2011–2012 External Quality Review Technical Report

for

Colorado Medicaid

September 2012

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

HSAG HEALTH SERVICES ADVISORY GROUP

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

Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

ACKNOWLEDGMENTS AND COPYRIGHTS

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

In fiscal year (FY) 2011–2012, all four of the compliance site review standards were assigned to the quality domain. Both health plans performed exceptionally well on the Subcontracts and Delegation standard and Member Information standards. One plan earned overall scores of 100 percent for all standards.

HSAG assigned 15 of the 20 measures reported in 2012 to the quality domain. Statewide rates on these measures remained mostly stable; however, HSAG observed a statistically significant decline in the statewide rate for *Well-Child Visits in the First 15 Months of Life—6+ Visits* and both *Pharmacotherapy Management of COPD Exacerbation* submeasures. HSAG also observed declines of more than 5 percentage points in six of the nine *Childhood Immunization Status* submeasures. However, five of these six submeasures with statistically significant declines still ranked above the national HEDIS Medicaid 90th percentile. Colorado experienced statistically significant improvements in *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Adult BMI Assessment*.

HSAG assigned all PIPs to the quality domain. All four 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 86 percent to 100 percent for all evaluation elements *Met*. Colorado's physical health plans have demonstrated a strong understanding and implementation of the CMS protocols.

All of the measures within the CAHPS survey addressed quality. The Colorado adult Medicaid population experienced slight increases for three measures and decreases for four. The only statistically significant difference was observed for the *Rating of Health Plan* measure, which increased by 5.2 percentage points. For the statewide child Medicaid population, the rates for all reportable measures increased slightly from the prior year.

Quality—Behavioral Health

HSAG assigned all four compliance standards to the quality domain. All five of the BHOs demonstrated good performance in communicating with their members. They provided information in multiple languages and formats, and all member communication was written in easy-to-understand language. The on-site record reviews demonstrated that all of the organizations were providing resolution within the required time frames and that the resolution letters included the required content. The corporate compliance plans were comprehensive, and each BHO's contractors were required to adhere to the BHO's plan. Most of the BHOs demonstrated robust monitoring programs that included ongoing and formal review. HSAG determined that BHO performance, as it related to quality, was very good.

For performance measures, the *Hospital Recidivism* measure was the only quality measure for this year. Four of the six submeasures reported a minor decline in rate (an improvement in performance) and the other two reported a minor increase in rate (a decline in performance). None of these rates changed by more than one percentage point. *Hospital Recidivism—Non-State* and *All Hospitals* rates were similar, with longer durations having higher recidivism. BHO variations in rates were smallest for *All Hospitals—7 Days* (3.8 percent) and largest for *Non-State Hospitals—90 Days* (15.2 percent). These results suggest that the BHOs have room for improvement.

PIPs were assigned to the quality domain. Four of the six PIPs validated by HSAG received a validation status of *Met*, with 100 percent of the critical elements for these four measures also receiving a score of *Met*. One PIP received a validation status of *Partially* Met and one received a validation status of *Not Met*—indicating need for improvement.

Timeliness—Physical Health

HSAG assigned one compliance standard (Grievance System) to the timeliness domain. One plan demonstrated strong performance with a score of 100 percent; the other plan had several required actions related to incorrect and inconsistent time frames.

For performance measures, statewide results relative to timeliness were generally consistent with last year's results, with most of the measures showing changes of less than 5 percentage points. The two measures that reflected significant change were *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life—6+ Visits*. Six of the nine *Childhood Immunization Status* submeasures experienced declines of at least 5 percentage points, as did *Well-Child Visits in the First 15 Months of Life—6+ Visits*.

HSAG assigned the *Getting Care Quickly* CAHPS measure to the timeliness domain. While the adult measure experienced a decrease of 0.7 percentage points and the child population experienced an increase of 4.8 percentage points, these fluctuations were not statistically significant.

Timeliness—Behavioral Health

Although some of the BHOs had required actions and associated time frames related to the grievance system, HSAG believed the BHOs as a whole performed very well in the timeliness domain. One BHO failed to send acknowledgement letters, which impacted the overall score; however, all BHOs met the required time frames for resolution of appeals. Two of the five BHOs processed expedited appeals, and four of the five filed extensions. In all instances, the policies were implemented properly and time frames were met.

The *Follow-Up After Hospitalization for Mental Illness* measure was the only timeliness measure this year. Statewide performance on this measure was very similar to last year's results. All submeasures reported an improvement, but the amount of improvement was less than 1 percentage point. For each of the submeasures, BHO rate variations were larger than 15 percent, which suggests that the BHOs have room for improvement.

Access—Physical Health

The three compliance monitoring standards associated with the access domain were (1) Member Information, which achieved a Statewide rate of 95 percent, (2) Grievance System, which earned the lowest score overall with 87 percent, and (3) Provider Participation and Program Integrity, which demonstrated good performance with an overall rate of 92 percent. One plan, DHMC, demonstrated outstanding performance by scoring 100 percent for all standards.

Statewide results for performance measures assigned to the access domain were consistent with last year's results, with all of the measures showing changes of less than 5 percentage points. One of the new measures in 2012, *Annual Dental Visit—Total* scored at or above the national HEDIS Medicaid 90th percentile.

HSAG assigned only one CAHPS survey measure to the access domain—*Getting Needed Care*. While the adult Medicaid population experienced an increase of 1.1 percentage points and the child population reported an increase of 1.0 percentage points from the prior year, neither of these increases were statistically significant. HSAG recommended that the health plans continue to direct quality improvement activities toward this measure.

Access—Behavioral Health

HSAG assigned Member Information, Grievance System, and Provider Participation and Program Integrity standards to the access domain. Based on review of these three standards, HSAG determined that the statewide performance was very good. All of the BHOs demonstrated commitments to ensuring that members understand the benefits and services available. These commitments were evidenced by the well-organized member handbooks, presented to members in a variety of formats and languages, all written at or below sixth-grade reading level. HSAG found evidence throughout its reviews that each BHO communicated the availability of the grievance system to its members and providers and offered members assistance at every stage. The BHOs also improved their performance in the access domain by ensuring the availability of an adequate and qualified provider network, as demonstrated by the credentialing and recredentialing programs.

Overall, statewide BHO performance in the access domain for performance measures was very similar to last year's performance. Although all submeasures under *Penetration Rate* showed either similar performance or a decline in performance compared to last year, none had a change in rate of more than five percentage points. Statewide performance on the utilization-based measures was characterized by a decline in *Inpatient Utilization* for *Non-State Hospitals* and a more than 10.5 percent decline in the rate for *All Hospitals*. Declining utilization rates were also noted in all *Hospital Average Length of Stay* submeasures and the *Emergency Room Utilization* measure. These decreasing rates indicate improved performance. 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.

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

Physical Health Compliance Review Standards	Quality	Timeliness	Access
Standard V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		
Performance Measures	**Quality**	**Timeliness**	**Access**
Childhood Immunization Status	✓	✓	
Immunizations for Adolescents	✓	✓	
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	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Annual Dental Visit	✓		✓
Prenatal and *Postpartum Care*	✓	✓	✓
Children's and Adolescents' Access to Primary Care Providers			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Use of Appropriate Medications for People with Asthma	✓		✓
Comprehensive Diabetes Care	✓		✓
Use of Imaging Studies for Low Back Pain	✓		
Annual Monitoring for Patients on Persistent Medications	✓		
Pharmacotherapy Management of COPD Exacerbation	✓		
Chlamydia Screening in Women	✓		
Adult BMI Assessment	✓		
Inpatient Utilization—General Hospital/Acute Care			✓
Ambulatory Care			✓
Frequency of Selected Procedures			✓

Table 1-1—Assignment of Activities to Performance Domains for Physical Health Plans			
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 Plans			
Behavioral Health Compliance Review Standards	**Quality**	**Timeliness**	**Access**
Standard V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		
Performance Measures	**Quality**	**Timeliness**	**Access**
Penetration Rate by Age Category			✓
Penetration Rate by Service Category			✓
Penetration Rate by Medicaid Eligibility Category			✓
Overall Penetration Rates			✓
Hospital Recidivism	✓		
Hospital Average Length of Stay			✓
Emergency Room Utilization			✓
Inpatient Utilization			✓
Follow-Up After Hospitalization for Mental Illness (7– and 30–Day Follow-Up)		✓	
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 D, 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

For the FY 2011–2012 site review process, the Department requested review of four areas of performance: member information, grievance system, provider participation and program integrity, and subcontracts and delegation. HSAG developed a review strategy that corresponded with the four areas identified by the Department. For each standard, HSAG conducted a desk review of documents sent by the health plans prior to the on-site portion of the review, conducted interviews with key health plan staff members on-site, and reviewed additional key documents on-site. As part of grievance system, HSAG conducted a record review of 10 appeals. 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 V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII— Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		

Denver Health Medicaid Choice

Findings

Table 3-2 and Table 3-3 present the number of elements for each of the four standards and record review; 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 2011–2012).

Table 3-2—Summary of Scores for the Standards for FY 2011–2012 *for* DHMC							
Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	21	21	21	0	0	0	100%
Standard VI—Grievance System	26	26	26	0	0	0	100%
Standard VII— Provider Participation and Program Integrity	13	13	13	0	0	0	100%
Standard IX—Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals	**66**	**66**	**66**	**0**	**0**	**0**	**100%***

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

Table 3-3—Summary of Scores for DHMC's Record Review							
Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals	18	15	14	0	1	3	93%
Total	**18**	**15**	**14**	**0**	**1**	**3**	**93%**

Strengths

DHMC's member handbook and other member communication materials, including complex medical information and process descriptions, were written in easy-to-understand language and format; and most materials distributed to members were produced bilingually within the same document. The handbook thoroughly described the benefits and services available to members. Policies and procedures specifically addressed the requirements of the standards, and HSAG found evidence that DHMC followed its policies and procedures. Provider communications and instructions accurately reinforced information being provided to members and member-related processes and requirements.

During the on-site interview, DHMC staff expressed a clear and thorough understanding of the Medicaid managed care grievance and appeal processes. DHMC demonstrated good communication and coordination between departments responsible for specific tasks involved in processing grievances and appeals. DHMC developed new templates that were simple, easy to understand, and included all requirements. DHMC's system to use attachments to the notice of action letters and appeal resolution letters for notifying members of the process for appeals and State fair hearing met the requirements and improved readability of the letters.

The staff model provider network, which consisted largely of employed physicians of Denver Health Hospital Authority (DHHA) resulted in increased control over the processes, systems, and performance of the provider system. DHMC has adequately integrated the activities and resources of DHHA with those of DHMC to achieve compliance with the Medicaid managed care requirements regarding provider participation.

HSAG found evidence of DHMC having performed predelegation review of a potential delegate, a process that culminated in a new contractual arrangement effective in 2012. The process for predelegation review was implemented as written in the policies and procedures. HSAG also found ample evidence of thorough ongoing monitoring and formal review of each delegate.

Recommendations

DHMC scored 100 percent on each of the four standards and was not required to submit a corrective action plan (CAP).

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: HSAG assigned all four of the standards reviewed to the quality domain. DHMC's score of 100 percent across all standards demonstrated strong performance and a clear improvement over prior years. By promoting accurate, clear, consistent, and thorough information to its employees, members, and providers, HSAG believes DHMC reduced confusion related to the administration of its policies and increased the likelihood of achieving desire health outcomes for its members.

Timeliness: Grievance system was the only standard assigned to the timeliness domain. DHMC staff members' clear understanding of the grievance and appeal process will better ensure that members receive timely responses and decisions. Furthermore, DHMC's revision of its template letters for grievance and appeal acknowledgement and resolution is likely to increase members' understanding related to time frames required for various parts of the grievance system.

Access: HSAG considered DHMC's performance in Member Information, Grievance System, and Provider Participation and Program Integrity when evaluating its performance in the access domain. By providing both members and providers with accurate, clear, consistent, and thorough information about the benefits and services available to members, DHMC helped to ensure that covered services are available to enrollees.

Rocky Mountain Health Plans

Findings

Table 3-4 and Table 3-5 present the number of elements for each of the four standards and record review; 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 2011–2012).

Table 3-4—Summary of Scores for the Standards for FY 2011–2012 *for* RMHP

	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	21	21	19	2	0	0	90%
Standard VI—Grievance System	26	26	19	7	0	0	73%
Standard VII—Provider Participation and Program Integrity	13	13	11	2	0	0	85%
Standard IX—Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals	**66**	**66**	**55**	**11**	**0**	**0**	**83%***

*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 Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals	60	52	48	0	4	8	92%
Totals	**60**	**52**	**48**	**0**	**4**	**8**	**92%**

Strengths

RMHP has extensive experience with the requirements and provision of information for the Medicaid population. Systems and communication materials reflect the ongoing efforts of working with this population. The Medicaid Member Handbook, which is the primary source of information to the members, was well organized, written in easy-to-understand language, and contained the majority of required information. Mechanisms for providing materials to meet the needs of non-English-speaking or special needs members were in place. Customer service personnel appeared well trained and were depicted as the primary source of providing information and assistance to members.

Ten of 10 appeal records reviewed on-site demonstrated that acknowledgment and resolution letters were sent within the required time frames. The records also demonstrated that providers filed on behalf of the members. The record review also demonstrated that members were provided the opportunity to submit additional documents in support of the appeal.

The credentialing and provider screening processes were complete and thorough and appeared to be well documented within the internal systems. The written compliance plan and related fraud and abuse policies and procedures were also robust. Because these policies and processes were corporate-wide, they could be applied consistently across all lines of business. In addition, the provider service agreements and applicable exhibits were very comprehensive and representative of all regulatory requirements and could similarly be consistently applied across all product lines.

RMHP had policies and procedures in place for monitoring delegates and provided evidence of having conducted both ongoing monitoring and formal review (annual audits) of each delegate. RMHP provided evidence of having required and followed up on required corrective actions, when necessary.

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:

Member Information

- RMHP was required to inform members of the rules that govern representation at the State fair hearing process.
- RMHP was required to address the poststabilization care financial responsibility rules as outlined in 42 CFR 422.13 (c) and make such information available to members.

Grievance System

- At the time of the review, RMHP had not been sending grievance resolution letters for quality of care grievances. RMHP was required to send each member a notice of resolution for all grievances. RMHP must also revise its procedures to accurately reflect the grievance resolution time frame as 15 working days.

- RMHP was required to review claims denial letters and revise, as needed, to ensure accurate reflection of the appeal filing time frame and consistency of compliance with Medicaid managed care regulations among RMHP's functional departments.
- RMHP was required to revise applicable policies and procedures to accurately reflect that expedited appeals must be decided, with written notice to the member, within three working days from the date RMHP received the appeal.
- RMHP was required to ensure that the individuals who make decisions on grievances and appeals are individuals who are not involved in any previous level of review or decision-making.
- RMHP was required to clarify its policies to accurately reflect the time frame for requesting a State fair hearing as 30 calendar days from the notice of action and ensure that appeal resolution letters also accurately reflect the time frame.
- RMHP was required to revise applicable documents such as notice of action and appeal resolution template letters; claims denial letters; member and provider materials; and policies, procedures, and processes to accurately reflect the circumstances under which members may request the continuation of previously authorized services during the appeal or State fair hearing. RMHP must also clearly reflect the circumstances under which members may be held liable for the cost of services related to those services that were previously authorized and continued as required in 42CFR438.420. Claims denials must not contain the general statement that members must pay for the services, as the situations under which members may be held liable for the costs are limited.
- RMHP was required to revise the provider manual to ensure that the 30-day filing time frame appears consistently in the manual. RMHP must also include in its provider manual the rules that govern representation at the State fair hearing.

Provider Participation and Program Integrity

- Although fraud and abuse policies and procedures were robust, RMHP provided minimal evidence of specific auditing as described in the policies. RMHP was asked to evaluate its policy that addresses internal auditing and monitoring for identification of potential fraud and abuse and should develop procedures for the threshold and frequency of auditing described in the policy. RMHP was asked to maintain documentation of fraud and abuse deterrent activities, such as audits and fraud and abuse deterrent committee meetings.
- RMHP was required to correct its reporting policies and guidelines to be in compliance with the time frames for reporting to the Department as specified in the contract. (RMHP policies incorrectly indicated a 10-day reporting time frame, while the requirement is to report suspicions of fraud immediately, verbally to the contract manager, submitting a preliminary written report within three days, and submitting a final written report 15 days after the initial identification of potential fraud.)

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: HSAG considered RMHP's performance in all four standards when assessing the quality domain. RMHP's customer service personnel appeared well trained and its member handbook well organized; however, RMHP did not include information about the rules that govern representation at the State fair hearing process. RMHP did a good job monitoring its delegates, imposing and following up on required actions, as necessary. RMHP also demonstrated well-documented credentialing and provider screening processes. Inconsistency among RMHP's departments, however, regarding implementation of grievance system requirements resulted in inaccurate and inconsistent communication to members and noncompliance regarding payment responsibilities. In addition, several corrective actions required as a result of the 2011–2012 site review process had been identified during previous site reviews, corrected, and found in compliance. That these same issues have recurred indicates a lack of follow through and/or consistency over time in compliance with federal managed care regulations.

Timeliness: The Grievance System was the only standard HSAG assigned to the timeliness domain, and this was RMHP's poorest area of performance. Many of RMHP's required actions for the grievance system were related to incorrect and/or inconsistent time frames. Incorrect and inconsistent time frames are likely to create systemwide confusion and interfere with member services.

Access: HSAG assigned Member Information, Grievance System, and Provider Participation and Program Integrity to the access domain. RMHP's member handbook was well organized and written in easy-to-understand language, and it repeatedly instructed members to call customer service for additional information or clarification. RMHP's robust credentialing program and provider screening process ensured member access to qualified health professionals. RMHP's poor performance regarding communication of grievance system time frames to members may negatively affect members' understanding and ability to access grievance system rights. In addition, several findings in the appeals record review were related to out-of-network emergency services claims. Inaccurate processing of out-of-network emergency claims and miscommunication to members regarding payment responsibilities will impede member access to services and must be corrected.

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 review. As part of its processes, HSAG analyzes recommendations across plans to identify potential areas for statewide focus. Because DHMC scored 100 percent, HSAG did not make any statewide 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

Standards	FY 2011–2012 Statewide Average*
Standard V—Member Information	95%
Standard VI—Grievance System	87%
Standard VII—Provider Participation and Program Integrity	92%
Standard IX—Subcontracts and Delegation	100%
Total	**92%**

* 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 Record Reviews

Standards	FY 2011–2012 Statewide Average*
Appeals	93%
Total	**93%**

* 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.

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

The Department required that 20 performance measures be validated in FY 2011–2012 based on HEDIS 2012 specifications. Several measures also were validated in FY 2010–2011. HSAG made comparisons between the previous year's and the current year's results, when possible.

Denver Health Medicaid Choice (DHMC)

Compliance With Information Systems (IS) Standards

HSAG reviewed and evaluated all data sources, including the plan's final 2012 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. DHMC continued to contract with an NCQA-certified software vendor to produce its HEDIS rates. DHMC's auditor indicated that in the past year there was considerable outreach to members discharged from the hospital in an effort to prevent readmission. The efforts of the quality team and their recognition of the HEDIS results guide this organization in its provision of quality care.

Pediatric Care Performance Measures

Table 3-9 displays the DHMC HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for each performance measure for pediatric care.

Table 3-9—Review Results and Audit Designation for Pediatric Care Performance Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Childhood Immunization Status—Combination 2	86.1%	84.2%	75th–89th	R
Childhood Immunization Status—Combination 3	85.6%	83.7%	≥ 90th	R
Childhood Immunization Status—Combination 4	55.2%	51.6%	≥ 90th	R
Childhood Immunization Status—Combination 5	78.1%	70.3%	≥ 90th	R
Childhood Immunization Status—Combination 6	76.9%	73.2%	≥ 90th	R
Childhood Immunization Status—Combination 7	50.9%	45.3%	≥ 90th	R
Childhood Immunization Status—Combination 8	51.8%	47.0%	≥ 90th	R
Childhood Immunization Status—Combination 9	70.8%	62.0%	≥ 90th	R
Childhood Immunization Status—Combination 10	47.9%	41.1%	≥ 90th	R
Immunizations for Adolescents—Combination 1	—	82.3%[2]	≥ 90th	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	67.7%	51.3%	10th–24th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.4%	68.6%[3]	25th–49th	R
Adolescent Well-Care Visits	49.1%	51.1%	50th–74th	R

Table 3-9—Review Results and Audit Designation for Pediatric Care Performance Measures *for* DHMC				
Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	77.9%	85.2%	≥ 90th	R
Counseling for Nutrition: Total	76.2%	80.3%	≥ 90th	R
Counseling for Physical Activity: Total	55.7%	61.3%	≥ 90th	R
Annual Dental Visit—Total	—	NB	NB	NB

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
NB is shown when the health plan did not offer the benefit required by the measure.
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.
[2] The rate displayed reflects administrative data only. DHMC reported a hybrid rate of 86.1 percent for the *Immunizations for Adolescents—Combination 1* measure for HEDIS 2012.
[3] The rate displayed reflects administrative data only. DHMC reported a hybrid rate of 70.3 percent for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure for HEDIS 2012.

Strengths

All DHMC performance measures received an audit result of *Reportable* (R) for HEDIS 2012. DHMC obtained notable improvement, at least a five percentage point increase from last year, for the *BMI Assessment* and *Counseling for Physical Activity* indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure. Additionally, almost all of the *Childhood Immunization Status* indicators, all indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, and the *Immunizations for Adolescents—Combination 1* measure benchmarked at or above the national HEDIS Medicaid 90th percentile.

Recommendations

A total of 10 measures for DHMC exhibited a decline in performance for 2012, and several *Childhood Immunization Status* indicators (Combinations 5, 7, 9, and 10) had a decline of more than five percentage points. The *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator reported the greatest decline of more than 15 percentage points. Based on the results of this year's performance measure validation findings, DHMC should conduct a barrier analysis to help identify the source of the declines, as well as design and implement interventions to target them.

Access to Care and Preventive Screening Performance Measures

Table 3-10 shows the DHMC HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for each performance measure for access to care and preventive screening.

Table 3-10—Review Results and Audit Designation for Access to Care and Preventive Screening Performance Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.9%	83.5%	25th–49th	R
Postpartum Care	61.0%	59.6%	25th–49th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	93.9%	95.0%	10th–24th	R
Ages 25 Months to 6 Years	80.0%	81.2%	< 10th	R
Ages 7 to 11 Years	81.5%	84.0%	< 10th	R
Ages 12 to 19 Years	85.3%	85.2%	10th–24th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	74.3%	73.5%	< 10th	R
Preventive Screening				
Chlamydia Screening in Women—Total	73.0%	67.8%	75th–89th	R
Adult BMI Assessment	82.2%	84.9%	≥ 90th	R

R is shown when the rate was reportable, according to NCQA standards.
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Strengths

All of DHMC's performance measures received an audit result of *Reportable (R)* for 2012. With the exception of a notable decline for one measure, DHMC's performance in the access to care and preventive screening domain was similar to last year's performance. Five measures reported an increase in rate, with the *Adult BMI Assessment* measure exhibiting the greatest improvement in 2012 (an increase of 2.7 percentage points). DHMC's performance on this measure also ranked above the national HEDIS Medicaid 90th percentile.

Recommendations

Four of DHMC's measures had a decrease in performance from HEDIS 2011 to 2012. More specifically, the *Chlamydia Screening in Women—Total* rate declined by 5.2 percentage points compared to last year. While four indicators demonstrated slight increases, including *Timeliness of Prenatal Care* and three age groups of *Children's and Adolescents' Access to Primary Care*

Practitioners (*Ages 12–24 Months*, *Ages 25 Months to 6 Years*, and *Ages 12 to 19 Years*), each indicator ranked below the national HEDIS Medicaid 50th percentile.

DHMC should continue efforts to improve performance across all measures in the access to care domain. While this year saw improvement in several rates, compared to national standards, there is still room for improvement. Providers should investigate instances of missed opportunities, when a child presents for a sick visit and other services can be rendered. Limited accessibility to a doctor visit could cause lower performance.

Living With Illness Performance Measures

Table 3-11 shows the DHMC HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for the living with illness performance measures.

Table 3-11—Review Results and Audit Designation for Living With Illness Performance Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Use of Appropriate Medications for People with Asthma—Total	—	81.6%	< 10th[2]	R
Comprehensive Diabetes Care				
HbA1c Testing	—	84.9%	50th–74th	R
*HbA1c Poor Control (>9.0%)**	—	37.7%	25th–49th	R
HbA1c Control (<8.0%)	—	46.7%	25th–49th	R
Eye Exam	—	56.2%	50th–74th	R
LDL-C Screening	—	75.4%	50th–74th	R
LDL-C Level <100 mg/dL	—	54.0%	≥ 90th	R
Medical Attention for Nephropathy	—	79.3%	50th–74th	R
Blood Pressure Controlled <140/80 mm Hg	—	55.5%	≥ 90th	R
Blood Pressure Controlled <140/90 mm Hg	—	71.0%	75th–89th	R
Use of Imaging Studies for Low Back Pain	75.5%	80.0%	75th–89th	R
Annual Monitoring for Patients on Persistent Medications—Total	84.7%	86.0%	50th–74th	R
Pharmacotherapy Management of COPD Exacerbation				
Bronchodilator	71.0%	65.9%	< 10th	R
Systemic Corticosteroid	60.9%	56.1%	10th–24th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
* A lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.
[2] For HEDIS 2012, the upper age limit for the *Use of Appropriate Medications for People with Asthma* measure was extended from 50 to 64; therefore, please use caution when comparing with HEDIS 2011 national Medicaid percentiles for the *Total* age group.

Strengths

All of DHMC's performance measures within the living with illness domain received an audit result of *Reportable (R)* for 2012. The *Use of Imaging Studies for Low Back Pain* measure and *Annual Monitoring for Patients on Persistent Medications—Total* indicator showed improved performance between 2011 and 2012, though neither showed notable improvement (i.e., at least five percentage points). Among the measures first reported in 2012, two *Comprehensive Diabetes Care* indicators (*LDL-C Level < 100 mg/dL* and *Blood Pressure Controlled <140/80 mm Hg*) benchmarked above the National HEDIS Medicaid 90th percentile.

Recommendations

Two of DHMC's reported rates exhibited a decline in performance for 2012 when compared to 2011. Both indicators were under the *Pharmacotherapy Management of COPD Exacerbation* measure. For the *Bronchodilator* indicator, the decline was 5.1 percentage points and for the *Systemic Corticosteroid* indicator, the decline was 4.8 percentage points. Additionally, two measures were ranked below the national HEDIS Medicaid 10th (*Use of Appropriate Medications for People with Asthma—Total* and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* measures).

Room for improvement exists for DHMC in the living with illness domain, specifically for the measures that rely on pharmacy data. DHMC should review the completeness of its pharmacy data and ensure that, when possible, all pharmacy data are being received.

Utilization Performance Measures

Table 3-12 shows the DHMC HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for utilization performance measures.

Table 3-12—Review Results and Audit Designation for Utilization of Services Performance Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient				
Discharges Per 1,000 MM: Total	9.9	10.9	≥ 90th	R
Average Length of Stay: Total	3.7	3.4	25th–49th	R
Inpatient Utilization—General Hospital/Acute Care: Medicine				
Discharges Per 1,000 MM: Total	5.9	7.1	≥ 90th	R
Average Length of Stay: Total	3.1	2.9	10th–24th	R
Inpatient Utilization—General Hospital/Acute Care: Surgery				
Discharges Per 1,000 MM: Total	1.5	1.4	50th–74th	R
Average Length of Stay: Total	8.1	6.8	75th–89th	R

Table 3-12—Review Results and Audit Designation for Utilization of Services Performance Measures *for* DHMC				
Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Inpatient Utilization—General Hospital/Acute Care: Maternity				
Discharges Per 1,000 MM: Total	5.3	4.4	25th–49th	R
Average Length of Stay: Total	2.5	2.5	25th–49th	R
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	264.5	289.6	10th–24th	R
Emergency Department Visits	47.3	40.5	< 10th	R
Frequency of Selected Procedures (Per 1,000 Member Months)				
Bariatric Weight Loss Surgery: Male—Ages 0–19 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Female—Ages 0–19 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Male—Ages 20–44 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Female—Ages 20–44 Years	—	0.1	—	R
Bariatric Weight Loss Surgery: Male—Ages 45–64 Years	—	< 0.1	—	R
Bariatric Weight Loss Surgery: Female—Ages 45–64 Years	—	0.0	—	R
Tonsillectomy: Ages 0–9 Years	0.4	0.3	< 10th	R
Tonsillectomy: Ages 10–19 Years	0.2	0.3	25th–49th	R
Abdominal Hysterectomy: Ages 15–44 Years	0.1	< 0.1	< 10th	R
Abdominal Hysterectomy: Ages 45–64 Years	0.2	0.1	< 10th	R
Vaginal Hysterectomy: Ages 15–44 Years	0.1	0.1	25th–49th	R
Vaginal Hysterectomy: Ages 45–64 Years	0.2	0.1	25th–49th	R
Open Cholecystectomy: Male—Ages 30–64 Years	0.1	0.1	≥ 75th††	R
Open Cholecystectomy: Female—Ages 15–44 Years	< 0.1	< 0.1	†	R
Open Cholecystectomy: Female—Ages 45–64 Years	0.1	0.0	< 50th††	R
Closed Cholecystectomy: Male—Ages 30–64 Years	0.2	0.1	10th–24th	R
Closed Cholecystectomy: Female—Ages 15–44 Years	0.6	0.5	10th–24th	R
Closed Cholecystectomy: Female—Ages 45–64 Years	0.4	0.6	25th–49th	R
Back Surgery: Male—Ages 20–44 Years	0.1	0.2	25th–49th	R
Back Surgery: Female—Ages 20–44 Years	< 0.1	< 0.1	< 10th	R
Back Surgery: Male—Ages 45–64 Years	0.3	0.3	25th–49th	R
Back Surgery: Female—Ages 45–64 Years	0.3	0.2	10th–24th	R
Mastectomy: Ages 15–44 Years	0.0	< 0.1	†	R
Mastectomy: Ages 45–64 Years	0.2	0.1	25th–74th††	R

Table 3-12—Review Results and Audit Designation for Utilization of Services Performance Measures *for* DHMC				
Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Lumpectomy: Ages 15–44 Years	< 0.1	0.1	10th–49th††	R
Lumpectomy: Ages 45–64 Years	0.3	0.2	10th–24th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.

† All percentiles were 0.0 for this indicator; therefore, percentile ranking is not applicable.

†† Two or more of the percentiles were the same as the plan rate; therefore, the percentile ranking was stretched to multiple ranges.

[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Utilization Observations

Compared to last year, DHMC reported minor fluctuations in rates among all utilization measures. Notable changes were found in the *Outpatient Visits Per 1,000 Member Months* under *Ambulatory Care*. Since these rates did not take into account the characteristics of the population, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, if combined with other performance metrics, each plan's utilization 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: Compared to last year, DHMC's performance was consistent for most of the quality-related measures. Statisically significant improvement was observed for two indicators under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*. Opportunities for improvement existed for indictors with a decline of more than five percentage points from last year's rate. These indicators include *Well-Child Visits in the First 15 Months of Life—6+ Visits*, four *Childhood Immunization Status* indicators (*Combinations 5, 7, 9, and 10*), *Chlamydia Screening in Women—Total*, and the *Bronchodilator* indicator for the *Pharmacotherapy Management of COPD Exacerbation* measure.

Timeliness: Although a majority of the timeliness-related measures performed consistently compared to last year, a decline of more than five percentage points was observed for *Well-Child Visits in the First 15 Months of Life—6+ Visits*, and four *Childhood Immunization Status* indicators (*Combinations 5, 7, 9, and 10*).

Access: DHMC has sustained performance in a majority of the access-related measures. Many of them, including the utilization measures, had slight changes in performance from last year. Among the newly reported measures, two indicators for the *Comprehensive Diabetes Care* (*LDL-C Level < 100 mg/dL* and *Blood Pressure Controlled <140/80 mm Hg*) benchmarked above the national HEDIS Medicaid 90th percentile. Conversely, the *Use of Appropriate Medications for People with Asthma—Total* indicator benchmarked below the national HEDIS Medicaid 10th percentile, presenting an opportunity for improvement for DHMC.

