	50th–74th	R	R
Lumpectomy (15–44 Female)	0.20	0.16	25th–49th	R	R
Lumpectomy (45–64 Female)	0.54	0.14	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.
[1] Percentile ratings were assigned to the HEDIS 2011 reported rates based on HEDIS 2010 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* measures, PCPP experienced small increases in the *Average Scripts PMPY for All Antibiotics*, but a decrease in *the Percentage of Antibiotics of Concern of All Antibiotic Scripts and Average Scripts PMPY for Antibiotics of Concern.* For the current year, PCPP showed a decrease in utilization under *Ambulatory Care* and *Average Length of Stay for Inpatient Utilization* but a slight increase in *Total Inpatient* utilization.

It is important to assess utilization based on the characteristics of the 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. The following is a summary assessment of PCPP's performance measure results related to the domains of quality, timeliness, and access.

- **Quality:** PCPP reported notable improvement in many measures but also declines in some measures. Two children's measures (*Well-Child Visits 3–6 Years of Life* and all the measures under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*) showed an improvement of at least 5 percentage points from last year. Adult quality-related measures also reflected notable changes since last year, with several measures (*Adult BMI Assessment*, *Prenatal and Postpartum Care*, and *Pharmacotherapy Management of COPD Exacerbation*) reporting substantial improvement. At the same time, PCPP reported a decline in performance for three measures (*Use of Imaging for Low Back Pain, Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis,* and *Chlamydia Screening in Women*). These three areas presented opportunities for improvement.
- **Timeliness:** PCPP reported consistent performance in the timeliness domain. The *Well-Child Visits 3–6 Years of Life* and *Prenatal and Postpartum Care* measures reported a notable improvement. Nonetheless, Well-Child Visits remained an area for improvement, based on its ranking below the national 50th percentile.
- **Access:** PCPP also reported consistent performance in the access domain, with a majority of the measures showing slight changes. The *Prenatal and Postpartum Care* measures reported an improvement of at least 10 percentage points. Nonetheless, certain age groups under the *Children's & Adolescents' Access to PCPs* (*25 Months–6 Years* and *7–11 Years*) and *Adults' Access to Preventive/Ambulatory Health Services* (*45–64 Years* and 65+ Years) measures ranked below the national 50th percentile. For the utilization-based access measures, PCPP reported mixed performance in the *Antibiotic Utilization* measure, a decrease in utilization under *Ambulatory Care* and *Average Length of Stay for Inpatient Utilization* but a slight increase in *Total Inpatient* utilization.

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

Table 3-19 shows the statewide weighted averages and audit designations for each performance measure for children.

Table 3-19—Statewide Summary of Rates for the Children's Performance Measures

Performance Measures	Rate		Percentile Ratings[1]
	HEDIS 2010	HEDIS 2011	
Childhood Immunization Status and Well-Child Visits			
Childhood Immunization Status (Combo #2)[2]	86.0%	84.6%	75th–89th
Childhood Immunization Status (Combo #3)[2]	84.1%	83.3%	≥90th
Well-Child Visits in the First 15 Months of Life, 6+ Visits	80.7%	69.9%	75th–89th
Well-Child Visits 3–6 Years of Life	64.7%	68.6%	25th–49th
Adolescent Well-Care Visits	47.9%	48.9%	50th–74th
Children's & Adolescents' Access to PCPs			
12–24 Months	95.2%	95.7%	25th–49th
25 Months–6 Years	83.0%	83.8%	10th–24th
7–11 Years	86.9%	86.1%	10th–24th
12–19 Years	88.0%	89.1%	50th–74th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)			
3–11 Years	66.8%	67.8%	≥90th
12–17 Years	58.9%	60.9%	≥90th
Total	64.6%	65.9%	≥90th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)			
3–11 Years	67.0%	69.5%	75th-89th
12–17 Years	55.0%	56.4%	50th–74th
Total	63.7%	65.7%	75th–89th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)			
3–11 Years	47.1%	51.1%	75th–89th
12–17 Years	48.5%	52.7%	75th–89th
Total	47.3%	51.5%	75th–89th

[1] Percentile ratings were assigned to the HEDIS 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.
[2] The dosage for Haemophilus influenza Type b vaccine (HiB) was changed from 2 to 3 in the HEDIS 2011 specification. Nonetheless, the change does not substantially impact trending from HEDIS 2010 to HEDIS 2011 results.

Strengths

Overall, statewide rates on the children's measures suggested stable performance compared to last year. All performance measures received an audit result of *Reportable* (R) for the current measurement cycle. Fourteen measures reported a slight increase, though none greater than 5 percentage points. *Childhood Immunization Status (Combo #3)* and all measures within *BMI Percentile* ranked in the top 10th percentile for the HEDIS 2010 national performance.

Recommendations

HSAG noted a few measures reported a decline in performance from last year. More specifically, statewide performance on *Well-Child Visits in the First 15 Months of Life, 6+ Visits* declined by more than 10 percentage points from the prior year. Substantial changes from last year were noted for each MCO, with one plan reporting a decline of more than 15 percentage points and another plan exhibiting improvement of more than 5 percentage points.

Adults' Performance Measures

Table 3-20 displays the statewide weighted averages and audit designations for each performance measure for adults.

Table 3-20—Statewide Summary of Rates for the Adults' Performance Measures

Performance Measures	Rate		Percentile Ratings[1]
	HEDIS 2010	HEDIS 2011	
Adult BMI Assessment	51.0%	57.6%	75th–89th
Annual Monitoring for Patients on Persistent Medications	82.2%	84.1%	25th–49th
Use of Imaging for Low Back Pain	78.5%	71.9%	10th–24th
Controlling High Blood Pressure	56.2%	59.4%	50th–74th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	49.8%	43.1%	≥90th
Timeliness of Prenatal Care	85.6%	88.8%	50th–74th
Postpartum Care	64.1%	69.2%	50th–74th
Chlamydia Screening in Women			
16–20 Years	57.3%	55.7%	50th–74th
21–24 Years	61.8%	55.8%	10th–24th
Total	59.3%	55.8%	50th–74th
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	80.8%	80.0%	25th–49th
45–64 Years	84.7%	84.8%	25th–49th
65+ Years	81.4%	81.9%	10th–24th
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	40.6%	56.3%	25th–49th
Bronchodilator	49.0%	71.3%	10th–24th

[1] Percentile ratings were assigned to the HEDIS 2011 reported rates based on HEDIS 2010 Ratios and Percentiles for Medicaid populations.

Strengths

Statewide performance in the current year demonstrated continual improvement on the adults' measures. Of the nine measures reporting increases in rates, four (*Adult BMI Assessment*, *Postpartum Care*, and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*) showed notable improvement (i.e., more than 5 percentage points). Specifically, both measures under *Pharmacotherapy Management of COPD Exacerbation* increased more than 15 percentage points over last year. Additionally, *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* ranked in the top 10 percent of HEDIS 2010 national performance.

Recommendations

Six measures showed a decline in statewide performance from last year. A decline of more than 5 percentage points was noted on three measures (*Use of Imaging for Low Back Pain, Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis,* and *Chlamydia Screening in Women—21–24 Years*), suggesting opportunities for improvement.

Utilization Performance Measures

Table 3-21 shows the statewide weighted averages and audit designations for each utilization performance measure.

Table 3-21—Statewide Summary of Rate for the Utilization Performance Measures

Performance Measures	Rate		Percentile Ratings[1]
	HEDIS 2010	HEDIS 2011	
Antibiotic Utilization			
Average Scrips PMPY for All Antibiotics	0.76	0.79	10th–24th
Average Scrips PMPY for Antibiotics of Concern	0.27	0.27	<10th
Percentage of Antibiotics of Concern of All Antibiotic Scrips	35.7%	33.5%	<10th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)			
Discharges (Per 1,000 Member Months)	12.31	10.71	75th–89th
Average Length of Stay	4.80	3.91	50th–74th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Medicine)			
Discharges (Per 1,000 Member Months)	7.25	5.76	75th–89th
Average Length of Stay	4.48	3.48	25th–49th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)			
Discharges (Per 1,000 Member Months)	2.03	2.17	75th–89th
Average Length of Stay	9.52	7.11	50th–74th
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)			
Discharges (Per 1,000 Member Months aged 10–64 Years)	6.14	5.43	25th–49th
Average Length of Stay	2.41	2.31	10th–24th

Table 3-21—Statewide Summary of Rate for the Utilization Performance Measures			
Performance Measures	Rate		Percentile Ratings[1]
	HEDIS 2010	HEDIS 2011	
Use of Services: Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	376.48	340.69	25th–49th
ED Visits	64.09	53.92	10th–24th
Frequency of Selected Procedures			
Bariatric Weight Loss Surgery (0–19 Male & Female)	—	0.00	—
Bariatric Weight Loss Surgery (20–44 Male & Female)	—	0.11	—
Bariatric Weight Loss Surgery (45–64 Male & Female)	—	0.09	—
Tonsillectomy (0–9 Male & Female)	0.64	0.73	50th–74th
Tonsillectomy (10–19 Male & Female)	0.62	0.52	75th–89th
Hysterectomy, Abdominal (15–44 Female)	0.22	0.19	10th–24th
Hysterectomy, Abdominal (45–64 Female)	0.29	0.21	10th–24th
Hysterectomy, Vaginal (15–44 Female)	0.31	0.42	≥90th
Hysterectomy, Vaginal (45–64 Female)	0.19	0.21	50th–74th
Cholecystectomy, Open (30–64 Male)	0.06	0.04	50th–74th
Cholecystectomy, Open (15–44 Female)	0.03	0.02	≥90th
Cholecystectomy, Open (45–64 Female)	0.02	0.06	50th–74th
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.30	0.33	50th–74th
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	0.83	0.95	50th–74th
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	0.64	0.71	50th–74th
Back Surgery (20–44 Male)	0.25	0.26	25th–49th
Back Surgery (20–44 Female)	0.23	0.19	25th–49th
Back Surgery (45–64 Male)	0.62	0.44	25th–49th
Back Surgery (45–64 Female)	0.75	0.62	50th–74th
Mastectomy (15–44 Female)	0.02	0.02	≥90th
Mastectomy (45–64 Female)	0.19	0.15	50th–74th
Lumpectomy (15–44 Female)	0.15	0.09	<10th
Lumpectomy (45–64 Female)	0.56	0.24	10th–24th

[1] Percentile ratings were assigned to the HEDIS 2011 reported rates based on HEDIS 2010 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 evaluate 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 *Antibiotic Utilization* was very similar to last year's performance. The rates for *Average Scrips PMPY for All Antibiotics* and *Average Scrips PMPY for Antibiotics of Concern* increased slightly from last year and a small decrease was noted for *Percentage of Antibiotics of Concern of All Antibiotic Scrips*. Inpatient discharges for General Hospital Acute Care showed a decline for all types except *Surgery*. Additionally, average length of stay for all *Inpatient Utilization—General Hospital Acute Care* measures declined from last year. Statewide utilization for *Ambulatory Care* (*Outpatient Visits* and *Emergency Department Visits*) also declined from last year.

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 consistent with last year's for most of the measures. There has been substantial improvement in *Pharmacotherapy Management of COPD Exacerbation* of which both submeasures demonstrated an increase in rate for more than 15 percentage points. Opportunities for improvement exist for several measures such as the *Well-Child Visits in the First 15 Months of Life, 6+ Visits*, *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, and *Use of Imaging for Low Back Pain* measures, where a decline in rate for at least 5 percentage points was noted.
- **Timeliness:** Statewide results on the timeliness measures were consistent with last year's results, with most of the measures showing changes less than 5 percentage points. The *Postpartum Care* measure exhibited a more than 5-percentage-point improvement. The *Well-Child Visits in the First 15 Months of Life, 6+ Visits* measure showed a decline of more than 10 percentage points, suggesting opportunities for improvement.
- **Access**: Statewide results on the access domain were also consistent with last year's results, with all but one measures showing changes less than 5 percentage points. Notable improvement was identified for the *Postpartum Care* measure. Opportunities for improvement exist for the *Children's & Adolescents' Access to PCPs* measures for select age groups that ranked below the national 25th percentiles. As for the utilization-based performance measures, *Antibiotic Utilization* was generally consistent with last year's performance. However, the use of inpatient services (except discharge for surgery) and ambulatory care has declined 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 2010–2011, 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. The focused study summary is 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 activities 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 PIP narrative), 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.

HSAG PIP reviewers validated each PIP twice—once when originally submitted and then again when the PIP was resubmitted. The BHOs and MCOs had the opportunity to receive technical assistance, incorporate HSAG's recommendations and resubmit the PIPs to improve overall validation scores and validation status. 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 second validation cycle for this PIP. HSAG reviewed Activities I through VIII. Table 3-22 and Table 3-23 show DHMC's scores based on HSAG's evaluation. HSAG reviewed and scored each activity according to HSAG's validation methodology.

Table 3-22—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	6	0	0	0	1	1	0	0	0
VI. Reliably Collect Data	11	11	0	0	0	1	1	0	0	0
VII. Implement Intervention and Improvement Strategies	4	2	0	0	2	1	1	0	0	0
VIII. Analyze Data and Interpret Results	9	5	0	0	4	2	2	0	0	0
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**	**39**	**0**	**0**	**9**	**13**	**13**	**0**	**0**	**0**

Table 3-23—FY 2009–2010 and FY 2010–2011 Overall PIP Validation Scores and Validation Status *for* Coordination of Care between Physical and Behavioral Health *for* DHMC		
	FY 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**100%**	**100%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

* The percentage score for all evaluation elements is calculated by dividing the total evaluation elements *Met* by the sum of the 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

Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results. DHMC demonstrated strength in its study design (Activities I–IV) and study implementation (Activities V–VII) by receiving *Met* scores for all applicable evaluation elements. DHMC implemented quality improvement processes and interventions that are likely to have a long-term effect. In addition, the plan identified potential factors that could threaten the validity of the data for Study Indicator 2 and implemented improvement strategies to address these factors.

Recommendations

HSAG determines opportunities for improvement based on those evaluation elements that receive a *Partially Met* or a *Not Met* score, indicating that those elements are not in full compliance with CMS protocols. Because DHMC received *Met* scores for all elements evaluated, there were no recommendations. However, HSAG identified 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. HSAG recommended the following *Point of Clarification* for DHMC's *Coordination of Care Between Physical and Behavioral Health* PIP:

- HSAG noted that the plan reported two components of Study Indicator 2 (2a and 2b) in Activities VIII and IX. DHMC should include a description of 2b in Activity III as part of Study Indicator 2.

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 designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for the successful progression to the next stage of the PIP process.

Rocky Mountain Health Plans (RMHP)

Findings

RMHP conducted two PIPs: *Improving Well-Care Visits 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 2009–2010.

For the *Improving Well-Care Visits for Adolescents* PIP, HSAG reviewed Activities I through X. Table 3-24 and Table 3-25 show RMHP's scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3-24—PIP Validation Scores *for* Improving Well-Care Visits 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	9	0	0	0	2	2	0	0	0
IX. Assess for Real Improvement	4	3	0	1	0	No Critical Elements				
X. Assess for Sustained Improvement	1	1	0	0	0	No Critical Elements				
Totals for All Activities	**53**	**49**	**0**	**1**	**3**	**13**	**13**	**0**	**0**	**0**

Table 3-25—FY 2009–2010 and FY 2010–2011 Overall PIP Validation Scores and Validation Status for *Improving Well-Care Visits for Adolescents* *for* RMHP		
	FY 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**98%**	**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

RMHP's strong performance in the study design (Activities I through IV) and study implementation (Activities V through VII) phases indicated that the *Improving Well-Care Visits for Adolescents* PIP was well designed and implemented appropriately to measure outcomes and improvement.

Recommendations

While RMHP's *Improving Well-Care Visits for Adolescents* PIP achieved real and sustained improvement when comparing Remeasurement 2 results to the baseline, the results continued to be below RMHP's goal of 55.8 percent; and the improvement from Remeasurement 1 to Remeasurement 2 was not statistically significant. RMHP should analyze its data to determine if any subgroup within its population has a disproportionately lower rate that negatively affects the overall rate. This "drill-down" type of analysis should be conducted before and after the implementation of any interventions.

HSAG noted that RMHP determined during its intervention planning meetings that, in addition to the well care mailings to parents, provider education was needed that would emphasize proper coding of well visits. As a *Point of Clarification*, HSAG recommended RMHP discuss the quality improvement tools used during its quality committee meetings that identified barriers that ultimately led to the implementation of provider education on proper coding and a new clinical editing system for claims payment. In addition, HSAG recommended that RMHP analyze its data to determine if any subgroup within its population had a disproportionately lower rate that negatively affected the overall rate.

For the *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP, HSAG reviewed Activities I through X. Table 3-26 and Table 3-27 show RMHP's scores based on HSAG's evaluation. HSAG reviewed and scored each activity according to HSAG's validation methodology.

Table 3-26—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	4	0	0	0	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	0	1	0	0	No Critical Elements				
Totals for All Activities	**53**	**33**	**3**	**1**	**16**	**13**	**10**	**0**	**0**	**3**

Table 3-27—FY 2009–2010 and FY 2010–2011 Overall PIP Validation Scores and Validation Status *for* Improving Coordination of Care for Members With Behavioral Health Conditions *for* RMHP		
	FY 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**91%**	**89%**
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

RMHP's strong performance in the study design (Activities I through IV) and study implementation (Activities V through VII) phases indicated that the PIP was well designed and implemented appropriately to measure outcomes and improvement. RMHP implemented several interventions during Remeasurement 1 that continued through Remeasurement 2. RMHP continued to collaborate with BHO case management in hopes that these efforts would have an effect on the ER visit rate.

Recommendations

During review of Activity IX, HSAG noted that while one of the two study indicators demonstrated improvement, the improvement was not statistically significant. HSAG also noted that in Activity X, RMHP achieved sustained improvement for one of the two study indicators (the number of members who had at least one visit to a primary care provider in an ambulatory setting during the measurement year). However, the primary focus of the PIP was to decrease ER utilization for seriously mentally ill (SMI) members and this has not occurred. There has been an upward trend in ER visits for the SMI cohort population. HSAG recommended that RMHP analyze its data to determine if any subgroup within its population had disproportionately affected the overall rate. This "drill-down" type of analysis should be conducted before and after the implementation of any interventions.

Summary Assessment Related to Quality, Timeliness, and Access

The focus of RMHP's *Improving Well-Care Visits 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 has designed a scientifically sound study that was supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes and the PIP's solid design allowed for the successful progression through all activities. This was clearly

demonstrated by the *Met* validation status the plan received for the *Improving Well-Care Visits for Adolescents* PIP and the *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP.

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

Table 3-28 shows the health plans' overall performance based on HSAG's validation of the FY 2010–2011 PIPs that were submitted for validation.

Table 3-28—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 Visits for Adolescents*	98%	100%	*Met*
RMHP	*Improving Coordination of Care for Members With Behavioral Health Conditions*	89%	100%	*Met*

Overall, the performance of the PIPs suggests a thorough application of the PIP's design. 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 89 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 3-29—Summary of Data From Validation of Performance Improvement Projects

Review Activity	Number of PIPs Meeting All Evaluation Elements/Number Reviewed		Number of PIPs Meeting All Critical Elements/Number Reviewed	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
I. Select the Study Topic(s)	3/3	3/3	3/3	3/3
II. Define the Study Question(s)	3/3	3/3	3/3	3/3
III. Select the Study Indicator(s)	3/3	3/3	3/3	3/3
IV. Use a Representative and Generalizable Study Population	3/3	3/3	3/3	3/3
V. Use Sound Sampling Techniques	2/2	3/3	2/2	2/2*
VI. Reliably Collect Data	2/2	3/3	2/2	2/2*

Table 3-29—Summary of Data From Validation of Performance Improvement Projects				
Review Activity	Number of PIPs Meeting All Evaluation Elements/Number Reviewed		Number of PIPs Meeting All Critical Elements/Number Reviewed	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
VII. Implement Intervention and Improvement Strategies	2/2	3/3	2/2	3/3
VIII. Analyze Data and Interpret Results	1/2	3/3	2/2	3/3
IX. Assess for Real Improvement	1/2	0/2	No Critical Elements	
X. Assess for Sustained Improvement	0/0	1/2	No Critical Elements	

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

* One of the three PIPs reviewed received "not applicable" scores for critical elements in Activities V and VI.