Rocky Mountain Health Plans (RMHP)

Compliance With Information Systems Standards

HSAG reviewed and evaluated all data sources—including the plan's final 2012 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 1.5—The auditor validated claims and found instances where Vertexers did not enter all diagnosis codes and processors did not correct the error. The auditor recommended that RMHP provide remedial training to claims processors. The auditor determined that these concerns had no impact on HEDIS reporting.[3-1]
- IS 7.3—The auditor recommended that the plan should incorporate more edit checks, validations, and reports when building a repository. The auditor determined that these concerns had no impact on HEDIS reporting.[3-2]

Pediatric Care Performance Measures

Table 3-13 shows the RMHP HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for each performance measure for pediatric care.

Table 3-13—Review Results and Audit Designation for Pediatric Care Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Childhood Immunization Status—Combination 2	82.2%	78.2%	50th–74th	R
Childhood Immunization Status—Combination 3	78.6%	76.2%	50th–74th	R
Childhood Immunization Status—Combination 4	22.1%	12.7%	< 10th	R
Childhood Immunization Status—Combination 5	63.5%	63.4%	≥ 90th	R
Childhood Immunization Status—Combination 6	55.0%	52.1%	≥ 90th	R
Childhood Immunization Status—Combination 7	20.2%	11.3%	< 10th	R
Childhood Immunization Status—Combination 8	18.0%	9.0%	10th–24th	R
Childhood Immunization Status—Combination 9	47.4%	44.9%	≥ 90th	R
Childhood Immunization Status—Combination 10	17.0%	8.1%	10th–24th	R
Immunizations for Adolescents—Combination 1	—	47.9%	25th–49th	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	81.2%	82.6%	≥ 90th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.1%	64.9%	10th–24th	R

[3-1] 2012 Compliance Audit, Final Audit Report, HEDIS, Rocky Mountain Health Plans, June 15, 2012.
[3-2] Ibid.

Table 3-13—Review Results and Audit Designation for Pediatric Care Performance Measures *for* RMHP				
Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Adolescent Well-Care Visits	49.9%	42.8%	25th–49th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	62.5%	71.1%	≥ 90th	R
Counseling for Nutrition: Total	59.6%	63.0%	75th–89th	R
Counseling for Physical Activity: Total	49.9%	56.7%	75th–89th	R
Annual Dental Visit—Total	—	NB	NB	NB

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
NB is shown when the health plan did not offer the benefit required by the measure.
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Strengths

All RMHP's performance measures received an audit designation of *Reportable* (R) for 2012. RHMP achieved at least a five percentage point increase from last year in the *BMI Assessment* and *Counseling for Physical Activity* indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure. Additionally, five indicators (*Childhood Immunization Status—Combinations 5, 6, and 9*; *Well-Child Visits in the First 15 Months of Life—6+ Visits*; and *BMI Assessment* under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure) were above national HEDIS Medicaid 90th percentile.

Recommendations

All but four Pediatric Care measures exhibited a decline in performance from 2011 to 2012. HSAG noted a decline of more than five percentage points from last year in four indicators under the *Childhood Immunization Status* measure (*Combinations 4, 7, 8, and 10*) and the *Adolescent Well-Care Visits* measure.

Based on the results of this year's performance measure validation findings, RMHP should conduct a barrier analysis to help identify the source of the declines, as well as design and implement interventions to target them.

Access to Care and Preventive Screening Performance Measures

Table 3-14 shows the RMHP HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for each performance measure for access to care and preventive screening.

Table 3-14—Review Results and Audit Designation for Access to Care and Preventive Screening Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care[2]	97.0%	97.0%	≥ 90th	R
Postpartum Care[2]	77.4%	77.4%	≥ 90th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	99.3%	98.5%	75th–89th	R
Ages 25 Months to 6 Years	90.0%	89.0%	25th–49th	R
Ages 7 to 11 Years	92.4%	92.1%	50th–74th	R
Ages 12 to 19 Years	93.4%	91.6%	50th–74th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	90.8%	89.8%	≥ 90th	R
Preventive Screening				
Chlamydia Screening in Women—Total	47.0%	45.4%	< 10th	R
Adult BMI Assessment	60.1%	69.9%	75th–89th	R

R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

[2] The plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the *HEDIS 2012 Technical Specifications for Health Plans, Volume 2*.

Strengths

All of RMHP's performance measures received an audit designation of *Reportable* (R) for 2012. Improvement of at least five percentage points from 2011 was seen in the *Adult BMI Assessment* measure. Additionally, the two indicators for the *Prenatal and Postpartum Care* measure and the *Adults' Access to Preventive/Ambulatory Health Services—Total* indicator benchmarked above the national HEDIS Medicaid 90th percentile.

Recommendations

All but three indicators exhibited a decline in performance from HEDIS 2011 to HEDIS 2012, but none of these declines were more than five percentage points. Nonetheless, RMHP should consider targeting its improvement efforts on measures with lower performance compared to the National HEDIS Medicaid performance. For HEDIS 2012, the *Chlamydia Screening in Women—Total* measure ranked below the 10th percentile of the National HEDIS Medicaid performance.

Living With Illness Performance Measures

Table 3-15 shows the RMHP HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for living with illness performance measures.

Table 3-15—Review Results and Audit Designation for Living With Illness Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Use of Appropriate Medications for People with Asthma—Total	—	86.6%	25th–49th[2]	R
Comprehensive Diabetes Care				
HbA1c Testing	—	92.2%	≥ 90th	R
*HbA1c Poor Control (>9.0%)**	—	19.2%	< 10th	R
HbA1c Control (<8.0%)	—	72.2%	≥ 90th	R
Eye Exam	—	60.8%	50th–74th	R
LDL-C Screening	—	74.6%	25th–49th	R
LDL-C Level <100 mg/dL	—	47.7%	≥ 90th	R
Medical Attention for Nephropathy	—	75.9%	25th–49th	R
Blood Pressure Controlled <140/80 mm Hg	—	61.5%	≥ 90th	R
Blood Pressure Controlled <140/90 mm Hg	—	79.9%	≥ 90th	R
Use of Imaging Studies for Low Back Pain	66.9%	74.0%	25th–49th	R
Annual Monitoring for Patients on Persistent Medications—Total	84.1%	85.0%	50th–74th	R
Pharmacotherapy Management of COPD Exacerbation				
Bronchodilator	65.9%	43.4%	< 10th	R
Systemic Corticosteroid	39.0%	28.9%	< 10th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
* A lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.
[2] For HEDIS 2012, the upper age limit for the *Use of Appropriate Medications for People with Asthma* measure was extended from 50 to 64; therefore, please use caution when comparing with HEDIS 2011 national Medicaid percentiles for the *Total* age group.

Strengths

All of RMHP's performance measures received an audit result of *Reportable (R)* for HEDIS 2012. HSAG noted at least a five percentage point increase from last year in the *Use of Imaging Studies for Low Back Pain* measure. Additionally, six indicators under the *Comprehensive Diabetes Care* measure (*HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), LDL-C Level < 100 mg/dL, Blood Pressure Controlled < 140/80 mm Hg*, and *Blood Pressure Controlled < 140/90 mm Hg*) benchmarked above the national HEDIS Medicaid 90th percentile.

Recommendations

Both indicators under the *Pharmacotherapy Management of COPD Exacerbation* measure exhibited a substantial decline in performance from 2011 to 2012. The *Bronchodilator* indicator rate declined by 22.5 percentage points, and the *Systemic Corticosteroid* indicator rate declined by 10.1 percentage points. Both of these measures ranked below the national HEDIS Medicaid 10th percentile.

These indicators rely on pharmacy data, and RMHP's Final Audit Report indicated that it was identified that the prescribing physician was not loaded into the MedAssurant repository for pharmacy data. The plan corrected the issue and reloaded the data. RMHP should ensure that it receives all pharmacy data and that it is loaded into the HEDIS repository for reporting.

Utilization Performance Measures

Table 3-16 shows the RMHP HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for the utilization performance measures.

Table 3-16—Review Results and Audit Designation for Utilization of Services Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient				
Discharges Per 1,000 MM: Total	11.6	10.6	75th–89th	R
Average Length of Stay: Total	2.9	2.9	10th–24th	R
Inpatient Utilization—General Hospital/Acute Care: Medicine				
Discharges Per 1,000 MM: Total	3.8	2.7	25th–49th	R
Average Length of Stay: Total	3.0	2.7	< 10th	R
Inpatient Utilization—General Hospital/Acute Care: Surgery				
Discharges Per 1,000 MM: Total	2.6	3.5	≥ 90th	R
Average Length of Stay: Total	4.7	4.5	10th–24th	R
Inpatient Utilization—General Hospital/Acute Care: Maternity				
Discharges Per 1,000 MM: Total	10.3	8.3	75th–89th	R
Average Length of Stay: Total	1.9	1.9	< 10th	R
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	437.8	436.6	75th–89th	R
Emergency Department Visits	56.9	62.9	25th–49th	R
Frequency of Selected Procedures (Per 1,000 Member Months)				
Bariatric Weight Loss Surgery: Male—Ages 0–19 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Female—Ages 0–19 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Male—Ages 20–44 Years	—	0.0	—	R

Table 3-16—Review Results and Audit Designation for Utilization of Services Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Bariatric Weight Loss Surgery: Female—Ages 20-44 Years	—	0.4	—	R
Bariatric Weight Loss Surgery: Male—Ages 45–64 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Female—Ages 45–64 Years	—	0.4	—	R
Tonsillectomy: Ages 0–9 Years	1.4	1.5	≥ 90th	R
Tonsillectomy: Ages 10–19 Years	1.1	1.4	≥ 90th	R
Abdominal Hysterectomy: Ages 15–44 Years	0.2	0.2	25th–74th††	R
Abdominal Hysterectomy: Ages 45–64 Years	0.3	0.2	10th–24th	R
Vaginal Hysterectomy: Ages 15–44 Years	1.3	1.2	≥ 90th	R
Vaginal Hysterectomy: Ages 45–64 Years	0.6	0.8	≥ 90th	R
Open Cholecystectomy: Male—Ages 30–64 Years	0.0	0.1	≥ 75th††	R
Open Cholecystectomy: Female—Ages 15–44 Years	0.0	<0.1	†	R
Open Cholecystectomy: Female—Ages 45–64 Years	0.2	0.0	< 50th††	R
Closed Cholecystectomy: Male—Ages 30–64 Years	0.8	0.6	≥ 90th	R
Closed Cholecystectomy: Female—Ages 15–44 Years	1.6	1.7	≥ 90th	R
Closed Cholecystectomy: Female—Ages 45–64 Years	1.4	1.2	≥ 90th	R
Back Surgery: Male—Ages 20–44 Years	0.8	0.5	75th–89th	R
Back Surgery: Female—Ages 20–44 Years	0.5	0.3	75th–89th	R
Back Surgery: Male—Ages 45–64 Years	0.7	1.1	≥ 90th	R
Back Surgery: Female—Ages 45–64 Years	1.2	1.1	≥ 90th	R
Mastectomy: Ages 15–44 Years	<0.1	0.0	†	R
Mastectomy: Ages 45–64 Years	0.3	0.2	75th–89th	R
Lumpectomy: Ages 15–44 Years	0.2	0.2	≥ 50th††	R
Lumpectomy: Ages 45–64 Years	0.4	0.7	75th–89th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.

† All percentiles were 0.0 for this indicator; therefore, percentile ranking is not applicable.

†† Two or more of the percentiles were the same as the plan rate; therefore, the percentile ranking was stretched to multiple ranges.

[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Utilization Observations

Compared to last year, RMHP reported minor variations in rates among most utilization measures. Notable changes were seen in the *Emergency Department Visits Per 1,000 Member Months* indicator under *Ambulatory Care* measure. Two *Inpatient Utilization—General Hospital/Acute*

Care indicators showed clear rate changes for the *Discharges Per 1,000 MM: Total* submeasures (*Medicine* and *Maternity*). The increased *Medicine* rate and the decreased *Maternity* rate may represent a change in administrative practices by RMHP, rather than a true reflection of service utilization. It is also possible that data were reported in the *Medicine* category rather than the *Maternity* category. RMHP should investigate what happened with these indicators.

Since these rates did not take into account the characteristics of the population, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, if combined with other performance metrics, each plan's utilization 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

RMHP had sustained performance for the majority of measures for HEDIS 2012. There were slight declines in performance, most notably among the *Childhood Immunization Status* indicators. 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 consistently for most of the quality-related measures. Improvement of more than 5 percentage points was observed for *Adult BMI Assessment*, *Use of Imaging Studies for Low Back Pain*, and two indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure. Several of the newly reported *Comprehensive Diabetes Care* indicators (*HbA1c Testing, HbA1c Poor Control [>9.0%], HbA1c Control [<8.0%], LDL-C Level <100 mg/dL, Blood Pressure Controlled <140/80 mm Hg,* and *Blood Pressure Controlled <140/90 mm Hg*) benchmarked above the national HEDIS Medicaid 90th percentile. Opportunities for improvement existed on measures with declines of more than five percentage points from last year's rate. These indicators include four *Childhood Immunization Status* indicators (*Combinations 4, 7, 8, and 10*), *Adolescent Well-Care Visits,* and the two indicators under *Pharmacotherapy Management of COPD Exacerbation*.

Timeliness: Although a majority of the timeliness-related measures performed consistently from last year, declines were observed for four *Childhood Immunization Status* indicators (*Combinations 4, 7, 8, and 10*) where the HEDIS 2012 rates were at least five percentage points lower than the HEDIS 2011 rates.

Access: RMHP sustained performance levels in a majority of the access-related measures. Many of them, including the utilization measures, had slight changes in rates from last year. Four first-time *Comprehensive Diabetes Care* indicators (*HbA1c Testing, HbA1c Poor Control [>9.0%], HbA1c Control [<8.0%], LDL-C Level <100 mg/dL, Blood Pressure Controlled <140/80 mm Hg,* and *Blood Pressure Controlled <140/90 mm Hg*) were at or above the 90th percentile of National HEDIS Medicaid performance. Although none of the access-related indicators had notable declines, several indicators ranked below the national HEDIS 50th percentiles. These measures presented an opportunity for improvement for RMHP.

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 3-17 displays the key types of data sources used in the validation of performance measures and the time period to which the data applied.

Table 3-17—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
HEDIS Record of Administration, Data Management, and Processes (Roadmap)	CY 2011
Certified Software Report	CY 2011
Performance Measure Reports	CY 2011
Supporting Documentation	CY 2011
On-site Interviews and Information Systems Demonstrations	CY 2011

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 2012 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—As in years past, during calendar year 2011, the Department paid Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) based on revenue codes. The contracts with these organizations continued to require a minimum of one diagnosis and one procedure code in order for the claim to adjudicate. While the Department worked to resolve the issue during the year, there were still problems with the data from both the FQHC and the RHC that resulted in substantial compliance with this standard. This resulted in minimal impact for reporting.[3-3]
- IS 2.0—The Department was substantially compliant with this standard because of a large increase in enrollment that backlogs processing enrollment applications. The issue was resolved and resulted in minimal impact to HEDIS reporting.

[3-3] HEDIS 2012 Compliance Audit, Final Report of Findings for Department of Health Care Policy & Financing, July 2012.

- IS 7.0—There was an issue identified during the rate review of HEDIS results. The State immunization file was not loaded to Q Mark for inclusion in the PCPP and FFS immunization rates for reporting rates via the IDSS to NCQA. The data were included, and a subsequent rate file was produced. The Department and HSAG should work on ways to ensure that this does not happen in future reporting years. This issue resulted in minimal impact to HEDIS reporting.

Pediatric Care Performance Measures

Table 3-18 shows the PCPP HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for each performance measure for pediatric care.

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

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Childhood Immunization Status—Combination 2	81.8%	76.6%	50th–74th	R
Childhood Immunization Status—Combination 3	80.8%	76.1%	50th–74th	R
Childhood Immunization Status—Combination 4	45.7%	53.3%	≥ 90th	R
Childhood Immunization Status—Combination 5	62.5%	58.3%	75th–89th	R
Childhood Immunization Status—Combination 6	46.5%	38.3%	50th–74th	R
Childhood Immunization Status—Combination 7	35.3%	41.2%	≥ 90th	R
Childhood Immunization Status—Combination 8	26.5%	27.8%	≥ 90th	R
Childhood Immunization Status—Combination 9	37.7%	31.2%	50th–74th	R
Childhood Immunization Status—Combination 10	21.4%	22.6%	75th–89th	R
Immunizations for Adolescents—Combination 1	—	64.2%	75th–89th	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	57.1%	61.4%	50th–74th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.1%	59.1%	< 10th	R
Adolescent Well-Care Visits	47.7%	47.9%	50th–74th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	46.7%	55.5%	50th–74th	R
Counseling for Nutrition: Total	51.6%	55.2%	50th–74th	R
Counseling for Physical Activity: Total	45.3%	51.1%	75th–89th	R
Annual Dental Visit—Total	—	70.7%	≥ 90th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Strengths

All of PCPP's performance measures received an audit designation of *Reportable* (R) for 2012. At least a five percentage point increase from last year was observed for two indicators related to the

Childhood Immunization Status (Combinations 4 and *7)* measure and two indicators under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure *(BMI Assessment* and *Counseling for Physical Activity)*. Additionally, three rates under the *Childhood Immunization Status* measure (*Combinations 4, 7,* and *8*) and the *Annual Dental Visit—Total* measure benchmarked above the national HEDIS Medicaid 90th percentile.

Recommendations

Six measures showed a decline in performance from 2011 to 2012. PCPP experienced a decline of at least five percentage points from last year for three indicators for the *Childhood Immunization Status* (*Combinations 2, 6,* and *9*) measure and the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. These indicators/measures presented opportunities for improvement.

Access to Care and Preventive Screening Performance Measures

Table 3-19 shows the PCPP HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for each performance measure for access to care and preventive screening.

Table 3-19—Review Results and Audit Designation for Access to Care and Preventive Screening Performance Measures *for* PCPP

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.0%	80.3%	25th–49th	R
Postpartum Care	70.3%	69.6%	50th–74th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	96.9%	97.0%	50th–74th	R
Ages 25 Months to 6 Years	88.4%	85.8%	10th–24th	R
Ages 7 to 11 Years	90.4%	90.2%	25th–49th	R
Ages 12 to 19 Years	91.7%	90.0%	50th–74th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	85.8%	83.9%	25th–49th	R
Preventive Screening				
Chlamydia Screening in Women—Total	29.4%	26.1%	< 10th	R
Adult BMI Assessment	35.5%	50.9%	50th–74th	R

R is shown when the rate was reportable, according to NCQA standards.
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Strengths

All of PCPP's performance measures received an audit result of *Reportable* (R) for HEDIS 2012. PCPP achieved an improvement of 15.4 percentage points for the *Adult BMI Assessment* measure.

Recommendations

Although seven measures showed a decrease in performance from 2011 to 2012, none reported a decline of more than five percentage points. The PCPP should consider implementing performance improvement on the *Timeliness of Prenatal Care* indicator for access to care and the *Chlamydia Screening in Women—Total* indicator for preventive screening because both reported a decline of more than three percentage points. Furthermore, the *Chlamydia Screening in Women—Total* indicator ranked below the national HEDIS Medicaid 10th percentile.

The PCPP should ensure that all data are received and included for HEDIS reporting.

Living With Illness Performance Measures

Table 3-20 shows the PCPP DHMC HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for living with illness measures and indicators.

Table 3-20—Review Results and Audit Designation for Living with Illness Performance Measures *for* PCPP

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Use of Appropriate Medications for People with Asthma—Total	—	90.6%	75th–89th[2]	R
Comprehensive Diabetes Care				
HbA1c Testing	—	65.7%	< 10th	R
*HbA1c Poor Control (>9.0%)**	—	63.7%	≥ 90th	R
HbA1c Control (<8.0%)	—	32.6%	< 10th	R
Eye Exam	—	45.7%	25th–49th	R
LDL-C Screening	—	56.4%	< 10th	R
LDL-C Level <100 mg/dL	—	25.3%	10th–24th	R
Medical Attention for Nephropathy	—	68.1%	10th–24th	R
Blood Pressure Controlled <140/80 mm Hg	—	27.7%	10th–24th	R
Blood Pressure Controlled <140/90 mm Hg	—	40.9%	< 10th	R
Use of Imaging Studies for Low Back Pain	71.1%	74.7%	25th–49th	R
Annual Monitoring for Patients on Persistent Medications—Total	83.2%	71.9%	< 10th	R

Table 3-20—Review Results and Audit Designation for Living with Illness Performance Measures *for* PCPP				
Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Pharmacotherapy Management of COPD Exacerbation				
Bronchodilator	75.0%	72.2%	10th–24th	R
Systemic Corticosteroid	62.5%	61.1%	25th–49th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
* A lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.
[2] For HEDIS 2012, the upper age limit for the *Use of Appropriate Medications for People with Asthma* measure was extended from 50 to 64; therefore, caution should be used when comparing with HEDIS 2011 national Medicaid percentiles for the *Total* age group.

Strengths

All of PCPP's performance measures received an audit result of *Reportable (R)* for HEDIS 2012. Improved performance was observed in the *Use of Imaging Studies for Low Back Pain* measure, though the increase in rate was less than five percentage points. Among the newly reported measures, the *Use of Appropriate Medications for People with Asthma—Total* indicator ranked in the top 25th percentile of the National HEDIS Medicaid performance.

Recommendations

The *Annual Monitoring for Patients on Persistent Medications—Total* measure decreased by 11.3 percentage points between 2011 and 2012 In addition, all of the measures except the *Use of Appropriate Medications for People with Asthma—Total* fell below the 50th percentile of the National HEDIS Medicaid performance, which represents an opportunity for improvement for this population.

Utilization Performance Measures

Table 3-21 shows the PCPP HEDIS 2011 and HEDIS 2012 rates, HEDIS 2012 percentile rankings, and HEDIS 2012 audit designations for utilization performance measures and indicators.

Table 3-21—Review Results and Audit Designation for Utilization of Services Performance Measures *for* PCPP

Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient				
Discharges Per 1,000 MM: Total	11.5	10.2	75th–89th	R
Average Length of Stay: Total	4.9	5.0	≥ 90th	R
Inpatient Utilization—General Hospital/Acute Care: Medicine				
Discharges Per 1,000 MM: Total	7.0	6.3	≥ 90th	R
Average Length of Stay: Total	4.2	4.3	≥ 90th	R
Inpatient Utilization—General Hospital/Acute Care: Surgery				
Discharges Per 1,000 MM: Total	3.0	2.7	≥ 90th	R
Average Length of Stay: Total	7.7	8.0	≥ 90th	R
Inpatient Utilization—General Hospital/Acute Care: Maternity				
Discharges Per 1,000 MM: Total	2.6	2.1	< 10th	R
Average Length of Stay: Total	2.6	2.3	10th–24th	R
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	410.0	379.5	50th–74th	R
Emergency Department Visits	63.9	55.5	10th–24th	R
Frequency of Selected Procedures (Per 1,000 Member Months)				
Bariatric Weight Loss Surgery: Male—Ages 0–19 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Female—Ages 0–19 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Male—Ages 20–44 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Female—Ages 20–44 Years	—	0.2	—	R
Bariatric Weight Loss Surgery: Male—Ages 45–64 Years	—	0.0	—	R
Bariatric Weight Loss Surgery: Female—Ages 45–64 Years	—	0.0	—	R
Tonsillectomy: Ages 0–9 Years	1.0	0.8	50th–74th	R
Tonsillectomy: Ages 10–19 Years	0.7	0.5	75th–89th	R
Abdominal Hysterectomy: Ages 15–44 Years	0.4	0.2	25th–74th††	R
Abdominal Hysterectomy: Ages 45–64 Years	0.2	0.1	< 10th	R
Vaginal Hysterectomy: Ages 15–44 Years	0.3	0.2	50th–74th	R
Vaginal Hysterectomy: Ages 45–64 Years	0.1	0.1	25th–49th	R

Table 3-21—Review Results and Audit Designation for Utilization of Services Performance Measures *for* PCPP				
Performance Measures	HEDIS Rate		Percentile Ratings[1]	HEDIS 2012 Audit Designation
	2011	2012		
Open Cholecystectomy: Male—Ages 30–64 Years	< 0.1	0.1	≥ 75th††	R
Open Cholecystectomy: Female—Ages 15–44 Years	0.1	< 0.1	†	R
Open Cholecystectomy: Female—Ages 45–64 Years	0.0	0.1	≥ 50th††	R
Closed Cholecystectomy: Male—Ages 30–64 Years	0.3	0.3	50th–74th	R
Closed Cholecystectomy: Female—Ages 15–44 Years	1.1	0.8	50th–74th	R
Closed Cholecystectomy: Female—Ages 45–64 Years	0.7	0.5	25th–49th	R
Back Surgery: Male—Ages 20–44 Years	0.2	0.3	50th–74th	R
Back Surgery: Female—Ages 20–44 Years	0.2	0.2	50th–74th	R
Back Surgery: Male—Ages 45–64 Years	0.6	0.5	50th–74th	R
Back Surgery: Female—Ages 45–64 Years	0.7	0.9	75th–89th	R
Mastectomy: Ages 15–44 Years	< 0.1	< 0.1	†	R
Mastectomy: Ages 45–64 Years	0.1	0.1	25th–74th††	R
Lumpectomy: Ages 15–44 Years	0.2	0.1	10th–49th††	R
Lumpectomy: Ages 45–64 Years	0.1	0.1	< 10th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.

† All percentiles were 0.0 for this indicator; therefore, percentile ranking is not applicable.

†† Two or more of the percentiles were the same as the plan rate; therefore, the percentile ranking was stretched to multiple ranges.

[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Utilization Observations

Compared to last year, PCPP exhibited minor variations in rates among the utilization measures. Notable changes were shown in the *Outpatient Visits* and *Emergency Department Visits* indicators under the *Ambulatory Care (Per 1,000 Member Months)* measure. Since these rates do not take into account the characteristics of the population, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, if combined with other performance metrics, each plan's utilization 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

PCPP's performance exhibited improvements as well as declines during 2012. The following is a summary assessment of PCPP's performance measure results related to the domains of quality, timeliness, and access.

Quality: Compared to last year, PCPP's HEDIS 2012 performance remained fairly stable for most of the measures. Statistically significant improvement was observed for *Adult BMI Assessment*, two indicators under the *Childhood Immunization Status* measure *(Combinations 4* and *7)*, and two

indicators under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure *(BMI Assessment: Total* and *Counseling for Physical Activity: Total)*. Nonetheless, several measures reported rate declines of more than five percentage points, including three indicators under the *Childhood Immunization Status (Combinations 2, 6,* and *9)*, the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure, and the *Annual Monitoring for Patients on Persistent Medications—Total* indicator. Among the newly reported measures, five *Comprehensive Diabetes Care* indicators (*HbA1c Testing, HbA1c Poor Control [>9.0%], HbA1c Control [<8.0%], LDL-C Screening,* and *Blood Pressure Controlled <140/90 mm Hg*) were in the bottom 10th percentile of the National HEDIS Medicaid performance. These measures, along with those with notable declines from HEDIS 2011, presented opportunities for improvement.

Timeliness: Although a majority of the timeliness-related measures performed consistently from last year, notable changes were also observed for some measures. Two *Childhood Immunization Status* indicators (*Combinations 4* and *7*) reported improvement of more than five percentage points. Several measures reported notable declines in rates, including three *Childhood Immunization Status (Combinations 2, 6,* and *9)* indicators, and the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure.

Access: PCPP's 2012 performance on access-related measures was very similar to 2011. Many measures, including the utilization measures, had only slight changes in rates from last year. Among the newly reported measures, the *Annual Dental Visit—Total* indicator was above the national HEDIS Medicaid 90th percentile. Nonetheless, among the newly reported measures, five *Comprehensive Diabetes Care* indicators (*HbA1c Testing, HbA1c Poor Control [>9.0%], HbA1c Control [<8.0%], LDL-C Screening,* and *Blood Pressure Controlled <140/90 mm Hg*) were in the bottom 10th percentile of the National HEDIS Medicaid performance. These measures presented opportunities for improvement.

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

Table 3-22 shows the statewide weighted averages for 2011 and 2012 and the percentile rankings for each performance measure for pediatric care.

Table 3-22—Statewide Summary of Rates for Pediatric Care Performance Measures

Performance Measures	HEDIS Rate		Percentile Ratings[1]
	2011	2012	
Childhood Immunization Status—Combination 2	84.6%	81.4%	75th–89th
Childhood Immunization Status—Combination 3	83.3%	80.5%	75th–89th
Childhood Immunization Status—Combination 4	46.5%	41.6%	75th–89th
Childhood Immunization Status—Combination 5	72.4%	66.6%	≥ 90th
Childhood Immunization Status—Combination 6	67.2%	62.2%	≥ 90th
Childhood Immunization Status—Combination 7	41.7%	35.7%	75th–89th

Table 3-22—Statewide Summary of Rates for Pediatric Care Performance Measures			
Performance Measures	HEDIS Rate		Percentile Ratings[1]
	2011	2012	
Childhood Immunization Status—Combination 8	40.4%	34.0%	≥ 90th
Childhood Immunization Status—Combination 9	60.3%	52.7%	≥ 90th
Childhood Immunization Status—Combination 10	36.9%	29.5%	≥ 90th
Immunizations for Adolescents—Combination 1	—	69.5%	75th–89th
Well-Child Visits in the First 15 Months of Life—6+ Visits	69.9%	62.5%	50th–74th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.6%	66.0%	10th–24th
Adolescent Well-Care Visits	48.9%	48.2%	50th–74th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment: Total	65.9%	74.8%	≥ 90th
Counseling for Nutrition: Total	65.7%	70.1%	75th–89th
Counseling for Physical Activity: Total	51.5%	57.8%	75th–89th
Annual Dental Visit—Total	—	70.7%	≥ 90th

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Strengths

Overall, statewide rates within the pediatric care domain showed improved performance in the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators. In particular, two indicators, *BMI Assessment: Total* and *Counseling for Physical Activity: Total*, had a rate increase of more than five percentage points. Additionally, one newly reported indicator, *Annual Dental Visit—Total*, benchmarked above the national HEDIS Medicaid 90th percentile.

Recommendations

HSAG noted opportunities for improvement in areas such as childhood immunization and well-child visits. Six indicators under the *Childhood Immunization Status* measure (*Combinations 5, 6, 7, 8, 9,* and *10*) and the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator reported a decline of more than five percentage points. Providers should look for missed opportunities and render needed services to children during face-to-face encounters.

Access to Care and Preventive Screening Performance Measures

Table 3-23 displays the statewide weighted averages for HEDIS 2011 and HEDIS 2012 and the percentile rankings for each performance measure for access to care and preventive screening.

Table 3-23—Statewide Summary of Rates for Access to Care and Preventive Screening Performance Measures

Performance Measures	HEDIS Rate		Percentile Ratings[1]
	2011	2012	
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	88.8%	88.6%	50th–74th
Postpartum Care	69.2%	68.6%	50th–74th
Children's and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	95.7%	96.3%	25th–49th
Ages 25 Months to 6 Years	83.8%	84.0%	10th–24th
Ages 7 to 11 Years	86.1%	87.2%	10th–24th
Ages 12 to 19 Years	89.1%	88.0%	25th–49th
Adults' Access to Preventive/Ambulatory Health Services—Total	82.0%	80.6%	25th–49th
Preventive Screening			
Chlamydia Screening in Women—Total	55.8%	52.0%	25th–49th
Adult BMI Assessment	57.6%	69.0%	75th–89th

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Strengths

Statewide performance for 2012 showed slight changes from 2011 for most of the measures. HSAG observed notable improvement in the *Adult BMI Assessment* measure, where the HEDIS 2012 rate increased by 11.4 percentage points and benchmarked above the national HEDIS Medicaid 75th percentile.