Table 3-29 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. Looking at both years, all submitted PIPs received scores of *Met* for all applicable evaluation elements, including critical elements, for Activities I through VII. In FY 2010–2011, two PIPs progressed to Activity X in the PIP Summary Form. Both PIPs received *Met* scores for all applicable evaluation elements in Activities I through VIII; however, neither PIP received a *Met* score for all evaluation elements in Activity IX (represented in the table as 0/2). The improvement achieved was not statistically significant. One of these two PIPs received a *Met* score for the evaluation element in Activity X, indicating the study demonstrated sustained improvement (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 2010 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 3-30 shows the adult Medicaid results achieved by DHMC during the current year (FY 2010–2011) and the prior year (FY 2009–2010).

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

Measure	FY 2009–2010 Rate	FY 2010–2011 Rate
Getting Needed Care	33.4%	35.5%
Getting Care Quickly	39.1%	42.7%
How Well Doctors Communicate	67.0%	66.7%
Customer Service	NA	NA
Shared Decision Making	54.6%	56.8%
Rating of Personal Doctor	65.7%	64.5%
Rating of Specialist Seen Most Often	57.1%	56.9%
Rating of All Health Care	36.8%	47.2%
Rating of Health Plan	46.0%	51.5%

NA indicates that the measure had fewer than 100 respondents.

Table 3-31 shows the child Medicaid results achieved by DHMC for the current year (FY 2010–2011) and the prior year (FY 2009–2010).

Table 3-31—Child Medicaid Question Summary Rates and Global Proportions *for* DHMC

Measure	FY 2009–2010 Rate	FY 2010–2011 Rate
Getting Needed Care	NA	44.7%
Getting Care Quickly	44.5%	54.2%
How Well Doctors Communicate	71.0%	72.7%
Customer Service	NA	51.2%
Shared Decision Making	60.6%	64.7%
Rating of Personal Doctor	74.3%	81.0%
Rating of Specialist Seen Most Often	NA	69.2%
Rating of All Health Care	55.4%	63.4%
Rating of Health Plan	63.9%	71.7%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

DHMC did not demonstrate any decreases in measure rates for the child population. For the adult Medicaid survey results, DHMC did not have any substantial decreases; however, three measures showed slight decreases: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. 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 adult Medicaid population, two of the eight reportable measures' rates increased substantially: *Rating of All Health Care* (10.4 percentage points) and *Rating of Health Plan* (5.5 percentage points). None of the measures decreased substantially; however, the rates decreased slightly for three measures: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. All eight of the reportable measures for the adult Medicaid population had the lowest rates among the health plans in FY 2010–2011: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate, Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*.

For the child Medicaid population, four of the six comparable measures' rates increased substantially: *Getting Care Quickly* (9.7 percentage points), *Rating of Personal Doctor* (6.7 percentage points), *Rating of All Health Care* (8.0 percentage points), and *Rating of Health Plan* (7.8 percentage points). None of the measures had a substantial rate decrease. DHMC had the

lowest rates among the health plans in FY 2010–2011 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of Specialist Seen Most Often*. DHMC had the highest rates among the health plans in FY 2010–2011 for three measures: *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan*.

Rocky Mountain Health Plans (RMHP)

Findings

Table 3-32 displays the adult Medicaid results achieved by RMHP during the current year (FY 2010–2011) and the prior year (FY 2009–2010).

Table 3-32—Adult Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2009–2010 Rate	FY 2010–2011 Rate
Getting Needed Care	58.4%	58.2%
Getting Care Quickly	61.4%	60.3%
How Well Doctors Communicate	68.3%	71.9%
Customer Service	68.7%	NA
Shared Decision Making	66.0%	69.3%
Rating of Personal Doctor	64.7%	65.3%
Rating of Specialist Seen Most Often	60.9%	60.7%
Rating of All Health Care	54.2%	51.8%
Rating of Health Plan	60.3%	59.1%

NA indicates that the measure had fewer than 100 respondents.

Table 3-33 shows the child Medicaid results achieved by RMHP for the current year (FY 2010–2011) and the prior year (FY 2009–2010).

Table 3-33—Child Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2009–2010 Rate	FY 2010–2011 Rate
Getting Needed Care	64.1%	57.4%
Getting Care Quickly	75.3%	71.2%
How Well Doctors Communicate	80.0%	76.8%
Customer Service	NA	NA
Shared Decision Making	72.6%	72.3%
Rating of Personal Doctor	78.0%	70.3%
Rating of Specialist Seen Most Often	NA	NA
Rating of All Health Care	64.6%	60.1%
Rating of Health Plan	66.9%	68.3%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

The adult Medicaid survey rates decreased for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. None of these decreases, however, were substantial. RMHP should continue to direct quality improvement activities toward these measures.

The child Medicaid survey rates decreased on six measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of All Health Care*. The decrease in rates for two of these measures was substantial: *Getting Needed Care* and *Rating of Personal Doctor*. RMHP 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 adult Medicaid population, none of the reportable measures rates increased or decreased substantially. However, the rates decreased slightly for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. None of the measures for the adult Medicaid population had the lowest rates among the health plans in FY 2010–2011. Three measures had the highest rates among the health plans in FY 2010–2011: *Getting Needed Care*, *Shared Decision Making*, and *Rating of Health Plan*.

For the child Medicaid population, two of the seven reportable measures' rates decreased substantially: *Getting Needed Care* (6.7 percentage points), and *Rating of Personal Doctor* (7.7 percentage points). None of the measures had a substantial rate increase. RMHP had the lowest rates among the health plans in FY 2010–2011 for two measures: *Rating of Personal Doctor* and *Rating of All Health Care*. RMHP also had the highest rates among the health plans in FY 2010–2011 for two measures: *Getting Needed Care* and *How Well Doctors Communicate*.

Primary Care Physician Program (PCPP)

Findings

Table 3-34 shows the adult Medicaid results achieved by PCPP during the current year (FY 2010–2011) and the prior year (FY 2009–2010).

Table 3-34—Adult Medicaid Question Summary Rates and Global Proportions *for* PCPP		
Measure	**FY 2009–2010 Rate**	**FY 2010–2011 Rate**
Getting Needed Care	53.3%	56.3%
Getting Care Quickly	58.7%	61.1%
How Well Doctors Communicate	68.5%	71.9%
Customer Service	NA	NA
Shared Decision Making	63.3%	64.3%
Rating of Personal Doctor	65.4%	70.2%
Rating of Specialist Seen Most Often	61.6%	65.6%
Rating of All Health Care	51.1%	52.3%
Rating of Health Plan	54.9%	55.3%

NA indicates that the measure had fewer than 100 respondents.

Table 3-35 shows the child Medicaid results achieved by PCPP during the current year (FY 2010–2011) and the prior year (FY 2009–2010).

Table 3-35—Child Medicaid Question Summary Rates and Global Proportions *for* PCPP		
Measure	**FY 2009–2010 Rate**	**FY 2010–2011 Rate**
Getting Needed Care	52.4%	53.5%
Getting Care Quickly	69.0%	72.8%
How Well Doctors Communicate	75.7%	76.0%
Customer Service	55.8%	NA
Shared Decision Making	70.7%	73.8%
Rating of Personal Doctor	69.8%	73.6%
Rating of Specialist Seen Most Often	69.0%	70.3%
Rating of All Health Care	59.3%	61.7%
Rating of Health Plan	62.6%	64.9%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

PCPP did not demonstrate any decreases in reportable measure rates for the adult or child populations; however, none of the increases in measure rates were substantial increases. One measure in the child population, *Rating of Health Plan*, was below the 2010 NCQA CAHPS National Average. 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 adult Medicaid population, all reportable rates demonstrated slight increases. None of the measures for the adult Medicaid population had the lowest rates among the health plans in FY 2010–2011. Four measures had the highest rates among the health plans in FY 2010–2011: *Getting Care Quickly*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*.

For the child Medicaid population, all reportable rates demonstrated slight increases. PCPP had the lowest rates among the health plans in FY 2010–2011 for one measure: *Rating of Health Plan*. PCPP had the highest rates among the health plans in FY 2010–2011 for three measures: *Getting Care Quickly*, *Shared Decision Making*, and *Rating of Specialist Seen Most Often*.

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

Table 3-36 shows the adult Medicaid statewide averages during the current year (FY 2010–2011) and the prior year (FY 2009–2010).

Table 3-36—Adult Medicaid Statewide Averages

Measure	FY 2009–2010 Rate	FY 2010–2011 Rate
Getting Needed Care	48.4%	50.0%
Getting Care Quickly	53.1%	54.7%
How Well Doctors Communicate	67.9%	70.2%
Customer Service	*	**
Shared Decision Making	61.3%	63.5%
Rating of Personal Doctor	65.3%	66.7%
Rating of Specialist Seen Most Often	59.9%	61.1%
Rating of All Health Care	47.4%	50.4%
Rating of Health Plan	53.7%	55.3%

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

** None of the health plans were able to report a rate for the *Customer Service* measure; therefore, a State average was not calculated.

Table 3-37 shows the child Medicaid statewide averages for the current year (FY 2010–2011) and the prior year (FY 2009–2010).

Table 3-37—Child Medicaid Statewide Averages		
Measure	**FY 2009–2010 Rate**	**FY 2010–2011 Rate**
Getting Needed Care	58.3%	51.9%
Getting Care Quickly	62.9%	66.1%
How Well Doctors Communicate	75.6%	75.2%
Customer Service	*	*
Shared Decision Making	68.0%	70.3%
Rating of Personal Doctor	74.0%	75.0%
Rating of Specialist Seen Most Often	*	69.8%
Rating of All Health Care	59.8%	61.7%
Rating of Health Plan	64.5%	68.3%

* Only one health plan was able to report a rate; therefore, a State average was not calculated for either 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 statewide adult Medicaid population, the rates for all reportable measures increased slightly from FY 2009–2010 to FY 2010–2011.

For the statewide child Medicaid population, the rates for five measures increased slightly from FY 2009–2010 to FY 2010–2011: *Getting Care Quickly*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan*. The statewide child Medicaid survey results decreased for two measures: *Getting Needed Care* and *How Well Doctors Communicate*. Furthermore, the rate for *Getting Needed Care* decreased substantially (6.4 percentage points). The State should continue to direct quality improvement activities toward these measures.

Recommendations

Recommendations for improvement were identified for each health plan based on its performance for the measures. Specific recommendations for the composite measures and global ratings are found in Table 3-38 and Table 3-39, respectively.

Table 3-38—Composite Measure Recommendations
Getting Needed Care
Enhancing provider directories will allow patients to effectively choose a physician that will meet their needs. Frequent production automated updates of provider directories is essential to ensure that the most current information is available. The utility of the provider directory can be enhanced by highlighting/emphasizing those providers who are currently accepting new patients.
Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care.
Getting Care Quickly
An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Open access scheduling has been shown to have the following benefits: (1) reduces delays in patient care, (2) increases continuity of care, and (3) decreases wait times and number of no-shows resulting in cost savings.
A patient flow analysis can be conducted to determine if dissatisfaction with timely care may be partly due to bottlenecks and redundancies in administrative and clinical patient flow processes. A patient flow analysis involves tracking a patient's experience throughout a visit or clinical process (e.g., diagnostic tests).
Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients that may not require an appointment with a physician. Furthermore, an online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate.
Health plans can establish a nurse advice help line to direct members to the most appropriate level of care for their health problem. Additionally, a 24-hour help line can improve members' perceptions of getting care quickly by providing quick, easy access to the resources and expertise of clinical staff.
How Well Doctors Communicate
Health plans can encourage patients to take a more active role in the management of their health care by providing them with the tools necessary to effectively communicate with their physicians. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.
Often health information is presented to patients in a way that is too complex and technical, which can result in patient nonadherence and poor health outcomes. To address this issue, health plans should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Furthermore, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication.
Shared Decision Making
Implementing a shared decision-making model requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision-making model is ensuring that physicians are properly trained. Training should focus on providing skills to facilitate the shared decision-making process, ensuring that physicians understand the importance of taking each patient's values into consideration, understanding patients' preferences and needs, and improving communication skills.
Physicians will be better able to encourage their patients to participate in shared decision making if the health plan provides physicians with literature that conveys the importance of the shared decision-making model. Furthermore, health plans can provide members with pre-structured question lists to assist them in asking all the necessary questions so the appointment is as efficient and effective as possible.

Table 3-39—Global Rate Recommendations
Rating of Personal Doctor
Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication.
Health plans should request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit. This will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times.
Rating of Specialist Seen Most Often
Specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients can improve physician-patient communication. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.
Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine such as live, interactive videoconferencing allows providers to offer care from a remote location.
Rating of All Health Care
Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office.
To improve patients' health care experience, health plans should identify and eliminate patient challenges when receiving health care. This includes ensuring that patients receive adequate time with a physician so that questions and concerns may be appropriately addressed and providing patients with ample information that is understandable.
Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Therefore, health plans should consider creating patient and family advisory councils composed of the patients and families who represent the population(s) they serve. The councils' roles can vary and responsibilities may include input into or involvement in program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.
Rating of Health Plan
It is important for health plans to view their organization as a collection of microsystems, (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The first step to this approach is to define a measurable collection of activities. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.
A secure online patient portal allows members easy access to a wide array of health plan and health care information and services that are particular to their needs and interests. To help increase members' satisfaction with their health plan, plans should consider establishing an online patient portal or integrating online tools and services into their current Web-based systems that focus on patient-centered care.
Implementation of organization-wide quality improvement (QI) initiatives are most successful when health plan staff at every level are involved; therefore, creating an environment that promotes QI in all aspects of care can encourage organization-wide participation in QI efforts. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members.

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

Introduction

The Department required each health plan to address recommendations and required actions following EQR activities conducted in FY 2009–2010. 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 2009–2010 site review, DHMC was required to submit a CAP to address two requirements within Standard IV—Member Rights and Protections, seven requirements within Standard V—Member Information, and thirteen requirements within Standard VI—Grievance System. DHMC submitted its CAP to HSAG in June 2010. HSAG and the Department agreed that the plan was not sufficient as written and asked DHMC to resubmit. DHMC revised its plan and resubmitted it to HSAG and the Department at the end of July 2010. HSAG and the Department determined that if DHMC implemented the CAP as written, it would achieve compliance with the specific requirements in question. DHMC was advised to move forward with implementation, and it was asked to submit documentation providing evidence of having completed the required actions. DHMC made its final submission of documents January 21, 2011.

DHMC successfully revised all documents, clarifying inconsistencies and inaccuracies. The final submission of documents, however, occurred following the FY 2010–2011 site review process. Therefore, DHMC continued to implement the designated changes to its processes during FY 2010–2011. One corrective action remained outstanding as DHMC continued to work with the Department to determine an appropriate method of evaluating its system for collecting and tracking grievances.

Validation of Performance Measures

Results of DHMC's 2009–2010 performance measures yielded several opportunities for improvement. Although *Well-Child Visits 3–6 Years of Life, Children's and Adolescents' Access to Primary Care Providers—12–24 months,* and *Children's and Adolescents' Access to Primary Care Providers—25 months–6 years* demonstrated improvement in their rates from FY 2008–2009, these measures only ranked between the national 10th and 25th percentiles. HSAG recommended that DHMC implement quality strategies to improve rates for these measures. Performance for the *Well-Child Visits 3–6 Years of Life* measure improved in FY 2010–2011 by 5.1 percentage points. These improvements may suggest the MCO identified and implemented improvement strategies to improve rates for this measure. The improvement observed in the *Children's and Adolescents'*

Access to Primary Care Providers—12–24 months and *25 months–6 years* measures, however, were too small to demonstrate the impact of any efforts DHMC attempted in improving the measures.

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. DHMC reported more than 10-percentage-point improvements in the *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measure, which suggests that the MCO implemented interventions to improve performance for this measure. The slight changes in rates in the *Adults' Access to Preventive/Ambulatory Health Services* measures, however, were too small to demonstrate whether the MCO had implemented any quality strategies to improve the rates.

All indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* maintained performance or showed improvement in rates from FY 2008-2009.

Validation of Performance Improvement Projects

For the FY 2009–2010 validation cycle, DHMC received *Met* scores for all elements evaluated; therefore, DHMC did not have any required actions. However, HSAG did identify a *Point of Clarification* in Activity IV of DHMC's *Coordination of Care Between Physical and Behavioral Health* study. HSAG noted that 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 submission. During the FY 2010–2011 validation cycle, HSAG noted that DHMC followed up on HSAG's recommendation and corrected the codes.

Consumer Assessment of Healthcare Providers and Systems

For the adult population measures between FY 2008–2009 and FY 2009–2010, HSAG did note that DHMC showed a substantial decline in the global rating reported for the *Rating of All Health Care* measure. Additionally, declining rates were observed in *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan* measures, even though these were not substantial decreases. For this reason, HSAG recommended that DHMC direct quality improvement activities toward these areas. Three of these measures showed improvement between FY 2009–2010 and FY 2010–2011: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan*. Additionally, the rate for *Rating of All Health Care* improved substantially. These increases indicate an improvement in consumer satisfaction in these domains. Nonetheless, two of the measures continued to slightly decline: *How Well Doctors Communicate* and *Rating of Personal Doctor*. Furthermore, one additional measure showed a decline between FY 2009–2010 and FY 2010–2011, *Rating of Specialist Seen Most Often*.

For the comparable child population measures between FY 2008–2009 and FY 2009–2010, HSAG did note that DHMC showed a substantial decline in the composite measure rate reported for

Getting Care Quickly. For this reason, HSAG recommended that DHMC direct quality improvement activities toward this area. DHMC experienced a substantial increase between FY 2009–2010 and FY 2010–2011 for this measure, which indicates an improvement in consumer satisfaction in this domain. Furthermore, DHMC did not experience any measure rate declines between FY 2009–2010 and FY 2010–2011.

Rocky Mountain Health Plans (RMHP)

Compliance Monitoring Site Reviews

As a result of the FY 2009–2010 site review, RMHP was required to address one requirement within Standard II—Coordination and Continuity of Care, six requirements within Standard V—Member Information, and thirteen requirements within Standard VI—Grievance System. RMHP submitted its CAP to HSAG in June 2010. HSAG and the Department agreed that the plan was not sufficient as written and asked RMHP to resubmit its CAP. RMHP revised the plan and resubmitted it to HSAG and the Department in September 2010. HSAG and the Department determined that if RMHP implemented the CAP as written, it would achieve compliance. RMHP was advised to move forward with implementation, and it was asked to submit documentation providing evidence of having completed the required actions. RMHP continued to work with HSAG and the Department to revise documents and made its final submission of documents February 7, 2011.