Recommendations

Five measures exhibited a decline in performance from HEDIS 2011 to HEDIS 2012, though none had a decrease of more than five percentage points. Opportunities for improvement existed for the *Chlamydia Screening in Women—Total* measure, where the rate decreased 3.8 percentage points from HEDIS 2011. Data completeness should be assessed. For any measures where lab testing and results data are needed, such as *Chlamydia Screening in Women*, efforts should be made to ensure these data are received. This will enhance the reporting of lab-related measures and reduce the need to report rates using the hybrid methodology.

Living With Illness Measures

Table 3-24 shows the statewide weighted averages for 2011 and 2012 and the percentile rankings for each performance measure for living with illness.

Table 3-24—Statewide Summary of Rates for Living With Illness Performance Measures

Performance Measures	HEDIS Rate		Percentile Ratings[1]
	2011	2012	
Use of Appropriate Medications for People with Asthma—Total	—	86.4%	10th–24th[2]
Comprehensive Diabetes Care			
HbA1c Testing	—	79.2%	25th–49th
*HbA1c Poor Control (>9.0%)**	—	43.8%	50th–74th
HbA1c Control (<8.0%)	—	46.5%	25th–49th
Eye Exam	—	53.2%	50th–74th
LDL-C Screening	—	68.2%	10th–24th
LDL-C Level <100 mg/dL	—	42.1%	75th–89th
Medical Attention for Nephropathy	—	74.5%	25th–49th
Blood Pressure Controlled <140/80 mm Hg	—	46.3%	75th–89th
Blood Pressure Controlled <140/90 mm Hg	—	61.6%	50th–74th
Use of Imaging Studies for Low Back Pain	71.9%	76.8%	50th–74th
Annual Monitoring for Patients on Persistent Medications—Total	84.1%	82.2%	25th–49th
Pharmacotherapy Management of COPD Exacerbation			
Bronchodilator	71.3%	58.2%	< 10th
Systemic Corticosteroid	56.3%	46.4%	< 10th

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report. R is shown when the rate was reportable, according to NCQA standards.

* A lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

[2] For HEDIS 2012, the upper age limit for the *Use of Appropriate Medications for People with Asthma* measure was extended from 50 to 64; therefore, caution should be used when comparing with HEDIS 2011 national Medicaid percentiles for the *Total* age group.

Strengths

Most of the measures within the living with illness domain were newly reported for 2012. HSAG noted improved performance in the *Use of Imaging Studies for Lower Back Pain* measure, with an increase of nearly five percentage points. Among the newly reported measures, two *Comprehensive Diabetes Care* indicators (*LDL-C Level <100 mg/dL* and *Blood Pressure Controlled <140/80 mm Hg)* benchmarked above the national HEDIS Medicaid 75th percentile.

Recommendations

Three measures/indicators exhibited a decrease in rate during HEDIS 2012. Both indicators under the *Pharmacotherapy Management of COPD Exacerbation* measure reported a decline in performance of more than five percentage points. Data completeness should be assessed to ensure any and all sources of vendor or supplemental data are received and included for HEDIS reporting. The *Pharmacotherapy Management of COPD Exacerbation* measure indicators rely on pharmacy data, and the completeness of the data should be assessed.

Utilization Measures

Table 3-25 shows the statewide weighted averages for 2011 and 2012 and the percentile rankings for the utilization performance measures.

Table 3-25—Statewide Summary of Rates for Utilization of Services Performance Measures

Performance Measures	HEDIS Rate		Percentile Ratings[1]
	2011	2012	
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient			
Discharges Per 1,000 MM: Total	10.7	10.6	75th–89th
Average Length of Stay: Total	3.9	3.7	50th–74th
Inpatient Utilization—General Hospital/Acute Care: Medicine			
Discharges Per 1,000 MM: Total	5.8	5.9	≥ 90th
Average Length of Stay: Total	3.5	3.3	25th–49th
Inpatient Utilization—General Hospital/Acute Care: Surgery			
Discharges Per 1,000 MM: Total	2.2	2.2	≥ 90th
Average Length of Stay: Total	7.1	6.3	50th–74th
Inpatient Utilization—General Hospital/Acute Care: Maternity			
Discharges Per 1,000 MM: Total	5.4	4.7	25th–49th
Average Length of Stay: Total	2.3	2.2	10th–24th
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	340.7	345.9	25th–49th
Emergency Department Visits	53.9	49.4	10th–24th

Table 3-25—Statewide Summary of Rates for Utilization of Services Performance Measures			
Performance Measures	HEDIS Rate		Percentile Ratings[1]
	2011	2012	
Frequency of Selected Procedures (Per 1,000 Member Months)			
Bariatric Weight Loss Surgery: Male—Ages 0–19 Years	—	0.0	—
Bariatric Weight Loss Surgery: Female—Ages 0–19 Years	—	0.0	—
Bariatric Weight Loss Surgery: Male—Ages 20–44 Years	—	0.0	—
Bariatric Weight Loss Surgery: Female—Ages 20–44 Years	—	0.2	—
Bariatric Weight Loss Surgery: Male—Ages 45–64 Years	—	< 0.1	—
Bariatric Weight Loss Surgery: Female—Ages 45–64 Years	—	0.1	—
Tonsillectomy: Ages 0–9 Years	0.7	0.6	25th–49th
Tonsillectomy: Ages 10–19 Years	0.5	0.6	≥ 90th
Abdominal Hysterectomy: Ages 15–44 Years	0.2	0.1	10th–24th
Abdominal Hysterectomy: Ages 45–64 Years	0.2	0.1	< 10th
Vaginal Hysterectomy: Ages 15–44 Years	0.4	0.4	≥ 90th
Vaginal Hysterectomy: Ages 45–64 Years	0.2	0.2	50th–74th
Open Cholecystectomy: Male—Ages 30–64 Years	< 0.1	0.1	≥ 75th††
Open Cholecystectomy: Female—Ages 15–44 Years	< 0.1	< 0.1	†
Open Cholecystectomy: Female—Ages 45–64 Years	0.1	< 0.1	< 50th††
Closed Cholecystectomy: Male—Ages 30–64 Years	0.3	0.2	25th–49th
Closed Cholecystectomy: Female—Ages 15–44 Years	1.0	0.9	50th–74th
Closed Cholecystectomy: Female—Ages 45–64 Years	0.7	0.7	50th–74th
Back Surgery: Male—Ages 20–44 Years	0.3	0.3	50th–74th
Back Surgery: Female—Ages 20–44 Years	0.2	0.1	10th–49th††
Back Surgery: Male—Ages 45–64 Years	0.4	0.5	50th–74th
Back Surgery: Female—Ages 45–64 Years	0.6	0.6	50th–74th
Mastectomy: Ages 15–44 Years	< 0.1	< 0.1	†
Mastectomy: Ages 45–64 Years	0.2	0.1	25th–74th††
Lumpectomy: Ages 15–44 Years	0.1	0.1	10th–49th††
Lumpectomy: Ages 45–64 Years	0.2	0.3	25th–49th

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report. R is shown when the rate was reportable, according to NCQA standards.

† All percentiles were 0.0 for this indicator; therefore, percentile ranking is not applicable.

†† Two or more of the percentiles were the same as the statewide rate; therefore, the percentile ranking was stretched to multiple ranges.

[1] Percentile ratings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations.

Utilization Observations

Compared to last year, there were small variations in rates among the utilization measures. Since these rates did not take into account the characteristics of the population, HSAG cannot draw conclusions on performance based on the reported utilization results. Nonetheless, if combined with other performance metrics, each plan's utilization 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

Statewide performance on the comparable measures exhibited improvement for some measures and a slight decline for other measures. The following is a summary assessment of statewide performance measure results related to the domains of quality, timeliness, and access.

Quality: Statewide performance on quality-related measures was mixed. Improvements were observed for the *Adult BMI Assessment* measure and two indicators under the *Weight Assessment and Counseling for Nutrition and Physical Activity* measure. Among the newly reported measures, the *Annual Dental Visit—Total* indicator benchmarked above the national HEDIS Medicaid 90th percentile. Nonetheless, several measures/indicators reported declines in performance of five or more percentage points, including six *Childhood Immunization Status* indicators *(Combinations 5, 6, 7, 8, 9,* and *10),* the *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure, and two *Pharmacotherapy Management of COPD Exacerbation* indicators (*Bronchodilator* and *Systemic Corticosteroid*). These measures presented opportunities for improvement.

Timeliness: Statewide performance on timeliness-related measures exhibited more of a decline during HEDIS 2012, especially in the area of immunizations. Six *Childhood Immunization Status* indicators *(Combinations 5, 6, 7, 8, 9,* and *10)* and the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator showed rate declines of at least five percentage points. Statewide opportunities for improvement could target pediatric care.

Access: Statewide performance on access-related measures was very similar to 2011. Many of them, including the utilization measures, had very slight changes in rates from last year. Among the newly reported measures, the *Annual Dental Visit—Total* indicator benchmarked above the national HEDIS Medicaid 90th percentile. Although none of the access-related measures had notable declines from last year, two newly reported measures (*Use of Appropriate Medications for People with Asthma—Total* and *Comprehensive Diabetes Care—LDL-C Screening*) were below the 25th percentile of National HEDIS Medicaid performance. These measures/indicators presented some opportunities for improvement.

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 2011–2012, the Department offered each health plan the option of conducting two PIPs or one PIP and one focused study with an intervention. Both DHMC and RMHP conducted two PIPs.

In recent years the Department had 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. Each plan was required to participate in the State-mandated collaborative PIP.

Appendix C, EQR Activities—Validation of Performance Improvement Projects, describes the manner in which the validation of PIP activities was conducted and how the resulting data were aggregated and analyzed by HSAG.

Denver Health Medicaid Choice (DHMC)

Findings

DHMC conducted two PIPs. The DHMC *Adults Access to Preventive/Ambulatory Health Services* PIP focused on increasing overall use of primary/ambulatory care to improve management of chronic conditions. Increasing members' use of primary/ambulatory care may prevent complications that contribute to poorer health outcomes and overall quality of life. It may also reduce members' inappropriate use of emergency department (ED) services. This was the first year for the *Adults Access to Preventive/Ambulatory Health Services* PIP and DHMC completed Activities I through VI. The plan's baseline data collection period was calendar year 2012; thus, the plan had not progressed to the point of reporting baseline data. DHMC will report and analyze baseline data, as well as develop and implement appropriate interventions, as the study progresses.

The DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP focused on identifying and studying ways to improve coordination of care between physical and behavioral health providers for Medicaid members over the age of 21 with a serious mental illness (SMI) diagnosis. This was the third year for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. DHMC completed Activities I through IX and reported Remeasurement 1 results.

Table 3-26 provides a summary of DHMC's combined PIP validation results for the FY 2011–2012 validation cycle.

Table 3-26—FY11–12 Performance Improvement Project Validation Results *for* DHMC (n=2 PIPs)

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (7/7)	0% (0/7)	0% (0/7)
	II.	Study Question	100% (3/3)	0% (0/3)	0% (0/3)
	III.	Study Indicator	100% (7/7)	0% (0/7)	0% (0/7)
	IV.	Study Population	100% (4/4)	0% (0/4)	0% (0/4)
	V.	Sampling Techniques	100% (6/6)	0% (0/6)	0% (0/6)
	VI.	Data Collection	100% (14/14)	0% (0/14)	0% (0/14)
Design Total			100% (41/41) n=2 PIPs	0% (0/41) n=2 PIPs	0% (0/41) n=2 PIPs
Implementation	VII.	Interventions and Improvement Strategies*	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Data Analysis and Interpretation*	100% (9/9)	0% (0/9)	0% (0/9)
Implementation Total			100% (12/12) n=1 PIP^	0% (0/12) n=1 PIP^	0% (0/12) n=1 PIP^
Outcomes	IX.	Real Improvement*	25% (1/4)	75% (3/4)	0% (0/4)
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			25% (1/4) n=1 PIP^	75% (3/4) n=1 PIP^	0% (0/4) n=1 PIP^
Percent Score of Applicable Evaluation Elements *Met*			**95% Percent (54/57)**		

*The *Adults Access to Preventive/Ambulatory Health Services* PIP had not progressed to reporting Activities VII through X.
^Only the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP reported Activities VII through IX.

Both DHMC PIPs demonstrated strong performance in Activities I through VI. The *Adults Access to Preventive/Ambulatory Health Services* PIP did not progress to baseline measurement; therefore, it could not be assessed beyond Activity VI. DHMC's strong performance in Activities VII and VIII of the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP indicates that the plan implemented interventions and accurately interpreted results for Remeasurement 1. Both DHMC PIPs received a *Met* validation status. The DHMC overall score for applicable evaluation elements was 95 percent wherein 54 of 57 elements received a *Met* score. All of DHMC's *Partially Met* scores occurred in Activity IX of the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. In Activity IX, only one of four study indicators demonstrated statistically significant improvement that appeared to be the result of implemented interventions.

Table 3-27 provides a summary of DHMC's PIP-specific outcomes for the FY 2011–2012 validation cycle. The *Adults Access to Preventive/Ambulatory Health Services* PIP is not included in the table because it did not progress to reporting baseline data.

Table 3-27—FY11–12 Performance Improvement Project-Specific Outcomes *for* DHMC (n=1 PIP)				
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Percentage Point Change**	**Statistical Significance (*p* value)**
PIP#2: *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*				
Study Indicator 1: The percentage of members with an SMI diagnosis who were 21 years of age and older and who had at least one primary care visit in an outpatient setting during the measurement year.	79.6%	71.5%	-8.1 Percentage points	$p < 0.0001$* Statistically significant decline
Study Indicator 2a: The percentage of members with an SMI diagnosis who were 21 years of age and older, had a primary care visit, and shared medical records and exchange of other information evidenced by certified copies of medical records or other correspondence in the medical record.	35.1%	32.0%	-3.1 Percentage points	$p > 0.3970$ Nonstatistically significant decline
Study Indicator 2b: The percentage of members with an SMI diagnosis who were 21 years of age and older, had a primary care visit, and evidence of a PCP-signed medications reconciliation list corresponding to an outpatient encounter with the medical record.	84.4%	71.1%	-13.3 Percentage points	$p<0.0000$* Statistically significant decline
Study Indicator 3: The percentage of members with an SMI diagnosis who were 21 years of age and older, had a primary care visit during the measurement year, and had their behavioral health medications filled at a Denver Health pharmacy.	63.3%	69.0%	5.7 Percentage points	$p<0.0068$* Statistically significant improvement

*Significance levels (*p* values) noted in the table demonstrated statistically significant performance between measurement periods. Statistical significance is traditionally reached when the *p* value is ≤ 0.05.

The DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, showed statistically significant declines in the rates for Study Indicators 1 and 2b. Conversely, the DHMC rate for Study Indicator 3 had statistically significant improvement. DHMC indicated that a staff members' three-month leave of absence and staff changes within the Quality Improvement and Patient Navigation departments, may have negatively affected Study Indicator 1 and 2 results. DHMC further surmised that Study Indicator 2's lower sample size may be attributed to the three-month absence of the staff member responsible for reminding members to make a PCP appointment. As a result, the health plan divided the PCP appointment reminder duties among three staff members. According to DHMC, the pharmacy departments' efforts to encourage Medicaid members to purchase their drugs from a Denver Health pharmacy may have resulted in the significant rate increase in Study Indicator 3. Additionally, DHMC concluded that having a Denver

Health provider on-site at the Mental Health Center of Denver (MHCD) clinic helped increase the number of claims filed at Denver Health pharmacies. DHMC anticipates that having a PCP on-site at MHCD will help improve the Study Indicator 1 rate for FY11–12. In its PIP submission, DHMC documented that a medical records review revealed that there were barriers affecting the receipt of records/information from behavioral health providers. DHMC determined that it needs to further educate PCPs about the process for requesting a copy of member treatment plans and/or prescribed medications from mental health providers. Finally, DHMC credited the Denver Health Care Support team and Denver Health Pharmacy team with developing processes that made scheduling appointments easier.

Strengths

The DHMC *Adults Access to Preventive/Ambulatory Health Services* PIP demonstrated strong performance in the study design phase and received *Met* scores for all applicable evaluation elements in Activities I through VI, which is essential to producing methodologically sound results.

The DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP demonstrated strong performance in the study design and implementation phases by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII. DHMC's sound quality improvement methodology helped increase the rate of SMI members who had a primary care visit and filled their behavioral health medications at a Denver Health pharmacy. DHMC identified a lack of time and resources as a barrier to members scheduling PCP appointments. In response to that barrier, DHMC collaborated with MHCD to develop an intervention for co-locating a PCP at MHCD. The co-location of a PCP at MHCD successfully increased the rate of Study Indicator 3.

Recommendations

DHMC should progress to reporting baseline results for its *Adults Access to Preventive/Ambulatory Health Services* PIP.

DHMC should routinely monitor its *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP interventions to determine if interventions are addressing the identified barriers and having the desired effect on outcomes. HSAG recommends that DHMC conduct a drill-down analysis to identify specific barriers that impede improvement for a particular subgroup. For example, Indicator 2b had the largest percentage point decline among the indicators. Because Indicator 2b is largely influenced by the actions or non-actions of the PCP (i.e., PCP-signed medications reconciliation list), DHMC should consider working with the PCP and the PCP's staff to determine what specific barriers exist to obtaining a signed medications reconciliation list.

Rocky Mountain Health Plans (RMHP)

Findings

RMHP conducted two PIPs. The RMHP *Adult BMI Assessment* PIP focused on improving the rate of body mass index (BMI) documentation in member medical records. This was the first validation year for the *Adult BMI Assessment* PIP, and RMHP completed Activities I through IV. The plan reported a baseline data collection period of calendar year 2011.

The RMHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP focused on improving care for members with behavioral health conditions through coordination of care efforts focused on appropriate use of ER visits. This was the fourth year for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. RMHP completed Activities I through X and reported Remeasurement 3 data.

Table 3-28 shows RMHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3-28—FY11–12 Performance Improvement Project Validation Results *for* RMHP (n=2 PIPs)

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (7/7)	0% (0/7)	0% (0/7)
	II.	Study Question	100% (3/3)	0% (0/3)	0% (0/3)
	III.	Study Indicator	100% (7/7)	0% (0/7)	0% (0/7)
	IV.	Study Population	100% (4/4)	0% (0/4)	0% (0/4)
	V.	Sampling Techniques*	Not applicable	Not applicable	Not applicable
	VI.	Data Collection**	100% (5/5) n=1 PIPs^	0% (0/5) n=1 PIPs^	0% (0/5) n=1 PIPs^
Design Total			100% (26/26) n=2 PIPs	0% (0/26) n=2 PIPs	0% (0/26) n=2 PIPs
Implementation	VII.	Interventions and Improvement Strategies**	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Data Analysis and Interpretation**	100% (8/8)	0% (0/8)	0% (0/8)
Implementation Total			91% (10/11) n=1 PIPs^	9% (1/11) n=1 PIPs^	0% (0/11) n=1 PIPs^
Outcomes	IX.	Real Improvement**	25% (1/4)	75% (3/4)	0% (0/4)
	X.	Sustained Improvement**	0% (0/1)	0% (0/1)	100% (1/1)
Outcomes Total			20% (1/5) n=1 PIPs^	60% (3/5) n=1 PIPs^	20% (1/5) n=1 PIPs^
Combined Percent Score of Applicable Evaluation Elements Met			**88% Percent (37/42)**		

* The PIPs did not use sampling techniques.
** The *Adult BMI Assessment* PIP only reported Activities I through IV.
^ Only the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP reported Activities V through X.

RMHP demonstrated strong performance in Activities I through IV of the *Adult BMI Assessment* PIP.

RMHP's strong performance in Activities VI and VIII of the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP indicates a solid foundation for data collection, analysis, and interpretation. The RMHP overall score for applicable evaluation elements *Met* was 88 percent wherein 37 of 42 elements received a *Met* score. All of RMHP's *Partially Met* and *Not Met* scores occurred in Activities VII, IX and X. In Activity VII, the plan documented a new focus on the top 10 ER utilizers but did not document any new interventions. Additionally, the plan did not document how it monitors implemented interventions to determine efficacy. In Activity IX, only Study Indicator 2 improved; therefore, improvement could not be linked to planned interventions for both indicators. Finally, in Activity X, neither study indicator demonstrated sustained improvement over comparable time periods.

Table 3-29 provides a summary of RMHP's PIP indicator outcomes for the FY 2011–2012 validation cycle. The RMHP *Adult BMI Assessment* PIP is not included in the table because it did not progress to reporting baseline data.

Table 3-29—FY11–12 Performance Improvement Project-Specific Outcomes *for* RMHP (n=1 PIPs)

PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Percentage Point Change	Statistical Significance (*p* value)	Sustained Improvement
PIP#2: *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*							
Study Indicator 1: The total number of members who had at least one visit to a primary care provider in an ambulatory setting during the measurement year.	85.2%	86.3%	88.8%	83.3%	-5.5 Percentage points	*p*=0.0374* Statistically significant decline	No
Study Indicator 2: The total number of members who had at least one emergency room visit during the measurement year.	39.9%	47.1%	49.7%	40.2%^	-9.5 Percentage points	*p*=0.0114* Statistically significant improvement	No

*Significance levels (*p* values) noted in the table demonstrated statistically significant performance between measurement periods. Statistical significance is traditionally reached when the *p* value is ≤ 0.05.
^Lower rates indicate better performance for this indicator.

The Remeasurement 3 rate for Study Indicator 1 of the RMHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP decreased by 5.5 percentage points, which was statistically significant. The Remeasurement 3 rate of 83.3 percent remains below the baseline rate of 85.2 percent. Despite a statistically significant rate decrease from Remeasurement 2 to Remeasurement 3, the health plan did not revise existing interventions or implement new interventions. RMHP stated that further research needs to be done to determine the cause of the decrease in Study Indicator 1. A focus on the top 10 ER utilizers by RMHP revealed that 80 percent of members had at least one PCP visit in 2011. RMHP documented a need to conduct additional research to determine why 20 percent of members did not have a PCP visit in 2011. Study Indicator 2 demonstrated statistically significant improvement, wherein lower rates indicate better performance for this measure. The Remeasurement 3 rate of 40.2 percent decreased 9.5 percentage points from the previous measurement but remained above the baseline rate of 39.9 percent. RMHP attributed the decrease in ER utilization to case managers' efforts to educate members on appropriate ER usage and assist with coordination of care. Both study indicators' rates for Remeasurement 3 performed worse than the baseline rates, signifying continued improvement opportunities for the health plan.

Strengths

The RMHP *Adult BMI Assessment* PIP established a solid study design, which is essential to producing methodologically sound results.

RMHP's ongoing efforts to improve collaboration between the physical health and behavioral health providers in its *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP included continued monitoring of case management activities and the planned implementation of a new joint case management program.

Recommendations

RMHP should progress to reporting baseline results for its *Adult BMI Assessment* PIP.

RMHP should consider revising its *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP interventions. Repeat measures for Study Indicator 1 indicate that some of the interventions have not been effective. The plan should regularly evaluate its interventions to determine the effectiveness of the interventions. RMHP should also conduct research to determine why 20 percent of members did not have a PCP visit in 2011. Finally, the plan should develop new interventions specific to its focus on the top ten ER utilizers, and then evaluate those interventions through interim measurements to determine if the interventions are successful.

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

Table 3-30 shows the health plans' overall performance based on HSAG's validation of the FY 2011–2012 PIPs that were submitted for validation.

Table 3-30—Summary of Each Health Plan's PIP Validation Scores and Validation Status

Health Plan	PIP Study	% of All Elements Met	% of Critical Elements Met	Validation Status
DHMC	*Adults Access to Preventive/Ambulatory Health Services*	100%	100%	*Met*
DHMC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	94%	100%	*Met*
RMHP	*Adult BMI Assessment*	100%	100%	*Met*
RMHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	86%	100%	*Met*

The four PIPs reviewed by HSAG received a *Met* validation status. Each health plan had a PIP that had not progressed to reporting baseline data.

Table 3-31 shows a comparison of the health plans' improvement results.

Table 3-31—Statewide Summary of Improvement

	DHMC	RMHP
Number of comparable rates (previous measurement to current measurement)	4*	2*
Number of rates that improved	25% (1/4)	50% (1/2)
Number of rates that declined	75% (3/4)	50% (1/2)
Number of rates that showed statistically significant improvement over the previous measurement period	25% (1/4)	50% (1/2)
Number of rates that showed statistically significant improvement over baseline	25% (1/4)	0% (0/2)

*Note: Numbers are based on the total number of indicators that had comparable rates for all PIPs submitted by the health plan.

The DHMC and RMHP PIPs that had not progressed to reporting baseline data were not included in Table 3-31. Although only one of four DHMC rates for the DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP improved, the rate improved by a statistically significant amount. One of two RMHP rates for the RMHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP improved and showed statistically significant improvement over the previous measurement period.

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. All four PIPs validated by HSAG earned a *Met* validation status. This demonstrates that each health plan has a strong understanding and implementation of processes required to conduct a valid study.

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 (*Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of All Health Care,* and *Rating of Health Plan*), 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 (*Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service,* and *Shared Decision Making*), the rates were based on responses by members who chose "Always" or "Definitely Yes." Measures that did not meet the minimum number of 100 responses are denoted as Not Applicable (NA). Appendix D contains additional details about the technical methods of data collection and analysis of survey data and the 2011 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 3-32 shows the adult Medicaid results achieved by DHMC during the current year (FY 2011–2012) and the prior year (FY 2010–2011).

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

Measure	FY 2010–2011 Rate	FY 2011–2012 Rate
Getting Needed Care	35.5%	38.7%
Getting Care Quickly	42.7%	42.2%
How Well Doctors Communicate	66.7%	69.9%
Customer Service	NA	NA
Shared Decision Making	56.8%	59.4%
Rating of Personal Doctor	64.5%	67.3%
Rating of Specialist Seen Most Often	56.9%	57.0%
Rating of All Health Care	47.2%	49.7%
Rating of Health Plan	51.5%	59.3%

NA indicates that the measure had fewer than 100 respondents.

Table 3-33 shows the child Medicaid results achieved by DHMC for the current year (FY 2011–2012) and the prior year (FY 2010–2011).

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

Measure	FY 2010–2011 Rate	FY 2011–2012 Rate
Getting Needed Care	44.7%	42.3%
Getting Care Quickly	54.2%	59.4%
How Well Doctors Communicate	72.7%	73.5%
Customer Service	51.2%	56.8%
Shared Decision Making	64.7%	69.6%
Rating of Personal Doctor	81.0%	80.1%
Rating of Specialist Seen Most Often	69.2%	NA
Rating of All Health Care	63.4%	64.9%
Rating of Health Plan	71.7%	71.9%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

DHMC did not have any substantial decreases for the adult Medicaid survey results; however, the Ge*tting Care Quickly* measure decreased slightly. For the child Medicaid survey, DHMC had no substantial decreases; however, two measures showed slight decreases: *Getting Needed Care* and *Rating of Personal Doctor*. 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, one of the eight reportable measure's rates increased substantially: *Rating of Health Plan* (7.8 percentage points). None of the measures decreased substantially. Five of the eight reportable measures for the adult Medicaid population had the lowest rates among the health plans in FY 2011–2012: *Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*. Two of the eight reportable measures for the adult Medicaid population, however, had the highest rates among the health plans in FY 2011–2012: *How Well Doctors Communicate* and *Rating of Personal Doctor*.

For the child Medicaid population, two measures' rates increased substantially: *Getting Care Quickly* (5.2 percentage points) and *Customer Service* (5.6 percentage points). None of the measures' rates decreased substantially. Four of the eight reportable measures for the child Medicaid population had the lowest rates among the health plans in FY 2011–2012: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. Two of the eight reportable measures for the child Medicaid population, however, had the highest rates among the health plans in FY 2011–2012: *Rating of Personal Doctor* and *Rating of Health Plan*.

Rocky Mountain Health Plans (RMHP)

Findings

Table 3-34 displays the adult Medicaid results achieved by RMHP during the current year (FY 2011–2012) and the prior year (FY 2010–2011).

Table 3-34—Adult Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2010–2011 Rate	FY 2011–2012 Rate
Getting Needed Care	58.2%	61.0%
Getting Care Quickly	60.3%	61.2%
How Well Doctors Communicate	71.9%	67.4%
Customer Service	NA	NA
Shared Decision Making	69.3%	62.3%
Rating of Personal Doctor	65.3%	64.4%
Rating of Specialist Seen Most Often	60.7%	64.7%
Rating of All Health Care	51.8%	50.0%
Rating of Health Plan	59.1%	64.0%

NA indicates that the measure had fewer than 100 respondents.

Table 3-35 shows the child Medicaid results achieved by RMHP for the current year (FY 2011–2012) and the prior year (FY 2010–2011).

Table 3-35—Child Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2010–2011 Rate	FY 2011–2012 Rate
Getting Needed Care	57.4%	60.4%
Getting Care Quickly	71.2%	74.7%
How Well Doctors Communicate	76.8%	75.4%
Customer Service	NA	NA
Shared Decision Making	72.3%	77.4%
Rating of Personal Doctor	70.3%	73.8%
Rating of Specialist Seen Most Often	NA	NA
Rating of All Health Care	60.1%	61.7%
Rating of Health Plan	68.3%	67.9%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

The adult Medicaid survey had one measure's rate decrease substantially: *Shared Decision Making.* Three measures' rates decrease slightly: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of All Health Care*. For the child Medicaid survey, RMHP had no measures' rates decrease substantially, but the rates for two measures decreased slightly: *How Well Doctors Communicate* and *Rating of Health Plan*. 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, one measure's rate decreased substantially: *Shared Decision Making* (7.0 percentage points), and none of the measures' rates increased substantially. Four measures' rates for the adult Medicaid population increased slightly: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. Four of the eight reportable measures had the highest rates among the health plans in FY 2011–2012: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. One measure had the lowest rate among the health plans in FY 2011–2012: *Rating of Personal Doctor*.

For the child Medicaid population, one of the seven reportable measures showed a substantial rate increase: *Shared Decision Making* (5.1 percentage points). None of the measures showed a substantial rate decrease. Four of the measures demonstrated slight rate increases: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Personal Doctor*, and *Rating of All Health Care*. Two of the seven reportable measures had the highest rates among the health plans in FY 2011–2012: *Getting Needed Care* and *Shared Decision Making*. Two of the seven reportable measures had the lowest rates among the health plans in FY 2011–2012: *Rating of All Health Care* and *Rating of Health Plan*.

Primary Care Physician Program (PCPP)

Findings

Table 3-36 shows the adult Medicaid results achieved by PCPP during the current year (FY 2011–2012) and the prior year (FY 2010–2011).

Table 3-36—Adult Medicaid Question Summary Rates and Global Proportions *for* PCPP		
Measure	**FY 2010–2011 Rate**	**FY 2011–2012 Rate**
Getting Needed Care	56.3%	53.6%
Getting Care Quickly	61.1%	58.5%
How Well Doctors Communicate	71.9%	66.5%
Customer Service	NA	NA
Shared Decision Making	64.3%	63.8%
Rating of Personal Doctor	70.2%	67.1%
Rating of Specialist Seen Most Often	65.6%	63.4%
Rating of All Health Care	52.3%	51.4%
Rating of Health Plan	55.3%	58.2%

NA indicates that the measure had fewer than 100 respondents.

Table 3-37 shows the child Medicaid results achieved by PCPP for the current year (FY 2011–2012) and the prior year (FY 2010–2011).

Table 3-37—Child Medicaid Question Summary Rates and Global Proportions *for* PCPP		
Measure	**FY 2010–2011 Rate**	**FY 2011–2012 Rate**
Getting Needed Care	53.5%	56.1%
Getting Care Quickly	72.8%	78.5%
How Well Doctors Communicate	76.0%	79.9%
Customer Service	NA	NA
Shared Decision Making	73.8%	72.5%
Rating of Personal Doctor	73.6%	71.9%
Rating of Specialist Seen Most Often	70.3%	NA
Rating of All Health Care	61.7%	67.6%
Rating of Health Plan	64.9%	69.0%

NA indicates that the measure had fewer than 100 respondents.