Validation of Performance Measures

Results of RMHP's 2009–2010 performance measures yielded several opportunities for improvement. In particular, *Well-Child Visits in the First 15 Months of Life, 6+ Visits* had a 4.7 percentage-point decrease. HSAG noted that the MCO's 2010–2011 performance in this measure improved by 8.6 percentage points. This increase in rate may suggest that RMHP had implemented quality strategies to improve this measure.

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. During FY 2010-2011, there were improvements on all of these measures. In particular, RMHP's performance on *Annual Monitoring for Patients on Persistent Medications* improved by 8.8 percentage points. This increase suggests that RMHP targeted the measure for improvement. Although slight increases in rates on the *Chlamydia Screening in Women—21–24 Years* and *Pharmacotherapy Management of COPD Exacerbation* measures were also noted, these changes may be too small to determine whether the MCO had followed up on these measures.

Validation of Performance Improvement Projects

For the FY 2009–2010 validation cycle, HSAG identified a *Partially Met* score in Activity VIII of RMHP's *Improving Well-Care Rates or Adolescents.* This was to include a complete interpretation of the study results that included a comparison of the Remeasurement 1 results to the Remeasurement 1 goal. In addition, HSAG identified *Points of Clarification* in Activities III, IV, and VI. In Activity III, HSAG recommended that the MCO provide complete and consistent measurement periods throughout the PIP. In Activity IV, HSAG recommended that the MCO accurately transcribe the HEDIS specifications used to define the study population, and in Activity VI, HSAG recommended that the MCO provide complete and consistent timelines for all measurement periods in Activities III, VI, and IX. During review of RMHP's FY 2010–2011 submission, HSAG found that RMHP had adequately addressed HSAG's recommendations.

HSAG's FY 2009–2010 validation of RMHP's *Improving Coordination of Care for Members With Behavioral Health Conditions* PIP resulted in two *Partially Met* scores and one *Not Met* score for Activity IX: Assessing for Real Improvement. According to the reported results, not all of the study indicators demonstrated improvement; only Study Indicator 1 demonstrated improvement. Furthermore, the improvement demonstrated for Study Indicator 1 was not statistically significant. HSAG's FY 2010–2011 validation of this PIP showed that although RMHP implemented several robust interventions and continued its collaborative efforts with the BHO, these efforts did not have enough impact on the study's outcomes.

Consumer Assessment of Healthcare Providers and Systems

For the adult population measures between FY 2008–2009 and FY 2009–2010, HSAG did note that RMHP showed a substantial decline in the global rate reported for *Rating of Specialist Seen Most Often*. Additionally, declining rates were observed in *Getting Needed Care*, *How Well Doctors Communicate*, and *Rating of Personal Doctor* even though these were not substantial decreases. For this reason, HSAG recommended that RMHP direct quality improvement activities toward these areas. Two of these measures showed improvement between FY 2009–2010 and FY 2010–2011: *How Well Doctors Communicate* and *Rating of Personal Doctor*. These increases indicate an improvement in consumer satisfaction in these domains. Nonetheless, two of the measures continued to slightly decline: *Getting Needed Care* and *Rating of Specialist Seen Most Often*. Furthermore, three additional measures showed a decline between FY 2009–2010 and FY 2010–2011, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan*.

For the comparable child population measures between FY 2008–2009 and FY 2009–2010, HSAG did note that RMHP did not show any decreases in measure rates. Furthermore, two of the measures rates increased substantially: *Rating of Personal Doctor* and *Rating of All Health Care*. The measures rates between FY 2009–2010 and FY 2010–2011, however, decreased on six measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of All Health Care*. Furthermore, two of these decreases were substantial, *Getting Needed Care* and *Rating of Personal Doctor*.

Primary Care Physician Program (PCPP)

Compliance Monitoring Site Reviews

As a primary care case management program run by Colorado Medicaid, PCPP was not subject to the compliance monitoring site review.

Validation of Performance Measures

Although a majority of the 2009–2010 measures exhibited a noticeable improvement from previous 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. PCPP's FY 2010–2011 performance on this measure demonstrated an effort for improvement. HSAG observed an increase in rate for the *Well-Child Visits 3–6 Years of Life* measure by at least 5 percentage points.

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

For the adult population measures between FY 2008–2009 and FY 2009–2010, HSAG did note that PCPP showed a slight decline in the global rate reported for *Rating of Specialist Seen Most Often*. For this reason, HSAG recommended that PCPP direct quality improvement activities toward this area. This measure showed improvement between FY 2009–2010 and FY 2010–2011, which indicates an improvement in consumer satisfaction in this domain. Furthermore, none of the measures' rates between FY 2009–2010 and FY 2010–2011 showed a decline.

For the child population measures between FY 2008–2009 and FY 2009–2010, HSAG did note that PCPP showed substantial declines in the global rates and composite measure rates reported for *Getting Care Quickly* and *Rating of All Health Care*. Additionally, declining rates were observed in *Getting Needed Care*, *How Well Doctors Communicate*, and *Rating of Personal Doctor* even though these were not substantial decreases. For this reason, HSAG recommended that PCPP direct quality improvement activities toward these areas. All of these measures showed improvement between FY 2009–2010 and FY 2010–2011. These increases indicate an improvement in consumer satisfaction in these domains. Furthermore, none of the measures rates between FY 2009–2010 and FY 2010–2011 showed a decline.

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 seventh year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the FY 2010–2011 site review process, the Department requested a review of three areas of performance that had not been reviewed within the previous two fiscal years. These were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard III—Coordination and Continuity of Care.

In developing the data collection tools and in reviewing the three 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. As part of the Coverage and Authorization of Services standard, HSAG conducted a record review of 20 denials. While HSAG incorporated the findings for particular elements of the record review into the score for the applicable standard, the record review score was also calculated separately. 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—Coverage and Authorization of Services	X	X	X
Standard II—Access and Availability		X	X
Standard III—Coordination and Continuity of Care	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 standards, the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*, and the overall compliance score for the current year (FY 2010–2011).

Table 5-2—Summary of Scores for ABC							
Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	33	33	31	2	0	0	94%
Standard II—Access and Availability	12	12	12	0	0	0	100%
Standard III—Coordination and Continuity of Care	6	6	6	0	0	0	100%
Totals	**51**	**51**	**49**	**2**	**0**	**0**	**96%***

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

Table 5-3—Summary of Scores for ABC's Record Review						
Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials Record Review	120	85	81	4	35	95%

Strengths

For two of the three standards that HSAG reviewed, ABC earned overall percentage-of-compliance scores of 100 percent, indicating a comprehensive understanding of the Medicaid managed care regulations. ABC's policies and procedures were comprehensive, easy to understand, and well organized. During the on-site interviews, ABC staff members were able to clearly articulate the procedures followed, which were consistent with written policies and procedures.

ABC ensured consistent application of its utilization criteria through use of InterQual utilization review criteria and interrater reliability studies. The on-site record review provided evidence that the medical directors were involved in clinical decisions and that peer-to-peer consultation was offered, as needed, to providers requesting services. ABC's meeting minutes demonstrated routine review and monitoring of the utilization management program. ABC notified its providers and members of its utilization policies and procedures. In addition, many routine services were not subject to prior authorization, making access to routine services easier for members.

ABC provided extensive evidence that it monitored the provider network with respect to the availability of services and provider compliance with access standards. ABC monitored its network on both a global level—with utilization reports, performance measures, and other quality initiatives—and on an individual provider level, with secret shopper audits and medical record reviews. This robust monitoring ensured that ABC's provider network was compliant with access to care standards, as well as ABC's standards for care and documentation.

ABC provided evidence of monitoring providers for the presence and content of individualized assessments and service plans and for the appropriateness of care provided. ABC provided evidence of comprehensive care coordination practices and provided comprehensive Health Insurance Portability and Accountability Act of 1996 (HIPAA) policies and procedures.

Recommendations

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

Coverage and Authorization of Services

Of the 20 denial records HSAG reviewed on-site, three records were out of compliance with the 10-calendar-day time frame for authorization decisions. One of these records did not include an extension letter. Three of these records included an extension letter that was sent only to the requesting facility and not to the member. ABC must ensure that authorization decisions are made within the required time frames; and, if ABC extends the time frame for making standard or expedited authorization decisions, it must give the enrollee written notice of the reason for the extension and inform the enrollee of the right to file a grievance if he or she disagrees with the decision.

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, Timeliness, and Access

ABC earned scores of 100 percent for Access and Availability and Coordination and Continuity of Care and a score of 94 percent for Coverage and Authorization of Services. ABC's denials record review score was 95 percent. ABC's overall percentage of compliance score was 96 percent. ABC demonstrated particular strengths in the area of utilization management and provider monitoring, which resulted in clear strengths in the quality, access, and timeliness domains.

Behavioral HealthCare, Inc. (BHI)

Findings

Table 5-4 presents the number of elements for each of the standards, the number of elements assigned a score of *Met, Partially Met, Not Met,* or *Not Applicable,* and the overall compliance score for the current year (FY 2010–2011).

Table 5-4—Summary of Scores for BHI

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	33	33	30	3	0	0	91%
Standard II—Access and Availability	12	12	12	0	0	0	100%
Standard III—Coordination and Continuity of Care	6	6	5	1	0	0	83%
Totals	**51**	**51**	**47**	**4**	**0**	**0**	**94%***

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

Table 5-5—Summary of Scores for BHI's Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials Record Review	120	85	60	25	35	71%

Strengths

For the three standards reviewed by HSAG, BHI earned an overall compliance score of 94 percent. BHI's strongest performance was in Access and Availability, where it earned a compliance score of 100 percent. Although HSAG identified three required actions for Coverage and Authorization of Services and one required action for Coordination and Continuity of Care, BHI demonstrated strong performance overall and an understanding of the federal Medicaid managed care regulations.

HSAG found BHI's utilization management (UM) department to be dynamic, with active monitoring and processes in place to ensure compliance with federal Medicaid managed care regulations. BHI's processes for delegation oversight were clearly delineated and executed, and the training provided to delegates was robust.

HSAG found that BHI used a significant number of single-case agreements, indicating responsiveness to membership needs and flexibility in developing the network. BHI's strong provider oversight included processes specific to the community mental health centers (CMHCs) and the contracted provider network. HSAG also found that BHI implemented new initiatives for cultural competency, including a comprehensive assessment of its system that resulted in a strategic plan that described specific activities to promote cultural competency.

BHI demonstrated a variety of clinical and operational processes for coordinating care for its members. For example, BHI had interagency collaborations with county departments of human services to provide and coordinate covered and wrap-around services without duplication of assessment or treatment efforts. BHI also located mental health clinicians in federally qualified health centers (FQHCs) and other physical health treatment practices. In addition, BHI placed care managers on-site at its in-network CMHCs to ensure timely access to medical care, coordination of behavioral health and medical services, and disease management for chronic medical conditions.

Recommendations

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

Coverage and Authorization of Services

- BHI's Utilization Management Program description stated that BHI UM staff engaged in ongoing consultation with the provider throughout the episode of care; however, the description did not specifically address consultation with a requesting provider for utilization determinations. Throughout the record review, HSAG was unable to determine if many of the records met the requirement for consulting the requesting provider because the documentation did not include who actually requested the service. BHI must ensure that the appropriate policy includes a mechanism to consult with the requesting provider. BHI must also adequately document any and all consultation with the requesting provider, if applicable.
- Also during the record review, HSAG encountered one record for which it was not clear that the reason for the denial was based on the utilization review criteria. BHI must clearly demonstrate the reason for denials and that utilization determinations are made based on utilization review criteria.
- HSAG found that the template BHI used for notice of actions included an incorrect time frame for appeal and/or requesting continuation of benefits related to cases which involved the termination, suspension, or reduction of previously authorized services. BHI must revise its template to include accurate time frames.
- There was inconsistency between BHI's documents regarding the time frame for making expedited service authorization decisions. The federal requirement is three working days. The Colorado rule does not specify calendar or working days. While three calendar days would exceed the federal requirement of three working days, BHI's documents must be revised to be consistent with each other.

Coordination and Continuity of Care

- BHI did not have policies that addressed the mechanisms for continuity of care through communication between providers or between BHOs regarding services provided. BHI must revise existing or develop new policies to address continuity of care for services provided.

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

Coverage and Authorization of Services and Coordination and Continuity of Care contained requirements that assessed quality. BHI earned a score of 91 percent for Coverage and Authorization of Services with a denials record review score of 70 percent and 83 percent for Coordination and Continuity of Care. BHI's overall score for the Quality domain was 77 percent, indicating mixed results with some clear strengths and some opportunities for improvement.

Timeliness

All three standards reviewed this year contained requirements that assessed timeliness. BHI's overall percentage of compliance score of 94 percent with the denials record review score of 71 percent resulted in an overall score of the Timeliness domain of 77 percent, indicating mixed results with some clear strengths and some opportunities for improvement.

Access

The Coverage and Authorization of Services and Access and Availability standards contained requirements that assessed access. BHI earned a score of 91 percent for Coverage and Authorization of Services with a score of 71 percent for the denials record review and a score of 100 percent for Access and Availability. BHI's UM program appeared to promote member access to services, as evidenced by member-run services and initial assessments being provided without requiring prior authorization. BHI's record review score also negatively impacted its overall score for the Access domain, which was 78 percent.

Colorado Health Partnerships, LLC (CHP)

Findings

Table 5-6 presents the number of elements for each of the standards, the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*, and the overall compliance score for the current year (FY 2010–2011).

Table 5-6—Summary of Scores for CHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	33	33	31	2	0	0	94%
Standard II—Access and Availability	12	12	12	0	0	0	100%
Standard III—Coordination and Continuity of Care	6	6	6	0	0	0	100%
Totals	**51**	**51**	**49**	**2**	**0**	**0**	**96%***

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

Table 5-7—Summary of Scores for CHP's Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials Record Review	120	88	87	1	32	99%

Strengths

CHP earned overall scores of 100 percent for two of the three standards HSAG reviewed (Access and Availability and Coordination of Care). For Coverage and Authorization of Services, CHP earned a score of 94 percent. CHP's policies and procedures were written clearly and included all the requirements. Staff members were able to articulate the processes followed, which coincided with the written procedures.

HSAG found evidence throughout its review of very extensive, open, and consistent communication between CHP administration and its providers. This open dialog was a strength for this organization and a benefit to its members. Although one case did not meet the timeliness standards, in 19 of 20 records reviewed on-site, the notification well exceeded the requirements for timely notification. The average time in which requests for services were processed and notification provided, was two days.

CHP had a variety of methods for monitoring the capacity of the provider network and the performance of the CMHC providers as well as the independent provider network. CHP's five-year

Cultural Competency Plan was comprehensive, with CHP having completed an impressive number of the activities described in the work plan after two years of implementation.

During the review of Coordination and Continuity of Care, HSAG found CHP's extensive and open communication with its providers, again, to be an asset for the BHO. CHP clearly communicated the expectations for its providers and closely monitored providers' compliance with these expectations. CHP responded to instances of noncompliance with education and training and implemented corrective action plans, when necessary.

Recommendations

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

Coverage and Authorization of Services

- During the on-site review of 20 denial records, HSAG found one record that did not meet the requirement for timely notification of denial to the member. CHP must ensure it meets requirements for timely notification for all notices of actions.
- HSAG found a conflict between CHP's policies and its member handbook. While this issue appeared to be an attempt at meeting the readability requirement, the member handbook led the reader to believe that prior authorization was required for poststabilization services. CHP must clarify the member handbook to provide information that is consistent with Value Options (VO)/CHP's policies.

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, Timeliness, and Access

CHP earned scores of 100 percent for Access and Availability and Coordination and Continuity of Care, and a score of 94 percent for Coverage and Authorization of Services. CHP's denials record review score was 99 percent. CHP's overall score was 96 percent. CHP demonstrated particular strengths in having clear policies and procedures and in oversight and monitoring of providers, which resulted in clear strengths in the quality, access, and timeliness domains.

Foothills Behavioral Health Partners, LLC (FBHP)

Findings

Table 5-8 presents the number of elements for each of the standards, the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*, and the overall compliance score for the current year (FY 2010–2011).

Table 5-8—Summary of Scores for FBHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	33	33	32	1	0	0	97%
Standard II—Access and Availability	12	12	12	0	0	0	100%
Standard III—Coordination and Continuity of Care	6	6	6	0	0	0	100%
Totals	**51**	**51**	**50**	**1**	**0**	**0**	**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.

Table 5-9—Summary of Scores for FBHP's Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials Record Review	120	81	81	0	39	100%

Strengths

FBHP earned an overall percentage-of-compliance score of 100 percent for two of the three standards HSAG reviewed (Access and Availability and Coordination and Continuity of Care). For Coverage and Authorization of Services, FBHP earned a score of 97 percent. These scores demonstrated a very strong understanding and implementation of the Medicaid managed care regulations.

While FBHP delegated utilization management and authorization of services to ValueOptions, HSAG found extensive evidence that FBHP maintained a close relationship with its delegate and demonstrated a strong ownership of delegated services. FBHP had standardized criteria for utilization review and showed that it used those criteria consistently to make utilization review determinations.

FBHP demonstrated strong provider oversight regarding access and availability, including processes for the CMHCs and the independent provider network. It employed several methods to ensure that its access standards were well known to both members and providers and that the standards were adhered to. FBHP's Office of Member and Family Affairs played an active role in ensuring that

members understood the standards and that care was readily accessible (especially regarding second opinions).

FBHP exhibited a very strong line of communication between its administration and its providers regarding expectations for coordination of care. FBHP employed a variety of methods to emphasize the importance of coordinating care and to ensure that its expectations were clear to all providers. FBHP conducted comprehensive medical record reviews to assess for the presence and content of the individualized assessments and service plans. If FBHP found instances of noncompliance, it required providers to develop corrective action plans and followed up to ensure that the plans were implemented.

Recommendations

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

Coverage and Authorization of Services

While FBHP's policies clearly stated that no prior authorization was required for poststabilization services, the member handbook led the reader to believe that prior authorization was required. FBHP must clarify the member handbook to provide information that is consistent with FBHP's/VO's policies.

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, Timeliness, and Access

FBHP earned scores of 100 percent for Access and Availability and Coordination and Continuity of Care and a score of 97 percent in for Coverage and Authorization of Services. FBHP's Denials record review score was 100 percent. FBHP's overall percentage of compliance score was 98 percent. FBHP demonstrated particular strengths in communication with its administrative services delegate, VO, as well as member and provider communications, which resulted in clear strengths in the quality, access, and timeliness domains.

Northeast Behavioral Health Partnership, LLC (NBHP)

Findings

Table 5-10 presents the number of elements for each of the seven standards, the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*, and the overall compliance score for the current year (FY 2010–2011).

Table 5-10—Summary of Scores for NBHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	33	33	32	1	0	0	97%
Standard II—Access and Availability	12	12	12	0	0	0	100%
Standard III—Coordination and Continuity of Care	6	6	6	0	0	0	100%
Totals	**51**	**51**	**50**	**1**	**0**	**0**	**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.

Table 5-11—Summary of Scores for NBHP's Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials Record Review	120	81	81	0	39	100%

Strengths

NBHP earned an overall percentage-of-compliance score of 100 percent for two of the three standards HSAG reviewed (Access and Availability and Coordination and Continuity of Care). For Coverage and Authorization of Services, NBHP earned a score of 97 percent. These scores demonstrated a very strong understanding and implementation of the Medicaid managed care regulations.

HSAG found evidence throughout its review of extensive, open, and consistent communication between NBHP/ValueOptions administration and its providers. This open dialogue was a strength for this organization and an added benefit to its members. HSAG's on-site review of 20 denial records confirmed that NBHP was consistently implementing its UM policies as written. NBHP notified its members and providers of authorization decisions well within the required time frames. NBHP notified its members in writing and providers both verbally and in writing of adverse authorization decisions.

NBHP offered a robust network of providers throughout its mostly rural service area and demonstrated effective methods of communication with its providers. NBHP informed its providers

and members about its access standards and requirements using the provider manual, the NBHP Web site, and a face-to-face provider forum. NBHP implemented a robust monitoring program to ensure provider compliance with requirements. NBHP had written processes to address instances of noncompliance.

NBHP's strong communication with providers proved to be a strength for this organization. The plan clearly conveyed expectations for coordination and continuity of care to its providers. NBHP conducted regular monitoring of medical records to ensure the presence and appropriateness of individualized assessments and treatment plans. NBHP's network and development support staff used educational tools to train providers whose documentation was inadequate.

Recommendations

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

Coverage and Authorization of Services

HSAG found a conflict between NBHP's policies and its member handbook. While NBHP's policies clearly stated that no prior authorization was required for poststabilization services, the member handbook led the reader to believe that prior authorization was required. NBHP must clarify the member handbook to provide information consistent with VO's/NBHP's policies.

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, Timeliness, and Access

NBHP earned scores of 100 percent for Access and Availability and Coordination and Continuity of Care, and a score of 97 percent for Coverage and Authorization of Services. NBHP's denials record review score was 100 percent. NBHP's overall percentage of compliance score was 98 percent. NBHP demonstrated particular strengths in its utilization management processes as well as provider communication and oversight, which resulted in clear strengths in the quality, access, and timeliness domains.

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

Table 5-12 and Table 5-13 show the overall statewide average for each standard and record review 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 5-12—Statewide Scores for Standards	
Standards	**FY 2010–2011 Statewide Average***
Standard I—Coverage and Authorization of Services	**95%**
Standard II—Access and Availability	**100%**
Standard III—Coordination and Continuity of Care	**97%**
Overall Statewide Compliance Score	**96%**

* Statewide average rates are weighted averages calculated by summing the individual numerators and dividing by the sum of the individual denominators for both the standard scores and the record review scores.

Table 5-13—Statewide Score for Record Review	
Standards	**FY 2010–2011 Statewide Average***
Denials Record Review	**93%**

* Statewide average rates are weighted averages calculated by summing the individual numerators and dividing by the sum of the individual denominators for both the standard scores and the record review scores.

As for statewide recommendations, two of the five BHOs had a required action related to the timeliness of notices of actions. Three of five BHOs shared member handbook language that was unclear regarding poststabilization services, and led the member to believe that prior authorization may be required for poststabilization services.

Quality, Timeliness, and Access

Overall statewide performance for Quality, Timeliness, and Access was very strong. Four of the five BHOs earned 96 percent or above overall percentage of compliance scores. The final BHO earned 94 percent, for an overall statewide performance rating of 96 percent. The overall statewide weighted score for the Quality domain was 93 percent. For the Timeliness domain it was 94 percent and for the Access domain it was 96 percent. All five BHOs earned a 100 percent score for the Access and Availability standard. For the Coverage and Authorization of Services standard all five BHOs earned 91 percent or greater, and for the Coordination and Continuity of Care standard, four of five BHOs earned a 100 percent score, with the remaining BHO earning 83 percent for the Coordination of Care standard.

Validation of Performance Measures

The Department required the collection and reporting of nine performance measures for the FY 2010–2011 validation process: five were HEDIS-like measures and four were developed by the Department. Some of these measures have submeasures (e.g., *Hospital Average Length of Stay* has two submeasures: *Non-State Hospitals* and *All Hospitals*). Counting all submeasures yielded a total of 33 rates. All measures originated from claims/encounter data. The specifications for these measures are included in a "scope document," which was drafted collaboratively by 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. Eight of the nine measures were validated and reported in the previous year; therefore, comparisons with last year's results are listed where available. Since this is the first year the *Penetration Rates by Eligibility Type* measure was reported, the rates are displayed for information only.

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 is reviewed by auditors prior to the on-site visit. During the on-site visit, HSAG auditors complete a detailed assessment 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 5-14 using findings from the validation of performance measures.

Table 5-14—Assignment of Performance Measures to Performance Domains			
Performance Measures	**Quality**	**Timeliness**	**Access**
Penetration Rates by Age Category			✓
Penetration Rates by Service Category			✓
Penetration Rates by Medicaid Eligibility 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. HSAG had no concerns with the methods used by ABC to process claims and encounter data. DST Data Solutions, the claims processing vendor, handled the processing of all paper and electronic claims. Using PowerSTEPP, ABC's transactional system, for both claims and encounter data processing made the work flow consistent. ABC's auto-adjudication rate was more than 83 percent, indicating that data received from the mental health centers (MHCs) and providers were clean. ABC had sufficient oversight of DST Data Solutions and performed quarterly audits. ABC was working diligently to prepare for the ICD-10 conversion and was in the process of moving all providers submitting through electronic data interchange to the 5010 model.

HSAG reviewers had no concerns with ABC's processing of State eligibility. Data files were downloaded from the State's portal and processed before being loaded into PowerSTEPP. All files were processed within 24 hours of receipt. Each individual was assigned a unique identifier for tracking and to avoid duplicate records. Eligibility data were uploaded to ABC's Web portal for providers and clinics to retrieve. Providers could also verify eligibility at time of service though the State's Web portal.

Findings—Performance Measure Results

Table 5-15 shows the ABC review results and audit designations for each performance measure.

Table 5-15—Review Results and Audit Designation *for* ABC

Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Penetration Rate by Age Category				
Children 12 Years of Age and Younger	6.8%	6.1%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	18.1%	18.6%	*Fully Compliant*	*Fully Compliant*
Adults 18 Through 64 Years of Age	23.6%	23.7%	*Fully Compliant*	*Fully Compliant*
Adults 65 Years of Age or Older	8.2%	7.5%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	0.9%	0.3%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.1%	0.0%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	11.2%	10.8%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rates	13.3%	12.8%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category				
AFDC/CWP Adults	—	17.2%	—	*Fully Compliant*
AFDC/CWP Children	—	7.2%	—	*Fully Compliant*
AND/AB-SSI	—	38.2%	—	*Fully Compliant*
BC Children	—	6.6%	—	*Fully Compliant*
BC Women	—	17.0%	—	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	—	33.3%	—	*Fully Compliant*
Foster Care	—	48.8%	—	*Fully Compliant*
OAP-A	—	7.6%	—	*Fully Compliant*
OAP-B-SSI	—	29.8%	—	*Fully Compliant*
Other[2]	—	18.0%	—	*Fully Compliant*
Hospital Recidivism[1]				
Non-State Hospitals—7 Days	4.6%	4.3%	*Fully Compliant*	*Fully Compliant*
30 Days	12.4%	14.3%	*Fully Compliant*	*Fully Compliant*
90 Days	23.0%	26.1%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	5.0%	5.2%	*Fully Compliant*	*Fully Compliant*
30 Days	13.0%	14.6%	*Fully Compliant*	*Fully Compliant*
90 Days	24.1%	26.9%	*Fully Compliant*	*Fully Compliant*

Table 5-15—Review Results and Audit Designation *for* ABC				
Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Hospital Average Length of Stay				
Non-State Hospitals	9.20	9.07	*Fully Compliant*	*Fully Compliant*
All Hospitals	12.15	15.88	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	11.10	9.35	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	7.08	6.52	*Fully Compliant*	*Fully Compliant*
All Hospitals	8.59	8.00	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 Days	38.1%	35.4%	*Fully Compliant*	*Fully Compliant*
30 Days	58.8%	57.8%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	40.4%	35.0%	*Fully Compliant*	*Fully Compliant*
30 Days	61.4%	57.5%	*Fully Compliant*	*Fully Compliant*

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

[2] The *OAP State Only* and *Unspecified* categories originally reported in the individual BHO Performance Measure Validation reports were combined into the *Others* category. Due to lags in BHO encounter submission and retroactive eligibility and ineligibility determinations in Colorado Benefits Management System (CBMS), clients' eligibility at the time of BHO enrollment or mental health encounter is difficult to assess. The *Other* category consists of clients who were enrolled in a BHO or had a mental health encounter whose eligibility type changed retroactively between the time of enrollment/encounter and the time penetration rates were calculated.

— Indicates the measure was not calculated.

Strengths

Since the FY 2009–2010 review, ABC transitioned to an automated process for generating performance measure rates. This required that staff members take a closer look at the previous performance measure process and identify areas where rates might have been under- or over-reported. This new process was efficient and allowed for tighter control of the reported rates. ABC also implemented a provider profile report. ABC used this report to track and inform providers on their performance. HSAG reviewers found ABC staff members to be extremely knowledgeable with regard to the performance measure specifications and fully involved in collaborating with the Department and other BHOs in updating the scope document.

ABC received a *Fully Compliant* status for all audited performance measures. HSAG observed slight improvement in two *Penetration Rate by Age Category* submeasures (*Adolescents 13 Through 17 Years of Age* and *Adults 18 Through 64 Years of Age*) and one *Hospital Recidivism*[5-1] submeasure (*Non-State Hospitals—7 Days*). The *Average Length of Stay* for *All Hospitals* also increased from last year.

[5-1] As an inverse measure, higher rates for *Hospital Recidivism* suggests poorer performance.

Recommendations

HSAG's recommendations to ABC regarding its performance measure validation processes and reporting were echoed for all BHOs and are included in the statewide recommendations section.

Although only one submeasure rate had a decrease of more than 5 percentage points (*Follow-Up After Hospitalization for Mental Illness—All Hospitals—7 Days*), many submeasures reported a decline in performance from last year. ABC should investigate reasons why the rates for follow-up visits have declined. Things to consider are: member compliance, appointment availability, and need for intensive case management after a discharge.

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 suggested opportunities for improvement. Although a slight improvement was observed for the *Non-State Hospitals—7 Days* submeasure, all other submeasures reported a decline in performance (increase in rate).
- **Timeliness:** *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported for this year. ABC's performance on this measure presented opportunities for improvement. All submeasures reported a decline from last year, with the *All Hospitals—7-day* submeasure rates showing a decline of more than 5 percentage points.
- **Access**: ABC's performance in the domain of quality was mixed, with continual opportunities for improvement presented for most of the measures. Two of the eight penetration-related submeasures demonstrated a slight improvement from the previous year and six exhibited a decline. These changes were within 1 percentage point. All utilization-based access measures except the *Hospital Average Length of Stay, All Hospitals*, experienced a decline in rates. It is important to assess utilization based on the characteristics of ABC'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.

HSAG reviewers had no concerns related to BHI's eligibility data system and processes. Colorado Access, BHI's new administrative services organization (ASO), provided daily eligibility files to each mental health center (MHC) for loading into its system. In addition, each center had access to the State's portal system to verify eligibility at the time of service. BHI identified consumers using a unique ID within the system.

Colorado Access also performed all claims and encounter processing and adjudication for BHI. MHC data were sent directly to Colorado Access for processing and BHI regularly monitored the volume and accuracy of these data via the encounter validation report.

Findings—Performance Measure Results

Table 5-16 shows the BHI review results and audit designations for each performance measure.

Table 5-16—Review Results and Audit Designation *for* BHI

Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Penetration Rate by Age Category				
Children 12 Years of Age and Younger	5.0%	6.1%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	17.8%	18.0%	*Fully Compliant*	*Fully Compliant*
Adults 18 Through 64 Years of Age	18.1%	20.0%	*Fully Compliant*	*Fully Compliant*
Adults 65 Years of Age or Older	3.6%	4.6%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	0.5%	0.1%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.2%	0.1%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	8.9%	10.6%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rate	9.9%	11.1%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category				
AFDC/CWP Adults	—	16.7%	—	*Fully Compliant*
AFDC/CWP Children	—	9.5%	—	*Fully Compliant*
AND/AB-SSI	—	33.4%	—	*Fully Compliant*
BC Children	—	6.7%	—	*Fully Compliant*

Table 5-16—Review Results and Audit Designation *for* BHI				
Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
BC Adults	—	9.9%	—	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	—	8.0%	—	*Fully Compliant*
Foster Care	—	37.4%	—	*Fully Compliant*
OAP-A	—	4.7%	—	*Fully Compliant*
OAP-B-SSI	—	21.8%	—	*Fully Compliant*
Other	—	13.9%	—	*Fully Compliant*
***Hospital Recidivism*[1]**				
Non-State Hospitals—7 Days	5.5%	0.4%	*Fully Compliant*	*Fully Compliant*
30 Days	11.0%	4.6%	*Fully Compliant*	*Fully Compliant*
90 Days	15.4%	12.1%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	5.0%	1.4%	*Fully Compliant*	*Fully Compliant*
30 Days	12.7%	7.2%	*Fully Compliant*	*Fully Compliant*
90 Days	19.9%	14.5%	*Fully Compliant*	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	7.63	7.28	*Fully Compliant*	*Fully Compliant*
All Hospitals	17.75	16.33	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	6.79	5.35	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	1.77	2.37	*Fully Compliant*	*Fully Compliant*
All Hospitals	5.44	4.67	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 Days	38.9%	54.7%	*Fully Compliant*	*Fully Compliant*
30 Days	58.0%	70.1%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	49.3%	52.8%	*Fully Compliant*	*Fully Compliant*
30 Days	64.0%	67.4%	*Fully Compliant*	*Fully Compliant*

[1] For the Hospital Recidivism measure, an increase in rates from last year's suggested poorer performance.
[2] The *OAP State Only* and *Unspecified* categories originally reported in the individual BHO Performance Measure Validation reports were combined into the *Others* category. Due to lags in BHO encounter submission and retroactive eligibility and ineligibility determinations in CBMS, clients' eligibility at the time of BHO enrollment or mental health encounter is difficult to assess. The *Other* category consists of clients who were enrolled in a BHO or had a mental health encounter whose eligibility type changed retroactively between the time of enrollment/encounter and the time penetration rates were calculated.
— Indicates the measure was not calculated.

Strengths

BHI thoroughly documented the transition process from its former ASO, InNET, to its new ASO, Colorado Access. HSAG reviewers found evidence of excellent collaboration between BHI and Colorado Access regarding oversight and ongoing monitoring of claims and encounter volumes, as well as the performance measure data validation and reporting process. BHI staff members were

knowledgeable regarding the performance measure specifications and were fully involved in collaborating with the Department and other BHOs in updating the scope document.

BHI received a *Fully Compliant* status for all audited performance measures. HSAG observed improvement in many submeasures, with six rates improving by more than 5 percentage points over last year's rates. These six submeasures included four under *Hospital Recidivism*, and two under *Follow-Up After Hospitalization for Mental Illness* (*Non-State Hospitals—7–Day and 30–Day*).

Recommendations

HSAG's recommendations to BHI regarding its performance measure validation processes and reporting were echoed for all BHOs and are included in the statewide recommendations section.

Although no measures had any notable decline in rates from last year, opportunities for improvement existed for penetration rate. Despite improvements from last year, all submeasures under *Penetration Rate by Age Category*, *Penetration Rate by Service Category—Ambulatory Care*, and the *Overall Penetration Rate* measure were below statewide averages.

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 reported improvement in all submeasures under *Hospital Recidivism*, with four rates improving by more than 5 percentage points.
- **Timeliness**: The *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported for this year. BHI's performance on this measure demonstrated improvement from last year, with two submeasures (*Non-State Hospitals—7–Day and 30–Day*) exhibiting an increase in rates of more than 10 percentage points.
- **Access**: BHI's performance demonstrated slight improvement on six of the eight penetration-related submeasures. For the two with a decline in rates, the decrease was less than 0.5 percentage points. The majority of the submeasures were below the current year's statewide averages. For the utilization-based access measures, all except the *Inpatient Utilization for Non-State Hospitals* measure reported a decline in rates. 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.

HSAG reviewers had no concerns regarding CHP's process for receiving and reporting claims and encounter data. CHP's MHCs used either Qualifacts/CareLogic or Profiler for its internal system, and CHP received all data from the MHCs in an electronic format monthly. The volumes of monthly encounter files were carefully monitored by both CHP and the MHCs. Each MHC received a report card with detailed information on the data CHP received from them. Most of CHP's contracted providers submitted claims data electronically. Paper claims, though few, were scanned and the data were translated into an electronic format via optical character recognition (OCR) software.

HSAG also had no concerns with CHP's process for receipt and processing of eligibility data from the State; processes during the measurement period remained stable since the previous year. CHP's finance department retrieved the proprietary flat file from the State, which was loaded into the local system monthly. Real-time eligibility was confirmed via the Sate's Web portal. As of July 2010, CHP began using the 834 eligibility file as the source for eligibility data; and this process will be reviewed in detail next year (FY 2011–2012).

Findings—Performance Measure Results

Table 5-17 shows the CHP review results and audit designations for each performance measure.

Table 5-17—Review Results and Audit Designation *for* CHP

Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Penetration Rate by Age Category				
Children 12 Years of Age and Younger	6.7%	6.9%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	18.9%	18.8%	*Fully Compliant*	*Fully Compliant*
Adults 18 Through 64 Years of Age	20.2%	20.0%	*Fully Compliant*	*Fully Compliant*
Adults 65 Years of Age or Older	6.8%	6.8%	*Fully Compliant*	*Fully Compliant*

Table 5-17—Review Results and Audit Designation *for* CHP				
Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Penetration Rate by Service Category				
Inpatient Care	0.7%	0.3%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.1%	0.0%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	12.5%	12.3%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rate	12.8%	12.7%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category				
AFDC/CWP Adults	—	17.7%	—	*Fully Compliant*
AFDC/CWP Children	—	10.3%	—	*Fully Compliant*
AND/AB-SSI	—	28.0%	—	*Fully Compliant*
BC Children	—	8.1%	—	*Fully Compliant*
BC Adults	—	15.8%	—	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	—	16.6%	—	*Fully Compliant*
Foster Care	—	34.7%	—	*Fully Compliant*
OAP-A	—	6.9%	—	*Fully Compliant*
OAP-B-SSI	—	20.6%	—	*Fully Compliant*
Other[2]	—	11.6%	—	*Fully Compliant*
Hospital Recidivism[1]				
Non-State Hospitals—7 Days	3.3%	4.8%	*Fully Compliant*	*Fully Compliant*
30 Days	9.8%	11.3%	*Fully Compliant*	*Fully Compliant*
90 Days	17.8%	18.0%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	2.4%	4.4%	*Fully Compliant*	*Fully Compliant*
30 Days	8.1%	12.1%	*Fully Compliant*	*Fully Compliant*
90 Days	14.2%	19.5%	*Fully Compliant*	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	8.32	6.60	*Fully Compliant*	*Fully Compliant*
All Hospitals	16.78	13.95	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	11.38	10.74	*Fully Compliant*	*Fully Compliant*

Table 5-17—Review Results and Audit Designation *for* CHP				
Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	2.55	3.08	*Fully Compliant*	*Fully Compliant*
All Hospitals	4.85	5.25	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 Days	47.7%	46.2%	*Fully Compliant*	*Fully Compliant*
30–day	69.2%	65.4%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	49.8%	48.3%	*Fully Compliant*	*Fully Compliant*
30–day	68.9%	68.4%	*Fully Compliant*	*Fully Compliant*

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

[2] The *OAP State Only* and *Unspecified* categories originally reported in the individual BHO Performance Measure Validation reports were combined into the *Others* category. Due to lags in BHO encounter submission and retroactive eligibility and ineligibility determinations in CBMS, clients' eligibility at the time of BHO enrollment or mental health encounter is difficult to assess. The *Other* category consists of clients who were enrolled in a BHO or had a mental health encounter whose eligibility type changed retroactively between the time of enrollment/encounter and the time penetration rates were calculated.