Recommendations

For the child Medicaid survey, PCPP demonstrated no substantial rate decreases; however, two measures' rates decreased slightly: *Shared Decision Making* and *Rating of Personal Doctor*. PCPP demonstrated a substantial decrease in one measure's rate for the adult Medicaid survey: *How Well Doctors Communicate*. PCPP 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, one of the eight reportable measures showed a slight rate increase: *Rating of Health Plan*. The remaining reportable measures showed rate decreases; furthermore, one measure's rate decreased substantially: *How Well Doctors Communicate* (5.4 percentage points). Two measures had the highest rates among the health plans in FY 2011–2012: *Shared Decision Making* and *Rating of All Health Care*. Two measures had the lowest rates among the health plans in FY 2011–2012: *How Well Doctors Communicate* and *Rating of Health Plan*.

For the child Medicaid population, five of the seven reportable measures rates demonstrated increases, two of which demonstrated substantial increases: *Getting Care Quickly* (5.7 percentage points) and *Rating of All Health Care* (5.9 percentage points). None of the reportable measures demonstrated substantial rate decreases; however, two measures' rates decreased slightly. Three measures had the highest rates among the health plans in FY 2011–2012: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*. One measure had the lowest rate among the health plans in FY 2011–2012: *Rating of Personal Doctor*.

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

Table 3-38 shows the adult Medicaid statewide averages during the current year (FY 2011–2012) and the prior year (FY 2010–2011).

Table 3-38—Adult Medicaid Statewide Averages		
Measure	**FY 2010–2011 Rate**	**FY 2011–2012 Rate**
Getting Needed Care	50.0%	51.1%
Getting Care Quickly	54.7%	54.0%
How Well Doctors Communicate	70.2%	67.9%
Customer Service	**	**
Shared Decision Making	63.5%	61.8%
Rating of Personal Doctor	66.7%	66.3%
Rating of Specialist Seen Most Often	61.1%	61.7%
Rating of All Health Care	50.4%	50.4%
Rating of Health Plan	55.3%	60.5%

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

Table 3-39 shows the child Medicaid statewide averages for the current year (FY 2011–2012) and the prior year (FY 2010–2011).

Table 3-39—Child Medicaid Statewide Averages		
Measure	**FY 2010–2011 Rate**	**FY 2011–2012 Rate**
Getting Needed Care	51.9%	52.9%
Getting Care Quickly	66.1%	70.9%
How Well Doctors Communicate	75.2%	76.3%
Customer Service	*	*
Shared Decision Making	70.3%	73.2%
Rating of Personal Doctor	75.0%	75.3%
Rating of Specialist Seen Most Often	69.8%	**
Rating of All Health Care	61.7%	64.7%
Rating of Health Plan	68.3%	69.6%

* 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 *Rating of Specialist Seen Most Often* measure; therefore, a State average was not calculated.

Summary Assessment Related to Quality, Timeliness, and Access

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

For the statewide adult Medicaid population, three of the eight reportable measures' rates increased from FY 2010–2011 to FY 2011–2012. For one of these measures, *Rating of Health Plan*, the rate increased substantially (5.2 percentage points). Four of the measures' rates decreased slightly from FY 2010–2011 to FY 2011–2012: *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of Personal Doctor*.

For the statewide child Medicaid population, the rates for all reportable measures increased slightly from FY 2010–2011 to FY 2011–2012.

Recommendations

HSAG identified recommendations for improvement for each health plan based on its performance for the measures. Specific recommendations for the composite measures and global ratings are found in Table 3-40 and Table 3-41, respectively.

Table 3-40—Composite Measure Recommendations
Getting Needed Care
A 24-hour bilingual nurse line can be implemented to provide medical advice to Spanish-speaking patients. Offering this service will dissolve any racial disparities resulting from an English language barrier. Having a bilingual nurse advice line will ensure that the needs of its Spanish-speaking patients are being met and can be beneficial in directing members to the most appropriate level of care for their health problem.
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.
Enhancing provider directories will allow patients to effectively choose a physician who 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. It is also helpful to include expanded information on each physician, such as training, specialty, and language(s) spoken.
Getting Care Quickly
Health plans should create or enhance existing Web sites to assist consumers seeking information about symptoms, drugs, conditions and diseases, fitness, and nutrition. The Internet is a useful research tool for consumers to access an abundance of information quickly and easily. The health plan's Web site can provide the platform from where patients can find the health information they are seeking.
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. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results. Furthermore, an online patient portal can aid in the use of electronic communication between patients and providers.

Table 3-40—Composite Measure Recommendations
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.
Dissatisfaction with timely care can often result in bottlenecks and redundancies in administrative and clinical patient flow processes. Health plans can conduct a patient flow analysis to track a patient's experience through a visit or clinical service. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or performed more efficiently.
How Well Doctors Communicate
Health plans can consider hiring an interpreter as a full-time staff member to ensure accurate communication among patients and physicians with an English language barrier. Offering an interpretation service promotes the development of relationships between the patient and family members with their physician. Having an interpreter on-site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule.
Often, health information is presented to patients in a manner that is too complex and technical, which can result in patient inadherence 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. Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice. Health plans can offer a full-day workshop where physicians have the opportunity to participate in simulation training resembling the clinical setting.
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 health care and/or treatment options.
Shared Decision Making
Patients may become more involved in the management of their health care if physicians promote shared decision making. Physicians will be able to better encourage their patients to participate if the health plan provides the physicians with literature that conveys the importance of the shared decision making model, as well as materials that assist physicians in facilitating the shared decision making process with their patients.
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.
Health plans should make an effort to match patients with physicians who speak their preferred language. Offering incentives for physicians to become fluent in another language, in addition to recruiting bilingual physicians, is important when such physicians are not readily available. Patients who can communicate with their physicians are more informed about their health issues and are able to make deliberate choices about an appropriate course of action for their treatment plan.
Patients who are educated about their medical condition(s) are more likely to play an active role in the management of their own health. Health plans can provide members with educational literature and information, such as brochures on a specific medical condition, to empower patients with the information they need to ask informed questions and express personal values and opinions about their condition and treatment options.

Table 3-41—Global Rate Recommendations
Rating of Personal Doctor
Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Indicators of good physician-patient communication include providing clear explanations, listening carefully, and being understanding of patients' perspectives. Health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication.
Health plans can 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 or clinical visit. This will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes need to be made to scheduling templates to ensure patients are receiving prompt, adequate care.
Health plans can explore additional methods for obtaining patient-direct feedback, such as comment cards. Asking patients to describe what they liked most about the care they received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). This direct feedback can be helpful in gaining a better understanding of the specific areas that are working well and areas which can be targeted for improvement.
Rating of Specialist Seen Most Often
Streamlining the referral process, can expedite the time from physician referral to the patient receiving needed specialty care. An electronic referral process, such as a Web-based system, allows providers to have access to a standardized referral form to ensure that all necessary information is timely collected from the parties involved (e.g., plans, patients, and providers).
To enhance the efficiency and effectiveness of specialist care, health plans could work with providers to identify patients with chronic conditions who have routine appointments; a system could be implemented to ensure that these patients have necessary tests completed before an appointment. Furthermore, follow-up with patients should be carried out to ensure that they understand all information provided to them during their visit.
To address issues with specialty provider access in certain geographic areas, health plans may want to explore the option of telemedicine. Telemedicine, such as live, interactive video conferencing, allows providers to offer care from a remote location. Telemedicine models also allow local providers to be more involved in the consultation process and more informed about the care the patient is receiving.
Health plans can create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters.
Rating of All Health Care
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 with an illness or the health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. 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.

Table 3-41—Global Rate Recommendations
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.
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 members who 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. Specific QI initiatives aimed at improving patient care and service and engaging employees can include quarterly employee forums, an annual all-staff assembly, topic-specific improvement team, leadership development courses, and employee awards.

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 2010–2011. 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 2010–2011 site review, DHMC was required to submit a CAP to address deficiencies in the areas of Coverage and Authorization of Services, Access and Availability, and Credentialing and Recredentialing. DHMC submitted a corrective action plan (CAP) in May 2011. HSAG and the Department reviewed DHMC's planned interventions and timelines and approved DHMC's CAP as written in May 2011. In July 2011 and August 2011, DHMC submitted documents as evidence that it had completed all but one required action, with an appropriate plan and timeline for submitted documents related to the last required action. In September 2011, DHMC submitted documents related to the final required action. HSAG and the Department informed DHMC that the evidence provided was insufficient to bring DHMC into full compliance with the requirement in question. In October 2011, DHMC submitted additional documentation related to the final required action. In February 2012, HSAG informed DHMC that it had successfully completed all required actions related to the FY 2010–2011 Site Review process. There were no required actions continued from FY 2010–2011.

Validation of Performance Measures

Results of DHMC's 2010–2011 performance measures yielded several opportunities for improvement. After observing a decrease of nearly 20 percentage points for *Well-Child Visits 3–6 Years of Life* between 2010 and 2011, HSAG recommended that DHMC implement quality strategies to improve rates for this measure. HSAG also suggested that DHMC implement strategies to improve rates for *Children's and Adolescents' Access to Primary Care Providers (PCPs)—25 Months to 6 Years* and *7 to 11 years*, which were ranked below 10 percent in the HEDIS 2010 national performance. Unfortunately, performance continued to decline for *Well-Child Visits 3–6 Years of Life*. DHMC experienced another decline of more than 16 percentage points. While DHMC's rates increased slightly for *Children's and Adolescents' Access to Primary Care Providers (PCPs)—25 Months to 6 Years* and *7 to 11 years*, the increases were not statistically significant; and DHMC continues to rank below the 10th percentile in the HEDIS 2011 national performance.

HSAG recommended that DHMC focus efforts on improving rates for measures that scored below the 50th percentile. Measures that fell within this category included *Pharmacotherapy Management of COPD Exacerbation, Adults' Access to Preventive Ambulatory Health Services, Prenatal and Postpartum Care,* and *Use of Imaging Studies for Low Back Pain.* DHMC experienced an increase of almost 5 percentage points for the *Use of Imaging Studies for Low Back Pain* measure, raising its rating to above the 75th percentile. HSAG noted a change in rates of less than 2 percentage points for the other measures.

Validation of Performance Improvement Projects

For the FY 2010–2011 validation cycle, DHMC received *Met* scores for all elements evaluated in the *Coordination of Care Between Physical and Behavioral Health* study; therefore, DHMC did not have any required actions. However, HSAG did identify two *Points of Clarification* as opportunities for improvement. In Activity III, HSAG noted that the plan reported two components for Study Indicator 2 (2a and 2b). HSAG suggested that DHMC include a description of Study Indicator 2b in Activity III. In Activity VI, HSAG noted that the plan provided the timeline for the collection of data for all measurement periods. However, the plan reported "FY" dates. HSAG suggested that all date ranges be documented as complete date ranges (e.g., July 1, 2009, through June 30, 2010). During the FY 2011–2012 validation cycle, HSAG noted that DHMC addressed all of the *Points of Clarification* per HSAG's recommendation.

Consumer Assessment of Healthcare Providers and Systems

For the adult population measures between FY 2009–2010 and FY 2010–2011, HSAG did note that DHMC's performance showed a slight decline in three measures: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often.* For this reason, HSAG recommended that DHMC direct quality improvement activities toward these areas. All of these measures showed improvement between FY 2010–2011 and FY 2011–2012. Additionally, for the *How Well Doctors Communicate* and *Rating of Personal Doctor* measures, DHMC had the highest rates among the health plans in FY 2011–2012. These increases indicate an improvement in consumer satisfaction in these domains. Nonetheless, one of the measures showed a slight decline between FY 2010–2011 and FY 2011–2012: *Getting Care Quickly*.

For the comparable child population measures between FY 2009–2010 and FY 2010–2011, HSAG noted that DHMC did not experience any measure rate declines. In addition, DHMC showed substantial increases in four measures: *Getting Care Quickly*, *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan*. Furthermore, between FY 2010–2012 and FY 2011–2012, DHMC continued to show improvement on the *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Health Plan* measures. For *Getting Care Quickly*, the rate increase was substantial. These increases demonstrated between FY 2009–2010 and FY 2011–2012 indicate an improvement in consumer satisfaction in these domains. However, DHMC's rate for the *Rating of Personal Doctor* measure showed a slight decrease between FY 2010–2011 and FY 2011–2012. In addition, *Getting Needed Care* demonstrated a slight decrease between FY 2010–2011 and FY 2011–2012.

Rocky Mountain Health Plans (RMHP)

Compliance Monitoring Site Reviews

As a result of the FY 2010–2011 site review, RMHP was required to make numerous revisions to its policies and procedures related to Coverage and Authorization of Services and Credentialing and Recredentialing. RMHP submitted a corrective action plan in July 2011. HSAG and the Department reviewed RMHP's planned interventions and timelines and provided feedback that RMHP should resubmit several aspects of its planned interventions, as they were not deemed to be sufficient to bring RMHP into compliance with Medicaid managed care requirements. In September 2011, RMHP resubmitted its corrective action plan with revised planned interventions and timelines. At that time, RMHP also submitted a revised claims processing manual and preauthorization and medical claims review polices to address deficiencies in the Coverage and Authorization of Services standard. In October 2011, RMHP submitted a final revised corrective action plan and additional documents, which included department meeting agendas and sign-in sheets, revised credentialing policies and procedures, and Medical Practice Review Committee/Credentialing Committee meeting minutes. In October 2011, HSAG notified RMHP that its final revised CAP was approved by the Department in its entirety and that RMHP should proceed with planned interventions.

During the on-site review in January 2012, RMHP submitted the final documents as evidence of CAP completion. In January 2012 following the site review, HSAG and the Department informed RMHP that it had completed all required actions; however, while reviewing the 2011–2012 CAP and documents, HSAG noted that the previously corrected documents were not used or were no longer in effect. HSAG and the Department continue to work with RMHP to ensure that previously corrected documents or processes previously determined to be in compliance remain effective.

Validation of Performance Measures

RMHP experienced a significant decline in rates between 2010 and 2011 for its *Childhood Immunization Status—Combination 2* and *Combination 3* measures (7.1 and 7.3 percentage points, respectively), as well as the *Counseling for Physical Activity—3–11 Years* measure. Because of this decline, HSAG recommended that RMHP implement improvement efforts. Results from the 2012 HEDIS review demonstrated a further decline in rates for the *Childhood Immunization Status—Combination 2* and *Combination 3* measures, though not statistically significant. HSAG recommended that RMHP continue its efforts to improve these rates. HSAG observed an increase of 6.8 percentage points in the rate for the *Counseling for Physical Activity: Total* measure.

RMHP's 2011 performance for the *Use of Imaging Studies for Low Back Pain* measure had decreased by nearly 6 percentage points from 2010 and ranked within the bottom 10 percent of the HEDIS 2010 national percentiles. Each of the indicators within the *Chlamydia Screening in Women* and *Pharmacotherapy Management of COPD Exacerbation* measures ranked below the 20th percentile within the HEDIS 2010 national performance. HSAG recommended that RMHP implement efforts targeted to improving these measures. Although RMHP experienced an improvement of 7.1 percentage points for the *Use of Imaging Studies for Low Back Pain* in 2012, the other measures continued to experience declines.

Validation of Performance Improvement Projects

For the FY 2010–2011 validation cycle, RMHP submitted two studies for validation; the *Improving Well-Care Rates for Adolescents* study and the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* study.

HSAG identified opportunities for improvement during the FY 2010–2011 validation cycle for the *Improving Well-Care Rates for Adolescents* study. However, per RMHP's request, and with the Department's permission, the *Improving Well-Care Rates for Adolescents* study was retired after the FY 2010–2011 validation cycle.

During the FY 2010–2011 validation cycle for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* study, RMHP received three *Partially Met* scores, and one *Not Met* score. RMHP received *Met* scores for all other elements evaluated. In Activity IX, the study did not document improvement in processes or outcomes for Study Indicator 2, and only the improvement for Study Indicator 1 appeared to be the result of planned interventions; thus, RMHP received *Partially Met* scores for two elements. Although the Study Indicator 1 rate improved, the improvement was not statistically significant and resulted in the *Not Met* score in Activity IX. In Activity X, the study received a *Partially Met* score because it demonstrated sustained improvement for Study Indicator 1, but not for Study Indicator 2. During the FY 2011–2012 validation cycle, RMHP received three *Partially Met* scores in Activity IX and one *Not Met* score in Activity X. HSAG noted that the study indicator rates for the FY 2011–2012 validation cycle performed worse than the baseline rates.

Consumer Assessment of Healthcare Providers and Systems

For the adult population measures between FY 2009–2010 and FY 2010–2011, HSAG did note that RMHP showed a slight decline in five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan.* For this reason, HSAG recommended that RMHP direct quality improvement activities toward these areas. Four of these measures showed improvement between FY 2010–2011 and FY 2011–2012: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. These increases indicate an improvement in consumer satisfaction in these domains. Nonetheless, one of the measures continued to slightly decline: *Rating of All Health Care*. Furthermore, three additional measures showed a decline between FY 2010–2011 and FY 2011–2012: *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of Personal Doctor*.

For the child population measures between FY 2009–2010 and FY 2010–2011, HSAG did note that RMHP showed a decline in 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.* For this reason, HSAG recommended that RMHP direct quality improvement activities toward these areas. Between FY 2010–2011 and FY 2011–2012, five of these measures showed improvement: *Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of All Health Care.* These increases indicate an improvement in consumer satisfaction in these domains. Nonetheless, one of the measures continued to decline

slightly: *How Well Doctors Communicate*. One additional measure, *Rating of Health Plan*, showed a decline between FY 2010–2011 and FY 2011–2012.

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

PCPP experienced a rate decrease of slightly more than 5 percentage points between 2010 and 2011 for the *Well-Child Visits in the First 15 Months of Life, 6+ Visits.* HSAG recommended that the Department implement efforts to improve the rates. While not statistically significant, HSAG observed a 4.3 percentage point increase from 2011 to 2012.

HSAG also recommended that the Department implement efforts to improve rates for *Use of Imaging Studies for Low Back Pain* and *Chlamydia Screening in Women*. While the PCPP experienced a slight increase of 3.6 percentage points for the *Use of Imaging Studies for Low Back Pain* measure, the rate for *Chlamydia Screening in Women* continued to decline.

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 2009–2010 and FY 2010–2011, HSAG noted that PCPP showed no decreases for any of the measures reported. In addition, none of the increases in the measure rates were substantial. Between FY 2010–2011 and FY 2011–2012, rates decreased for seven of the reported measures. Furthermore, one of the measures decreased substantially: *How Well Doctors Communicate*.

For the child population measures between FY 2009–2010 and FY 2010–2011, HSAG noted that PCPP showed no decreases for any of the measures reported. However, one measure, *Rating of Health Plan*, was noted to be below the 2010 NCQA CAHPS national average. For this reason, HSAG recommended that PCPP direct quality improvement activities toward this area. This measure showed improvement between FY 2010–2011 and FY 2011–2012, indicating consumer satisfaction in this domain. Nonetheless, the *Shared Decision Making* and *Rating of Personal Doctor* measures showed slight declines between FY 2010–2011 and FY 2011–2012.

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

For the FY 2011–2012 site review process, the Department requested a review of four areas of performance that had not been reviewed within the previous two fiscal years. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

In developing the data collection tools and in reviewing the four 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 Grievance System standard, HSAG conducted a record review of 10 appeals. 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 V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		

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 2011–2012).

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 V—Member Information	19	19	18	1	0	0	95%
Standard VI—Grievance System	26	26	24	2	0	0	92%
Standard VII—Provider Participation and Program Integrity	15	15	15	0	0	0	100%
Standard IX—Subcontracts and Delegation	8	8	8	0	0	0	100%
Totals	**68**	**68**	**65**	**3**	**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)
Appeals Record Review	54	54	54	0	0	100%

Strengths

ABC used multiple member communications to inform its members that all written materials were available in alternative formats and translations. ABC provided documentation of having had one letter translated into 10 different languages. ABC also had a process for maintaining a list of employees and providers who spoke non-English languages for easy reference when meeting the needs of non-English-speaking members.

The on-site appeals record review demonstrated good communication with members during the appeal process, and provided examples of designated client representatives or providers filing the appeal and members providing additional information for consideration. The records demonstrated that ABC met all the required time frames for appeals acknowledgement, extending the time frame for resolution, and providing notice of the appeal resolution.

ABC provided numerous documents that detailed a robust and comprehensive program to guard against fraud and abuse. The Fraud, Waste, and Abuse policy delineated ABC's processes for investigation. During the on-site review, ABC provided documentation of an instance of suspected fraud. ABC's investigation was very complex and followed its written processes. ABC identified the suspected fraud through its claims monitoring process, conducted a preliminary investigation, and immediately notified the Department upon confirmation of the suspected fraud. ABC conducted an intensive, thorough investigation while providing ongoing and frequent communication with the Department. At the conclusion of the investigation, ABC provided a final, written report to the Department and notified the appropriate agencies. ABC also provided timely transfer of all members to other providers.

ABC had a comprehensive process for oversight of the delegated activities and conducted both ongoing monitoring and formal review (annual audits) of each delegate. ABC provided evidence of having required corrective actions and followed up on those corrective actions, when necessary.

Recommendations

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

Member Information

- ABC was required to revise the member handbook and other member communications to specify the accurate time frames for requesting a State fair hearing for appeals related to a new request for services. The handbook must also accurately reflect the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services.

Grievance System

- ABC was required to modify its appeal resolution letter to include the correct time frame for requesting a State fair hearing.
- ABC was required to revise its applicable policies to accurately reflect the timely filing requirement for appeals and State fair hearings when continuation of benefits is requested.

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: All four standards related to the quality domain, and ABC demonstrated sound performance. ABC's efforts to provide all members with information in an appropriate language and format helped ensure that its members understood the benefits and services available to them. ABC communicated the availability of the grievance and appeal process and repeatedly offered assistance. ABC employed a comprehensive program designed to guard against fraud and abuse and demonstrated implementation of the program during an instance of suspected fraud. Additionally, ABC's processes for oversight of delegated activities ensured that its contractors met all requirements and expectations.

Timeliness: Although all three of its required actions were related to incorrect or inconsistent communication of time frames, ABC performed very well in the timeliness domain. The on-site record review showed that ABC met all the required time frames for appeals acknowledgement, extending the time frame for resolution, and providing notice of appeal resolution.

Access: ABC's performance as it related to the access domain also proved to be above average. ABC used multiple mechanisms to communicate to both members and providers the services and benefits available to its members, including the grievance and appeal process. It implemented comprehensive, NCQA-compliant policies and procedures for credentialing, recredentialing, and ongoing monitoring of its providers, ensuring access for its members to qualified providers.

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 2011–2012).

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 V—Member Information	19	19	16	3	0	0	84%
Standard VI—Grievance System	26	25	19	5	1	1	76%
Standard VII—Provider Participation and Program Integrity	15	15	14	1	0	0	93%
Standard IX—Subcontracts and Delegation	8	8	6	2	0	0	75%
Totals	**68**	**67**	**55**	**11**	**1**	**1**	**82%**

*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)
Appeals Record Review	37	37	30	7	0	81%

Strengths

The member handbook and other materials, such as member newsletters and topic-specific flyers and brochures, were comprehensive and easy to understand, as was the BHI Web site content. BHI offered community-based wellness programs that provided information on nutrition, relaxation therapies, physical exercise, and community resources. The Wellness Recovery Action Plan (WRAP) brochure described the eight-week program designed to assist members with incorporating wellness tools and strategies into their lives and maintain long-term mental health wellness.

BHI's process for deciding appeals was a clear strength. Using this process ensured that members had the opportunity to attend the panel and present evidence and that decision makers were not involved in previous levels of review. Panel members consisted of board certified psychiatrists and clinical team members from the two community mental health centers that had not been involved with the original notice of action.

BHI's corporate compliance plan was comprehensive and robust, and BHI provided evidence of following procedures outlined in the corporate compliance plan in a case of suspected fraud. The

case demonstrated preliminary investigation to confirm suspicion, immediate notification of the Department regarding suspicion, an exhaustive investigation of medical records against claims, and processing of results internally—including financial recovery, credentialing committee determinations, referral to legal authorities, and placement of members with appropriate alternative providers.

BHI had a process for evaluating prospective delegates for the ability to perform the activities to be delegated, and described its pre-delegation evaluation activities conducted prior to delegating certain functions to Colorado Access. Ongoing reports submitted by Colorado Access included information regarding the progress and status of each delegated activity and information about activities that were further subcontracted to DST Solutions.

Recommendations

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

Member Information

- BHI was required to revise the information in its Member and Family Handbook regarding time frames for filing grievances, appeals, and requesting a State fair hearing to comply with the Colorado Rule and BHI policies, and reflect the 30-calendar-day time frame for each.
- BHI was required to revise the handbook to accurately reflect the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services.
- BHI was required to include a statement in the member information materials concerning the availability, upon request, of information concerning physician incentive plans.
- BHI was required to develop a mechanism to address education of staff concerning its policies and procedures on advance directives, and revise the Advance Directives policy accordingly.

Grievance System

- BHI was required to review its processes to ensure that members receive accurate information provided during the appeal process regarding the time frame for filing appeals.
- BHI was required to review and revise training materials and other applicable documents to ensure consistency and accuracy of information given to staff and providers related to the processing and resolution of appeals.
- BHI was required to evaluate its systems and take steps to ensure that appeal acknowledgement letters are sent within the required time frame and that BHI's policies and procedures regarding the appeals process are followed.
- BHI was required to revise templates used for member information during the review process to accurately state that members may request continuation of services (during the appeal or State fair hearing) within 10 calendar days of the notice of action, or before the effective date of the intended action.

- BHI was required to review its distribution patterns for the member handbook and ensure that all documents, including the provider manual and mailings or postings that reproduce the member handbook, contain the correct information.

Provider Participation and Program Integrity

- BHI had suspended its audit process for community mental health center medical records during the review period. BHI must ensure that it monitors for compliance with all medical record requirements for community mental health center providers.

Subcontracts and Delegation

- BHI was required to revise its current policies and procedures or develop new policies and procedures to address requirements related to the provision of ongoing monitoring of its subcontractors and delegates. BHI must also ensure the completion of both ongoing monitoring and formal review for each of its delegates.
- BHI was required to renew delegation agreements with the community mental health centers to specify reporting responsibilities related to the delegated activity and the provision of required reporting of federal expenditures from all sources equal to or in excess of $500,000. BHI must ensure accurate description of performance evaluation in the delegation agreements.

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: All four standards included components that HSAG considered when evaluating BHI's performance as it related to the quality domain. While its policies and procedures provided foundation for a very good quality program, recent and significant staff changes may have had a significant impact on the implementation of these programs. This was most evident in Standard VII—Provider Participation and Program Integrity and Standard IX—Subcontracts and Delegation. BHI was inconsistent in its formal review and ongoing monitoring of delegates and not comprehensive enough in its review of medical record requirements. HSAG also noted areas where staff training was either not inclusive enough, or it included incorrect information. While these deficiencies are significant enough to impact BHI's performance related to the standards, HSAG noted that BHI continued to implement high-quality, community-based and member-focused programs.

Timeliness: HSAG assigned Standard VI—Grievance System to the timeliness domain. BHI struggled with communicating correct and consistent time frames to its employees, members, and providers. In spite of these inconsistencies, HSAG's review of BHI's appeal records demonstrated that appeals were resolved and resolution letters sent within the required time frames. HSAG also reviewed evidence that BHI's grievances were also resolved, with resolution letters mailed, within the required time frames.

Access: BHI performed very well in the access domain. Its member handbook provided information about the benefits and services in a well-organized manner using easy-to-understand language. It had thorough processes for credentialing and recredentialing providers, consistent with NCQA guidelines; and its corporate compliance plan was comprehensive.

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 2011–2012).

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 V—Member Information	19	19	17	2	0	0	89%
Standard VI—Grievance System	26	26	22	4	0	0	85%
Standard VII—Provider Participation and Program Integrity	15	15	15	0	0	0	100%
Standard IX—Subcontracts and Delegation	8	7	6	1	0	0	86%
Totals	**68**	**67**	**60**	**7**	**0**	**1**	**90%**

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

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)
Appeals Record Review	60	60	60	0	0	100%

Strengths

CHP demonstrated very strong commitment to making its materials available to all members in an easy-to-understand language and format. Its policies required that all member materials be subjected to multiple levels of review to ensure clarity and relevance. All printed materials were translated into Spanish and English versions and included statements written in Spanish informing members that documents were available in Spanish. Materials also included statements reminding members that documents were available in large type or on audiotape and that interpreter services were available for any language, free of charge.

CHP used multiple methods to communicate to members the right to file grievances and appeals, and to request a State fair hearing. Record reviews demonstrated that appeals had been filed by members, designated client representatives (DCRs), and providers. CHP used training materials to familiarize new network providers with members' grievance rights.

CHP's delegate is ValueOptions (VO). VO's use of automated systems through Network Connect proved to be an asset to its ability to monitor providers. The program allowed for cross-referencing of processes with provider files and for tracking and documenting provider-related information. The

program efficiently linked provider functions and information from numerous sources into a single electronic record of all provider information and activity.

After reviewing multiple examples of CHP's ongoing monitoring and formal review of its delegates, HSAG concluded that CHP demonstrated clear oversight and ultimate responsibility of delegated tasks. Ongoing monitoring included regular review of reports submitted by CHP's delegates, regular meetings between CHP and its delegates, and review of the delegates' managers and directors. Formal review included review or audit of policies, procedures, financial records, and annual on-site contract compliance audits.

Recommendations

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

Member Information

- CHP was required to review and revise its member materials and policies to clarify the requirement that CHP provides annual notice to members of the right to request the required information at any time and receive it upon request.
- CHP erroneously interchanged the terms "calendar days" and "working days" when describing the appeal resolution time frames in its member handbook. CHP was required to revise its member handbook to accurately describe appeal resolution time frames.

Grievance System

- CHP was required to clarify in its member materials the circumstances under which members may request that previously authorized services continue during the appeal or State fair hearing and accurately describe the duration of continued benefits.
- CHP was required to specifically notify providers that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.
- CHP was required to revise its policy to clearly state that language regarding continuation of previously authorized services is required (if applicable) regardless of whether the member or the provider, acting as the DCR, requested the appeal.

Subcontracts and Delegation

- The two agreements between CHP and VO, as well as CHP's member participation agreements with the community mental health centers (CMHCs), included each of the required provisions except the clause to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. CHP was required to revise its agreements with VO and with the CMHCs to address these requirements.

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: HSAG found CHP's performance related to quality to be good. While CHP failed to meet all requirements in three of the four standards reviewed, these deficiencies were relatively few and can be easily corrected. Alternatively, CHP's programs related to its providers and delegates proved to be a real strength. CHP demonstrated an extensive program designed to guard against fraud and abuse that included a detailed corporate compliance plan, code of conduct, and comprehensive policies and procedures. CHP employed several mechanisms that allowed it to regularly monitor its delegates and demonstrated a commitment to ensure effective communication with its members.

Timeliness: Standard V—Grievance System was the only standard assigned to the timeliness domain. While CHP's score for this standard was only 85 percent, the actions required were more related to the communication of time frames rather than actual performance related to timeliness. HSAG's on-site review of CHP's appeal files showed that CHP had met all required time frames for acknowledgement and appeal resolution letters. HSAG noted two cases in which CHP had used the extension process accurately in instances where it additional information was required from the member. CHP's performance, as it related to the timeliness domain, was strong.

Access: CHP's commitment to effective communication with its members also proved to be an asset when viewed in the context of the access domain. By ensuring that both members and providers understand the benefits and services available, CHP helped facilitate access to those services. CHP delegated the credentialing and recredentialing of providers to VO. VO's thorough credentialing and recredentialing processes helped CHP establish a robust network of qualified physicians. CHP also demonstrated strong performance within the access domain.

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 V—Member Information	19	19	17	2	0	0	89%
Standard VI—Grievance System	26	26	24	2	0	0	92%
Standard VII—Provider Participation and Program Integrity	15	15	15	0	0	0	100%
Standard IX—Subcontracts and Delegation	8	7	6	1	0	1	86%
Totals	**68**	**67**	**62**	**5**	**0**	**1**	**93%**

*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)
Appeals Record Review	60	59	59	0	1	100%

Strengths

FBHP demonstrated a strong commitment to making its member materials available to all members in language and format that was easy to understand. FBHP's member materials were reviewed by member groups to ensure functionality and readability. FBHP also provided a "Navigation Team" at each of its partner mental health centers to assist members in understanding the benefits available at the BHO. These teams also provided assistance with understanding and navigating public benefits and community resources.

FBHP had a robust system for processing grievances and appeals. It employed tracking mechanisms that ensured the timeliness of grievance and appeal processing. On-site review of its appeal records showed that resolution letters included all of the required information. HSAG found evidence that FBHP's Office of Member and Family Affairs (OMFA) staff worked with members to gather additional information needed to decide the appeal and, when necessary, staff members used the extension process appropriately.

FBHP delegated some of its provider network management functions to VO. VO's use of Network Connect enhanced FBHP's ability to manage its provider network. In addition to the Network Connect features, FBHP demonstrated several other mechanisms it used to monitor covered services provided by its partner mental health centers and independent provider network. These many avenues of monitoring helped to ensure the quality and appropriateness of services.

FBHP had policies and procedures in place that addressed the delegation of specific tasks and included all of the required information. HSAG reviewed evidence that FBHP had a signed, executed agreement with each delegate.

Recommendations

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

Member Information

- FBHP mistakenly depicted the standard appeal resolution time frame as 10 "calendar" days in its member handbook FBHP was required to revise its handbook to accurately describe the resolution time frame for standard appeals.
- FBHP was required to revise applicable member materials and policies to clarify the requirement for FBHP to provide annual notice to members of the right to request information at any time and receive it upon request.

Grievance System

- FBHP was required to ensure that individuals who make clinical decisions related to grievances and appeals have clinical expertise in treating the member's condition.
- FBHP was required to specifically notify providers that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services if the final decision is adverse to the member.

Subcontracts and Delegation

- The two agreements between FBHP and VO included each of the required provisions except the clause to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. FBHP must revise its agreements with VO to address these requirements.

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: All four standards reviewed were assigned to the quality domain, and FBHP's overall compliance score of 93 percent is a good assessment of its performance. FBHP demonstrated a commitment to ensuring that its members received information in a language and format that is easy

to understand. This commitment to strong communication was also seen in FBHP's interactions with its providers and contractors. FBHP's contracts included clear delineation of expectations and responsibilities. FBHP demonstrated clear oversight of delegated tasks.

Timeliness: The Grievance System standard was the only standard assigned to the timeliness domain. HSAG's on-site review of appeal records showed that FBHP had met all of the required time frames. HSAG noted an instance in the Member Information standard where FBHP had mistakenly used the word "calendar" instead of "working" when describing the number of days allowed for appeal resolution. Aside from this minor issue, FBHP's performance, as it related to the timeliness domain, proved very strong.

Access: The three standards used by HSAG to evaluate FBHP's performance in the access domain were Member Information, Grievance System, and Provider Participation and Program Integrity. FBHP scored 100 percent in the Provider Participation and Program Integrity standard. FBHP's delegate, VO, had a robust credentialing and recredentialing program, which helped to ensure FBHP's members had access to quality providers. FBHP's use of multiple formats and its mechanism to communicate information to members were seen throughout HSAG's review of the Grievance System and Member Information standards. This commitment to effective communication will help FBHP members understand the benefits and services available to them. Overall, FBHP performed very well in the access domain.

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 V—Member Information	19	19	18	1	0	0	95%
Standard VI—Grievance System	26	26	23	3	0	0	88%
Standard VII—Provider Participation and Program Integrity	15	15	15	0	0	0	100%
Standard IX—Subcontracts and Delegation	8	7	6	1	0	1	86%
Totals	**68**	**67**	**62**	**5**	**0**	**1**	**93%**

*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)
Appeals Record Review	24	24	24	0	0	100%

Strengths

NBHP's member handbook was comprehensive and easy to follow, and available in alternative formats and languages. The member handbook included information about benefits and covered services. NBHP included a list of member rights in its member handbook and required that posters containing these rights be displayed in all provider locations.

NBHP used multiple methods to communicate to members regarding the right to file grievances and appeals, and to request State fair hearings. HSAG found evidence that appeals had been filed by members, DCRs, and providers acting on behalf of the member. HSAG's on-site review of appeals records demonstrated that notices included required content, were written in a way that was easily understood, and were clearly customized to the member's situation.

NBHP demonstrated an extensive program developed to guard against fraud and abuse. This program included a detailed corporate compliance plan, standards of conduct, and policies and procedures. Review of compliance committee meeting minutes, and NBHP's compliance training and compliance awareness week demonstrated a robust compliance plan.

NBHP demonstrated clear oversight and ultimate responsibility of delegated tasks, as evidenced by multiple methods of ongoing monitoring and formal review. NBHP had policies and procedures in place that addressed delegation of specific BHO tasks and included all of the required information.

Recommendations

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

Member Information

- NBHP erroneously depicted the expedited appeal resolution time frame as three *working* days in its member handbook. NBHP was required to revise the member handbook to accurately describe the resolution time frame for expedited appeals.
- NBHP was required to also clarify in the member handbook the circumstances under which members may request that previously authorized services continue during the appeal or State fair hearing and accurately describe the duration of continued services.

Grievance System

- NBHP was required to revise its policy to clearly state that language regarding continuation of previously authorized services is required (if applicable) regardless of whether the member or the provider, acting as the DCR, requested the appeal.
- NBHP was required to revise member materials to clearly reflect the continuation of previously authorized services rights and information.
- NBHP was required to specifically notify providers that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services if the final decision is adverse to the member.

Subcontracts and Delegation

- The two agreements between NBHP and VO, as well as the delegation agreements with the CMHCs, included each of the required provisions except the provision to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. NBHP must revise its agreements with VO and with the CMHCs to address this requirement.

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: NBHP's overall compliance score of 93 percent is a good assessment of its performance as it relates to quality. The relatively few corrective actions required of NBHP were far outweighed by the numerous examples of processes it implemented to ensure high quality services to its members. NBHP used multiple methods for monitoring its delegates and confirming that each one met the high level of standards required by NBHP. Careful credentialing and recredentialing processes

guaranteed that NBHP only contracted with qualified providers. NBHP's commitment to providing each member with materials in a language and format that is easy to understand helps make certain its members understand the services and benefits available. HSAG felt that NBHP performed well related to the standard assigned to the quality domain.

Timeliness: The Grievance System standard was the only standard assigned to the timeliness domain. Although NBHP erroneously depicted the expedited appeal time frame as *working days* instead of *calendar days*, HSAG's review of appeal records showed that all time frames had been met. HSAG reviewed an appeal file where the time frame had been extended, and found that NBHP had followed the extension process appropriately. NBHP performed very well in the timeliness domain.

Access: NBHP employed a variety of mechanisms to communicate the availability of services and benefits to both its members and its providers. By providing members and providers with this information, NBHP helped facilitate access. The Network Connect system efficiently linked provider functions and information from numerous sources and provided NBHP with an overview of the services available to its members. NBHP performed very well in the access domain.

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 2011–2012 Statewide Average***
Standard V—Member Information	**91%**
Standard VI—Grievance System	**87%**
Standard VII—Provider Participation and Program Integrity	**99%**
Standard IX—Subcontracts and Delegation	**86%**
Overall Statewide Compliance Score	**90%**

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

Table 5-13—Statewide Score for Record Review	
Standards	**FY 2011–2012 Statewide Average***
Appeals Record Review	**97%**

* 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.

HSAG noted a few required actions that were required by more than one BHO. Four of the five BHOs were missing a clause from their delegation agreements. This clause requires a subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.

Another required action that was common among more than one BHO is the mistaken use of *working days* instead of *calendar days*.

Two of the BHOs had a corrective action related to the time frames for requesting a grievance, appeal, and/or State fair hearing. HSAG believes this may be in part due to a 2010 change in the Colorado Rule that extended the time frame for requesting a grievance, appeal, or State fair hearing to 30 days (it was previously 20 days). While HSAG found evidence that the BHOs attempted to make this change, some of their documents were overlooked. HSAG also noted several of the BHOs had trouble with information related to the continuation of services during an appeal or State fair hearing (the information was incorrect or missing). The Department noted these common issues and made arrangements with HSAG to present the requirements related to the continuation of services to the BHOs at a following Behavioral Health Quality Improvement Committee (BQuIC) meeting.

Quality: All five of the BHOs did a commendable job communicating with their members. They provided information in multiple languages and formats, and all communication with members was written in easy-to-understand language. The on-site record reviews demonstrated that all of the organizations were providing resolution within the required time frames and that the resolution letters included required content. The corporate compliance plans were comprehensive, and each BHO's contractors were required to adhere to its plan. Most of the BHOs demonstrated robust monitoring programs that included ongoing and formal review. HSAG determined the performance of the BHOs, as it related to quality, as very good.

Timeliness: Although some of the BHOs had required actions related to the grievance system and associated time frames, HSAG believed the BHOs, as a whole, performed very well in the timeliness domain. One BHO failed to send acknowledgement letters, which impacted the overall score; however, all BHOs met the required time frames for appeal resolutions. Two of the five BHOs processed expedited appeals, and four of the five filed extensions. In all instances, the policies were implemented properly and time frames were met.

Access: Based on its review of three standards—Member Information, Grievance System, and Provider Participation and Program Integrity—HSAG determined the statewide performance in the access domain was very good. All of the BHOs demonstrated commitments to ensuring that its members understand the benefits and services available. These commitments were evidenced by the well-organized member handbooks, presented to members in a variety of formats and languages, all written at or below sixth-grade reading level. HSAG found evidence throughout its reviews that each BHO communicated the availability of the grievance system to its members and providers and offered members assistance at every stage. The BHOs also improved their performance in the access domain by ensuring the availability of an adequate and qualified provider network, as demonstrated by the credentialing and recredentialing programs.

Validation of Performance Measures

The Department required the collection and reporting of nine performance measures for the FY 2011–2012 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, the results 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. All nine measures were validated and reported in the previous year, and comparisons with last year's results are listed.

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 five 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 found no issues with the processing of eligibility files from the State. Files were loaded into ABC's eligibility transactional system (PowerSTEPP) after being downloaded daily from the State's portal. Enrollment files were reviewed, and errors were worked prior to disseminating to the mental health center and providers. ABC did not experience any data delays from the State portal during the past year.

HSAG identified no issues with the processing of claims and encounter data. ABC demonstrated evidence of a good working relationship with, and appropriate oversight of, its claims processing vendor, DST. As part of its oversight processes, ABC periodically conducted on-site visits to DST in Alabama. DST internally audited two percent of each claims processor's work daily and sent results to ABC daily. Summaries of findings were sent monthly and quarterly. Additionally, Colorado Access audited three to five percent of claims processed daily and found no discrepancies.

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		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	6.1%	5.0%	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	18.6%	14.9%	*Fully Compliant*
Adults 18 Through 64 Years of Age	23.7%	19.4%	*Fully Compliant*
Adults 65 Years of Age or Older	7.5%	6.5%	*Fully Compliant*
Penetration Rate by Service Category			
Inpatient Care	0.3%	0.3%	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.04%	0.05%	*Fully Compliant*
Ambulatory Care	10.8%	8.9%	*Fully Compliant*
Overall Penetration Rates	12.8%	10.9%	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	17.2%	11.6%	*Fully Compliant*
AFDC/CWP Children	7.2%	5.1%	*Fully Compliant*
AND/AB-SSI	38.2%	32.9%	*Fully Compliant*
BC Children	6.6%	4.9%	*Fully Compliant*
BC Women	17.0%	13.1%	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	33.3%	17.2%	*Fully Compliant*
Foster Care	48.8%	39.7%	*Fully Compliant*

Table 5-15—Review Results and Audit Designation *for* ABC			
Performance Measures	Rate		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
OAP-A	7.6%	6.4%	*Fully Compliant*
OAP-B-SSI	29.8%	22.6%	*Fully Compliant*
Other[1]	18.0%	—	*Fully Compliant*
Hospital Recidivism[2]			
Non-State Hospitals—7 Days	4.3%	3.8%	*Fully Compliant*
30 Days	14.3%	11.1%	*Fully Compliant*
90 Days	26.1%	21.9%	*Fully Compliant*
All Hospitals—7 Days	5.2%	3.7%	*Fully Compliant*
30 Days	14.6%	10.7%	*Fully Compliant*
90 Days	26.9%	21.1%	*Fully Compliant*
Hospital Average Length of Stay			
Non-State Hospitals	9.07	8.17	*Fully Compliant*
All Hospitals	15.88	19.97	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	9.35	7.95	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	6.52	5.41	*Fully Compliant*
All Hospitals	8.00	6.30	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	35.4%	39.7%	*Fully Compliant*
30 Days	57.8%	58.7%	*Fully Compliant*
All Hospitals—7 Days	35.0%	40.4%	*Fully Compliant*
30 Days	57.5%	59.1%	*Fully Compliant*

[1] The *OAP State Only* and *Unspecified* categories originally reported in the individual FY2010–2011 BHO Performance Measure Validation reports were combined into the *Other* category. Due to lags in BHO encounter submission and retroactive eligibility and ineligibility determinations in the 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. The *OAP State Only* and *Unspecified* categories were not reported in the FY 2011–2012 BHO Performance Measure Validation reports. Therefore, no percentages were displayed for FY 2011–2012.

[2] For the *Hospital Recidivism* measure, an increase over last year's rates would suggest poorer performance.

Strengths

ABC acted on the recommendations made by HSAG during the previous year's audit and is making strides in preparing for the ICD-10 conversion. ABC's performance measure reporting and process flow document was very detailed and was a valuable resource. The ABC performance measure team retained its core members for the past several years, adding to the reliability of processes in place.

ABC received a *Fully Compliant* status for all audited performance measures. HSAG observed improvement in all *Hospital Recidivism*[5-1] submeasures and all *Follow-Up After Hospitalization for Mental Illness* submeasures. In particular, the *All Hospitals—90 Days Hospital Recidivism* submeasure and the *All Hospitals—7-Days Follow-Up After Hospitalization for Mental Illness* submeasure improved more than five percentage points from last year.

Recommendations

HSAG noted that one individual was responsible for the performance measure rate calculation process. HSAG recommended that ABC implement a process to have other staff serve as backup should the primary person be unavailable to perform the calculation. Also, as ABC begins the transition to a new transactional system, it should thoroughly document the process, including any issues encountered along the way and how those issues were resolved. HSAG's other recommendations to ABC regarding its performance measure validation processes and reporting were echoed for all BHOs and are included in the Statewide recommendations section.

HSAG observed lack of improvement on the most *Penetration Rate* measures. Specifically, several *Penetration Rate by Medicaid Eligibility Category* submeasures reported a decrease in rate of more than five percentage points (i.e., AFDC-CWP Adults, AND/AB-SSI, BCCP—Women Breast and Cervical Cancer, Foster Care, and OAP-B-SSI). ABC should investigate reasons why the penetration rates have declined.

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 demonstrated some improvement. In particular, the *All Hospitals—90 Days* submeasure showed a decline in rate (suggesting improvement) of more than five percentage points.

Timeliness: *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported for this year. ABC's performance on this measure demonstrated some improvement. In particular, the *All Hospitals—7-Days* submeasure rate showed an increase of more than five 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 17 penetration rate-related submeasures (*Penetration Rate by Service Category—Inpatient Care* and *Hospitalization*) showed the same level of performance as the previous year. The remaining 15 submeasures exhibited a decline, with five measures declining by more than five percentage points. All utilization-based access measures except the *Hospital Average Length of Stay—All Hospitals,* experienced a decline in utilization. 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.

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

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.

BHI contracted with Colorado Access to manage eligibility data processing. During the audit of BHI and Colorado Access, HSAG found no issues with the processing of eligibility files from the State. Files were loaded into the transactional system (PowerSTEPP) after being downloaded daily from the State's portal. The IT department ensured that files met necessary requirements to be loaded into PowerSTEPP. Daily eligibility files were sent to the mental health centers. The centers were also able to check eligibility through the State Web portal. There were no delays in processing enrollment data during the past year.

HSAG identified no issues or concerns with the claims and encounter data systems. BHI contracted with Colorado Access to handle the processing and adjudication of all claims and encounters, most of which were electronic. BHI monitored the volume of encounter data submitted. BHI also had good oversight processes in place to monitor Colorado Access' processes.

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		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	6.1%	5.8%	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	18.0%	16.5%	*Fully Compliant*
Adults 18 Through 64 Years of Age	20.0%	17.4%	*Fully Compliant*
Adults 65 Years of Age or Older	4.6%	4.1%	*Fully Compliant*
Penetration Rate by Service Category			
Inpatient Care	0.1%	0.2%	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.1%	0.1%	*Fully Compliant*
Ambulatory Care	10.6%	10.1%	*Fully Compliant*
Overall Penetration Rate	11.1%	10.5%	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	16.7%	11.8%	*Fully Compliant*
AFDC/CWP Children	9.5%	6.3%	*Fully Compliant*
AND/AB-SSI	33.4%	31.8%	*Fully Compliant*
BC Children	6.7%	4.7%	*Fully Compliant*
BC Women	9.9%	6.9%	*Fully Compliant*
BCCP—Women Breast and Cervical	8.0%	9.3%	*Fully Compliant*

Table 5-16—Review Results and Audit Designation *for* BHI			
Performance Measures	Rate		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
Cancer			
Foster Care	37.4%	34.8%	*Fully Compliant*
OAP-A	4.7%	4.1%	*Fully Compliant*
OAP-B-SSI	21.8%	19.6%	*Fully Compliant*
Other[1]	13.9%	—	*Fully Compliant*
Hospital Recidivism[2]			
Non-State Hospitals—7 Days	0.4%	2.9%	*Fully Compliant*
30 Days	4.6%	11.5%	*Fully Compliant*
90 Days	12.1%	18.0%	*Fully Compliant*
All Hospitals—7 Days	1.4%	4.1%	*Fully Compliant*
30 Days	7.2%	12.6%	*Fully Compliant*
90 Days	14.5%	19.4%	*Fully Compliant*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	7.28	7.80	*Fully Compliant*
All Hospitals	16.33	14.31	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	5.35	6.64	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	2.37	3.26	*Fully Compliant*
All Hospitals	4.67	4.78	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	54.7%	50.0%	*Fully Compliant*
30 Days	70.1%	67.6%	*Fully Compliant*
All Hospitals—7 Days	52.8%	51.0%	*Fully Compliant*
30 Days	67.4%	67.4%	*Fully Compliant*

[1] The *OAP State Only* and *Unspecified* categories originally reported in the individual FY 2010–2011 BHO Performance Measure Validation reports were combined into the *Other* 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. The *OAP State Only* and *Unspecified* categories were not reported in the FY 2011–2012 BHO Performance Measure Validation reports. Therefore, no percentages were displayed for FY 2011–2012.

[2] For the *Hospital Recidivism* measure, an increase over last year's rates would suggest poorer performance.

— Indicates the measure was not calculated.

Strengths

BHI thoroughly documented the transition process from its former administrative services organization (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 minor improvement in two *Penetration Rate* submeasures (*Penetration Rate by Service Category—Inpatient Care* and *Penetration Rate by Medicaid Eligibility Category—BCCP—Women Breast and Cervical Cancer*).

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.

HSAG observed a general lack of improvement on almost all of the *Penetration Rate* submeasures and all *Hospital Recidivism* submeasures. Specifically, three *Hospital Recidivism* submeasures reported an increase in rate of more than five percentage points (i.e., *Non-State Hospitals—30 Days* and *90 Days, and All Hospitals—30 Days*), indicating poorer performance. Although no measures had any notable decline in rates from last year, opportunities for improvement existed for *Penetration Rate* submeasures.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: *Hospital Recidivism* was the only quality measure reported for this year. BHI's performance suggested opportunities for improvement. All six submeasures reported rate increases compared to last year, with three experiencing increases of more than five percentage points, indicating poorer performance for this measure.

Timeliness: The *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported for this year. BHI's performance on this measure suggested opportunities for improvement. Specifically, performance on one measure (*All Hospitals—30 Days*) stayed the same; and three of the four submeasures reported declines of less than five percentage points.

Access: BHI's performance on the penetration-related measures was mixed. Only two (*Penetration Rate by Service Category-Inpatient Care* and *Penetration Rate by Medicaid Eligibility Category-BCCP—Women Breast and Cervical Cancer*) of the 17 submeasures reported a slight improvement. The rate for the *Intensive Outpatient/Partial Hospitalization* submeasure stayed the same, while all other submeasures showed a decline, though the magnitude was less than five percentage points. For the utilization-based access measures, all except the *Hospital Average Length of Stay, All Hospitals* submeasure reported an increase in utilization. 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 had no concerns with CHP's process for receipt and processing of eligibility data from the State. 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 State's portal. Due to some issues with the 834 eligibility file, CHP returned to using the PHP interface file and the mid-month large file. CHP plans to transition to the new 834 (5010 compliant) file for the next fiscal year.

HSAG had no concerns regarding CHP's process for receiving and reporting claims and encounter data. There were no major changes in CHP processes compared to last year; the CMHCs used either Qualifacts/CareLogic or Profiler as their internal system, and CHP received data from the CMHCs in an electronic format. The volumes of monthly encounter files were carefully monitored by both CHP and the CMHCs via the data report card. Each CMHC received a report card with detailed information on the data CHP received from them. CMHCs with low volumes or high error rates were researched and continually corrected.

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		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	6.9%	7.1%	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	18.8%	19.2%	*Fully Compliant*
Adults 18 Through 64 Years of Age	20.0%	19.2%	*Fully Compliant*
Adults 65 Years of Age or Older	6.8%	6.1%	*Fully Compliant*
Penetration Rate by Service Category			
Inpatient Care	0.3%	0.2%	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.02%	0.003%	*Fully Compliant*
Ambulatory Care	12.3%	12.1%	*Fully Compliant*
Overall Penetration Rate	12.7%	12.9%	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	17.7%	15.1%	*Fully Compliant*
AFDC/CWP Children	10.3%	8.2%	*Fully Compliant*
AND/AB-SSI	28.0%	27.6%	*Fully Compliant*
BC Children	8.1%	6.2%	*Fully Compliant*

Table 5-17—Review Results and Audit Designation *for* CHP			
Performance Measures	Rate		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
BC Women	15.8%	14.5%	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	16.6%	16.4%	*Fully Compliant*
Foster Care	34.7%	32.4%	*Fully Compliant*
OAP-A	6.9%	6.1%	*Fully Compliant*
OAP-B-SSI	20.6%	18.0%	*Fully Compliant*
Other[1]	11.6%	—	*Fully Compliant*
Hospital Recidivism[2]			
Non-State Hospitals—7 Days	4.8%	4.8%	*Fully Compliant*
30 Days	11.3%	12.0%	*Fully Compliant*
90 Days	18.0%	22.3%	*Fully Compliant*
All Hospitals—7 Days	4.4%	4.1%	*Fully Compliant*
30 Days	12.1%	11.4%[3]	*Fully Compliant*
90 Days	19.5%	21.6%	*Fully Compliant*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	6.60	6.57	*Fully Compliant*
All Hospitals	13.95	10.38	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	10.74	10.02	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.08	3.39	*Fully Compliant*
All Hospitals	5.25	5.03	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	46.2%	46.0%	*Fully Compliant*
30–day	65.4%	65.6%	*Fully Compliant*
All Hospitals—7 Days	48.3%	48.5%	*Fully Compliant*
30–day	68.4%	67.8%	*Fully Compliant*

[1] The *OAP State Only* and *Unspecified* categories originally reported in the individual FY 2010–2011 BHO Performance Measure Validation reports were combined into the *Other* 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. The *OAP State Only* and *Unspecified* categories were not reported in the FY 2011–2012 BHO Performance Measure Validation reports. Therefore, no percentages were displayed for FY 2011–2012.

[2] For the *Hospital Recidivism* measure, an increase over last year's rates would suggest poorer performance.

[3] The denominator for this measure was submitted by CHP to the Department as 983 and was reported as such in the CHP's FY 2010–2011 BHO Performance Measure Validation report. HSAG checked that the correct value should be 985. The rate reported here as well as the statewide rate reported in a later section were calculated based on the 985 value. Despite a slight difference in the denominator, the HSAG-calculated CHP rate was the same as the one listed in CHP's FY 2010–2011 BHO Performance Measure Validation report.

— Indicates the measure was not calculated.

Strengths

Similarly to prior years, CHP demonstrated outstanding monitoring of the CMHC monthly encounter submissions via a report card format, which included drill-down capabilities for data mining and other activities. The staff members responsible for performance measure calculation and reporting were the same staff as in prior years and continue to be a cohesive team with a high degree of technical expertise. CHP received most data electronically. The few paper claims received were scanned and translated to an electronic format to minimize issues related to the accuracy of data entry. System edits allowed the CMHCs to make necessary corrections prior to official encounter submission to the Department. The amount of encounter data rejection to the Department was very low, indicating CHP has complete and accurate encounter data.

CHP received a *Fully Compliant* status in its audit for all nine performance measures. HSAG observed minor improvement (less than one percentage point increase from last year) for seven submeasures, three of which related to *Penetration Rate*, two related to *Hospital Recidivism*, and two related to *Follow-Up After Hospitalization for Mental Illness*.

Recommendations

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

Although none of the measures reported a decline in performance of more than five percentage points in their rates, CHP's performance presented opportunities for improvement. Specifically, the *Non-State Hospitals—90 Days* submeasure under *Hospital Recidivism* reported a 4.3 percentage point increase from last year, indicating decreased performance. CHP should investigate reasons why this particular recidivism rate 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. Although two submeasures reported minor improvements (less than one percentage point decrease from last year's rates), one submeasure's rate (*Non-State Hospitals—90-Days)* increased by more than four percentage points.

Timeliness: CHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) stayed relatively the same as last year's performance, suggesting an opportunity for improvement. Two submeasures reported minor improvements, and the other two showed a decline. Nonetheless, these changes were less than one percentage point.

Access: CHP's performance in the domain of access suggested room for improvement. Three submeasures of *Penetration Rate* reported a less than one percentage point improvement over last year's rates. Among those submeasures that showed a decline, all were less than three percentage points. For utilization-based measures, HSAG observed that the *Hospital Average Length of Stay* submeasures reported a shorter average length of stay. Compared to last year, the *Hospital Average*

Length of Stay, All Hospitals submeasure declined by 25.6 percent and *Emergency Room Utilization* declined by 6.7 percent. For the *Inpatient Utilization* measures, *Non-State Hospitals* reported an increase in utilization of slightly over 10 percent. 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 had no concerns with FBHP's process for receipt and processing of eligibility data from the State. FBHP'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 State's portal. Due to some issues with the 834 eligibility file, FBHP returned to using the PHP interface file and the mid-month large file. FBHP plans to transition to the new 834 (5010 compliant) file for the next fiscal year.

HSAG had no concerns regarding FBHP's process for receiving and reporting claims and encounter data. There were no major changes in the processes compared to last year; the CMHCs used either Qualifacts/CareLogic or Profiler as their internal system, and FBHP received data from the CMHCs in an electronic format. The volumes of monthly encounter files were carefully monitored by both FBHP and the CMHCs via the data report card. Each CMHC received a report card with detailed information on the data FBHP received from them. CMHCs with low volumes or high error rates were researched and continually corrected.

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		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	16.3%	13.8%	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	33.2%	28.6%	*Fully Compliant*
Adults 18 Through 64 Years of Age	30.9%	25.8%	*Fully Compliant*
Adults 65 Years of Age or Older	12.2%	11.3%	*Fully Compliant*
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.1%	0.04%	*Fully Compliant*

Table 5-18—Review Results and Audit Designation *for* FBHP			
Performance Measures	Rate		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
Ambulatory Care	17.6%	15.6%	*Fully Compliant*
Overall Penetration Rate	22.6%	19.5%	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	28.4%	20.0%	*Fully Compliant*
AFDC/CWP Children	23.4%	15.6%	*Fully Compliant*
AND/AB-SSI	38.4%	35.8%	*Fully Compliant*
BC Children	18.8%	11.8%	*Fully Compliant*
BC Women	32.1%	21.7%	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	21.2%	24.7%	*Fully Compliant*
Foster Care	45.1%	37.5%	*Fully Compliant*
OAP-A	12.2%	11.2%	*Fully Compliant*
OAP-B-SSI	34.8%	27.5%	*Fully Compliant*
Other[1]	33.9%	—	*Fully Compliant*
Hospital Recidivism[2]			
Non-State Hospitals—7 Days	3.3%	3.2%	*Fully Compliant*
30 Days	9.4%	8.8%	*Fully Compliant*
90 Days	12.7%	15.2%	*Fully Compliant*
All Hospitals—7 Days	2.6%	3.3%	*Fully Compliant*
30 Days	7.7%	11.1%	*Fully Compliant*
90 Days	12.9%	18.3%	*Fully Compliant*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	6.24	6.27	*Fully Compliant*
All Hospitals	13.35	14.63	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	6.35	6.30	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.17	3.34	*Fully Compliant*
All Hospitals	6.11	5.56	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	60.9%	53.6%	*Fully Compliant*
30 Days	75.0%	70.5%	*Fully Compliant*
All Hospitals—7 Days	63.6%	55.5%	*Fully Compliant*
30 Days	77.1%	74.7%	*Fully Compliant*

[1] The *OAP State Only* and *Unspecified* categories originally reported in the individual FY 2010–2011 BHO Performance Measure Validation reports were combined into the *Other* 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. The *OAP State Only* and *Unspecified* categories were not reported in the FY 2011–2012 BHO Performance Measure Validation reports. Therefore, no percentages were displayed for FY 2011–2012.

[2] For the *Hospital Recidivism* measure, an increase over last year's rates would suggest poorer performance.

— Indicates the measure was not calculated.

Strengths

FBHP demonstrated good oversight of its CMHCs and received most data electronically. The few paper claims received were scanned and translated to an electronic format to minimize issues related to the accuracy of data entry. FBHP had an extra layer of validation for encounter data completeness and accuracy prior to submission to the State, meeting twice a month with ValueOptions (VO) and the CMHCs 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 CMHC monthly encounter submissions via a report card format, which included drill-down capabilities for data mining and other activities. The staff members responsible for performance measure calculation and reporting were the same staff as in prior years and continue to be a cohesive team with a high degree of technical expertise.

FBHP received a *Fully Compliant* status for all audited performance measures. FBHP's performance showed a minor improvement (less than one percentage point) on two submeasures under *Hospital Recidivism* (*Non-State Hospitals—7 Days* and *30 Days*). An improvement of 3.5 percentage points was also noted for one *Penetration Rate by Medicaid Eligibility Category* submeasure (*BCCP—Women Breast and Cervical Cancer*).

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.

FBHP's performance suggested room for improvement on *Penetration Rate*, *Hospital Recidivism*, and *Follow-Up After Hospitalization for Mental Illness* measures. HSAG observed an overall decline in rate for almost all *Penetration Rate*-related measures, with seven submeasures reporting a decline of more than five percentage points. Four of the six *Hospital Recidivism* submeasures showed a decline in performance, with one submeasure (*All Hospitals—90 Days*) having a rate increase of 5.4 percentage points, indicating a decline in performance. All four submeasures under *Follow-Up After Hospitalization for Mental Illness* also reported poorer performance from last year. Both *7 Days* follow-up visit submeasures reported a decline of more than five percentage points.

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 poorer performance (increased rates) from last year with one submeasure's rate exhibiting a decline of more than five percentage points. Performance for two other submeasures (*Hospital Recidivism—Non-State Hospitals—7 Days* and *30 Days*) improved by less than one percentage point.

Timeliness: FBHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) suggested room for improvement. All four submeasures under *Follow-Up After Hospitalization for Mental Illness* reported poorer performance than last year, with the two *7Days* submeasures declining by more than five percentage points.