— Indicates the measure was not calculated.

Strengths

CHP demonstrated outstanding monitoring of the MHC monthly encounter submissions via a report card format, which included drill-down capabilities for data mining and other activities. System edits allowed centers to make necessary corrections prior to official encounter submission to the Department, helping to minimize errors during file submission and greatly reducing the number of corrections. CHP had good oversight of its centers and received most data electronically, with the few paper claims being scanned and translated to an electronic format, minimizing concerns related to data entry accuracy. The staff members responsible for performance measure calculation and reporting were a cohesive team with a high degree of technical expertise.

CHP received a *Fully Compliant* status for all audited performance measures.

Recommendations

HSAG recommended that CHP monitor report card data errors due to an incorrect provider type, based on new coding manual directives. HSAG's other recommendations to CHP regarding its performance measure validation processes and reporting were echoed for all BHOs and are included in the statewide recommendations section.

This year's CHP performance results highlighted some areas for improvement. The majority of the performance measures declined from last year's rates. Performance on all but one *Hospital*

Recidivism submeasures was below the statewide average. In particular, performance on the *Recidivism—All Hospitals—90-Day* rate was 5.3 percentage points higher than last year's rate. CHP should investigate reasons why the recidivism rates increased.

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 suggested room for improvement. All submeasures under the *Hospital Recidivism* measure reported a decline in performance (increase in rates), with the *All Hospitals—90-Day* rate showing an increase of more than 5 percentage points.

- **Timeliness**: CHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) suggested an opportunity for improvement. All submeasures reported a decline from last year's rate.

- **Access**: CHP's performance in the domain of access was consistent with the previous year. Although all but two *Penetration Rate* submeasures (*Children 12 Years of Age and Younger* and *Adults 65 Years of Age or Older*) showed a decline from last year, the decreases in rates were less than 0.5 percentage points. For utilization-based measures, HSAG observed that the *Inpatient Utilization* measures demonstrated an increase in rates over last year and the two *Hospital Average Length of Stay* and *Emergency Room Utilization* submeasures reported a decline in rates. 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.

HSAG identified no issues related to FBHP's process for receiving and reporting claims and encounter data. FBHP received all data from the MHCs in an electronic format monthly. The volumes of the monthly encounter files were carefully monitored by both FBHP and the MHCs, and each MHC received a report card with detailed information on the data FBHP received. Most of FBHP's contracted providers submitted claims data electronically. The small volume of paper claims received was scanned and the data translated to an electronic format via OCR software.

HSAG had no concerns with FBHP's process for receipt and processing of eligibility data from the State. Processes during the measurement period remained stable since the previous year. FBHP's finance department retrieved the proprietary flat file from the State, which was loaded into the local

system monthly. Real-time eligibility could be confirmed via the State's portal. As of July 2010, FBHP began using the 834 eligibility file as the source for eligibility data, and this process will be reviewed in detail next year.

Findings—Performance Measure Results

Table 5-18 shows the FBHP review results and audit designations for each performance measure.

Table 5-18—Review Results and Audit Designation *for* FBHP

Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Penetration Rate by Age Category				
Children 12 Years of Age and Younger	12.4%	16.3%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	28.9%	33.2%	*Fully Compliant*	*Fully Compliant*
Adults 18 Through 64 Years of Age	29.1%	30.9%	*Fully Compliant*	*Fully Compliant*
Adults 65 Years of Age or Older	9.9%	12.2%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	0.8%	0.2%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.2%	0.1%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	18.7%	17.6%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rate	19.5%	22.6%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category				
AFDC/CWP Adults	—	28.4%	—	*Fully Compliant*
AFDC/CWP Children	—	23.4%	—	*Fully Compliant*
AND/AB-SSI	—	38.4%	—	*Fully Compliant*
BC Children	—	18.8%	—	*Fully Compliant*
BC Adults	—	32.1%	—	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	—	21.2%	—	*Fully Compliant*
Foster Care	—	45.1%	—	*Fully Compliant*
OAP-A	—	12.2%	—	*Fully Compliant*
OAP-B-SSI	—	34.8%	—	*Fully Compliant*
Other[2]	—	33.9%	—	*Fully Compliant*
Hospital Recidivism[1]				
Non-State Hospitals—7 Days	6.3%	3.3%	*Fully Compliant*	*Fully Compliant*
30 Days	8.0%	9.4%	*Fully Compliant*	*Fully Compliant*
90 Days	21.4%	12.7%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	3.3%	2.6%	*Fully Compliant*	*Fully Compliant*
30 Days	6.6%	7.7%	*Fully Compliant*	*Fully Compliant*
90 Days	16.6%	12.9%	*Fully Compliant*	*Fully Compliant*

Table 5-18—Review Results and Audit Designation *for* FBHP				
Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	6.40	6.24	*Fully Compliant*	*Fully Compliant*
All Hospitals	20.32	13.35	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	8.14	6.35	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	2.24	3.17	*Fully Compliant*	*Fully Compliant*
All Hospitals	6.04	6.11	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 Days	77.3%	60.9%	*Fully Compliant*	*Fully Compliant*
30 Days	84.1%	75.0%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	77.7%	63.6%	*Fully Compliant*	*Fully Compliant*
30 Days	87.3%	77.1%	*Fully Compliant*	*Fully Compliant*

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

[2] The *OAP State Only* and *Unspecified* categories originally reported in the individual BHO Performance Measure Validation reports were combined into the *Others* category. Due to lags in BHO encounter submission and retroactive eligibility and ineligibility determinations in CBMS, clients' eligibility at the time of BHO enrollment or mental health encounter is difficult to assess. The *Other* category consists of clients who were enrolled in a BHO or had a mental health encounter whose eligibility type changed retroactively between the time of enrollment/encounter and the time penetration rates were calculated.

— Indicates the measure was not calculated.

Strengths

The staff members at FBHP responsible for performance measure calculation and reporting were a cohesive team with a high degree of technical expertise. The FBHP staff members worked closely with ValueOptions (VO) to establish oversight procedures and implemented changes from the new coding manual. They also worked with the State to develop the new measures.

FBHP demonstrated good oversight of its MHCs and received most data electronically, minimizing concerns related to data entry accuracy. FBHP worked directly with and showed a thorough understanding of its data. FBHP had an extra layer of validation for encounter data completeness and accuracy prior to submission to the State, meeting twice a month with VO and the MHCs to discuss encounter data. In addition, FBHP sent all encounters (Medicaid and non-Medicaid) to VO to ensure that VO had complete data, which helped to ensure that encounters were already submitted for retro-enrollments).

FBHP demonstrated outstanding monitoring of the MHC monthly encounter submissions via a report card format, which included drill-down capabilities for data mining and other activities. System edits allowed centers to make necessary corrections prior to official encounter submission to the Department, helping to ensure minimal errors during file submission and greatly reducing the number of corrections.

FBHP received a *Fully Compliant* status for all audited performance measures. FBHP's performance improved from the previous year for five submeasures under *Penetration Rate*, and four

submeasures under *Hospital Recidivism*. In particular, the performance for the *Hospital Recidivism—Non-State Hospitals—3-Day* and *All Hospitals—30-Day* submeasures reflected at least a 5 percentage point improvement (drop in rate).

Recommendations

HSAG's recommendations to FBHP regarding its performance measure validation processes and reporting were echoed for all BHOs and are included in the Statewide recommendations section.

Although all submeasures under *Follow-Up After Hospitalization for Mental Illness* were at least 5 percentage points above their statewide averages, FBH's performance showed a notable decline from last year. All submeasures were at least 9 percentage points lower than last year's rates, presenting opportunities for improvement.

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. Four submeasures showed improved performance (drop in rates) from last year with one exhibiting improvement of more than 5 percentage points. Two other submeasures (*Hospital Recidivism—All Hospitals—90-Day* both *30-day* rates) had an increase of less than 1.5 percentage points.

- **Timeliness**: FBHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) suggested room for improvement.

- **Access**: FBHP's performance in the domain of access was mixed, with five penetration-related measures exhibiting improvement and the remaining three a decline. The improvement ranged from an increase of 1.8 percentage points to 4.3 percentage points from last year. Among those submeasures reporting a decline, none was greater than 5 percentage points. For the utilization-based measures, *Inpatient Utilization* for both non-state and all hospitals reported an increase in rate, whereas both *Hospital Average Length of Stay* submeasures and the *Emergency Room Utilization* submeasure reported a decline. In particular, the *Hospital Average Length of Stay — All Hospitals* submeasure exhibited a decline of nearly seven days.

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.

HSAG had no concerns with NBHP's processes for receiving and reporting claims and encounter data. ValueOptions (VO), NBHP's ASO, received all data from NBHP's MHCs in an electronic format monthly. NBHP carefully monitored the volumes of monthly encounter files and NBHP sent each MHC a report card with detailed information on the data VO received. Most of NBHP's contracted providers submitted claims data electronically, and the few paper claims received were scanned and the data translated into electronic format via OCR software.

HSAG had no concerns with NBHP's process for receipt and processing of eligibility data from the State. Processes during the measurement period remained stable since the previous year. The ASO's finance department retrieved the proprietary flat file from the State, which was loaded into the MHCs' local systems monthly. MHCs were able to confirm real-time eligibility via the State's portal. As of July 2010, NBHP began using the 834 eligibility file as the source for eligibility data. HSAG will review this process in detail next year.

Findings – Performance Measure Results

Table 5-19 shows the NBHP review results and audit designations for each performance measure.

Table 5-19—Review Results and Audit Designation *for* NBHP

Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Penetration Rate by Age Category				
Children 12 Years of Age and Younger	8.0%	7.1%	*Fully Compliant*	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	23.6%	23.7%	*Fully Compliant*	*Fully Compliant*
Adults 18 Through 64 Years of Age	21.6%	20.0%	*Fully Compliant*	*Fully Compliant*
Adults 65 Years of Age or Older	5.0%	4.6%	*Fully Compliant*	*Fully Compliant*
Penetration Rate by Service Category				
Inpatient Care	0.8%	0.3%	*Fully Compliant*	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.03%	0.02%	*Fully Compliant*	*Fully Compliant*
Ambulatory Care	13.3%	12.3%	*Fully Compliant*	*Fully Compliant*
Overall Penetration Rate	13.7%	12.8%	*Fully Compliant*	*Fully Compliant*

Table 5-19—Review Results and Audit Designation *for* NBHP				
Performance Measures	Rate		Audit Designation	
	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
Penetration Rate by Medicaid Eligibility Category				
AFDC/CWP Adults	—	17.0%	—	*Fully Compliant*
AFDC/CWP Children	—	11.9%	—	*Fully Compliant*
AND/AB-SSI	—	33.0%	—	*Fully Compliant*
BC Children	—	8.7%	—	*Fully Compliant*
BC Adults	—	12.0%	—	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	—	17.1%	—	*Fully Compliant*
Foster Care	—	40.9%	—	*Fully Compliant*
OAP-A	—	4.6%	—	*Fully Compliant*
OAP-B-SSI	—	25.1%	—	*Fully Compliant*
Other[2]	—	15.5%	—	*Fully Compliant*
Hospital Recidivism[1]				
Non-State Hospitals—7 Days	3.5%	3.2%	*Fully Compliant*	*Fully Compliant*
30 Days	6.2%	8.1%	*Fully Compliant*	*Fully Compliant*
90 Days	10.4%	13.0%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	3.6%	3.3%	*Fully Compliant*	*Fully Compliant*
30 Days	6.9%	8.9%	*Fully Compliant*	*Fully Compliant*
90 Days	12.7%	14.4%	*Fully Compliant*	*Fully Compliant*
Hospital Average Length of Stay (All Ages)				
Non-State Hospitals	4.91	5.32	*Fully Compliant*	*Fully Compliant*
All Hospitals	11.02	7.52	*Fully Compliant*	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	6.38	5.03	*Fully Compliant*	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)				
Non-State Hospitals	5.21	5.38	*Fully Compliant*	*Fully Compliant*
All Hospitals	7.10	6.16	*Fully Compliant*	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness				
Non-State Hospitals—7 Days	46.0%	51.9%	*Fully Compliant*	*Fully Compliant*
30–day	63.6%	72.0%	*Fully Compliant*	*Fully Compliant*
All Hospitals—7 Days	48.1%	51.5%	*Fully Compliant*	*Fully Compliant*
30 Days	66.7%	71.6%	*Fully Compliant*	*Fully Compliant*

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

[2] The *OAP State Only* and *Unspecified* categories originally reported in the individual BHO Performance Measure Validation reports were combined into the *Others* category. Due to lags in BHO encounter submission and retroactive eligibility and ineligibility determinations in CBMS, clients' eligibility at the time of BHO enrollment or mental health encounter is difficult to assess. The *Other* category consists of clients who were enrolled in a BHO or had a mental health encounter whose eligibility type changed retroactively between the time of enrollment/encounter and the time penetration rates were calculated.

— Indicates the measure was not calculated.

Strengths

NBHP continued to closely monitor data from its three MHCs and integrated its new ASO's monitoring tools into NBHP's existing Finance and Information Technology (FIT) Committee's audit and review functions. NBHP staff members were very familiar with the claims and encounter volumes of its MHCs as well as performance measure rates. The transition to the new ASO was seamless, well planned, and well documented. VO offered NBHP additional information technology expertise and data monitoring tools, which NBHP shared with its MHCs.

NBHP received a *Fully Compliant* status for all audited performance measures. Performance improved from the previous year for nine submeasures (*Penetration Rate—Adolescents 13 Through 17 Years of Age*, *Hospital Recidivism—Non-State Hospitals* and *All Hospitals—7Days*, *Hospital Average Length of Stay—Non-State Hospitals*, *Inpatient Utilization—Non-State Hospitals*, and all *Follow-Up After Hospitalization for Mental Illness* submeasures). Two of the submeasures under *Follow-Up After Hospitalization for Mental Illness* showed at least a 5 percentage point improvement from last year's results.

Recommendations

HSAG repeated its FY 2009–2010 recommendation that NBHP monitor the Larimer and North Range mental health centers' data related to kept appointments until the electronic medical record (EMR) is implemented. Although NBHP followed this recommendation since the last review, the go-live date was delayed until March 2011. NBHP should also monitor report card data errors due to incorrect provider type, based on new coding manual directives. HSAG's other recommendations to NBHP regarding its performance measure validation processes and reporting were echoed for all BHOs and are included in the statewide recommendations section.

Compared to last year's results, several submeasures under *Penetration Rate* reported a slight decrease in rate of no more than 1 percentage point. The rates for the 30-day and 90-day submeasures under *Hospital Recidivism* increased from last year, showing a decline in performance and representing an opportunity for improvement. The rates for all other measures were relatively static. NBHP should evaluate utilization trends routinely and monitor utilization patterns and performance improvement opportunities.

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 consistent with last year's results. Two of the six submeasures reported an improvement in performance (drop in rates) and four rates showed a decline in performance (increase in rates). Nonetheless, the changes in rates for all the submeasures were less than 5 percentage points.

- **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 two exhibiting a rate increase of at least 5 percentage points.

These two submeasures (*Non-State Hospitals—7 Days and 30 Days*) also performed above the statewide average.

- **Access**: NBHP's performance in the domain of access was also consistent with the previous year. One of the eight submeasures under *Penetration Rate* demonstrated a slight increase over last year's results. The decline in rates observed in five of the seven submeasures was less than 1 percentage point and decline for the two remaining submeasures was 2 percentage points below last year's rates. For the utilization-based measures, *Hospital Average Length of Stay—Non-State Hospitals, Inpatient Utilization—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 5-20 presents the statewide number and percentage of BHOs achieving each validation status for each performance measure for FY 2010–2011 and the prior year.

Table 5-20—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 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011	FY 2009–2010	FY 2010–2011
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 5-21 provides a summary of the statewide weighted averages for the performance measure rates for FY 2010–2011 and the prior year. In general, Table 5-21 shows that statewide use of inpatient services, emergency room services, and hospital length of stay increased over last year.

Table 5-21—Statewide Weighted Average Rates for the Performance Measures

	Rate		
Performance Measures	FY 2009–2010	FY 2010–2011	BHO FY 2010-2011 Rate Variations
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.1%	7.6%	6.1%–16.3%
Adolescents 13 Through 17 Years of age	20.2%	20.8%	18.0%–33.2%
Adults 18 Through 64 Years of age	21.6%	21.9%	20.0%–30.9%
Adults 65 Years of Age or Older	6.6%	6.9%	4.6%–12.2%
Penetration Rate by Service Category			
Inpatient Care	0.7%	0.2%	0.1%–0.3%
Intensive Outpatient/Partial Hospitalization	0.1%	0.0%	0.0%–0.1%
Ambulatory Care	12.2%	12.2%	10.6%–17.6%
Overall Penetration Rate	13.1%	13.5%	11.1%–22.6%

Table 5-21—Statewide Weighted Average Rates for the Performance Measures			
Performance Measures	Rate		BHO FY 2010-2011 Rate Variations
	FY 2009–2010	FY 2010–2011	
Penetration Rate by Medicaid Eligibility			
AFDC/CWP Adults	—	18.5%	16.7%–28.4%
AFDC/CWP Children	—	11.1%	7.2%–23.4%
AND/AB-SSI	—	32.7%	28.0%–38.4%
BC Children	—	8.7%	6.6%–18.8%
BC Adults	—	15.9%	9.9%–32.1%
BCCP—Women Breast and Cervical Cancer	—	18.0%	8.0%–33.3%
Foster Care	—	39.6%	34.7%–48.8%
OAP-A	—	7.0%	4.6%–12.2%
OAP-B-SSI	—	25.0%	20.6%–34.8%
Other[2]	—	16.6%	11.6%–33.9%
Hospital Recidivism[1]			
Non-State Hospitals—7 Days	4.3%	3.6%	0.4%–4.8%
30 Days	10.1%	10.5%	4.6%–14.3%
90 Days	18.3%	18.2%	12.1%–26.1%
All Hospitals—7 Days	3.9%	3.7%	1.4%–5.2%
30 Days	9.9%	10.8%	7.2%–14.6%
90 Days	17.9%	18.9%	12.9%–26.9%
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	7.78	7.19	5.32–9.07
All Hospitals	15.36	13.93	7.52–16.33
Emergency Room Utilization (Rate/1000 Members, All Ages)	9.28	8.00	5.03–10.74
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.48	3.83	2.37–6.52
All Hospitals	6.07	5.81	4.67–8.00
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	45.1%	46.8%	35.4%–60.9%
30 Days	64.2%	66.1%	57.8%–75.0%
All Hospitals—7 Days	49.7%	48.2%	35.0%–63.6%
30 Days	67.3%	67.3%	57.5%–77.1%

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

[2] The *OAP State Only* and *Unspecified* categories originally reported in the individual BHO Performance Measure Validation reports were combined into the *Others* category. Due to lags in BHO encounter submission and retroactive eligibility and ineligibility determinations in CBMS, clients' eligibility at the time of BHO enrollment or mental health encounter is difficult to assess. The *Other* category consists of clients who were enrolled in a BHO or had a mental health encounter whose eligibility type changed retroactively between the time of enrollment/encounter and the time penetration rates were calculated.

— Indicates the measure was not calculated.

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.

As in the prior year, all of the performance measures for all BHOs received a score of *Fully Compliant*. Ten of the 18 non-utilization measures demonstrated slight improvement in performance from the previous year. The *7-Day* and *30-Day Follow-Up After Hospitalization for Mental Illness—Non-State Hospitals* demonstrated the greatest statewide improvement (1.7 and 1.9 percentage points) across all measures.

Statewide Recommendations

HSAG reviewers noted that all BHOs used a manual process to populate the Department's reporting template. While all BHOs validated the data entry, the process was not formally documented. Several of the plans noted errors in their rate submissions after submitting rates to the Department. The Department and HSAG agreed to allow these plans to resubmit corrected rates. However, because this was a manual process, HSAG recommended that all BHOs formally document the validation of the Department's reporting template when it is populated to avoid potential errors.

HSAG recommended that all the BHOs continue to collaborate with the Department and each other to address the challenges with formatting in the scope document. Review of the performance measure programming code highlighted the fragmented nature of the document and the difficulty faced when ensuring updates were uniformly integrated into the necessary sections. As new measures are added, the document will grow exponentially, making it difficult to work with and review for validation purposes. HSAG recommended that the BHOs and the Department reformat the document before the next performance measure validation cycle.

Quality

The *Hospital Recidivism* measure was the only quality measure for this year. Statewide BHO performance on the *Hospital Recidivism* submeasures was mixed but consistent with last year's results. Three of the six submeasures reported a slight decline in rate (an improvement in performance) and the other three reported a slight increase in rate (a decline). None of these rates declined more than 5 percentage points. *Hospital Recidivism— Non-State* and *All Hospitals* rates were similar, with longer durations having higher recidivism. BHO variations in rates were smallest for the 7-day *Hospital Recidivism* (3.7 percent) and largest for the 90-day recidivism for All Hospitals (14 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. Statewide performance on this measure was mixed, with the submeasure for *Non-State Hospitals* demonstrating an improvement but *All Hospitals* a decline or the same from last year. Nonetheless, all changes were within 2 percentage points. BHO variations in rates for all the submeasures were larger than 15 percent, with the *Non-State Hospitals—30-day Follow-Up* measure for 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 25.6 percent and for *State Hospitals*, the variation was 28.5 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 very similar to last year. Six of the eight submeasures under *Penetration Rate* showed a slight increase and two had a slight decline. None reported changes in rate of more than 1 percentage point. The greatest variations in rates among the BHOs were noted in the *Penetration Rate—Adolescents 13 Through 17 Years of Age* and the *Overall Penetration Rate* measures, where a 10 percentage-point difference was observed. Statewide performance on the utilization-based measures was characterized by a slight increase in *Inpatient Utilization* for *Non-State Hospitals* but a slight decline in *Inpatient Utilization* for *All Hospitals*, *Emergency Room Utilization* and *Hospital Average Length of Stay*. 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.

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.

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 continued from the previous year.

For the first PIP, HSAG reviewed Activities I through X. Table 5-22 and Table 5-23 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 5-22—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	4	0	0	0	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	3	1	0	0	No Critical Elements				
X. Describe sustained improvement	1	0	1	0	0	No Critical Elements				
Totals for All Activities	**53**	**35**	**2**	**0**	**16**	**13**	**10**	**0**	**0**	**3**

Table 5-23—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 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**91%**	**95%**
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 by documenting a solid study design in compliance with the CMS PIP protocol. ABC received *Met* scores for all applicable evaluation elements in Activities I through VIII. In addition, ABC completed a causal/barrier analysis and linked the interventions with the barriers. The plan implemented member-, provider-, and system-level interventions. The interventions included pulling a monthly report to identify members who used the ED on an ambulatory basis three or more times a month within a 90-day period, forming relationships with EDs to obtain access to real-time data, member outreach, posting a community resource list on its Web site, providing reports to providers, and employing a peer specialist. For this year's submission, the plan progressed to reporting a second annual remeasurement.

Recommendations

When reviewing Activity IX, HSAG noted that only one of the study indicators demonstrated statistically significant improvement from Remeasurement 1 to Remeasurement 2. HSAG also noted in Activity X that while Study Indicator 1 demonstrated improvement from the first remeasurement to the second remeasurement, the Remeasurement 2 result was not better than the baseline result. Study Indicator 2 demonstrated improvement from the first remeasurement to the second remeasurement, and the Remeasurement 2 result was better than the baseline result. However, the improvement from baseline to Remeasurement 2 was not statistically significant.

ABC's second PIP was the State-mandated collaborative PIP. HSAG reviewed Activities I through X. Table 5-24 and Table 5-25 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 5-24—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	3	0	0	0	No Critical Elements			
X. Describe sustained improvement	1	0	1	0	0	0	No Critical Elements			
Totals for All Activities	**53**	**35**	**4**	**0**	**14**	**13**	**11**	**0**	**0**	**2**

Table 5-25—FY 2009–2010 and FY 2010–2011 PIP Overall Validation Scores and Validation Status
***for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers**
***for* ABC**

	Prior Year FY 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**92%**	**90%**
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, ABC demonstrated strength by documenting a solid study design in compliance with the CMS PIP protocol. ABC received *Met* scores for all applicable evaluation elements in Activities I through VIII. In addition, ABC completed a causal/barrier analysis and linked the interventions with the barriers. The plan implemented member-, provider-, and system-level interventions. The interventions included pulling a monthly report to identify members who used the emergency department on an ambulatory basis three or more times a month within a 90-day period, forming relationships with emergency departments to obtain access to real-time data, member outreach, posting a community resource list on its Web site, providing reports to providers, and employing a peer specialist.

Recommendations

When reviewing Activities IX and X, HSAG noted that only one of the study indicators demonstrated statistically significant improvement from Remeasurement 1 to Remeasurement 2. Although Study Indicator 1 demonstrated improvement from the first remeasurement to the second remeasurement, the Remeasurement 2 result was not better than the baseline result. Furthermore, while Study Indicator 2 demonstrated improvement from the first remeasurement to the second remeasurement and the Remeasurement 2 result was better than the baseline result, the improvement from baseline to Remeasurement 2 was not statistically significant.

ABC identified that it needs to target the smaller mental health providers and provide education on the importance of documenting care coordination efforts. HSAG recommended that ABC continue these efforts and that it perform additional drill-down analysis to further develop targeted interventions that could have a positive impact on the outcomes.

Summary Assessment Related to Quality, Timeliness, and Access

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.

ABC's scores clearly demonstrated it had effective processes for conducting valid PIPs. HSAG's assessment determined confidence in the results for both PIPs.

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 X. Table 5-26 and Table 5-27 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 5-26—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	9	0	0	2	1	1	0	0	0
VII. Implement intervention and improvement strategies	4	4	0	0	0	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	2	1	0	0	No Critical Elements			
X. Describe sustained improvement	1	1	0	0	0	0	No Critical Elements			
Totals for All Activities	**53**	**46**	**2**	**1**	**4**	**13**	**13**	**0**	**0**	**0**

Table 5-27—FY 2009–2010 and FY 2010–2011 PIP Overall Validation Scores and Validation Status *for* Coordination of Care Between Medicaid Physical and Behavioral Health Providers *for* BHI		
	Prior Year FY 2009–2010	**FY 2010–2011**
Percentage Score of Evaluation Elements *Met**	**96%**	**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

BHI demonstrated strength in its study design and study implementation by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII. BHI achieved improvement for all indicators when compared to the baseline.

Recommendations

In Attachment H of BHI's submission, BHI discussed how the rates would be calculated and which statistical test would be used. BHI also identified the goal for each indicator. However, BHI did not state that the rates would be compared to the established goal. HSAG recommends that BHI revise its data analysis plan to include how the rates will be calculated, how the rates will be compared to the goal, and which statistical test will be used to determine the statistical significance.

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. After reviewing BHI's PIP, HSAG had high confidence in the validity of its outcomes.

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 X. Table 5-28 and Table 5-29 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 5-28—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	8	1	0	2	1	1	0	0	0
VII. Implement intervention and improvement strategies	4	4	0	0	0	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	0	1	0	0	0	No Critical Elements			
Totals for All Activities	**53**	**47**	**2**	**0**	**4**	**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* CHP		
	Prior Year FY 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**94%**	**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

CHP demonstrated strength in its study design and study implementation phases (Activities I through VII). 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 also demonstrated strength in the study outcomes achieved by receiving *Met* scores for all applicable evaluation elements in Activities VIII and IX.

Recommendations

HSAG noted that only one of two study indicators achieved sustained improvement. HSAG recommends that CHP analyze its data to determine if any subgroup has a disproportionately lower rate that negatively affects the overall rate. This "drill-down" type of analysis should be conducted before and after implementation of any interventions.

HSAG also suggested, as a *Point of Clarification* for Activity VI, that CHP document complete date ranges for all measurement periods (i.e., January 1, 2010, through December 31, 2010).

For the second PIP, HSAG reviewed Activities I through X. Table 5-30 and Table 5-31 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 5-30—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	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	2	0	1	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	0	3	0	0	No Critical Elements			
X. Describe sustained improvement	1	0	0	1	0	0	No Critical Elements			
Totals for All Activities	**53**	**30**	**0**	**5**	**18**	**13**	**10**	**0**	**0**	**3**

Table 5-31—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 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**91%**	**86%**
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 strength by documenting a solid study design in compliance with the CMS PIP protocol. CHP received *Met* scores for all applicable evaluation elements in Activities I through VI and Activity VIII. In addition, CHP completed a causal/barrier analysis and linked the interventions with the barriers. CHP's interventions included distributing educational brochures at a variety of mental health-related events and locations and mass mailing the brochures to all eligible members 60 years of age and older in CHP's service area. The brochure included a mental health assessment tool that could be self-administered.

Recommendations

In Activity VII, HSAG noted that the Remeasurement 2 result demonstrated a statistically significant decline, yet CHP did not revise the current interventions or develop new interventions. CHP received three *Not Met* scores in Activity IX and one *Not Met* score in Activity X. These scores are a result of a statistically significant decline in the Remeasurement 2 result that was also below the baseline result. HSAG recommends that CHP reassess the causes and barriers and revise the current interventions and/or develop new interventions.

HSAG also suggested CHP address the following *Points of Clarification*:

- CHP should strike through Study Question 2 since it is no longer reporting the Study Indicator 2 result.
- HSAG found two instances of discrepancies in CHP's PIP Summary Form. One instance involved the percentage of data completeness and the other instance involved rates. CHP should ensure that the information presented in the PIP is accurate and consistent.

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. Based on validation of CHP's PIPs, HSAG's assessment determined high confidence in the results.

Foothills Behavioral Health Partners (FBHP)

Findings

FBHP conducted two PIPs. The *Reducing Emergency Department (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. Both PIPs were continued from the prior year.

For the first PIP, HSAG reviewed Activities I through IX. Table 5-32 and Table 5-33 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 5-32—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
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	4	0	0	0	No Critical Elements				
X. Describe sustained improvement	1	Not Assessed				No Critical Elements				
Totals for All Activity	**53**	**35**	**0**	**0**	**17**	**13**	**10**	**0**	**0**	**3**

Table 5-33—FY 2009–2010 PIP Overall Validation Scores and Validation Status *for* Reducing ED Utilization for Youth *for* FBHP		
	Prior Year FY 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**100%**	**100%**
Percentage Score of Critical Elements *Met***	**100%**	**100%**
Validation Status***	***Met***	***Met***

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

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

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

Strengths

FBHP demonstrated strength in the study design, study implementation, and quality outcomes achieved. The PIP reported a first remeasurement of the study indicator and demonstrated statistically significant improvement from baseline in the rate of ED visits for a covered mental health diagnosis that did not result in a hospitalization within 24 hours of the visit. FBHP completed causal/barrier analysis and implemented interventions to address the barriers that included distributing flyers, developing a written crisis plan for consumers to use at home, and a telephone call and survey from a clinician to consumers the day after and ED visit. FBHP documented the PIP in compliance with the CMS PIP protocol, and HSAG did not identify any areas for improvement.

Recommendations

HSAG did not make any recommendations or identify any opportunities for improvement for the *Reducing ED Utilization for Youth* PIP.

For the second PIP, HSAG reviewed Activities I through X. Table 5-34 and Table 5-35 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 5-34—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	4	0	0	0	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	No Critical Elements				
X. Describe sustained improvement	1	1	0	0	0	No Critical Elements				
Totals for All Activities	**53**	**48**	**1**	**0**	**4**	**13**	**13**	**0**	**0**	**0**

Table 5-35—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 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**98%**	**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, study implementation, and quality outcomes achieved by receiving *Met* scores for all applicable evaluation elements for Activities I through VIII and X. FBHP documented a solid study design, specified a systematic method for collecting data,

implemented interventions that were related to causes/barriers, and completed data analysis according to the data analysis plan. For this year's submission, FBHP progressed to reporting a second remeasurement and both study indicators demonstrated improvement.

Recommendations

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG noted that Study Indicator 1 demonstrated a statistically significant increase from Remeasurement 1 to Remeasurement 2; however, Study Indicator 2 demonstrated an increase that was not statistically significant. HSAG also noted that FBHP documented an increase for Study Indicator 1 as 6.6 percent; however, the increase was actually 6.6 percentage points. HSAG recommended, as a *Point of Clarification*, that in future submissions, FBHP ensure all information is presented accurately.

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.

Overall, FBHP had effective processes for conducting valid PIPs, clearly demonstrated by the high percentage of evaluation elements having a *Met* score and an overall validation status of *Met* received for both PIPs. HSAG's assessment determined high confidence in the results.

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 X. Table 5-36 and Table 5-37 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 5-36—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	3	0	1	0	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	0	1	0	0	0	No Critical Elements			
Totals for All Activities	**53**	**34**	**3**	**2**	**14**	**13**	**10**	**0**	**0**	**3**

Table 5-37—FY 2009–2010 and FY 2010–2011 PIP Overall Validation Scores and Validation Status *for* Therapy With Children and Adolescents: Increasing Caregiver Involvement *for* NBHP		
	Prior Year FY 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**92%**	**87%**
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

NBHP demonstrated strength by documenting a solid study design in compliance with the CMS PIP protocol. NBHP received *Met* scores for all applicable evaluation elements in Activities I through VI. In addition, NBHP completed causal/barrier analysis and linked the interventions with the barriers. The plan implemented member-, provider-, and system-level interventions that were likely to induce permanent change. The interventions included redefining "family" and "caregiver" to include important people who may not be immediate family members (i.e., friends, mentors, foster families), revising the medical records database to allow for appropriate coding for family and caregiver telephone contacts, conducting PIP and computer training for staff members to ensure consistency and accuracy in medical record documentation, and implementing a standardized caregiver therapy contract. The caregiver therapy contract was implemented to provide more information regarding what consumers can expect from the therapy process, why it is important for family members to be involved in therapy, and what the mental health centers expect from consumers.

Recommendations

When reviewing Activity VII, HSAG noted that two of the study indicators demonstrated statistically significant declines and the plan reported that the interventions remained the same. Although NBHP completed a causal/barrier analysis in the third remeasurement, it did not identify new or revised interventions to address the causes/barriers that were identified. NBHP should have implemented targeted interventions to address problems identified. HSAG also noted in Activities IX and X that NBHP only demonstrated improvement in one of the three study indicators.

HSAG also recommended as *Points of Clarification* that NBHP address the following:

- The dates of the measurement period in the text of the study population definition should be updated to reflect the current measurement period.
- NBHP should discuss the actual rates for each study indicator, comparing these rates to the previous measurement period rates. NBHP should also discuss how the rates compared to the goal/benchmark as part of the interpretation.

For the second PIP, HSAG reviewed Activities I through X. Table 5-38 and Table 5-39 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 5-38—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	8	0	1	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	8	0	0	1	2	1	0	0	1
IX. Report improvement	4	1	3	0	0	No Critical Elements				
X. Describe sustained improvement	1	1	0	0	0	No Critical Elements				
Totals for All Activities	**53**	**37**	**3**	**1**	**12**	**13**	**11**	**0**	**0**	**2**

Table 5-39—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 2009–2010	FY 2010–2011
Percentage Score of Evaluation Elements *Met**	**98%**	**90%**
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

NBHP demonstrated strength in its study design and study implementation by receiving *Met* scores for all but one applicable evaluation elements for Activities I through VIII. In addition, NBHP presented the results accurately and demonstrated statistically significant improvement in Study Indicator 1.

Recommendations

In Activity IX, HSAG noted that while three of the four study indicators demonstrated improvement, only one of the three indicators demonstrated statistically significant improvement. HSAG recommended that NBHP analyze its data to determine if any subgroup has a disproportionately lower rate that negatively affects the overall rate. This analysis should be conducted before and after implementing any interventions. HSAG also recommended that NBHP address the following *Points of Clarification*:

- NBHP should set a goal greater than zero percent for Study Indicator 4. The current goal of zero percent was not in alignment with the CMS protocols or quality improvement principles.
- NBHP should document complete date ranges for all measurement periods.
- The instructions for the manual data collection tool should include an overview or purpose for the data collection.

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.

Overall, NBHP had effective processes in place for conducting valid PIPs, demonstrated by the *Met* validation status received for both PIPs. Based on the validation of the PIPs, HSAG's assessment determined confidence in the results.

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

Table 5-40 shows the BHOs' overall performance based on HSAG's validation of the FY 2009–2010 PIPs that were submitted for validation.

Table 5-40––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*	95%	100%	*Met*
ABC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	90%	100%	*Met*
BHI	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	94%	100%	*Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	96%	100%	*Met*
CHP	*Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+*	86%	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*	87%	100%	*Met*
NBHP	*Coordination of Care Between Psychiatric Providers and Physical Health Providers*	90%	100%	*Met*

Overall, the BHOs' PIPs demonstrated good performance. All nine PIPs received a validation status of *Met*, with scores of 100 percent for critical elements *Met* and scores ranging from 86 percent to 100 percent for all evaluation elements *Met*. The BHOs' performance decreased slightly from the previous year. While the BHOs have not yet met their identified goals, their processes continue to produce valid results. 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. Strong performance by the BHOs will increase the likelihood of desired health outcomes for 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 desired outcomes for their studies and meet all documentation requirements.

Table 5-41 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 and received scores of *Met* for all critical evaluation elements.

Table 5-41—Summary of Data From Validation of Performance Improvement Projects					
	Validation Activity	Prior Year (FY 2009–2010) Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	FY 2010–2011 Number of PIPs Meeting All Evaluation Elements/ Number Reviewed	Prior Year (FY 2009–2010) Number of PIPs Meeting All Critical Elements/ Number Reviewed	FY 2010–2011 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	9/9	9/9	9/9	9/9
VI.	Use valid and reliable data collection procedures	8/9	8/9	9/9	9/9
VII.	Implement intervention and improvement strategies	8/9	7/9	9/9	9/9
VIII.	Data analysis and interpretation of study results	8/9	9/9	9/9	9/9
IX.	Report improvement	2/8	2/9	No Critical Elements	
X.	Describe sustained improvement	0/0	3/8	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 recommendations and required actions following the EQR activities conducted in FY 2009–2010. In this section of the report, HSAG assesses the degree to which the BHOs effectively addressed the improvement recommendations or required actions from the previous year.

Access Behavioral Care

Compliance Monitoring Site Reviews

As a result of the FY 2009–2010 compliance review, ABC was required to ensure that all grievances were acknowledged and resolved within the required time frames. Furthermore, ABC was required to ensure that letters of grievance disposition contained the resolution of the disposition process and the correct date on which the grievance was resolved. ABC submitted its CAP to HSAG and the Department in June 2010. HSAG and the Department determined that if the CAP was implemented as written, ABC would achieve compliance with the specified requirements. ABC submitted documentation to demonstrate the implementation of its plan in July 2010. HSAG and the Department carefully reviewed all submitted materials and determined that ABC had successfully addressed all required actions. There were no required actions continued from FY 2009–2010.