Access: FBHP's overall performance in the domain of access was poorer than last year's performance, with only one penetration-related submeasure exhibiting improvement, while the remaining submeasures' rates declined. Among those submeasures showing a decline, seven demonstrated a performance decline of more than five percentage points from last year's rates. For the utilization-based measures, *Inpatient Utilization* for both *Non-State Hospitals* and *All Hospitals* reported different trends from last year: non-state hospitals showed a 5.4 percent increase in inpatient utilization while all hospitals reported a decline of 9.0 percent. Both *Hospital Average Length of Stay (All Ages)* submeasures reported an increase in members' average length of stay and the *Emergency Room Utilization* submeasure reported a decline. In particular, the *Hospital Average Length of Stay —All Hospitals* submeasure exhibited a 9.6 percent increase in the length of stay.

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 process for receipt and processing of eligibility data from the State. NBHP'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 State's portal. Due to some issues with the 834 eligibility file, NBHP returned to using the PHP interface file and the mid-month large file. NBHP plans to transition to the new 834 (5010 compliant) file for the next fiscal year.

HSAG had no concerns with NBHP's processes for receiving and reporting claims and encounter data. There were no major changes in the processes compared to last year; the CMHCs used either Qualifacts/CareLogic or Profiler as their internal system, and NBHP received data from the CMHCs in an electronic format. The volumes of monthly encounter files were carefully monitored by both NBHP and the CMHCs via the data report card. Each CMHC received a report card with detailed information on the data NBHP received from them. CMHCs with low volumes or high error rates were researched and continually corrected.

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		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.1%	7.0%	*Fully Compliant*
Adolescents 13 Through 17 Years of Age	23.7%	22.0%	*Fully Compliant*
Adults 18 Through 64 Years of Age	20.0%	18.8%	*Fully Compliant*
Adults 65 Years of Age or Older	4.6%	5.7%	*Fully Compliant*
Penetration Rate by Service Category			
Inpatient Care	0.3%	0.2%	*Fully Compliant*
Intensive Outpatient/Partial Hospitalization	0.02%	0.01%	*Fully Compliant*
Ambulatory Care	12.3%	12.2%	*Fully Compliant*
Overall Penetration Rate	12.8%	12.6%	*Fully Compliant*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	17.0%	13.6%	*Fully Compliant*
AFDC/CWP Children	11.9%	8.6%	*Fully Compliant*
AND/AB-SSI	33.0%	31.8%	*Fully Compliant*
BC Children	8.7%	5.8%	*Fully Compliant*
BC Women	12.0%	8.8%	*Fully Compliant*
BCCP—Women Breast and Cervical Cancer	17.1%	11.9%	*Fully Compliant*
Foster Care	40.9%	35.7%	*Fully Compliant*
OAP-A	4.6%	5.7%	*Fully Compliant*
OAP-B-SSI	25.1%	22.8%	*Fully Compliant*
Other[1]	15.5%	—	*Fully Compliant*
Hospital Recidivism[2]			
Non-State Hospitals—7 Days	3.2%	0.3%	*Fully Compliant*
30 Days	8.1%	2.3%	*Fully Compliant*
90 Days	13.0%	7.1%	*Fully Compliant*
All Hospitals—7 Days	3.3%	0.3%	*Fully Compliant*
30 Days	8.9%	2.4%	*Fully Compliant*
90 Days	14.4%	7.4%	*Fully Compliant*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	5.32	5.74	*Fully Compliant*
All Hospitals	7.52	8.88	*Fully Compliant*
Emergency Room Utilization (Rate/1000 Members, All Ages)	5.03	5.40	*Fully Compliant*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	5.38	4.29	*Fully Compliant*
All Hospitals	6.16	4.65	*Fully Compliant*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	51.9%	55.3%	*Fully Compliant*
30–day	72.0%	75.3%	*Fully Compliant*

Table 5-19—Review Results and Audit Designation *for* NBHP			
Performance Measures	Rate		FY 2011–2012 Audit Designation
	FY 2010–2011	FY 2011–2012	
All Hospitals—7 Days	51.5%	55.3%	*Fully Compliant*
30 Days	71.6%	74.8%	*Fully Compliant*

[1] The *OAP State Only* and *Unspecified* categories originally reported in the individual FY 2010–2011 BHO Performance Measure Validation reports were combined into the *Other* 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. The *OAP State Only* and *Unspecified* categories were not reported in the FY 2011–2012 BHO Performance Measure Validation reports. Therefore, no percentages were displayed for FY 2011–2012.

[2] For the *Hospital Recidivism* measure, an increase over last year's rates would suggest poorer performance.

— Indicates the measure was not calculated.

Strengths

Similarly to prior years, NBHP demonstrated outstanding monitoring of the CMHC monthly encounter submissions via a report card format, which included drill down capabilities for data mining and other activities. The staff members responsible for performance measure calculation and reporting were the same staff as in prior years and continue to be a cohesive team with a high degree of technical expertise.

NBHP also demonstrated good oversight of its CMHCs and received most data electronically. The few paper claims received were scanned and translated to an electronic format to minimize issues related to the accuracy of data entry. System edits allowed the CMHCs to make necessary corrections prior to official encounter submission to the Department. The amount of encounter data rejection to the Department was very low, indicating NBHP has complete and accurate encounter data.

NBHP received a *Fully Compliant* status for all audited performance measures. Performance improved from the previous year for twelve submeasures (*Penetration Rate—Adults 65 Years of Age or Older*, all *Hospital Recidivism* submeasures, and all *Follow-Up After Hospitalization for Mental Illness* submeasures). In particular, four of the six *Hospital Recidivism* submeasures (*30 Days* and *90 Days* for both *Non-State Hospitals* and *All Hospitals*) reported an improvement of more than five percentage points.

Recommendations

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

NBHP's performance under *Penetration Rate* suggested some room for improvement. A majority of the submeasures under *Penetration Rate* demonstrated a decline from last year's results, with two submeasures under *Penetration Rate by Medicaid Eligibility Category (BCCP—Women Breast and Cervical Cancer* and *Foster Care*) showing a decline of more than five percentage points.

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*) suggested a strength. All six submeasures reported an improvement in performance (a drop in rates) with four rates improving by more than five percentage points.

Timeliness: NBHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) demonstrated improvement. All submeasures reported an improvement in performance of at least three percentage points.

Access: NBHP's performance in the domain of access showed some decline from last year's results. Two of the seventeen *Penetration Rate* submeasures showed a slight improvement (just over one percentage point), and two submeasures reported a decline of more than five percentage points. For the utilization-based measures, all *Hospital Average Length of Stay* submeasures showed longer average stays by at least five percent over last year's results. All *Inpatient Utilization* submeasures showed a decline in utilization of at least 20 percent from last year's 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.

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

Table 5-20 provides a summary of the statewide weighted averages for the performance measure rates for FY 2011–2012 and the prior year.

Table 5-20—Statewide Weighted Average Rates for the Performance Measures

Performance Measures	Rate		
	FY 2010–2011	FY 2011–2012	BHO FY 2011–2012 Rate Variations
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.6%	7.1%	5.0%–13.8%
Adolescents 13 Through 17 Years of age	20.8%	19.3%	14.9%–28.6%
Adults 18 Through 64 Years of age	21.9%	19.6%	17.4%–25.8%
Adults 65 Years of Age or Older	6.9%	6.4%	4.1%–11.3%
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	0.2%–0.3%
Intensive Outpatient/Partial Hospitalization	0.04%	0.03%	0.003%–0.1%
Ambulatory Care	12.2%	11.5%	8.9%–15.6%
Overall Penetration Rate	13.5%	12.7%	10.5%–19.5%
Penetration Rate by Medicaid Eligibility			
AFDC/CWP Adults	18.5%	14.2%	11.6%–20.0%
AFDC/CWP Children	11.1%	8.0%	5.1%–15.6%
AND/AB–SSI	32.7%	30.9%	27.6%–35.8%
BC Children	8.7%	6.1%	4.7%–11.8%
BC Women	15.9%	12.6%	6.9%–21.7%
BCCP—Women Breast and Cervical Cancer	18.0%	16.1%	9.3%–24.7%
Foster Care	39.6%	35.1%	32.4%–39.7%
OAP-A	7.0%	6.4%	4.1%–11.2%
OAP-B-SSI	25.0%	21.0%	18.0%–27.5%
Other[1]	16.6%	—	—
Hospital Recidivism[2]			
Non-State Hospitals—7 Days	3.6%	3.4%	0.3%–4.8%
30 Days	10.5%	10.0%	2.3%–12.0%
90 Days	18.2%	18.4%	7.1%–22.3%
All Hospitals—7 Days	3.7%	3.5%	0.3%–4.1%
30 Days	10.8%	10.4%	2.4%–12.6%
90 Days	18.9%	19.0%	7.4%–21.6%

Table 5-20—Statewide Weighted Average Rates for the Performance Measures			
Performance Measures	Rate		BHO FY 2011–2012 Rate Variations
	FY 2010–2011	FY 2011–2012	
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	7.19	7.07	5.74–8.17
All Hospitals	13.93	13.60	8.88–19.97
Emergency Room Utilization (Rate/1000 Members, All Ages)	8.00	7.84	5.40–10.02
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.83	3.82	3.26–5.41
All Hospitals	5.81	5.20	4.65–6.30
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	46.8%	47.4%	39.7%–55.3%
30 Days	66.1%	66.3%	58.7%–75.3%
All Hospitals—7 Days	48.2%	49.0%	40.4%–55.5%
30 Days	67.3%	67.7%	59.1%–74.8%

[1] The *OAP State Only* and *Unspecified* categories originally reported in the individual FY 2010–2011 BHO Performance Measure Validation reports were combined into the *Other* 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. The *OAP State Only* and *Unspecified* categories were not reported in the FY 2011–2012 BHO Performance Measure Validation reports. Therefore, no percentages were displayed for FY 2011–2012.

[2] For the *Hospital Recidivism* measure, an increase over last year's rates would suggest poorer performance.

— 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 in the prior year, all of the performance measures for each of the BHOs received a score of *Fully Compliant*. Eight of the 27 non-utilization submeasures (four under *Hospital Recidivism* and four *Follow-Up After Hospitalization for Mental Illness* submeasures) demonstrated very minor improvement (changes of no more than one percentage point) in performance from the previous year. Performance of two additional measures, both under *Penetration Rate by Service Category*, stayed the same from last year.

Statewide Recommendations

HSAG recommended that all BHOs continue to collaborate with the Department and each other to update/correct issues in the scope document, such as indicating required continuous enrollment, when needed. Tables used for more than one measure should be consistent. While not applicable to any of the validated measures currently, the BHOs and the Department should provide the list of medications for various measures and update at least annually, and as needed, to ensure that all

BHOs are using the same list of medications for the measures. HSAG also recommends that the numbering of the indicators remain consistent from year-to-year to avoid confusion when referring to an indicator by number.

HSAG also recommended that all of the BHOs implement a rate validation process to ensure accurate rates. This process should include checking the source data using various data sorts to ensure that proper date ranges and codes are used, as well as ensuring all data for the review period have been included.

HSAG observed that while statewide improvement was noted on four of the six *Hospital Recidivism* submeasures and all *Follow-Up After Hospitalization for Mental Illness* submeasures, the magnitude was very minimal. Additionally, there was a wide BHO variation in *Hospital Recidivism* rates. The Department should consider developing statewide performance improvement projects to improve these rates and reduce wide variation in performance among the BHOs.

Quality: The *Hospital Recidivism* measure was the only quality measure for this year. Statewide BHO performance on the *Hospital Recidivism* submeasures did not change very much from last year's results. Four of the six submeasures reported a minor decline in rate (an improvement in performance), and the other two reported a minor increase in rate (a decline in performance). None of these rates changed by more than one percentage point. *Hospital Recidivism—Non-State Hospitals* and *All Hospitals* rates were similar, with longer durations having higher recidivism. BHO variations in rates were smallest for *All Hospitals—7 Days* (3.8 percent) and largest for *Non-State Hospitals—90 Days* (15.2 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 very similar to last year's results. All submeasures reported an improvement, but the amount was less than 1 percentage point. BHO variations in rates for each of the submeasures were larger than 15 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's performance. Although all submeasures under *Penetration Rate* showed either similar performance or a decline in performance compared to last year, none had a change in rate of more than five percentage points. Statewide performance on the utilization-based measures was characterized by a decline in *Inpatient Utilization* for *Non-State Hospitals* and a more than 10.5 percent decline in the rate for *All Hospitals*. Declining utilization rates were also noted in all *Hospital Average Length of Stay* submeasures and the *Emergency Room Utilization* measure. These decreasing rates indicate improved performance. 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

HSAG validated BHO PIPs for ABC, BHI, CHP, FBHP, and NBHP.

For FY 2011–2012, the Department offered each BHO the option of conducting two PIPs, or one PIP and one focused study that included interventions. ABC conducted two PIPs. BHI, CHP, FBHP, and NBHP chose to conduct one PIP and one focused study. The Department evaluated the focused studies, 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. Table 5-21 below lists the PIP topics identified by each BHO.

Table 5-21—FY11–12 PIP Topics Selected by BHOs

BHO	PIP Topic
Access Behavioral Care (ABC)	*Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers*
	Coordination of Care Between Medicaid Physical and Behavioral Health Providers
Behavioral Healthcare, Inc. (BHI)	*Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics*
Colorado Health Partnerships, LLC (CHP)	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*
Foothills Behavioral Health Partners (FBHP)	*Reducing Emergency Department (ED) Utilization for Youth*
Northeast Behavioral Health Partnership (NBHP)	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*

Appendix C, EQR Activities—Validation of Performance Improvement Projects, describes the manner in which the validation of PIP activities was conducted and how the resulting data were aggregated and analyzed by HSAG.

Access Behavioral Care (ABC)

Findings

The ABC *Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers* PIP focused on reducing the use of unnecessary psychiatric emergency services through improved coordination of care between emergency department (ED) facilities and outpatient providers. This was the fifth year for the *Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers* PIP, and ABC completed Activities I through X. The plan reported Remeasurement 3 results.

The ABC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP focused on increasing the number of consumers receiving physical health care and increasing communication between physical and mental health providers. This was the fifth year for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, and ABC completed Activities I through X. The plan reported Remeasurement 3 results.

Table 5-22 provides a summary of ABC's combined PIP validation results for the FY 2011–2012 validation cycle.

Table 5-22—FY11–12 Performance Improvement Project Validation Results *for* ABC (n=2 PIPs)

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (10/10)	0% (0/10)	0% (0/10)
	II.	Study Question	100% (4/4)	0% (0/4)	0% (0/4)
	III.	Study Indicator	100% (12/12)	0% (0/12)	0% (0/12)
	IV.	Study Population	100% (5/5)	0% (0/5)	0% (0/5)
	V.	Sampling Techniques*	Not Applicable	Not Applicable	Not Applicable
	VI.	Data Collection	100% (12/12)	0% (0/12)	0% (0/12)
Design Total			100% (43/43)	0% (0/43)	0% (0/43)
Implementation	VII.	Interventions and Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	VIII.	Data Analysis and Interpretation	100% (16/16)	0% (0/16)	0% (0/16)
Implementation Total			100% (22/22)	0% (0/22)	0% (0/22)
Outcomes	IX.	Real Improvement	25% (2/8)	50% (4/8)	25% (2/8)
	X.	Sustained Improvement	0% (0/2)	50% (1/2)	50% (1/2)
Outcomes Total			20% (2/10)	50% (5/10)	30% (3/10)
Percent Score of Applicable Evaluation Elements *Met*			**89% Percent (67/75)**		

* The PIPs did not use sampling techniques.

ABC demonstrated strong performance in Activities I through VIII, indicating the PIPs were appropriately designed and implemented to measure outcomes and improvement. All of ABC's *Partially Met* and *Not Met* scores occurred in Activities IX and X. In Activity IX of the ABC *Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers* PIP, only Study Indicator 1 demonstrated improvement. Neither study indicator demonstrated statistically significant improvement. Sustained improvement was not achieved in Activity X. In Activity IX of the ABC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, Study Indicator 2 demonstrated a statistically significant decline. Neither study indicator demonstrated statistically significant improvement. Study Indicator 1 demonstrated sustained improvement in Activity X while Study Indicator 2 did not. The ABC overall score for applicable evaluation elements *Met* was 89 percent wherein 67 of 75 elements received a *Met* score. The ABC PIPs received a *Met* validation status.

Table 5-23 provides a summary of ABC's PIP specific outcomes for the FY 2011–2012 validation cycle.

Table 5-23—FY11–12 Performance Improvement Project Specific Outcomes *for* ABC (n=2 PIPs)

PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Rate or Percentage Point Change	Statistical Significance (*p* value)	Sustained Improvement
PIP#1: Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers							
Study Indicator 1: The total number of per thousand members per year (PTMPY) emergency department (ED) visits not resulting in an inpatient admission.	9.87	12.54	10.42	9.87^	-0.55¥ Rate change for ED visits	*p*=0.2516 non statistically significant improvement	No
Study Indicator 2: The rate of consumers returning to the emergency department within 3 months.	15.02%	18.73%	14.92%	15.09%^	0.17 Percentage points	*p*=0.9348 non statistically significant decline	No
PIP#2: Coordination of Care Between Medicaid Physical and Behavioral Health Providers							
Study Indicator 1: The percentage of consumers with a preventive or ambulatory medical office visit during the measurement period.	52.1%	53.6%	80.5%	80.8%	0.3 Percentage points	*p*=0.8541 non statistically significant improvement	Yes

Table 5-23—FY11–12 Performance Improvement Project Specific Outcomes *for* ABC (n=2 PIPs)							
PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Rate or Percentage Point Change	Statistical Significance (*p* value)	Sustained Improvement
Study Indicator 2: The percentage of the study population consumers with documentation of coordination of care in the behavioral health record.	89.3%	86.7%	82.5%	72.1%	-10.4 Percentage points	*p*=0.0006* statistically significant decline	No

^ Lower rates indicate better performance for this PIP.

¥ Rate change for the total number of PTMPY ED visits not resulting in an inpatient admission.

* Significance levels (*p* values) noted in the table demonstrated statistically significant performance between measurement periods. Statistical significance is traditionally reached when the *p* value is ≤ 0.05.

For the ABC *Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers* PIP, lower rates are indicative of better performance. The ED visit rate, per thousand members per year (PTMPY), for Study Indicator 1 improved from 10.42 to 9.87. However, the change was not statistically significant, and the current rate was equal to the baseline rate. The rate for Study Indicator 2 increased from 14.92 percent to 15.09 percent. The Study Indicator 2 rate increase signifies an opportunity for improvement. Both study indicator rates demonstrated statistically flat performance, and neither achieved sustained improvement. ABC noted that a substantial population increase may have affected the outcomes.

For the ABC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, Study Indicator 1 had a not statistically significant increase from 80.5 to 80.8 percent. Study Indicator 2 had a statistically significant decrease from 82.5 percent to 72.1 percent. Study Indicator 2 continued its trend of declining performance from baseline to Remeasurement 3. ABC attributed the stable Study Indicator 1 rate to its continued coordination with Denver Health Medicaid Choice, and extended member outreach and education efforts. ABC documented that personnel changes at ABC and Denver Health, interrater reliability, and incomplete surveys may have negatively impacted the Study Indicator 2 rate.

Strengths

ABC performed a drill-down analysis by facility, age group, day of week, and diagnosis for the *Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers* PIP. ABC continued to execute systemwide interventions designed to increase coordination of care for consumers and decrease ED visits.

In the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, ABC documented ongoing efforts to meet with Denver Health and Mental Health Center Denver (MHCD) to discuss barriers, interventions, and options for developing an automated provider notification process. ABC stated that interventions need to occur at all levels (institutional,

practitioner, and consumer) and that follow-up with large-volume providers is necessary to address the decline in Study Indicator 2.

Recommendations

Although ABC will be retiring both PIPs, it should continue to monitor the PIP rates internally. If ABC performs a drill-down analysis for the *Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers* PIP, it should share those results with Denver Health as ABC identified Denver Health as having provided the majority of ED services.

Based on the emphasis ABC placed upon provider coordination, ABC should continue its plan to review study results and interventions for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP with Denver Health and the MHCD.

Behavioral HealthCare, Inc. (BHI)

Findings

This was the first year for BHI's *Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics* PIP. The PIP focused on improving timely metabolic lab documentation, and appropriate follow-up, for clients prescribed atypical antipsychotics. BHI completed Activities I through IV and reported a baseline data collection period of July 1, 2011, through June 30, 2012. The baseline results are to be determined (TBD).

Table 5-24 shows BHI scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 5-24—FY11–12 Performance Improvement Project Validation Results *for* BHI (n=1 PIP)

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Study Indicator	100% (3/3)	0% (0/3)	0% (0/3)
	IV.	Study Population	0% (0/1)	100% (1/1)	0% (0/1)
	V.	Sampling Techniques	Not Assessed		
	VI.	Data Collection	Not Assessed		
Design Total			86% (6/7)	14% (1/7)	0% (0/7)
Implementation	VII.	Data Analysis and Interpretation	Not Assessed		
	VIII.	Interventions and Improvement Strategies	Not Assessed		
Implementation Total			Not Assessed		
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements *Met*			**86% Percent (6/7)**		

The BHI overall score for applicable evaluation elements *Met* was 86 percent wherein six of seven elements received a *Met* score. BHI's only *Partially Met* score occurred in Activity IV, for a critical element, and resulted in BHI receiving a *Partially Met* validation status. The enrollment criteria specified by BHI in Activity IV was not specific enough to ensure that members captured in the denominator would have the opportunity to be included in the numerator.

The BHI *Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics* PIP did not progress to reporting baseline data; thus, rates for baseline and subsequent measurements were not available.

Strengths

BHI demonstrated strong performance in study topic selection, study question design, and study indicator construction as supported by the validation results scores for Activities I through III.

Recommendations

BHI should ensure that all members included in the PIP denominator(s) have the opportunity to be measured in the numerator(s). If the plan specifies that a member must be enrolled to be counted in either the denominator or the numerator, the plan should ensure that the length of the enrollment requirement matches the measurement period specified in the denominator and the numerator.

Colorado Health Partnerships, LLC (CHP)

Findings

This was the fifth year for the CHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. The PIP focused on increasing the number of consumers receiving physical health care and increasing communication between physical and mental health providers. CHP completed Activities I through X and reported Remeasurement 3 data.

Table 5-25 shows CHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 5-25—FY11–12 Performance Improvement Project Validation Results *for* CHP (n=1 PIP)

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (5/5)	0% (0/5)	0% (0/5)
	II.	Study Question	100% (2/2)	0% (0/2)	0% (0/2)
	III.	Study Indicator	100% (6/6)	0% (0/6)	0% (0/6)
	IV.	Study Population	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Sampling Techniques	100% (6/6)	0% (0/6)	0% (0/6)
	VI.	Data Collection	100% (9/9)	0% (0/9)	0% (0/9)
		Design Total	100% (31/31)	0% (0/31)	0% (0/31)

Table 5-25—FY11–12 Performance Improvement Project Validation Results *for* CHP (n=1 PIP)					
Study Stage	**Activity**		**Percent of Applicable Elements**		
			Met	**Partially Met**	**Not Met**
Implementation	VII.	Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Data Analysis and Interpretation	100% (9/9)	0% (0/9)	0% (0/9)
		Implementation Total	100% (12/12)	0% (0/12)	0% (0/12)
Outcomes	IX.	Real Improvement	25% (1/4)	0% (0/4)	75% (3/4)
	X.	Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
		Outcomes Total	40% (2/5)	0% (0/5)	60% (3/5)
Percent Score of Applicable Evaluation Elements *Met*			**94% Percent (45/48)**		

CHP's strong performance in Activities I through VIII indicates that the PIP was appropriately designed to measure outcomes and improvement. The CHP overall score for applicable evaluation elements *Met* was 94 percent wherein 45 of 48 elements received a *Met* score. CHP's *Not Met* scores in Activity IX were due to the rate decline of both study indicators in Remeasurement 3, which did not support improvement in processes or outcomes of care. CHP received a *Met* validation status.

Table 5-26 provides a summary of CHP's PIP specific outcomes for the FY 2011–2012 validation cycle.

Table 5-26—FY11–12 Performance Improvement Project Specific Outcomes *for* CHP (n=1 PIP)							
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Remeasurement 2**	**Remeasurement 3**	**Percentage Point Change**	**Statistical Significance (*p* value)**	**Sustained Improvement**
PIP#1: Coordination of Care Between Medicaid Physical and Behavioral Health Providers							
Study Indicator 1: The percentage of consumers with a preventive or ambulatory medical office visit during the measurement period.	80.0%	76.7%	84.9%	82.9%	-2.0 Percentage points	p=0.0599 non statistically significant decline	Yes
Study Indicator 2: The percentage of the study population consumers with documentation of coordination of care in the behavioral health record.	45.9%	55.5%	83.1%	71.1%	-12.0 Percentage points	p<0.0001* statistically significant decline	Yes

*Significance levels (*p* values) noted in the table demonstrated statistically significant performance between measurement periods. Statistical significance is traditionally reached when the *p* value is ≤ 0.05.

The CHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP reported Remeasurement 3 data. Study Indicators 1 and 2 declined during this measurement period. Study Indicator 1 declined 2.0 percentage points, from 84.9 percent to 82.9 percent. The decline was not statistically significant. CHP stated that the Remeasurement 3 rate for Study Indicator 1 is comparable to other BHO rates for this topic. The Study Indicator 2 rate declined 12 percentage points from 83.1 percent to 71.1 percent. The decline was statistically significant and signifies an opportunity for improvement. CHP attributed the Study Indicator 2 rate decline to changes in electronic records systems, increased staff turnover, and departmental restructuring at its three larger mental health centers. CHP requested that the mental health centers negatively influencing the Study Indicator 2 rate submit corrective action plans to address deficiencies. Additionally, CHP noted that more members refused to consent to care coordination during this measurement period. CHP is re-designing the data collection tool to address feedback received from data auditors. Repeated measurements over comparable time periods demonstrated overall sustained improvement, from baseline to Remeasurement 3, for both study indicators.

Strengths

The CHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP demonstrated strong performance in the study design and implementation phases by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII. CHP encouraged inter-rater reliability during record reviews and conducted data collection training to ensure that member record information was properly collected. CHP developed interventions based on the specific causes and barriers it identified. CHP interventions were varied and included establishment of face-to-face provider forums, provider documentation training, and a request to mental health agencies to submit plans to improve documentation of coordination of care.

Recommendations

CHP should routinely monitor implemented interventions on an interim basis to determine if the interventions are successful. HSAG recommends that CHP conduct a drill-down analysis to identify specific barriers that impede improvement for a particular subgroup. For example, Indicator 2 had a statistically significant decline. Because CHP noted that Indicator 2 is influenced by member refusal to consent to care coordination, CHP should consider working with members to determine what specific barriers exist to obtaining a consent to care coordination.

Foothills Behavioral Health Partners (FBHP)

Findings

The FBHP *Reducing Emergency Department (ED) Utilization for Youth* PIP focused on reducing the rate of ED visits, for a covered mental health diagnosis, that did not result in a hospitalization within 24 hours of the ED visit. This was the third year for this PIP. FBHP completed Activities I through X and reported Remeasurement 2 data.

Table 5-27 shows FBHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 5-27—FY11–12 Performance Improvement Project Validation Results *for* FBHP (n=1 PIP)

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (6/6)	0% (0/6)	0% (0/6)
	II.	Study Question	100% (2/2)	0% (0/2)	0% (0/2)
	III.	Study Indicator	100% (5/5)	0% (0/5)	0% (0/5)
	IV.	Study Population	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Sampling Techniques*	Not Applicable	Not Applicable	Not Applicable
	VI.	Data Collection	100% (5/5)	0% (0/5)	0% (0/5)
Design Total			100% (20/20)	0% (0/20)	0% (0/20)
Implementation	VII.	Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
Implementation Total			100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement	75% (3/4)	0% (0/4)	25% (1/4)
	X.	Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			80% (4/5)	0% (0/5)	20% (1/5)
Percent Score of Applicable Evaluation Elements Met			**97% Percent (35/36)**		

***** The PIP did not use sampling techniques.

FBHP's strong performance in Activities I through VIII indicates that the PIP was appropriately designed and implemented to measure outcomes and improvement. The FBHP overall score for applicable evaluation elements *Met* was 97 percent wherein 35 of 36 elements received a *Met* score. FBHP's only *Not Met* score occurred in Activity IX. In Activity IX, the observed improvement could not be considered true improvement because it was not statistically significant. The FBHP *Reducing Emergency Department (ED) Utilization for Youth* PIP received a *Met* validation status.

Table 5-28 provides a summary of FBHP's PIP specific outcomes for the FY 2011–2012 validation cycle.

Table 5-28—FY11–12 Performance Improvement Project Specific Outcomes *for* FBHP (n=1 PIP)

PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Rate Change	Statistical Significance (*p* value)	Sustained Improvement
PIP#1: Reducing Emergency Department (ED) Utilization for Youth						
Study Indicator 1: The rate of ED visits (per 1,000 members) for a covered mental health diagnosis that did not result in a hospitalization within 24 hours of the ED visit for the study population.	6.48	4.84	3.87^	-.97¥ Rate change for ED visits	*p*=.0717 non statistically significant improvement	Yes

^Lower rates indicate better performance for this PIP.
¥ Rate change for the rate of ED visits, per 1,000 members, not resulting in an inpatient admission within 24 hours of the ED visit.

The FBHP *Reducing Emergency Department (ED) Utilization for Youth* PIP Study Indicator 1 rate demonstrated not statistically significant improvement, wherein lower rates indicate better performance for this measure. The Study Indicator 1 rate improved from 4.84 percent to 3.87 percent, with a 0.97 percentage point decrease in the rate of ED visits per 1,000 members. An ad hoc analysis performed by FBHP led the plan to conclude that youth members seem less likely to use the ED for an initial behavioral health visit, and less likely to visit the ED more than once in a study period. The plan stated that the decrease in ED visits may be attributed to the creation of flyers that educate members about how to use crisis services, and aggressive clinician follow-up the day after a member's ED visit. FBHP implemented a tracking method to ensure that clinician follow-up the day after an ED visit was being performed consistently and efficiently. The PIP demonstrated sustained improvement from baseline to Remeasurement 2.

Strengths

FBHP exhibited strong performance in quality outcomes with demonstrated sustained improvement in its Study Indicator 1 rate. FBHP developed a solid process for monitoring interventions and standardizing effective interventions.

Recommendations

Although the PIP will be retired, HSAG recommends that FBHP continue to monitor the indicators to ensure performance does not decline.

Northeast Behavioral Health Partnership (NBHP)

Findings

The NBHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP focused on increasing the number of consumers receiving physical health care and increasing communication between physical and mental health providers. This was the fifth year for this PIP, and NBHP completed Activities I through X. The plan reported Remeasurement 3 data for Study Indicator 1 and Remeasurement 2 data for Study Indicators 2 through 4.

Table 5-29 shows NBHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 5-29—FY11–12 Performance Improvement Project Validation Results *for* NBHP (n=1 PIP)

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (5/5)	0% (0/5)	0% (0/5)
	II.	Study Question	100% (2/2)	0% (0/2)	0% (0/2)
	III.	Study Indicator	100% (6/6)	0% (0/6)	0% (0/6)
	IV.	Study Population	100% (3/3)	0% (0/3)	0% (0/3)
	V.	Sampling Techniques	67% (4/6)	0% (0/6)	33% (2/6)
	VI.	Data Collection	100% (9/9)	0% (0/9)	0% (0/9)
Design Total			94% (29/31)	0% (0/31)	6% (2/31)
Implementation	VII.	Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Data Analysis and Interpretation	67% (6/9)	22% (2/9)	11% (1/9)
Implementation Total			75% (9/12)	17% (2/12)	8% (1/12)
Outcomes	IX.	Real Improvement	0% (0/4)	75% (3/4)	25% (1/4)
	X.	Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			20% (1/5)	60% (3/5)	20% (1/5)
Percent Score of Applicable Evaluation Elements Met			**81% Percent (39/48)**		

The overall score for applicable evaluation elements *Met* was 81 percent wherein 39 of 48 elements received a *Met* score. NBHP's *Partially Met* and *Not Met* scores occurred in Activities V, VIII, and IX. In Activity V of the PIP, NBHP did not provide separate population sizes for the individual mental health centers included in Study Indicators 2 through 4. Instead, the health plan equally distributed the population size between the mental health centers. This approach for calculating the sample size would only be appropriate if the individual populations for each mental health center were the same. The *p* values in Activity VIII were not reported correctly. In Activity IX of the PIP, HSAG noted that the remeasurement methodology used by NBHP was not the same as the baseline methodology. Although NBHP documented its rationale for changing the methodology, it did not apply the new methodology to all prior measurements and report new results. Because NBHP did not apply the new PIP methodology to all prior measurements, and report new results, an equitable comparison of the rates was not possible. NBHP received a *Not Met* validation status.