Performance Measures

During the FY 2009–2010 performance measure validation audit, HSAG noted that ABC was implementing a new coding manual and that ABC expected to have this change completed by April 2010. HSAG recommended that ABC continue monitoring provider submissions to ensure that accurate and complete coding was performed. ABC also stated, during the FY 2009–2010 audit, that it was looking at targeting high-volume providers for specific interventions. HSAG highly recommended moving forward with developing targeted interventions and providing specific feedback (rates) to providers demonstrating their individual performance. HSAG recommended that ABC continue working with the Department and the other BHOS to continue modifying and updating the scope document as necessary.

During the FY 2010–2011 audits, HSAG found evidence that ABC followed HSAG's recommendations. ABC began running provider profile reports monthly for its highest-volume mental health center and quarterly for the other centers. The reports included metrics that assessed ongoing performance on selected key measures. ABC also began implementing its coding manual in April 2010. This process has been successful and was tightly monitored through data submission reviews for coding accuracy and errors.

Performance Improvement Projects

For the FY 2009–2010 validation cycle, ABC completed two PIPs. HSAG reviewed and validated Activities I through IX 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.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG recommended, as *Points of Clarification*, that ABC provide date ranges for the remeasurement periods in Activity III and that it clearly identify factors that could affect the ability to compare measurements. In addition to the *Points of Clarification*, ABC received two *Partially Met* scores and one *Not Met* score in Activity IX because only one of the study indicators demonstrated improvement and none of the study indicators demonstrated statistically significant improvement. During its FY 2010–2011 review, HSAG found that ABC addressed the *Points of Clarification*. In Activity IX, ABC improved the *Not Met* score to a *Partially Met* score because one of the two study indicators demonstrated statistically significant improvement for Remeasurement 2. ABC did not improve the *Partially Met* scores from 2009–2010's validation in Activity IX because only one of the two study indicators demonstrated improvement for Remeasurement 2. ABC reviewed its data and found that it needed to educate some of the smaller mental health providers on the importance of documenting coordination of care efforts with primary care physicians. HSAG recommended that ABC continue these efforts and perform additional drill-down analysis to further develop targeted interventions that could have a positive impact on the outcomes.

For the *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP, HSAG recommended, as a *Point of Clarification*, that ABC include a comparison of the baseline results to the baseline goals in the interpretation of the findings. Furthermore, ABC received three *Not Met* scores in Activity IX because the study indicators demonstrated an increase (for this PIP, a decrease indicates improvement). During its FY 2010–2011 review, HSAG found that ABC had addressed the *Point of Clarification* and improved two of the *Not Met* scores in Activity IX to *Met* scores because all of the study indicators demonstrated improvement. In addition, ABC improved the remaining *Not Met* score to a *Partially Met* score because one of the study indicators demonstrated statistically significant improvement from Remeasurement 1 to Remeasurement 2.

Behavioral HealthCare, Inc.

Compliance Monitoring Site Reviews

As a result of the 2009–2010 site review, BHI was required to ensure that all grievances were acknowledged within two working days of receipt of the grievance, that all grievances were resolved within 15 working days, and that all grievance resolution letters contained the results of the disposition process. BHI was also required to 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 and the risks, benefits, and consequences of treatment or nontreatment.

BHI submitted its plan of corrective action to HSAG and the Department in June 2010. After careful review and discussion, HSAG and the Department approved BHI's plan. BHI provided documentation demonstrating the successful implementation of its plan. After review of all submitted documentation, HSAG and the Department determined that BHI had sufficiently completed all required actions. There were no required actions continued from FY 2009–2010.

Performance Measures

During the FY 2009–2010 performance measure validation audit, HSAG learned that BHI intended to transition its ASO from InNET to Colorado Access. Because of this pending transition, HSAG made no recommendations related to BHI's processes. HSAG did, however, recommend that BHI carefully document the transition process. HSAG also recommended that BHI continue working with the Department to resolve issues related to the 837 file submissions and ensure that any aspect of the file submission process that can be impacted by BHI is addressed. As with all the BHOs, HSAG recommended that BHI continue working with the Department and the other BHOS to continue modifying and updating the scope document as necessary.

BHI acted on recommendations from the previous year by thoroughly documenting the transition process to its new ASO, Colorado Access. BHI and Colorado Access participated in frequent system configuration meetings. BHI carefully documented these meetings and provided minutes to HSAG for review. BHI also continued to collaborate with the Department relating to the 837 file submission process, and collaborated with other BHOs to update the scope document.

Performance Improvement Projects

For the FY 2009–2010 validation cycle, BHI submitted one PIP. HSAG reviewed and validated Activities I through IX for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. After validating the PIP, HSAG recommended that BHI address six *Points of Clarification* in Activities I, III, and VIII. In addition to the *Points of Clarification*, BHI received two Partially Met scores in Activities VI and VII. The BHO did not document the date range for Remeasurement 2. Although the interventions were ongoing, BHI did not discuss standardization and monitoring of the interventions. During its FY 2010–2011 review, HSAG found that BHI had addressed the *Partially Met* scores in Activities VI and VII and all of the *Points of Clarification*, except for one in Activity VIII. In Activity VIII, the plan discussed how the rates will be calculated, what statistical test was used, and provided information on what the goal was for each indicator; however, it did not state that the rates will be compared to this established goal.

Colorado Health Partnerships

Compliance Monitoring Site Reviews

CHP scored 100 percent on the FY 2009–2010 compliance review and had no required actions.

Performance Measures

After the FY 2009–2010 performance measure validation review, HSAG recommended that CHP continue developing the documentation related to its encounter file submission process and to continue preparing for ICD-10 implementation. HSAG recommended CHP continue efforts to move toward using 834 eligibility files and 820 capitation files as sources for eligibility data. As with all the BHOs, HSAG recommended that CHP continue working with the Department and the other BHOS to continue modifying and updating the scope document as necessary.

During the FY 2010–2011 review, HSAG found ample evidence that CHP had followed up on all prior recommendations. CHP developed a formal document outlining its encounter file submission process. CHP also successfully migrated to using the State's 834 eligibility file as its source for eligibility data (although not fully implemented until July 2010). CHP demonstrated its plans for ICD implementation and 5010 testing. Finally, CHP participated with the Department and other BHOs to update the scope document.

Performance Improvement Projects

For the FY 2009–2010 validation cycle, CHP conducted two PIPs. HSAG reviewed and validated Activities I through IX for the *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP and 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 recommended two *Points of Clarification*. Furthermore, CHP received three *Partially Met* scores in Activity IX because not all of the study indicators demonstrated improvement and only one of the study indicators demonstrated statistically significant improvement. During its FY 2010–2011 review, HSAG found that while CHP had addressed one of the two *Points of Clarification*, it had not addressed the *Point of Clarification* in Activity VII, resulting in a *Not Met* score for Evaluation Element III in Activity VII. HSAG also found that the scores in Activity IX did not improve for this year's validation because the Remeasurement 2 result demonstrated a statistically significant decline and was lower than the baseline result.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, there were no required actions; however, HSAG identified seven *Points of Clarification.* CHP also received three *Partially Met* scores in Activity IX because only one study indicator demonstrated statistically significant improvement. For the FY 2010–2011 review, HSAG found that CHP had addressed all except two *Points of Clarification*. The BHO did not document the complete date

ranges in Activity IX for all of the measurement periods and continued to incorrectly interpret some of the changes as percent increases rather than percentage point increases. However, CHP achieved its goals for both study indicators and statistically significant improvement, resulting in improved scores of *Met* in Activity IX.

Foothills Behavioral Health Partners

Compliance Monitoring Site Reviews

As a result of the FY 2009–2010 site review, FBHP was required to 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. Furthermore, FBHP was required to ensure that it investigates and resolves all grievances, that the BHO provides notice of disposition to the member within 15 working days of receiving a grievance, and that all grievance notices include the results of the disposition/resolution process. FBHP submitted its corrective action plan in June 2010, which was reviewed and approved by HSAG and the Department. In August 2010, FBHP submitted revised documents in support of having completed all required actions. FBHP had no actions continued from the FY 2009–2010 site review process.

Performance Measures

Because FBHP intended to change its ASO from InNET to Value Options, HSAG did not make any recommendations regarding InNET's claims and encounter data processing and performance monitoring. HSAG did recommend that FBHP work with the State on submission of the 837 files and 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.

During the FY 2010–2011 site review, FBHP demonstrated that it had followed up on all of HSAG's recommendations. All data fields were complete and appropriately checked for data anomalies (e.g., dates of service and dates of birth in the correct time frame). Furthermore, HSAG found evidence that FBHP participated with the Department and the other BHOs in updating the scope document and demonstrated its plans for ICD-10 implementation and 5010 testing. HSAG recommended that FBHP continue working with the Department and the other BHOS to continue modifying and updating the scope document as necessary.

Performance Improvement Projects

FBHP submitted two PIPs during the FY 2009–2010 validation cycle. HSAG reviewed and validated Activities I through VIII for FBHP's *Reducing ED Utilization for Youth* PIP and Activities I through IX for the *Care Coordination Between Behavioral Health and Primary Care* PIP.

Based on HSAG's FY 2009–2010 validation, there were no required actions for the *Reducing ED Utilization for Youth* PIP; however, HSAG recommended as *Points 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. HSAG noted that FBHP successfully addressed the *Points of Clarification* in its FY 2010–2011 submission.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG recommended six *Points of Clarification* in Activities VI and VIII. FBHP also received one *Partially* Met score in Activity IX because one study indicator demonstrated an increase that was not statistically significant. HSAG's review of the FY 2010–2011 submission showed that FBHP addressed all of the *Points of Clarification*. FBHP did not improve the *Partially Met* score in Activity IX because from Remeasurement 1 to Remeasurement 2, only one study indicator achieved statistically significant improvement.

Northeast Behavioral Health Partnership

Compliance Monitoring Site Reviews

NBHP scored 100 percent on the FY 2009–2010 compliance review and had no required actions.

Performance Measures

During the FY 2009–2010 site review, HSAG discovered that run-out claims (claims received after the former ASO InNET was no longer in business) were not included in the preliminary performance measure calculations. HSAG advised NBHP to ensure these claims were included in the final rate submission, documenting the process thoroughly. HSAG also discovered that discharges in June 2009 with follow-up visits in July 2009 were not being counted appropriately. HSAG recommended that NBHP correct the programming code. Finally, HSAG recommended that until the new electronic medical record was implemented, North Range and Larimer mental health centers enforce a more formal process to manually track kept appointments to ensure that each resulted in an encounter. HSAG recommended that NBHP continue working with the Department and the other BHOS to continue modifying and updating the scope document as necessary.

During the FY 2010-2011 site review, NBHP demonstrated that it had followed up on all of HSAG's recommendations. While on-site, HSAG reviewers found ample evidence that NBHP corrected programming related to the follow-up after hospitalization measure. NBHP also included the run-out claims that had been excluded for rate calculation and submitted the revised rates. NBHP provided HSAG with documentation that it monitored kept appointments for North Range and Larimer mental health centers. Furthermore, HSAG found evidence that NBHP participated with the Department and the other BHOs in updating the scope document.

Performance Improvement Projects

NBHP submitted two PIPs during the FY 2009–2010 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 both PIPs.

For the *Therapy With Children and Adolescents: Increasing Caregiver Involvement* PIP. HSAG recommended, as a *Point of Clarification* that NBHP provide details of the causal/barrier analysis, including how the interventions were revised based on analysis. NBHP also received two *Partially Met* scores and one *Not Met* score in Activity IX because not all the study indicators demonstrated improvement and none of the study indicators demonstrated statistically significant improvement. HSAG's FY 2010–2011 review showed that NBHP did not completely address the *Point of Clarification*, which resulted in a *Not* Met score for Evaluation Element 3 in Activity VII. Furthermore, NBHP was not able to achieve real and sustained improvement across all indicators. There was non-statistically significant improvement for one of three study indicators.

For the *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP, NBHP received a *Partially Met* score because the BHO did not include a comparison to goals in the interpretation for Study Indicator 1. HSAG recommended that NBHP address eight *Points of Clarification*. During the FY 2010–2011 validation, HSAG found evidence that NBHP improved the *Partially Met* score and addressed all *Points of Clarification*.

Introduction

The Department offered each behavioral and physical health plan the option of conducting two PIPs or one PIP and one focused study with intervention. Denver Health Medicaid Choice (DHMC) and Behavioral HealthCare, Inc. (BHI) 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)* measure 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 identified the percentage of members ages 20 through 44, 45 through 64, and 65 years and older who had a preventive/ambulatory visit, and the percentage of those who did 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 was also collected on any DHMC member who reported a grievance for 2010 related to access and availability. No sampling or medical record review was used; all data were collected administratively (claims/encounter data). Three study indicators were used:

Study Indicator 1: The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age groups were included: members ages 20 through 44, 45 through 64, and 65 years and older.

Study Indicator 2: The number of noncompliant members from the numerator of Study Indicator 1 that visited the ER one or more times during the measurement year with an acute care diagnosis.

Study Indicator 3: The number of members reporting grievances in the access and availability category. Data were analyzed quarterly.

Summary and Findings

Table 7-1 presents Study Indicator 1 rates and percentile rankings compared to HEDIS 2010 Audit Means, Percentiles and Ratios for Medicaid populations.

Table 7-1—Adults' Access to Preventive/Ambulatory Health Services			
Study Indicator 1	**HEDIS 2009 Rates**	**HEDIS 2010 Rates**	**Percentile Ratings[1]**
The percentage of members 20–44 years of age that had a preventive/ambulatory visit with a PCP during the measurement year.	68.8%	74.9%	10th–25th
The percentage of members 45–64 years of age that had a preventive/ambulatory visit with a PCP during the measurement year.	70.7%	78.7%	Equal to the 10th
The percentage of members 65 years of age and older that had a preventive/ambulatory visit with a PCP during the measurement year.	59.9%	69.5%	<10th

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

All DHMC study indicators demonstrated improvement ranging from 6.6 to 9.6 percentage points. When 2010 rates were compared to the Medicaid 2009 Audit Means, Percentiles and Ratios, an opportunity for improvement still existed. None of the rates exceeded the 25th percentile and two either were equal to or below the 10th percentile.

Improvements may have resulted from a multi-tiered intervention strategy to improve the HEDIS 2010 Adult Access and Availability measure rate. The intervention strategy focused members in need of an appointment through an outreach designed for specific sub-groups of the population identified via mid-year stratification analysis. Tiers or stratifications included various age groups, members with a diagnosis of severe mental illness, and members who were residing in a skilled nursing facility.

Interventions consisted of:

- Newsletter articles and telephone calls to members with a reminder about covered benefits and the importance of making an appointment with a PCP annually.
- Postcards sent to members with no record of a visit encouraging them to make an appointment.
- Follow-up telephone calls to members who received the mailed postcard, offering assistance with scheduling an appointment, transportation, or other needs.
- An Interactive Voice Response (IVR) automated message script was developed for future interventions to remind members to make an appointment with their PCP.
- Telephone calls and follow-up letters to Medicaid Choice members with a diagnosis of severe mental illness to coordinate behavioral and physical health care needs and to make an appointment with a Denver Health PCP.

For Study Indicator 2, DHMC performed a drill-down analysis on the 1,304 Medicaid members who did not have a preventive/ambulatory visit during the 2009 measurement year. Analysis of member data indicated the following:

- 1,082 (83 percent) had no claim encounters and/or visit according to the claims database in the Denver Health System or elsewhere including emergency department or urgent care in 2009.
- 100 (8 percent) received care in a skilled nursing facility.
- 253 (19 percent) had a script filled through the Caremark Pharmacy Benefit Manager.
- 247 (19 percent) did not have a DHMC medical record number indicating they had never been seen at DHMC.
- 222 patients (17 percent) had other claim encounters but did not meet the HEDIS Specifications for the AAP measure:
  - 69 had ER/Urgent Care visits.
  - 49 had an inpatient stay.
  - 154 had other outpatient visits (e.g., dental, mobile health, physical therapy, optometry, behavioral health).

DHMC targeted the 1,304 members without an ambulatory or preventive care visit through the following interventions:

- 116 were identified needing a PCP visit and were contacted through behavioral health outreach to set up an appointment.
- 32 received a reminder for a retinal eye exam.
- 36 received a reminder for a PCP visit through the PopHealth Man outreach program.
- 20 received a reminder for a mammogram screening.

DHMC documented 110 grievances (Study Indicator 3) related to access and/or availability, which represented 64 percent of the total grievances received during the 2010 calendar year. Of the 110 access/availability grievances, 93 (85 percent) were further categorized as "appointment delay." Other grievance categories included referral process, call-back issues and limited choice of specialist. DHMC identified that six health system departments accounted for 60 percent of the grievances, with the highest number of grievances noted in larger primary care clinics.

Conclusions

DHMC demonstrated improvement for all three adult access measures. The interventions of centralized appointment assistance, as well as member telephone calls, post cards, and newsletter articles appear to have impacted the *Adult's Access to Preventive/Ambulatory Health Services* measure rates.

Knowledge gained from the three test sites pursuing recognition as a Primary Care Medical Home by the National Center for Quality Assurance (NCQA) has improved patient tracking mechanisms that link new members to a PCP. As a result, DHMC anticipates improvement in established patients achieving a better experience in having their needs met through the implementation of the

new communication tools combined with new information workflows developed through this effort. DHMC expects this improved access to care process to be implemented in all sites by mid-year 2011.

Behavioral HealthCare, Inc.

Study Topic and Goal

The purpose of BHI's study was to review data for clients prescribed both psychotropic medication and analgesics for specific characteristics or patterns compared to a control group of clients prescribed a psychotropic, but not an analgesic. Research has shown that mental illness and chronic pain co-occur in a high percentage of individuals, leading to a high prevalence of concomitant use of psychotropic and analgesic medication. Numerous potential risk factors (increased health care costs, medication interaction, adverse drug effects, analgesic misuse/abuse, unintentional overdose, and suicidal behavior) are associated with this co-occurrence.

Methodology

BHI collected and analyzed calendar year 2010 data from various sources (e.g., BHI claims and encounters, diagnoses and appointment information, emergency room claims) on members prescribed a psychotropic in the Analgesic study group and Non-Analgesic control group. BHI conducted chi-square tests of independence on each indicator and several additional data points for statistical analysis.

Summary and Findings

During 2010, a total of 5,088 BHI members were identified as the study population (Analgesic = 2095; Non-Analgesic = 2993). Analysis showed the Analgesic group members to be more often female between the ages of 18–64 with diagnoses of anxiety disorders, mood-related disorders, substance-related diagnoses, and possible personality disorders. Significantly more members of the Analgesic group had psychiatric and medical emergency room visits, including suicide attempt/overdose related visits, substance-related visits, as well as missed ("no show") psychiatric service appointments than did the Non-Analgesic group. Significantly more members of the Non-Analgesic group received psychiatric services and psychiatric hospitalizations than the Analgesic group.

Conclusions

In response to the data analysis results, several interventions and recommended next steps were discussed within BHI. It was agreed that coordination of care between physical and mental health is key for clients prescribed both psychotropic medication and analgesics. The mental health centers will continue expanding their coordination of care initiatives such as screening clients for pain or physical health concerns as well as other medications prescribed outside of their practice; educating

clients on the relationship between physical and mental health; ensuring clients have and are seeing a PCP regularly; communicating with clients' PCPs; and providing health coordination services to clients with health concerns to help them navigate the physical and mental health care systems. BHI determined that more research is needed to better understand the trends found in this analysis as well as the impact pain has on mental health clients. Possible analyses that BHI is considering include examining more physical health data for frequency and types of physical health services received, frequency of cancellations or missed physical appointments, as well as a possible focus on the subset of the study group that had suicide attempt/overdose-related emergency room visits.