Table 5-30 provides a summary of NBHP's PIP specific outcomes for the FY 2011–2012 validation cycle.

Table 5-30—FY11–12 Performance Improvement Project Specific Outcomes *for* NBHP (n=1 PIP)

PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Percentage Point Change	Statistical Significance (*p* value)	Sustained Improvement
PIP#1: Coordination of Care Between Medicaid Physical and Behavioral Health Providers							
Study Indicator 1: The percentage of consumers with a preventive or ambulatory medical office visit during the measurement period.	78.2%	84.7%	87.2%	83.9%	-3.3 Percentage points	*p*=0.0969 Non statistically significant decline	Yes
Study Indicator 2: The percentage of Centennial Mental Health Center (CMHC) consumers with documented care coordination between the psychiatric provider and the physical health care provider in the behavioral health record.	60.7%	50.0%	27.8%	NA^	-22.2 Percentage points	*p*=0.0259* Statistically significant decline	No
Study Indicator 3: The percentage of Larimer Center for Mental Health (LCMH) consumers with documented care coordination between the psychiatric provider and the physical health care provider in the behavioral health record.	18.5%	34.0%	55.1%	NA^	21.1 Percentage points	*p=0.0055** Statistically significant increase	Yes

Table 5-30—FY11–12 Performance Improvement Project Specific Outcomes *for* NBHP (n=1 PIP)

PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Percentage Point Change	Statistical Significance (*p* value)	Sustained Improvement
Study Indicator 4: The percentage of North Range Behavioral Health (NRBH) consumers with documented care coordination between the psychiatric provider and the physical health care provider in the behavioral health record.	0.0%	2.1%	7.7%	NA^	5.6 Percentage points	*p=0.0844* Non statistically significant increase	Yes

*Significance levels (*p* values) noted in the table demonstrated statistically significant changes in performance between measurement periods. Statistical significance is traditionally reached when the *p* value is ≤ 0.05.
^Data for Remeasurement 3 were not available for Study Indicators 2 through 4.

Study Indicator 1 had a not statistically significant decline of 3.3 percentage points. The rate for Study Indicator 2 declined 22.2 percentage points from 50 percent to 27.8 percent. The rate decline for Study Indicator 2 was statistically significant. NBHP attributed the decrease in Study Indicator 2 to inconsistent documentation of care coordination by psychiatric providers. Additionally, the plan concluded that requiring the prescribing physician to conduct outreach will continue to yield poor rate results. NBHP stated that future interventions will focus on physicians assessing the level of care coordination needed. The rate increase for Study Indicator 3 was statistically significant. Study Indicator 3 increased 21.1 percentage points from 34 percent to 55.1 percent. Study Indicator 4 had a not statistically significant rate increase of 5.6 percentage points. NBHP did not report Remeasurement 3 data for Study Indicators 2 through 4. Although the reported rates suggest NBHP achieved sustained improvement from baseline for Study Indicators 1, 3, and 4, the change in methodology implemented by NBHP prevents an equitable comparison of current rates to previously reported rates.

Strengths

NBHP demonstrated strength by receiving *Met* scores for Activities I through IV, VI, and VII. The plan's reported rates imply that the plan achieved sustained improvement for Study Indicators 1, 3, and 4. Sustained improvement indicates that the plan successfully influenced the outcomes of the PIP.

Recommendations

Although the PIP will be retired, HSAG recommends that NBHP continue to monitor the study indicators to ensure that performance does not decline. In future PIP submissions, NBHP should ensure that the PIP methodology is consistent. Additionally, NBHP should regularly evaluate interventions to determine which interventions are successful.

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

Table 5-31 shows the health plans' overall performance based on HSAG's validation of the FY 2011–2012 PIPs that were submitted for validation.

Table 5-31—Summary of Each BHO's PIP Validation Scores and Validation Status

BHO	PIP Study	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
ABC	*Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers*	89%	100%	*Met*
ABC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	90%	100%	*Met*
BHI	*Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics*	86%	80%	*Partially Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	94%	100%	*Met*
FBHP	*Reducing Emergency Department (ED) Utilization for Youth*	97%	100%	*Met*
NBHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	81%	85%	*Not Met*

Four of the six BHO PIPs reviewed by HSAG received a *Met* validation status, suggesting a thorough application of the PIP's design. One BHO PIP received a *Partially Met* validation status, and one BHO PIP received a *Not Met* validation status.

Figure 5.1—BHO FY11–12 Overall Validation Status Comparison

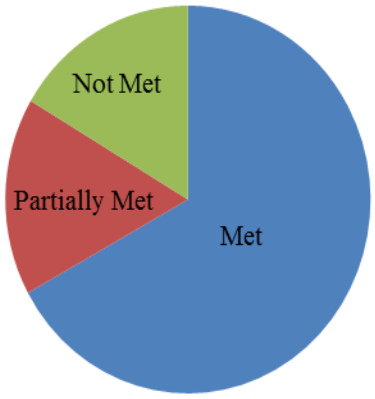


Table 5-32 shows a comparison of the BHO plans' improvement results.

Table 5-32—Statewide Summary of BHO Improvement

	BHO			
	ABC	CHP	FBHP	NBHP
Number of comparable rates (previous measurement to current measurement)	4*	2*	1*	4*
Number of rates that improved	50% (2/4)	0% (0/2)	100% (1/1)	50% (2/4)
Number of rates that declined	50% (2/4)	100% (2/2)	0% (0/1)	50% (2/4)
Number of rates that showed statistically significant improvement over the previous measurement period	0% (0/4)	0% (0/2)	0% (0/1)	25% (1/4)
Number of rates that showed statistically significant improvement over baseline	25% (1/4)	50% (1/2)	100% (1/1)	75% (3/4)

*The total number of indicators for BHOs with PIPs that reported a baseline and at least one remeasurement.

Two of ABC's four rates improved during this measurement period, and one rate showed statistically significant improvement over baseline. CHP's rates declined during this measurement period; however, one rate showed statistically significant improvement over baseline. FBHP's rate improved during this measurement period and showed statistically significant improvement over baseline. Two of NBHP's four rates improved during this measurement period. One rate showed statistically significant improvement over the previous measurement period, and three rates showed statistically significant improvement over the baseline rate. BHI had a PIP that had not progressed to reporting baseline data.

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 2010–2011. 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 2010–2011 compliance review, ABC was required to ensure that authorization decisions were made within the required time frames. Furthermore, ABC was required to provide enrollees with written notice of the reason for extensions and include the right to file a grievance, if the member disagrees with the decision to extend the decision time frame. ABC submitted its CAP to HSAG and the Department in May 2011. 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 June 2011. 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 2010–2011.

Performance Measures

During the FY 2010–2011 audit, HSAG recommended that ABC add language to its internal performance measure reporting process document about auditing the performance measure data spreadsheet prior to submission to the State. HSAG also recommended that ABC continue to collaborate with the Department and other BHOs regarding the scope document, addressing the challenges with formatting. HSAG found evidence during the FY 2011–2012 audit that ABC acted upon both recommendations.

Performance Improvement Projects

For the FY 2010–2011 validation cycle, ABC completed two PIPs. HSAG reviewed and validated Activities I through X 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 a *Point of Clarification* in Activity VII, that ABC document any interventions aimed at educating the smaller mental health providers on the importance of documenting coordination of care efforts with primary care physicians. In addition to the *Point of Clarification*, ABC received three *Partially Met* scores in Activity IX, and one *Partially Met* score in Activity X. Only one of the study indicators demonstrated improvement. During its FY 2011–2012 review, HSAG found that ABC addressed the *Point of Clarification*. In Activity IX, two of the three *Partially Met* scores remained *Partially Met*, while one *Partially Met* score declined to *Not Met*. In Activity IX, one indicator demonstrated a statistically significant decline from the second remeasurement to the third remeasurement, and none of the indicators demonstrated statistically significant improvement. The *Partially Met* score in Activity X did not improve as only one of the study indicators demonstrated sustained improvement. Although ABC will be retiring this PIP, HSAG recommended that ABC continue to monitor the PIP rates internally.

For the *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment* PIP, ABC received one *Partially Met* score in Activity IX, and one *Partially Met* score in Activity X. Only one of the study indicators demonstrated statistical evidence that observed improvement was true improvement, and only one of the study indicators demonstrated sustained improvement over comparable time periods. During its FY 2011–2012 review, HSAG found that ABC did not improve its scores in Activities IX and X. In Activity IX, ABC's previous *Partially Met* score declined to *Not Met*. Additionally, two Activity IX *Met* scores declined to *Partially Met*. In Activity IX, only one of the study indicators demonstrated improvement; and none of the study indicators demonstrated statistical evidence that the observed improvement was true improvement. In Activity X, none of the study indicators achieved sustained improvement. Although ABC will be retiring this PIP, HSAG recommended that ABC continue to monitor the PIP rates internally.

Behavioral HealthCare, Inc.

Compliance Monitoring Site Reviews

As a result of the 2010–2011 site review, BHI was required to ensure that all denial decisions were based on utilization review criteria and to ensure that the appropriate policy included a mechanism to consult with the requesting provider and to adequately document any and all consultation with the requesting provider, if applicable. BHI was also required to revise its notice of action template to include accurate time frames and review and revise documents to ensure consistent time frames. BHI was required to revise existing policies or develop new policies to address continuity of care for services provided.

BHI submitted its plan of corrective action to HSAG and the Department in May 2011. 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 in July 2011 that BHI had sufficiently completed all required actions. There were no required actions continued from FY 2010–2011.

Performance Measures

Based on the FY 2010–2011 performance measure validation audit, HSAG recommended that BHPO collaborate with the Department and other BHOs regarding the scope document, addressing the challenges that were faced due to its formatting. HSAG found evidence during the FY 2011–2012 audit that the issues with the scope document had been addressed through a collaborative effort between BHI, the Department, and the other BHOs.

Performance Improvement Projects

For the FY 2010–2011 validation cycle, BHI submitted one PIP. HSAG reviewed and validated Activities I through X for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. HSAG recommended, as a *Point of Clarification* in Activity VIII, that BHI compare its reported rates to its established goal in the data analysis plan. In addition to the *Point of Clarification*, BHI received two *Partially Met* scores in Activity IX, and one *Not Met* score in Activity IX. The scores in Activity IX reflect that only some of the study indicators demonstrated improvement, and that none of the study indicators demonstrated statistically significant improvement. Per BHI's request, and with the Department's permission, the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP was retired after the FY 2010–2011 validation cycle.

Colorado Health Partnerships

Compliance Monitoring Site Reviews

During the 2010–2011 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 was required to ensure that it met the requirements for timely notification for all denials. CHP was also required to clarify the member handbook to provide information that was consistent with its policies.

CHP submitted its CAP to HSAG and the Department in June 2011. HSAG and the Department reviewed and approved the plan. CHP submitted documents demonstrating that it had implemented its plan, as written, in July 2011. In August 2011, HSAG and the Department notified CHP that it had successfully completed all required actions. There were no required actions continued from 2010–2011.

Performance Measures

HSAG recommended that CHP monitor report card data errors due to an incorrect provider type, based on new coding manual directives. HSAG also recommended that CHP continue working with the Department and BHOs to address issues with the scope document. HSAG found evidence in the FY 2011–2012 audit that CHP had added additional encounter data edits to ensure more accurate data, and it performed cross training to ensure continuity of reporting. Furthermore, HSAG found the scope document vastly improved over the prior year.

Performance Improvement Projects

For the FY 2010–2011 validation cycle, CHP conducted two PIPs. HSAG reviewed and validated Activities I through X 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, HSAG documented four *Points of Clarification*. CHP received a *Not Met* score in Activity VII because it did not revise the existing interventions, or develop new interventions, in response to the statistically significant decline it reported. CHP received *Not Met* scores in Activities IX and X because the indicator rates demonstrated a statistically significant decline, and did not demonstrate sustained improvement. Per CHP's request, and with the Department's permission, the *Increasing Penetration Rate for Older Adult Medicaid Members Aged 60+* PIP was retired after the FY 2010–2011 validation cycle. HSAG did not validate this PIP during FY 2011–2012.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG identified two *Points of Clarification* in Activity VIII. The two *Points of Clarification* in Activity VIII recommended that CHP correct the percent difference it identified to a percentage point difference during its next annual submission. CHP received a *Partially Met* score in Activity VI because it did not document complete date ranges. The plan received a *Partially Met* in Activity X because the PIP did not demonstrate sustained improvement. For the FY 2011–2012 review, HSAG found that CHP addressed the two *Points of Clarification*. Additionally, the Activity VI score improved from *Partially Met* to *Met*. However, three of four element scores in Activity IX declined from *Met* to *Not Met* because CHP study indicator rates decreased. The Activity X score improved from *Partially Met* to *Met* because the overall study indicator improvement from baseline to Remeasurement 3 was statistically significant.

Foothills Behavioral Health Partners

Compliance Monitoring Site Reviews

As a result of the FY 2010–2011 site review, FBHP was required to clarify its member handbook to provide information consistent with its policies. FBHP submitted its corrective action plan in May 2011, which was reviewed and approved by HSAG and the Department. In August 2011, FBHP submitted its revised handbook, demonstrating that it had completed the required action. FBHP had no actions continued from the FY 2010–2011 site review process.

Performance Measures

HSAG recommended that FBHP continue to collaborate with the Department and other BHOs 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. HSAG found evidence

during the FY 2011–2012 audit that FBHP had worked with the Department and the other BHOs to address the formatting issues with the scope document.

Performance Improvement Projects

FBHP submitted two PIPs during the FY 2010–2011 validation cycle. HSAG reviewed and validated Activities I through IX for FBHP's *Reducing ED Utilization for Youth* PIP. HSAG reviewed and validated Activities I through X for the *Care Coordination Between Behavioral Health and Primary Care* PIP.

During HSAG's FY 2010–2011 validation, FBHP's overall score for applicable evaluation elements *Met* in the *Reducing ED Utilization for Youth* PIP was 100 percent, wherein 35 of 35 elements received a *Met* score. There were no required actions for the PIP, and no *Points of Clarification*. During the FY 2011–2012 review and validation by HSAG, the score for one element in Activity IX decreased from *Met* to *Not Met*. In Activity IX, the improvement demonstrated was not statistically significant and therefore did not evidence that observed improvement was true improvement.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG documented one *Point of Clarification* in Activity VIII. In Activity VIII, FBHP documented the rate increase as a percent difference instead of a percentage point difference. FBHP also received one *Partially Met* score in Activity IX because only one of the study indicators demonstrated a statistically significant increase. Per FBHP's request, and with the Department's permission, the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP was retired after the FY 2010–2011 validation cycle. HSAG did not validate this PIP during FY 2011–2012.

Northeast Behavioral Health Partnership

Compliance Monitoring Site Reviews

During the 2010–2011 site review, HSAG found a conflict between NBHP's policies and its member handbook. NBHP was required to clarify its member handbook to provide information consistent with its policies. NBHP submitted its CAP to HSAG and the Department in July 2011. HSAG and the Department approved NBNP's plan. NBHP submitted its revised member handbook in August 2011. HSAG and the Department determined that NBHP had successfully addressed the required action. There were no actions continued from FY 2010–2011.

Performance Measures

Based on the FY 2010–2011 audit, HSAG repeated its FY 2009–2010 recommendation that NBHP monitor its mental health centers' data related to kept appointments until the electronic medical record is implemented. Although NBHP had followed this recommendation since the 2009–2010 review, the go-live date was delayed until March 2011. HSAG also recommended that NBHP monitor report card data errors due to incorrect provider type, based on new coding manual

directives. HSAG's final recommendation, which was echoed across all BHOs, was that NBHP work with the Department and the other BHOs to update the formatting for the scope document. HSAG found ample evidence during the 2011–2012 that NBHP had followed up on all recommendations.

Performance Improvement Projects

NBHP submitted two PIPs during the FY 2010–2011 validation cycle. HSAG reviewed and validated Activities I through X for NBHP's *Therapy With Children and Adolescents: Increasing Caregiver Involvement* PIP, and NBHP's *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP.

For the *Therapy With Children and Adolescents: Increasing Caregiver Involvement* PIP, HSAG identified two *Points of Clarification,* one in Activity IV and one in Activity VIII. HSAG requested that NBHP update the dates of the measurement period in Activity IV. In Activity VIII, HSAG recommended that NBHP discuss the actual rates for each study indicator and discuss how the rates compared to the goal. NBHP also received one *Not Met* score in Activity VII, two *Partially Met* scores in Activity IX, one *Not Met* score in Activity IX, and one *Partially Met* score in Activity X. In Activity VII, HSAG noted that the plan did not implement interventions to address the barriers it identified. HSAG documented that the plan should have either implemented appropriate interventions or documented that it did not have sufficient time to implement interventions. The *Partially Met* and *Not Met* scores in Activities IX and X reflect that only one of the study indicators improved. Per NBHP's request, and with the Department's permission, the *Therapy With Children and Adolescents: Increasing Caregiver Involvement* PIP was retired after the FY 2010–2011 validation cycle. HSAG did not validate this PIP during FY 2011–2012.

For the *Coordination of Care Between Psychiatric Providers and Physical Health Providers* PIP, HSAG identified, two *Points of Clarification,* one in Activity III and one in Activity VI. In Activity III, HSAG noted that NBHP did not document a goal higher than zero percent per HSAG's recommendation. In Activity VI, the plan did not document complete date ranges. NBHP also received a *Not Met* score in Activity VI and three *Partially Met* scores in Activity IX. In Activity VI, the plan did not document that the data collection instructions included an overview or purpose for the data collection. For Activity IX, NBHP received *Partially Met* scores because not all of the study indicators demonstrated improvement. During the FY 2011–2012 validation, HSAG found that NBHP addressed the *Not Met* score in Activity VI and all of the *Points of Clarification*. However, NBHP's scores for Activities V, VIII, and IX declined. The *Not Met* scores in Activities V and VIII were attributed to the plan's decision to equally split the sample size between three study indicators (health centers). HSAG noted that proportional allocation of the sample size would only be appropriate if all three study indicators (health centers) had the same population size. Additionally, NBHP received a *Partially Met* score in Activity VIII due to its incorrect calculation of *p* values. NBHP received a *Not Met* score in Activity IX because the plan changed the remeasurement methodology but did not apply the methodology change to previous measurement periods, which prevented an equitable comparison of results. The remaining elements in Activity IX were scored *Partially Met* because not all of the study indicators demonstrated improvement.

Introduction

For FY 2011–2012, the Department offered each behavioral and physical health plan the option of conduction two PIPs or one PIP and one focused study with intervention. BHI, CHP, FBHP, and NBHP opted to conduct one PIP and one focused study. The Department evaluated the focused studies, and those results are presented here.

Behavioral HealthCare, Inc.

Study Topic and Goal

The purpose of this focused study was to identify the top five physical chronic diseases in BHI's Medicaid members and compare physical hospital and emergency department (ED) use patterns. Findings will be used to determine interventions to address the barriers to effectively managing co-occurring chronic diseases.

Methodology

This study of members with one or more of five chronic diseases (asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, and ischemic heart disease) compares hospital and ED utilization of a "treatment group" (members receiving behavioral health services) with a "control group" (members not receiving behavioral health services). For study indicators, BHI calculated percentages of members and utilization rates per 1,000 members from claims files provided by the Department. The Department provided summary statistics for the control group.

Summary and Findings

A comparison of demographics of the treatment and control groups revealed important differences. The treatment group had higher percentages in these categories: females (62.9 percent vs. 55.1 percent), 18–64 age group (57.6 percent vs. 36.6 percent), the "Other-White" race (33.1 percent vs. 20.7 percent) and the AND/AB-SSI eligibility type (34.2 percent vs. 12.3 percent). Members of the treatment group were more likely to have one or more of the five chronic diseases (12.4 percent vs. 9.7 percent). A lower percentage of the treatment group members had one or more ED visits for physical health (56.7 percent vs. 60.8 percent). However, the rate of ED visits for physical health conditions was higher for the treatment group that did have one or more ED visits (1,709 per 1,000 vs. 1,560 per 1,000). A higher percentage of treatment group members had an inpatient stay for a physical health condition (21.4 percent vs. 18.1 percent). The number of stays per thousand was also higher for the treatment group (363 per 1,000 vs. 267 per 1,000). However, the treatment group had a shorter average length of stay (5.06 days vs. 5.75 days).

Conclusions

The study succeeded in identifying that the treatment group had a higher incidence of the five chronic conditions than those in the control group. This result supports the correlation between mental illness and increased physical health conditions and increased mortality rates (Scott & Happell, 2011), underscoring the importance of care coordination between behavioral and physical health care providers.

Generally, those with mental illness are less likely to seek psychiatric services due to the stigma associated with mental illness. They are even less likely to seek physical health treatment at primary care physician (PCP) offices or EDs. This may explain why the treatment group had a lower percentage of members with ED visits. Conversely, the higher rate of ED visits per 1000 supports the trend that a certain population of persons with mental illness use the ED frequently.

It is a widely held belief that polypharmacy combined with physical health conditions increases the complexity in symptoms and subsequent care, possibly explaining the higher rate of inpatient stays in the treatment group. Because some mental health symptoms (like panic attacks) can mimic physical conditions such as heart issues, mis-diagnosis may also lead to increased inpatient stays. The treatment group's lower length of stay cannot be readily explained based on the data available.

Colorado Health Partnerships and Northeast Behavioral Health Partnership

Study Topic and Goal

CHP and NBHP worked together with FBHP on a joint focused study based on research showing the effectiveness of "peer services." The focused study is designed to evaluate the current status of Peer Support programming and coding of Peer Service encounters across numerous mental health centers and across three BHOs.

Methodology

The Pearson Chi-square test was used to assess frequencies of distinct Peer Service Types offered within each of the three BHOs and also to evaluate the different types of encounter procedure codes that were being used for Peer Services across each of the BHOs. Peer Service encounter codes will be extracted from ValueOption's data warehouse using mental health center-specific and BHO-specific identifiers to group data sets for comparison.

Summary and Findings

Study Indicator 1: Frequencies of distinct Peer Service Types offered within each of the three BHOs.

For each distinct Peer Service Type, the Pearson Chi-square test for difference was used to assess any statistical differences across the BHOs ($p<.05$) using Statistical Package for the Social Sciences SPSS. Results are presented in Table 7-1 through Table 7-5.

Table 7-1—Outreach & Advocacy Services

Service	Percent of Peer Specialist Providing Service			Overall (N=52)	Pearson Chi-Square (*p* value)
	CHP (n=20)	FBHP (n=21)	NBHP (n=11)		
Outreach to the Community	80.0	52.4	63.6	65.4	.176
Outreach to Engage Clients	90.0	90.5	81.8	88.5	.739
Advocating for Clients	75.0	90.5	90.9	84.6	.315
Political/Community Advocacy	30.0	47.6	36.4	38.5	.504
Peer Specialist Group Development	75.0	90.5	45.5	75.0	.020*****
Committee Membership	45.0	47.6	72.7	51.9	.294

*****Statistical significance assessed as $p<.05$ per Pearson Chi-Square, which indicates that there is significant variability in the percent of peer specialists providing the service across the three BHOs.

******No statistical significance assessed; however, notable variability exists when comparing the percent of peer specialists providing the service.

Table 7-2—Client Education and/or Orientation Services

Service	Percent of Peer Specialist Providing Service			Overall (N=52)	Pearson Chi-Square (p value)
	CHP (n=20)	FBHP (n=21)	NBHP (n=11)		
Education Services on Recovery	95.0	81.0	100	90.4	.149
Client Orientation to Mental Health Services	90.0	66.7	81.8	78.8	.181
Treatment Planning Support	90.0	90.5	72.7	86.5	.319
Medication Education &/or Appointment Prep	80.0	47.6	36.4	57.7	.030*

*Statistical significance assessed as $p<.05$ per Pearson Chi-Square. This indicates that there is significant variability in the percent of peer specialists providing the service across the three BHOs.

**No statistical significance assessed; however, notable variability exists when comparing the percent of peer specialists providing the service.

Table 7-3—Treatment Support Services					
	Percent of Peer Specialist Providing Service				
Service	CHP (n=20)	FBHP (n=21)	NBHP (n=11)	Overall (N=52)	Pearson Chi-Square (*p* value)
Peer Led Groups	95.0	90.5	72.7	88.5	.166
Co-Facilitation of Clinical Groups	55.0	42.9	72.7	53.8	.271
Supporting Families	65.0	42.9	36.4	50.0	.218
Case Management	80.0	90.5	63.6	80.8	.186
Life Skills Training	75.0	100	81.8	86.5	.056**
Counseling and Support	95.0	100	81.8	94.2	.109
Transitional Assistance at Treatment Discharge	45.0	42.9	54.5	46.2	.813
Crisis/Emergency Support	60.0	76.2	63.6	67.3	.521
Transitional Assistance at Hospital Discharge	35.0	23.8	27.3	28.8	.725

*Statistical significance assessed as $p<.05$ per Pearson Chi-Square, which indicates that there is significant variability in the percent of peer specialists providing the service across the three BHOs.
**No statistical significance assessed; however, notable variability exists when comparing the percent of peer specialists providing the service.

Table 7-4—Community Support Services					
	Percent of Peer Specialist Providing Service				
Service	CHP (n=20)	FBHP (n=21)	NBHP (n=11)	Overall (N=52)	Pearson Chi-Square (*p* value)
Finding Housing	60.0	76.2	72.7	69.2	.512
Vocational Rehabilitation &/or Support	55.0	85.7	54.5	67.3	.066**
Transportation Support	85.0	100	91.8	90.4	.147
Accessing Healthcare	60.0	61.9	45.5	57.7	.647
Assistance with Other Community Agencies	70.0	81.0	63.6	73.1	.534

*Statistical significance assessed as $p<.05$ per Pearson Chi-Square, which indicates that there is significant variability in the percent of peer specialists providing the service across the three BHOs.
**No statistical significance assessed; however, notable variability exists when comparing the percent of peer specialists providing the service.

Table 7-5—Leisure or Social Activity Services					
Service	Percent of Peer Specialist Providing Service			Overall (N=52)	Pearson Chi-Square (*p* value)
	CHP (n=20)	FBHP (n=21)	NBHP (n=11)		
Interpersonal Support	70.0	100	100	88.5	.004*
Telephone Support	95.0	95.2	81.8	92.3	.339
Recreation/Leisure Activity Coordination	75.0	90.5	72.7	80.8	.340

*Statistical significance assessed as $p<.05$ per Pearson Chi-Square, which indicates that there is significant variability in the percent of peer specialists providing the service across the three BHOs.

**No statistical significance assessed; however, notable variability exists when comparing the percent of peer specialists providing the service.

Study Indicator 2: Frequencies of the different types of encounter Procedure Codes being used across each of the three BHOs.

The BHOs developed queries to extract data from the all-inclusive data warehouse that met the following parameters:

- Peer Services with the procedure codes indicated in Attachment B of the study (not included with this technical report).
- This subset of Peer Services encountered between September 1, 2011, through June 30, 2012.
- Individual Medicaid member received three or more of the identified Peer Services during the study period.

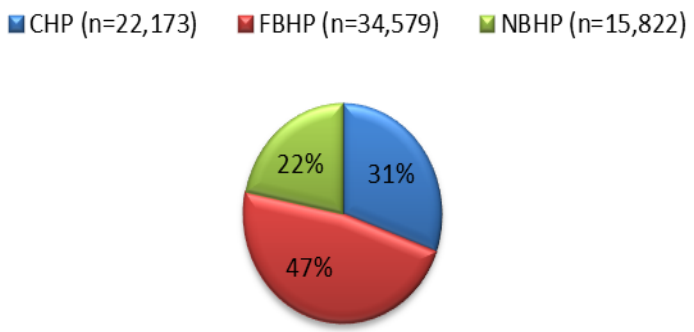
Quality checks verified that the encounters were provided during the specified period, had a procedure code that was identified, and the count of Peer Service Procedure Codes for a unique Medicaid member was three or more.

A frequency distribution was calculated for the Peer Service Procedure Codes encountered for each BHO. Using SPSS, the Pearson Chi-square test for difference was used to assess for any statistical differences in codes with a utilization rate of more than 5 percent within a BHO.

Following the parameters set forth in the proposed focus study, a total of 72,574 Peer Service encounters were extracted from the all-inclusive data warehouse for the period of September 1, 2011, through all data received up to June 30, 2012.

Figure 7.1 describes the distribution of those encounters by BHO.

Figure 7.1—Total Proportion of Peer Service Encounters by BHO September 1, 2011, through June 30, 2012



Of the 32 codes listed in Attachment B of the study (not included with this technical report), the following six codes were excluded from analysis as none of the BHOs used the procedure code during September 1, 2011, through June 30, 2012.

Table 7-6 lists the procedure codes not used by any BHO from September 1, 2011, through June 30, 2012.

Table 7-6—Procedure Codes not Used	
H2000	Comprehensive multidisciplinary evaluation
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0037	Community psychiatric supportive treatment, face-to-face, per diem
97535	Self-care/home management training, direct one-on-one contact by provider, each 15 minutes
99367	Medical team conference with interdisciplinary team, patient and/or family not present, 30 minutes or more, participation by physician.

Conclusions

This study has furthered efforts to identify the extent to which Peer Services offered across BHOs in Colorado vary. It is clear that peer specialists are providing a broad range of services ranging from outreach and advocacy, to counseling and support and life skills education. It is the BHOs' interpretation that the codes available exclusively for peer specialists to encounter are likely not broad enough to capture the full array of services being offered. In addition to a greater understanding of services offered and how they are coded, it is expected that these results will be clinically useful in informing and enhancing current peer specialist programs.

Foothills Behavioral Health Partners

Study Topic and Goal

The purpose of this focus study was to support Foothills Behavioral Health Partners' (FBHP's) overall goal of developing a health care management (HCM) program, in collaboration with its two Partner Mental Health Centers (PMHCs), to improve overall health behaviors and overall health for individuals with a diagnosis of schizophrenia or bipolar disorder. As an initial step to establishing the HCM program, the goal of this study was to address the following study questions:

- What are the gaps in guideline adherence, as documented in the study population's electronic medical record (EMR), based on the best practice components of a health care management guideline?
- What are the self-reported health behaviors that may affect the study population's prevention and management of cardiovascular disease (CVD) and diabetes?

Methodology

Measures

Healthcare Management Program Audit Form. This audit tool, based on FBHP's Healthcare Monitoring (HCM) Guideline, includes seven items, considered minimum activities of the HCM Guideline, each with a *Met*, *Not Met*, and *Partially Met* response.

Health Behavior Survey. The survey, based on the health behavior literature, includes 10 items using a Likert scale with five levels of response, from most healthy to least healthy.

Sample

The study population included members with the diagnosis of schizophrenia, schizoaffective or bipolar disorder, and at least two PMHC prescriber services in the study period. For Study Question 1, a 411 random sample of the study population was chosen. For Study Question 2, a non-statistically significant convenience sample was chosen (n=127).

Procedures

The draft audit form was piloted, auditors were trained, and an interrater reliability study was completed. Once 80 percent item interrater reliability was obtained, the audit was completed using a revised audit form. The draft Health Behavior Survey was tested for face validity and clarity, piloted by PMHC peer specialists, and administered by PMHC staff during a two-week data collection period.

Analysis

Basic descriptive analysis on audit and health survey results was conducted, determining, by response category, percent by item; and aggregating, for the health survey, response results into fewer categories. An overall percent correct was determined for the audit results.