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 third year that HSAG had performed compliance monitoring reviews of the Medicaid physical health plans. For the FY 2010–2011 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy that corresponded with the three areas identified by the Department. These were: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VIII—Credentialing and Recredentialing. Compliance with federal Medicaid managed care regulations and contract requirements was evaluated through review of the three standards.

This was the seventh year that HSAG had performed compliance monitoring reviews of the BHOs. For the FY 2010–2011 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy that corresponded with the three areas identified by the Department. These were: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard III—Coordination and Continuity of Care. Compliance with federal Medicaid managed care regulations and contract requirements was evaluated through review of the three 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 of all Medicaid managed care requirements within a three-year period to determine an MCO's or PIHP's compliance with required 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 two 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 Medicaid managed care 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 Medicaid physical health plans and the behavioral health organizations (BHOs), 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 federal health care regulations and implementation of the organizations' policies. As part of Standard I—Coverage and Authorization of Services for both physical health plans and BHOs, HSAG conducted an on-site review of 20 denials records. HSAG also conducted an on-site review of 10 credentialing files and 10 recredentialing files as part of its review of Standard VIII—Credentialing and Recredentialing for the physical health plans only. HSAG incorporated the results of the record reviews into the score for each applicable standard.

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 2010–2011.

Table A-1—Compliance Monitoring Review Activities Performed	
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 assigned staff to the review team. ◆ 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.
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 three components. ◆ 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.

Table A-1—Compliance Monitoring Review Activities Performed	
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. ◆ As part of Standard I—Coverage and Authorization of Services for both physical health plans and BHOs, HSAG conducted a record review of 20 denials. HSAG also conducted a review of 10 credentialing files and 10 recredentialing files as part of its review of Standard VIII—Credentialing and Recredentialing for the physical health plans only. ◆ 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 2010–2011 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 2010–2011 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 administrative tasks
- 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 denials record review (physical health plans and BHOs), scores were incorporated into Standard I—Coverage and Authorization of Services; and for the credentialing and recredentialing record reviews (physical health plans only), scores were incorporated into Standard VIII—Credentialing and Recredentialing. 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 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)—2011 completed by the Department and/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 2011(CY 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 the 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 Information Systems Capabilities Assessment Tool (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 2010
Certified Software Report	CY 2010
Performance Measure Reports	CY 2010
Supporting Documentation	CY 2010
On-site Interviews and Demonstrations	CY 2010

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 2009–2010
Source code (programming language) for performance measures (from the Department)	FY 2009–2010
Previous year's performance measure reports	FY 2008–2009
Current performance measure results (from BHOs and the Department)	FY 2009–2010
Supporting documentation (from BHOs and the Department)	FY 2009–2010
On-site interviews and demonstrations (from BHOs and the Department)	FY 2009–2010

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 three PIPs for the MCOs. For the BHOs, HSAG performed validation activities on two PIPs for four of the BHOs and one PIP for the remaining BHO. For the MCOs, HSAG performed validation activities on two PIPs for one 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 activities:

- Activity I. Select the Study Topic(s)
- Activity II. Define the Study Question(s)
- Activity III. Select the Study Indicator(s)
- Activity IV. Use a Representative and Generalizable Study Population
- Activity V. Use Sound Sampling Techniques
- Activity VI. Reliably Collect Data
- Activity VII. Implement Intervention and Improvement Strategies
- Activity VIII Analyze Data and Interpret Study Results
- Activity IX. Assess for Real Improvement
- Activity 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 activities 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 2010–2011

[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 activity 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.

HSAG PIP reviewers validated each PIP twice—once when originally submitted and then again when the PIP was resubmitted. The BHOs and MCOs had the opportunity to receive technical assistance, incorporate HSAG's recommendations and resubmit the PIPs to improve the validation scores and validation status. HSAG organized, aggregated, and analyzed the BHOs' and MCOs' data to draw conclusions about their quality improvement efforts. HSAG prepared a report of these findings, including the requirements and recommendations for each validated PIP. HSAG provided the Department and health plans with final PIP Validation Reports.

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. 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 is 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 2011 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

	Adult Medicaid 2011			
Measure of Member Satisfaction	2010 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	60.4%	64.5%	65.3%	70.2%
Rating of Specialist Seen Most Often	60.8%	56.9%	60.7%	65.6%
Rating of All Health Care	47.2%	47.2%	51.8%	52.3%
Rating of Health Plan	52.8%	51.5%	59.1%	55.3%

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 2010 NCQA CAHPS national average.

Table D-2—NCQA National Averages and Question Summary Rates for Global Ratings				
	Child Medicaid 2011			
Measure of Member Satisfaction	2010 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	69.8%	81.0%	70.3%	73.6%
Rating of Specialist Seen Most Often	66.5%	69.2%	NA	70.3%
Rating of All Health Care	60.0%	63.4%	60.1%	61.7%
Rating of Health Plan	65.4%	71.7%	68.3%	64.9%

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 2010 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 2011 composite scores for the adult and child populations. DHMC and RMHP provided HSAG with the data presented in the following tables. Morpace and 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				
	Adult Medicaid 2011			
Measure of Member Satisfaction	2010 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	49.4%	35.5%	58.2%	56.3%
Getting Care Quickly	55.2%	42.7%	60.3%	61.1%
How Well Doctors Communicate	67.7%	66.7%	71.9%	71.9%
Customer Service	58.2%	NA	NA	NA
Shared Decision Making	59.6%	56.8%	69.3%	64.3%

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 2010 NCQA CAHPS national average.

Table D-4—NCQA National Averages and Global Proportions for Composite Scores				
	Child Medicaid 2011			
Measure of Member Satisfaction	2010 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	53.2%	44.7%	57.4%	53.5%
Getting Care Quickly	68.0%	54.2%	71.2%	72.8%
How Well Doctors Communicate	73.2%	72.7%	76.8%	76.0%
Customer Service	61.5%	51.2%	NA	NA
Shared Decision Making	65.4%	64.7%	72.3%	73.8%

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 2010 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 2010–2011.

Results from the Compliance Monitoring Site Reviews

Table E-1 and Table E-2 show the compliance summary scores and record review 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 2010–2011 Standard Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services	85%	81%	83%
Standard II—Access and Availability	85%	100%	92%
Standard VIII—Credentialing and Recredentialing	92%	87%	89%
Totals	**88%**	**87%**	**88%**

Table E-2—FY 2010–2011 Record Review Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Denials	98%	56%	77%
Credentialing	100%	100%	100%
Recredentialing	100%	100%	100%
Totals	**99%**	**84%**	**91%**

Table E-3 and Table E-4 show the summary compliance monitoring scores and record review scores for each BHO as well as 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-3—FY 2010–2011 Standard Scores for the BHOs						
Description of Component	ABC	BHI	CHP	FBHP	NBHP	Statewide Average
Standard I—Coverage and Authorization of Services	94%	91%	94%	97%	97%	95%
Standard II—Access and Availability	100%	100%	100%	100%	100%	100%
Standard III—Coordination and Continuity of Care	100%	83%	100%	100%	100%	97%
Totals	**96%**	**94%**	**96%**	**98%**	**98%**	**96%**

Table E-4—FY 2010–2011 Record Review Scores for the BHOs						
Description of Component	ABC	BHI	CHP	FBHP	NBHP	Statewide Average
Denials	95%	71%	99%	100%	100%	93%

Results from the Validation of Performance Measures

Table E-5 presents children's performance measure results for each physical health plan and the statewide average.

Table E-5—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%	82.2%	81.8%	84.6%
Childhood Immunization Status (Combo #3)	85.6%	78.6%	80.8%	83.3%
Well-Child Visits in the First 15 Months of Life, 6+ Visits	67.7%	81.2%	57.1%	69.9%
Well-Child Visits 3–6 Years of Life	68.4%	68.1%	70.1%	68.6%
Adolescent Well-Care Visits	49.1%	49.9%	47.7%	48.9%
Children's and Adolescents' Access to Primary Care Providers (PCPs)				
12–24 Months	93.9%	99.3%	96.9%	95.7%
25 Months–6 Years	80.0%	90.0%	88.4%	83.8%
7–11 Years	81.5%	92.4%	90.4%	86.1%
12–19Years	85.3%	93.4%	91.7%	89.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile)				
3–11 Years	78.6%	64.8%	48.3%	67.8%
12–17 Years	75.5%	56.1%	44.4%	60.9%
Total	77.9%	62.5%	46.7%	65.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Nutrition)				
3–11 Years	79.2%	61.5%	56.6%	69.5%
12–17 Years	66.3%	54.2%	44.4%	56.4%
Total	76.2%	59.6%	51.6%	65.7%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity)				
3–11 Years	55.3%	48.0%	45.5%	51.1%
12–17 Years	57.1%	55.1%	45.0%	52.7%
Total	55.7%	49.9%	45.3%	51.5%

Table E-6 presents adult's performance scores for each physical health plan, and the statewide average.

Table E-6—Adult's Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Adult BMI Assessment	82.2%	60.1%	35.5%	57.6%
Annual Monitoring for Patients on Persistent Medications	84.7%	84.1%	83.2%	84.1%
Use of Imaging for Low Back Pain	75.5%	66.9%	71.1%	71.9%
Controlling High Blood Pressure	66.2%	80.1%	43.3%	59.4%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	44.4%	48.6%	40.1%	43.1%
Timeliness of Prenatal Care	82.9%	97.0%	84.0%	88.8%
Postpartum Care	61.0%	77.4%	70.3%	69.2%
Chlamydia Screening in Women				
16–20 Years	73.1%	47.4%	30.5%	55.7%
21–24 Years	72.8%	46.5%	27.7%	55.8%
Total	73.0%	47.0%	29.4%	55.8%
Adult's Access to Preventive/Ambulatory Health Services				
20–44 Years	73.2%	87.7%	83.6%	80.0%
45–64 Years	78.7%	91.8%	88.0%	84.8%
65+ Years	70.2%	96.1%	86.0%	81.9%
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	60.9%	39.0%	62.5%	56.3%
Bronchodilator	71.0%	65.9%	75.0%	71.3%

Table E-7 presents utilization performance scores for each physical health plan and the statewide average.

Table E-7—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	0.48	1.09	1.25	0.79
Average Scrips PMPY for Antibiotics of Concern	0.12	0.40	0.47	0.27
Percentage of Antibiotics of Concern of all Antibiotic Scrips	25.8%	36.7%	37.9%	33.5%
Use of Services: Inpatient Utilization—General Hospital Acute Care (Total Inpatient)				
Discharges (Per 1,000 Member Months)	9.93	11.57	11.51	10.71
Average Length of Stay	3.75	2.92	4.90	3.91

Table E-7—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 (Medicine)				
Discharges (Per 1,000 Member Months)	5.87	3.80	6.97	5.76
Average Length of Stay	3.14	3.02	4.19	3.48
Use of Services: Inpatient Utilization—General Hospital Acute Care (Surgery)				
Discharges (Per 1,000 Member Months)	1.53	2.64	3.02	2.17
Average Length of Stay	8.13	4.73	7.68	7.11
Use of Services: Inpatient Utilization—General Hospital Acute Care (Maternity)				
Discharges (Per 1,000 Member Months Aged 10–64 years)	5.28	10.29	2.62	5.43
Average Length of Stay	2.52	1.91	2.63	2.31
Use of Services: Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	264.51	437.76	409.99	340.69
ED Visits	47.30	56.89	63.92	53.92
Frequency of Selected Procedures				
Bariatric Weight Loss Surgery (0–19 Male & Female)	0.00	0.00	0.01	0.00
Bariatric Weight Loss Surgery (20–44 Male & Female)	0.08	0.23	0.08	0.11
Bariatric Weight Loss Surgery (45–64 Male & Female)	0.08	0.11	0.09	0.09
Tonsillectomy (0–9 Male & Female)	0.39	1.36	1.02	0.73
Tonsillectomy (10–19 Male & Female)	0.17	1.09	0.73	0.52
Hysterectomy, Abdominal (15–44 Female)	0.08	0.20	0.40	0.19
Hysterectomy, Abdominal (45–64 Female)	0.19	0.27	0.21	0.21
Hysterectomy, Vaginal (15–44 Female)	0.08	1.26	0.30	0.42
Hysterectomy, Vaginal (45–64 Female)	0.19	0.62	0.07	0.21
Cholecystectomy, Open (30–64 Male)	0.05	0.00	0.03	0.04
Cholecystectomy, Open (15–44 Female)	0.01	0.00	0.06	0.02
Cholecystectomy, Open (45–64 Female)	0.08	0.18	0.00	0.06
Cholecystectomy, Closed (laparoscopic) (30–64 Male)	0.21	0.81	0.29	0.33
Cholecystectomy, Closed (laparoscopic) (15–44 Female)	0.59	1.59	1.07	0.95
Cholecystectomy, Closed (laparoscopic) (45–64 Female)	0.41	1.43	0.71	0.71
Back Surgery (20–44 Male)	0.13	0.75	0.19	0.26
Back Surgery (20–44 Female)	0.04	0.49	0.21	0.19
Back Surgery (45–64 Male)	0.26	0.74	0.57	0.44
Back Surgery (45–64 Female)	0.34	1.16	0.67	0.62
Mastectomy (15–44 Female)	0.00	0.04	0.02	0.02

Table E-7—Adult's Performance Measure Results for Physical Health Plans and Statewide Average				
Measure	DHMC	RMHP	PCPP	Statewide Average
Mastectomy (45–64 Female)	0.15	0.27	0.11	0.15
Lumpectomy (15–44 Female)	0.01	0.20	0.16	0.09
Lumpectomy (45–64 Female)	0.26	0.45	0.14	0.24

Table E-8 includes FY 2010-2011 performance measure results for each BHO as well as the statewide average.

Table E-8—2010-2011 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	6.1%	6.1%	6.9%	16.3%	7.1%	7.6%
Adolescents 13 Through 17 Years of Age	18.6%	18.0%	18.8%	33.2%	23.7%	20.8%
Adults 18 Through 64 Years of Age	23.7%	20.0%	20.0%	30.9%	20.0%	21.9%
Adults 65 Years of Age or Older	7.5%	4.6%	6.8%	12.2%	4.6%	6.9%
Penetration Rate by Service Category						
Inpatient Care	0.3%	0.1%	0.3%	0.2%	0.3%	0.2%
Intensive Outpatient/Partial Hospitalization	0.0%	0.1%	0.0%	0.1%	0.02%	0.0%
Ambulatory Care	10.8%	10.6%	12.3%	17.6%	12.3%	12.2%
Overall Penetration Rate	12.8%	11.1%	12.7%	22.6%	12.8%	13.5%
Penetration Rate by Medicaid Eligibility Category						
AFDC/CWP Adults	17.2%	16.7%	17.7%	28.4%	17.0%	18.5%
AFDC/CWP Children	7.2%	9.5%	10.3%	23.4%	11.9%	11.1%
AND/AB-SSI	38.2%	33.4%	28.0%	38.4%	33.0%	32.7%
BC Children	6.6%	6.7%	8.1%	18.8%	8.7%	8.7%
BC Women	17.0%	9.9%	15.8%	32.1%	12.0%	15.9%
BCCP—Women Breast and Cervical Cancer	33.3%	8.0%	16.6%	21.2%	17.1%	18.0%
Foster Care	48.8%	37.4%	34.7%	45.1%	40.9%	39.6%
OAP-A	7.6%	4.7%	6.9%	12.2%	4.6%	25.0%
OAP-B-SSI	29.8%	21.8%	20.6%	34.8%	25.1%	16.6%
Other	18.0%	13.9%	11.6%	33.9%	15.5%	18.5%
Hospital Recidivism						
Non-State Hospitals—7Days	4.3%	0.4%	4.8%	3.3%	3.2%	3.6%
30 Days	14.3%	4.6%	11.3%	9.4%	8.1%	10.5%
90 Days	26.1%	12.1%	18.0%	12.7%	13.0%	18.2%
All Hospitals—7 Days	5.2%	1.4%	4.4%	2.6%	3.3%	3.7%
30 Days	14.6%	7.2%	12.1%	7.7%	8.9%	10.8%
90 Days	26.9%	14.5%	19.5%	12.9%	14.4%	18.9%

Table E-8—2010-2011 Performance Measure Results for BHOs						
Performance Measures	**ABC**	**BHI**	**CHP**	**FBH**	**NBH**	**Statewide Average**
Hospital Average Length of Stay						
Non-State Hospitals	9.07	7.28	6.60	6.24	5.32	7.19
All Hospitals	15.88	16.33	13.95	13.35	7.52	13.93
Emergency Room Utilization (Rate/1000 Members, All Ages)	9.35	5.35	10.74	6.35	5.03	8.00
Inpatient Utilization (Rate/1000 Members, All Ages)						
Non-State Hospitals	6.52	2.37	3.08	3.17	5.38	3.83
All Hospitals	8.00	4.67	5.25	6.11	6.16	5.81
Follow-Up After Hospitalization for Mental Illness						
Non-State Hospitals—7 Days	35.4%	54.7%	46.2%	60.9%	51.9%	46.8%
30 Days	57.8%	70.1%	65.4%	75.0%	72.0%	66.1%
All Hospitals—7 Days	35.0%	52.8%	48.3%	63.6%	51.5%	48.2%
30 Days	57.5%	67.4%	68.4%	77.1%	71.6%	67.3%

Results from the Validation of Performance Improvement Projects

Table E-9 lists the PIP study conducted by each physical health plan and the corresponding summary scores.

Table E-9—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*	89%	100%	*Met*

Table E-10 lists the PIP study conducted by each BHO and the corresponding summary scores.

Table E-10––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*	95%	100%	*Met*
ABC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	90%	100%	*Met*
BHI	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	94%	100%	*Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	96%	100%	*Met*
CHP	*Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+*	86%	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*	87%	100%	*Met*
NBHP	*Coordination of Care Between Psychiatric Providers and Physical Health Providers*	90%	100%	*Met*

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

Table E-11 shows each physical health plan's summary rates and global proportions for the adult CAHPS survey.

Table E-11—Adult Medicaid Question Summary Rates and Global Proportions				
Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	35.5%	58.2%	56.3%	50.0%
Getting Care Quickly	42.7%	60.3%	61.1%	54.7%
How Well Doctors Communicate	66.7%	71.9%	71.9%	70.2%
Customer Service	NA	NA	NA	*
Shared Decision Making	56.8%	69.3%	64.3%	63.5%
Rating of Personal Doctor	64.5%	65.3%	70.2%	66.7%
Rating of Specialist Seen Most Often	56.9%	60.7%	65.6%	61.1%
Rating of All Health Care	47.2%	51.8%	52.3%	50.4%
Rating of Health Plan	51.5%	59.1%	55.3%	55.3%

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.

Table E-12 shows each physical health plan's summary rates and global proportions for the child CAHPS survey.

Table E-12—Child Medicaid Question Summary Rates and Global Proportions				
Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	44.7%	57.4%	53.5%	51.9%
Getting Care Quickly	54.2%	71.2%	72.8%	66.1%
How Well Doctors Communicate	72.7%	76.8%	76.0%	75.2%
Customer Service	51.2%	NA	NA	*
Shared Decision Making	64.7%	72.3%	73.8%	70.3%
Rating of Personal Doctor	81.0%	70.3%	73.6%	75.0%
Rating of Specialist Seen Most Often	69.2%	NA	70.3%	69.8%
Rating of All Health Care	63.4%	60.1%	61.7%	61.7%
Rating of Health Plan	71.7%	68.3%	64.9%	68.3%

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.