Summary and Findings

Gaps in guideline adherence: Only 6.3 percent of the 411 audited medical records had a *Met* status on three of the first four items. For those medical records with identified *At Risk* status, n=189, only 2.6 percent of audited medical records had a *Met* status for six of the seven applicable audit items.

Health behavior issues: Issues identified from the Health Behavior Survey results that inform the HCM program include: (1) a large percent of respondents reported poor health, (2) many still do not believe an annual doctor visit is needed, (3) smoking and nutrition is still a concern, (4) inactivity and alcohol abuse are not as prominent, and (5) garnering support for health changes is more common.

Conclusions and Recommendations

1. Further refine the HCM Guideline based on the audit and Health Behavior Survey results.
2. Develop a performance improvement project (PIP) proposal for the HCM program.

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.

For the FY 2011–2012 site review process, the Department requested a review of four areas of performance: member information, grievance system, provider participation and program integrity, and subcontracts and delegation. HSAG developed a review strategy that corresponded with the four areas identified by the Department.

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 VI—Grievance System for both physical health plans and BHOs, HSAG conducted an on-site review of 10 appeal records.

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 2011–2012.

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.

Table A-1—Compliance Monitoring Review Activities Performed	
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.
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 VI—Grievance System for both physical health plans and BHOs, HSAG conducted a record review of 10 appeals. ◆ 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 2011–2012 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.

Table A-1—Compliance Monitoring Review Activities Performed	
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2011–2012 Site Review Report. ◆ HSAG submitted the site review report to the Department and the respective health plan/BHO for review and comment. ◆ HSAG coordinated with the Department to incorporate all 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 appeal record review, scores were incorporated into Standard VI—Grievance System. Each health plan or BHO was given an overall percentage-of-compliance score. This score represented the percentage of the applicable elements met by the health plan or BHO. This scoring methodology allowed the Department to identify areas of best practice and areas where corrective actions were required or training and technical assistance were needed to improve performance.

Appendix B. EQR Activities—Validation of Performance Measures

Introduction

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

Objectives

As set forth in 42 CFR 438.358, validation of performance measures was one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

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

Technical Methods of Data Collection—Physical Health

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

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

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

- On-site meetings at the Department's offices, including:
  - Staff interviews.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary 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)—2012 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 2012 (CY 2011) 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 2011
Certified Software Report	CY 2011
Performance Measure Reports	CY 2011
Supporting Documentation	CY 2011
On-site Interviews and Demonstrations	CY 2011

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 2010–2011
Source code (programming language) for performance measures (from the Department)	FY 2010–2011
Previous year's performance measure reports	FY 2010–2011
Current performance measure results (from BHOs and the Department)	FY 2010–2011
Supporting documentation (from BHOs and the Department)	FY 2010–2011
On-site interviews and demonstrations (from BHOs and the Department)	FY 2010–2011

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 Reporting, Control Procedures That Support Measure 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. Medicaid HEDIS 2011 Percentiles

Performance Measures	P10	P25	P50	P75	P90
Pediatric Care					
Childhood Immunization Status—Combination 2	62.3%	69.0%	75.1%	80.7%	85.8%
Childhood Immunization Status—Combination 3	56.8%	64.4%	71.0%	76.7%	82.6%
Childhood Immunization Status—Combination 4	20.0%	25.8%	31.4%	37.0%	41.9%
Childhood Immunization Status—Combination 5	34.4%	39.4%	47.4%	55.0%	62.5%
Childhood Immunization Status—Combination 6	16.8%	28.0%	37.0%	44.8%	51.5%
Childhood Immunization Status—Combination 7	13.6%	17.5%	23.1%	28.0%	35.9%
Childhood Immunization Status—Combination 8	8.8%	13.0%	18.0%	22.1%	27.4%
Childhood Immunization Status—Combination 9	12.2%	20.4%	26.8%	34.3%	39.9%
Childhood Immunization Status—Combination 10	6.3%	9.9%	14.4%	18.6%	23.6%
Immunizations for Adolescents—Combination 1	33.8%	40.0%	49.8%	63.7%	75.5%
Well-Child Visits in the First 15 Months of Life—6+ Visits	41.9%	52.2%	61.3%	68.9%	77.1%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.9%	66.1%	72.3%	77.6%	82.9%
Adolescent Well-Care Visits	35.0%	39.6%	46.1%	57.2%	64.1%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Assessment: Total	0.7%	19.7%	37.5%	58.8%	69.8%
Counseling for Nutrition: Total	0.7%	39.0%	51.1%	61.6%	72.0%
Counseling for Physical Activity: Total	0.0%	28.5%	40.6%	51.0%	60.6%
Annual Dental Visit—Total	27.1%	41.4%	51.6%	57.6%	64.5%

Performance Measures	P10	P25	P50	P75	P90
Access to Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	71.4%	80.3%	86.0%	90.0%	93.2%
Postpartum Care	53.7%	59.6%	64.6%	70.6%	75.2%
Children's and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	92.6%	95.1%	97.0%	97.8%	98.6%
Ages 25 Months to 6 Years	82.0%	86.8%	89.6%	91.2%	92.7%
Ages 7 to 11 Years	85.2%	87.9%	91.3%	93.3%	94.7%
Ages 12 to 19 Years	81.1%	86.5%	89.7%	91.9%	93.4%
Adults' Access to Preventive/Ambulatory Health Services—Total	74.4%	80.4%	84.5%	87.5%	89.4%
Preventive Screening					
Chlamydia Screening in Women—Total	46.0%	51.5%	57.2%	63.4%	69.1%
Adult BMI Assessment	3.2%	29.2%	47.6%	61.7%	70.5%

Performance Measures	P10	P25	P50	P75	P90
Living With Illness					
Use of Appropriate Medications for People with Asthma—Total†	83.6%	86.6%	88.9%	90.5%	93.2%
Comprehensive Diabetes Care					
HbA1c Testing	73.6%	77.6%	82.2%	87.1%	90.9%
*HbA1c Poor Control (>9.0%)**	29.1%	34.9%	42.6%	52.1%	60.4%
HbA1c Control (<8.0%)	33.8%	39.9%	47.4%	54.8%	59.1%
Eye Exam	34.0%	43.8%	52.8%	63.7%	70.6%
LDL-C Screening	63.7%	70.4%	75.4%	80.3%	84.2%
LDL-C Level <100 mg/dL	21.5%	27.3%	35.2%	41.4%	45.9%
Medical Attention for Nephropathy	68.1%	73.9%	78.5%	82.5%	86.9%
Blood Pressure Controlled <140/80 mm Hg	25.0%	32.0%	38.5%	44.2%	54.8%
Blood Pressure Controlled <140/90 mm Hg	43.8%	54.3%	61.2%	68.3%	76.0%
Use of Imaging Studies for Low Back Pain	67.0%	72.3%	75.6%	79.7%	82.3%
Annual Monitoring for Patients on Persistent Medications—Total	78.3%	81.8%	84.2%	86.7%	88.1%
Pharmacotherapy Management of COPD Exacerbation					
Bronchodilator	71.1%	77.5%	84.3%	87.1%	89.3%
Systemic Corticosteroid	46.5%	59.4%	67.6%	73.5%	76.8%

† For HEDIS 2012, the upper age limit for the *Use of Appropriate Medications for People With Asthma* measure was extended from 50 to 64; therefore, please use caution when comparing with HEDIS 2011 national Medicaid percentiles for the *Total* age group.

* A lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

Performance Measures	P10	P25	P50	P75	P90
Utilization of Services					
Inpatient Utilization—General Hospital Acute Care: Total Inpatient					
Discharges (Per 1,000 Member Months)	5.6	6.4	7.9	9.0	10.7
Average Length of Stay	2.8	3.2	3.6	3.9	4.2
Inpatient Utilization—General Hospital Acute Care: Medicine					
Discharges (Per 1,000 Member Months)	1.4	2.2	3.0	3.7	4.8
Average Length of Stay	2.8	3.2	3.5	3.8	4.0
Inpatient Utilization—–General Hospital Acute Care: Surgery					
Discharges (Per 1,000 Member Months)	0.7	0.9	1.3	1.8	2.2
Average Length of Stay	3.7	4.7	5.7	6.6	7.5
Inpatient Utilization—General Hospital Acute Care: Maternity					
Discharges (Per 1,000 Member Months)	3.1	4.1	5.3	7.6	10.7
Average Length of Stay	2.2	2.5	2.6	2.8	2.9
Ambulatory Care (Per 1,000 Member Months)					
Outpatient Visits	264.5	314.7	349.5	391.9	439.0
Emergency Department Visits	44.4	55.7	63.3	70.5	76.6
Frequency of Selected Procedures (Per 1,000 Member Months)					

Performance Measures	P10	P25	P50	P75	P90
Bariatric Weight Loss Surgery: Male—Ages 0-19 Years	—	—	—	—	—
Bariatric Weight Loss Surgery: Female—Ages 0-19 Years	—	—	—	—	—
Bariatric Weight Loss Surgery: Male—Ages 20-44 Years	—	—	—	—	—
Bariatric Weight Loss Surgery: Female—Ages 20-44 Years	—	—	—	—	—
Bariatric Weight Loss Surgery: Male—Ages 45-64 Years	—	—	—	—	—
Bariatric Weight Loss Surgery: Female—Ages 45-64 Years	—	—	—	—	—
Tonsillectomy: Ages 0-9 Years	0.4	0.6	0.8	1.0	1.2
Tonsillectomy: Ages 10-19 Years	0.1	0.3	0.4	0.5	0.6
Abdominal Hysterectomy: Ages 15-44 Years	0.1	0.2	0.2	0.3	0.4
Abdominal Hysterectomy: Ages 45-64 Years	0.2	0.3	0.5	0.6	0.7
Vaginal Hysterectomy: Ages 15-44 Years	0.0	0.1	0.2	0.3	0.4
Vaginal Hysterectomy: Ages 45-64 Years	0.0	0.1	0.2	0.3	0.5
Open Cholecystectomy: Male—Ages 30-64 Years	0.0	0.0	0.0	0.1	0.1
Open Cholecystectomy: Female—Ages 15-44 Years	0.0	0.0	0.0	0.0	0.0
Open Cholecystectomy: Female—Ages 45-64 Years	0.0	0.0	0.1	0.1	0.1
Closed Cholecystectomy: Male—Ages 30-64 Years	0.1	0.2	0.3	0.4	0.5
Closed Cholecystectomy: Female—Ages 15-44 Years	0.5	0.6	0.8	1.0	1.2
Closed Cholecystectomy: Female—Ages 45-64 Years	0.3	0.5	0.7	0.8	1.1
Back Surgery: Male—Ages 20-44 Years	0.1	0.2	0.3	0.5	0.6
Back Surgery: Female—Ages 20-44 Years	0.1	0.1	0.2	0.3	0.4
Back Surgery: Male—Ages 45-64 Years	0.1	0.3	0.5	0.8	1.0
Back Surgery: Female—Ages 45-64 Years	0.1	0.3	0.5	0.7	1.0
Mastectomy: Ages 15–44 Years	0.0	0.0	0.0	0.0	0.0
Mastectomy: Ages 45–64 Years	0.0	0.1	0.1	0.2	0.3
Lumpectomy: Ages 15–44 Years	0.1	0.1	0.2	0.2	0.2
Lumpectomy: Ages 45—64 Years	0.2	0.3	0.4	0.6	0.8

—HEDIS 2011 national percentiles are not available because these are new sub-measures for HEDIS 2012.

Appendix D. 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 health plan 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 health plan processes was designed to have a favorable effect 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 health plans. The Department contracted with HSAG to meet this validation requirement.

The primary objective of PIP validation was to determine each health plan'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 six PIPs for the behavioral health organizations (BHOs) and four PIPs for the physical health plans. For the BHOs, HSAG performed validation activities on two PIPs for one of the BHOs and one PIP for each of the remaining BHOs. For the physical health plans, HSAG performed validation activities on two PIPs for each plan. Table D-1 lists the BHOs and their PIP study titles. Table D-2 below lists the MCOs and their PIP study titles.

Table D-1—Summary of Each BHO's PIP

BHO	PIP Study
Access Behavioral Care (ABC)	*Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers*
	Coordination of Care Between Medicaid Physical and Behavioral Health Providers
Behavioral Healthcare, Inc. (BHI)	*Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics*

Table D-1—Summary of Each BHO's PIP	
BHO	**PIP Study**
Colorado Health Partnerships, LLC (CHP)	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*
Foothills Behavioral Health Partners (FBHP)	*Reducing Emergency Department (ED) Utilization for Youth*
Northeast Behavioral Health Partnership (NBHP)	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*

Table D-2—Summary of Each MCO's PIP	
Health Plan	**PIP Study**
Denver Health Medicaid Choice (DHMC)	*Adults Access to Preventive/Ambulatory Health Services*
	Coordination of Care Between Medicaid Physical and Behavioral Health Providers
Rocky Mountain Health Plans (RMHP)	*Adult BMI Assessment*
	Coordination of Care Between Medicaid Physical and Behavioral Health Providers

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.[D-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)

[D-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.

- 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

*To ensure that health plans analyzed and interpreted data prior to identifying and implementing interventions, HSAG reversed the order of Activities VII and VIII for new PIPs that were implemented during FY 2012. Thus, for all PIPs developed during and after FY 2012, health plans are required to provide an analysis and interpretation of data in Activity VII and then describe the planned interventions and improvement strategies in Activity VIII when they submit their PIP Summary Forms for validation.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the health plans' 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. 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 D-3—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
PIP Summary Form (completed by each health plan)	FY 2011–2012

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 health plans 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 health plans' 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 E. 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 E-1 and Table E-2 present the question summary rates (i.e., the percentage of respondents offering a positive response) for the 2012 global ratings for the adult and child populations, respectively. 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 2011 NCQA national averages are highlighted in yellow.

Table E-1—NCQA National Averages and Question Summary Rates for Global Ratings

	Adult Medicaid 2012			
Measure of Member Satisfaction	2011 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	61.3%	67.3%	64.4%	67.1%
Rating of Specialist Seen Most Often	61.3%	57.0%	64.7%	63.4%
Rating of All Health Care	48.6%	49.7%	50.0%	51.4%
Rating of Health Plan	54.6%	59.3%	64.0%	58.2%

A question summary rate is the percentage of respondents offering a positive response (a value of 9 or 10).

Indicates a rate is at or above the 2011 NCQA CAHPS national average.

Table E-2—NCQA National Averages and Question Summary Rates for Global Ratings				
	Child Medicaid 2012			
Measure of Member Satisfaction	2011 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	70.6%	80.1%	73.8%	71.9%
Rating of Specialist Seen Most Often	68.0%	NA	NA	NA
Rating of All Health Care	62.5%	64.9%	61.7%	67.6%
Rating of Health Plan	66.1%	71.9%	67.9%	69.0%

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 is at or above the 2011 NCQA CAHPS national average.

Table E-3 and Table E-4 present the global proportions (i.e., the percentage of respondents offering a positive response) for the 2012 composite scores for the adult and child populations, respectively. 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 2011 NCQA national averages are highlighted in yellow.

Table E-3—NCQA National Averages and Global Proportions for Composite Scores				
	Adult Medicaid 2012			
Measure of Member Satisfaction	2011 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	50.4%	38.7%	61.0%	53.6%
Getting Care Quickly	56.4%	42.2%	61.2%	58.5%
How Well Doctors Communicate	69.0%	69.9%	67.4%	66.5%
Customer Service	59.3%	NA	NA	NA
Shared Decision Making	59.5%	59.4%	62.3%	63.8%

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 is at or above the 2011 NCQA CAHPS national average.

Table E-4—NCQA National Averages and Global Proportions for Composite Scores				
	Child Medicaid 2012			
Measure of Member Satisfaction	2011 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	56.4%	42.3%	60.4%	56.1%
Getting Care Quickly	71.5%	59.4%	74.7%	78.5%
How Well Doctors Communicate	75.2%	73.5%	75.4%	79.9%
Customer Service	61.1%	56.8%	NA	NA
Shared Decision Making	66.8%	69.6%	77.4%	72.5%

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 2011 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 E-5 shows HSAG's assignment of the CAHPS measures to these performance domains.

Table E-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 F. 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 2011–2012.

Results from the Compliance Monitoring Site Reviews

Table F-1 and Table F-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 F-1—FY 2011–2012 Standard Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Standard V—Member Information	100%	90%	95%
Standard VI—Grievance System	100%	73%	87%
Standard VII— Provider Participation and Program Integrity	100%	85%	92%
Standard IX—Subcontracts and Delegation	100%	100%	100%
Totals	**100%**	**83%**	**92%**

Table F-2—FY 2011–2012 Record Review Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Appeals	93%	92%	93%

Table F-3 and Table F-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 F-3—FY 2011–2012 Standard Scores for the BHOs						
Description of Component	ABC	BHI	CHP	FBHP	NBHP	Statewide Average
Standard V—Member Information	95%	84%	89%	89%	95%	91%
Standard VI—Grievance System	92%	76%	85%	92%	88%	87%
Standard VII— Provider Participation and Program Integrity	100%	93%	100%	100%	100%	99%
Standard IX—Subcontracts and Delegation	100%	75%	86%	86%	86%	86%
Totals	**96%**	**82%**	**90%**	**93%**	**93%**	**90%**

Table F-4—FY 2011–2012 Record Review Scores for the BHOs						
Description of Component	ABC	BHI	CHP	FBHP	NBHP	Statewide Average
Appeals	100%	81%	100%	100%	100%	97%

Results from the Validation of Performance Measures

Table F-5 presents pediatric care performance measure results for each physical health plan and the statewide average.

Table F-5—Pediatric Care Performance Measure Results for Physical Health Plans and Statewide Average

Performance Measures	DHMC	RMHP	PCPP	Statewide Average
Childhood Immunization Status—Combination 2	84.2%	78.2%	76.6%	81.4%
Childhood Immunization Status—Combination 3	83.7%	76.2%	76.1%	80.5%
Childhood Immunization Status—Combination 4	51.6%	12.7%	53.3%	41.6%
Childhood Immunization Status—Combination 5	70.3%	63.4%	58.3%	66.6%
Childhood Immunization Status—Combination 6	73.2%	52.1%	38.3%	62.2%
Childhood Immunization Status—Combination 7	45.3%	11.3%	41.2%	35.7%
Childhood Immunization Status—Combination 8	47.0%	9.0%	27.8%	34.0%
Childhood Immunization Status—Combination 9	62.0%	44.9%	31.2%	52.7%
Childhood Immunization Status—Combination 10	41.1%	8.1%	22.6%	29.5%
Immunizations for Adolescents—Combination 1	82.3%	47.9%	64.2%	69.5%
Well-Child Visits in the First 15 Months of Life—6+ Visits	51.3%	82.6%	61.4%	62.5%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.6%	64.9%	59.1%	66.0%
Adolescent Well-Care Visits	51.1%	42.8%	47.9%	48.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	85.2%	71.1%	55.5%	74.8%
Counseling for Nutrition: Total	80.3%	63.0%	55.2%	70.1%
Counseling for Physical Activity: Total	61.3%	56.7%	51.1%	57.8%
Annual Dental Visit—Total	NB	NB	70.7%	70.7%

Table F-6 presents access to care and preventive screening performance scores for each physical health plan, and the statewide average.

Table F-6—Access to Care and Preventive Screening Performance Measures for Physical Health Plans and Statewide Average				
Performance Measures	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.5%	97.0%	80.3%	88.6%
Postpartum Care	59.6%	77.4%	69.6%	68.6%
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	95.0%	98.5%	97.0%	96.3%
Ages 25 Months to 6 Years	81.2%	89.0%	85.8%	84.0%
Ages 7 to 11 Years	84.0%	92.1%	90.2%	87.2%
Ages 12 to 19 Years	85.2%	91.6%	90.0%	88.0%
Adults' Access to Preventive/Ambulatory Health Services—Total	73.5%	89.8%	83.9%	80.6%
Preventive Screening				
Chlamydia Screening in Women—Total	67.8%	45.4%	26.1%	52.0%
Adult BMI Assessment	84.9%	69.9%	50.9%	69.0%

Table F-7 presents living with illness performance scores for each physical health plan and the statewide average.

Table F-7—Living with Illness Performance Measures for Physical Health Plans and Statewide Average				
Performance Measures	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Use of Appropriate Medications for People with Asthma—Total	81.6%	86.6%	90.6%	86.4%
Comprehensive Diabetes Care				
HbA1c Testing	84.9%	92.2%	65.7%	79.2%
HbA1c Poor Control (>9.0%)	37.7%	19.2%	63.7%	43.8%
HbA1c Control (<8.0%)	46.7%	72.2%	32.6%	46.5%
Eye Exam	56.2%	60.8%	45.7%	53.2%
LDL-C Screening	75.4%	74.6%	56.4%	68.2%
LDL-C Level <100 mg/dL	54.0%	47.7%	25.3%	42.1%
Medical Attention for Nephropathy	79.3%	75.9%	68.1%	74.5%
Blood Pressure Controlled <140/80 mm Hg	55.5%	61.5%	27.7%	46.3%

Table F-7—Living with Illness Performance Measures for Physical Health Plans and Statewide Average				
Performance Measures	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Blood Pressure Controlled <140/90 mm Hg	71.0%	79.9%	40.9%	61.6%
Use of Imaging Studies for Low Back Pain	80.0%	74.0%	74.7%	76.8%
Annual Monitoring for Patients on Persistent Medications—Total	86.0%	85.0%	71.9%	82.2%
Pharmacotherapy Management of COPD Exacerbation				
Bronchodilator	65.9%	43.4%	72.2%	58.2%
Systemic Corticosteroid	56.1%	28.9%	61.1%	46.4%

Table F-8 presents utilization performance scores for each physical health plan and the statewide average.

Table F-8—Utilization of Services Performance Measures for Physical Health Plans and Statewide Average				
Performance Measures	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Inpatient Utilization—General Hospital/Acute Care: Total Inpatient				
Discharges Per 1,000 MM: Total	10.9	10.6	10.2	10.6
Average Length of Stay: Total	3.4	2.9	5.0	3.7
Inpatient Utilization—General Hospital/Acute Care: Medicine				
Discharges Per 1,000 MM: Total	7.1	8.2	6.3	7.1
Average Length of Stay: Total	2.9	2.6	4.3	3.2
Inpatient Utilization—General Hospital/Acute Care: Surgery				
Discharges Per 1,000 MM: Total	1.4	2.3	2.7	2.0
Average Length of Stay: Total	6.8	4.1	8.0	6.5
Inpatient Utilization—General Hospital/Acute Care: Maternity				
Discharges Per 1,000 MM: Total	4.4	0.1	2.1	2.8
Average Length of Stay: Total	2.5	1.7	2.3	2.5
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	289.6	436.6	379.5	345.9
Emergency Department Visits	40.5	62.9	55.5	49.4
Frequency of Selected Procedures (Per 1,000 Member Months)				
Bariatric Weight Loss Surgery: Male—Ages 0–19 Years	0.0	0.0	0.0	0.0
Bariatric Weight Loss Surgery: Female—Ages 0–19 Years	0.0	0.0	0.0	0.0
Bariatric Weight Loss Surgery: Male—Ages 20–44 Years	0.0	0.0	0.0	0.0

Table F-8—Utilization of Services Performance Measures for Physical Health Plans and Statewide Average				
Performance Measures	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Bariatric Weight Loss Surgery: Female—Ages 20–44 Years	0.1	0.4	0.2	0.2
Bariatric Weight Loss Surgery: Male—Ages 45–64 Years	<0.1	0.0	0.0	<0.1
Bariatric Weight Loss Surgery: Female—Ages 45–64 Years	0.0	0.4	0.0	0.1
Tonsillectomy: Ages 0–9 Years	0.3	1.5	0.8	0.6
Tonsillectomy: Ages 10–19 Years	0.3	1.4	0.5	0.6
Abdominal Hysterectomy: Ages 15–44 Years	<0.1	0.2	0.2	0.1
Abdominal Hysterectomy: Ages 45–64 Years	0.1	0.2	0.1	0.1
Vaginal Hysterectomy: Ages 15–44 Years	0.1	1.2	0.2	0.4
Vaginal Hysterectomy: Ages 45–64 Years	0.1	0.8	0.1	0.2
Open Cholecystectomy: Male—Ages 30–64 Years	0.1	0.1	0.1	0.1
Open Cholecystectomy: Female—Ages 15–44 Years	<0.1	<0.1	<0.1	<0.1
Open Cholecystectomy: Female—Ages 45–64 Years	0.0	0.0	0.1	<0.1
Closed Cholecystectomy: Male—Ages 30–64 Years	0.1	0.6	0.3	0.2
Closed Cholecystectomy: Female—Ages 15–44 Years	0.5	1.7	0.8	0.9
Closed Cholecystectomy: Female—Ages 45–64 Years	0.6	1.2	0.5	0.7
Back Surgery: Male—Ages 20–44 Years	0.2	0.5	0.3	0.3
Back Surgery: Female—Ages 20–44 Years	<0.1	0.3	0.2	0.1
Back Surgery: Male—Ages 45–64 Years	0.3	1.1	0.5	0.5
Back Surgery: Female—Ages 45–64 Years	0.2	1.1	0.9	0.6
Mastectomy: Ages 15–44 Years	<0.1	0.0	<0.1	<0.1
Mastectomy: Ages 45–64 Years	0.1	0.2	0.1	0.1
Lumpectomy: Ages 15–44 Years	0.1	0.2	0.1	0.1
Lumpectomy: Ages 45–64 Years	0.2	0.7	0.1	0.3

Table F-9 includes FY 2011–2012 performance measure results for each BHO as well as the statewide average.

Table F-9—2011–2012 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	5.0%	5.8%	7.1%	13.8%	7.0%	7.1%
Adolescents 13 Through 17 Years of Age	14.9%	16.5%	19.2%	28.6%	22.0%	19.3%
Adults 18 Through 64 Years of Age	19.4%	17.4%	19.2%	25.8%	18.8%	19.6%
Adults 65 Years of Age or Older	6.5%	4.1%	6.1%	11.3%	5.7%	6.4%
Penetration Rate by Service Category						
Inpatient Care	0.3%	0.2%	0.2%	0.2%	0.2%	0.2%
Intensive Outpatient/Partial Hospitalization	0.05%	0.1%	0.003%	0.04%	0.01%	0.03%
Ambulatory Care	8.9%	10.1%	12.1%	15.6%	12.2%	11.5%
Overall Penetration Rate	10.9%	10.5%	12.9%	19.5%	12.6%	12.7%
Penetration Rate by Medicaid Eligibility Category						
AFDC/CWP Adults	11.6%	11.8%	15.1%	20.0%	13.6%	14.2%
AFDC/CWP Children	5.1%	6.3%	8.2%	15.6%	8.6%	8.0%
AND/AB-SSI	32.9%	31.8%	27.6%	35.8%	31.8%	30.9%
BC Children	4.9%	4.7%	6.2%	11.8%	5.8%	6.1%
BC Women	13.1%	6.9%	14.5%	21.7%	8.8%	12.6%
BCCP—Women Breast and Cervical Cancer	17.2%	9.3%	16.4%	24.7%	11.9%	16.1%
Foster Care	39.7%	34.8%	32.4%	37.5%	35.7%	35.1%
OAP-A	6.4%	4.1%	6.1%	11.2%	5.7%	6.4%
OAP-B-SSI	22.6%	19.6%	18.0%	27.5%	22.8%	21.0%
Other	—	—	—	—	—	—
Hospital Recidivism						
Non-State Hospitals—7Days	3.8%	2.9%	4.8%	3.2%	0.3%	3.4%
30 Days	11.1%	11.5%	12.0%	8.8%	2.3%	10.0%
90 Days	21.9%	18.0%	22.3%	15.2%	7.1%	18.4%
All Hospitals—7 Days	3.7%	4.1%	4.1%	3.3%	0.3%	3.5%
30 Days	10.7%	12.6%	11.4%	11.1%	2.4%	10.4%
90 Days	21.1%	19.4%	21.6%	18.3%	7.4%	19.0%
Hospital Average Length of Stay						
Non-State Hospitals	8.17	7.80	6.57	6.27	5.74	7.07
All Hospitals	19.97	14.31	10.38	14.63	8.88	13.60
Emergency Room Utilization (Rate/1000 Members, All Ages)	7.95	6.64	10.02	6.30	5.40	7.84

Table F-9—2011–2012 Performance Measure Results for BHOs						
Performance Measures	**ABC**	**BHI**	**CHP**	**FBH**	**NBH**	**Statewide Average**
Inpatient Utilization (Rate/1000 Members, All Ages)						
Non-State Hospitals	5.41	3.26	3.39	3.34	4.29	3.82
All Hospitals	6.30	4.78	5.03	5.56	4.65	5.20
Follow-Up After Hospitalization for Mental Illness						
Non-State Hospitals—7 Days	39.7%	50.0%	46.0%	53.6%	55.3%	47.4%
30 Days	58.7%	67.6%	65.6%	70.5%	75.3%	66.3%
All Hospitals—7 Days	40.4%	51.0%	48.5%	55.5%	55.3%	49.0%
30 Days	59.1%	67.4%	67.8%	74.7%	74.8%	67.7%

Results from the Validation of Performance Improvement Projects

Table F-10 lists the PIP study conducted by each physical health plan and the corresponding summary scores.

Table F-10—Summary of Physical Health Plans PIP Validation Scores and Validation Status				
Health Plan	**PIP Study**	**% of All Elements Met**	**% of Critical Elements Met**	**Validation Status**
DHMC	*Adults Access to Preventive/ Ambulatory Health Services*	100%	100%	Met
DHMC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	94%	100%	Met
RMHP	*Adult BMI Assessment*	100%	100%	Met
RMHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	86%	100%	Met

Table F-11 lists the PIP study conducted by each BHO and the corresponding summary scores.

Table F-11—Summary of Each BHO's PIP Validation Scores and Validation Status				
BHO	**PIP Study**	**% of All Elements *Met***	**% of Critical Elements *Met***	**Validation Status**
ABC	*Coordination of Care Between Psychiatric Emergency Facilities and Outpatient Providers*	89%	100%	*Met*
ABC	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	90%	100%	*Met*
BHI	*Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics*	86%	80%	*Partially Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	94%	100%	*Met*
FBHP	*Reducing Emergency Department (ED) Utilization for Youth*	97%	100%	*Met*
NBHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	81%	85%	*Not Met*

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

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

Table F-12—Adult Medicaid Question Summary Rates and Global Proportions				
Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	38.7%	61.0%	53.6%	51.1%
Getting Care Quickly	42.2%	61.2%	58.5%	54.0%
How Well Doctors Communicate	69.9%	67.4%	66.5%	67.9%
Customer Service	NA	NA	NA	*
Shared Decision Making	59.4%	62.3%	63.8%	61.8%
Rating of Personal Doctor	67.3%	64.4%	67.1%	66.3%
Rating of Specialist Seen Most Often	57.0%	64.7%	63.4%	61.7%
Rating of All Health Care	49.7%	50.0%	51.4%	50.4%
Rating of Health Plan	59.3%	64.0%	58.2%	60.5%

NA indicates that the measure had fewer than 100 respondents.

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

Table F-13 shows each physical health plan's summary rates and global proportions for the child CAHPS survey.

Table F-13—Child Medicaid Question Summary Rates and Global Proportions				
Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	42.3%	60.4%	56.1%	52.9%
Getting Care Quickly	59.4%	74.7%	78.5%	70.9%
How Well Doctors Communicate	73.5%	75.4%	79.9%	76.3%
Customer Service	56.8%	NA	NA	*
Shared Decision Making	69.6%	77.4%	72.5%	73.2%
Rating of Personal Doctor	80.1%	73.8%	71.9%	75.3%
Rating of Specialist Seen Most Often	NA	NA	NA	**
Rating of All Health Care	64.9%	61.7%	67.6%	64.7%
Rating of Health Plan	71.9%	67.9%	69.0%	69.6%

NA indicates that the measure had fewer than 100 respondents.

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

** None of the health plans were able to report the *Rating of Specialist Seen Most Often* measure; therefore, a State average was not calculated.