2012–2013 External Quality Review Technical Report

for

Colorado Medicaid

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

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Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with the Code of Federal Regulations (CFR), 42 CFR 438.358, were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' health plans. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which the health plans addressed any previous recommendations. To meet this requirement, the State of Colorado Department of Health Care Policy and 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), a managed care organization (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 compliance monitoring standards developed collaboratively with the Department.
- **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 health plans and 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 F.

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

Physical Health Compliance Review Standards	Quality	Timeliness	Access
Coordination and Continuity of Care	✓	✓	✓
Member Rights and Protections	✓		✓
Credentialing and Recredentialing	✓		✓
Quality Assessment and Performance Improvement	✓		
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	✓		
Appropriate Testing for Children with Pharyngitis	✓		
Prenatal Care and *Postpartum Care*	✓	✓	✓
Children's and Adolescents' Access to Primary Care Providers (PCPs)			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Chlamydia Screening in Women	✓		
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Adult BMI Assessment	✓		
Anti-depressant Medication Management	✓		
Follow-up Care for Children Prescribed ADHD Medication	✓	✓	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	
Controlling High Blood Pressure	✓		

Table 1-1—Assignment of Activities to Performance Domains for Physical Health Plans			
Comprehensive Diabetes Care	✓		✓
Annual Monitoring for Patients on Persistent Medications	✓		
Ambulatory Care			✓
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**
Coordination and Continuity of Care	✓	✓	✓
Member Rights and Protections	✓		✓
Credentialing and Recredentialing	✓		✓
Quality Assessment and Performance Improvement	✓		
Performance Measures	**Quality**	**Timeliness**	**Access**
Percent of Members with Serious Mental Illness (SMI) with a Focal Point of Behavioral Health Care	✓		✓
Improving Physical Healthcare 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	✓		

Quality—Physical Health

In fiscal year (FY) 2012–2013, all four of the compliance site review standards contained requirements that pertained to the quality domain. While overall performance was good, HSAG made recommendations to both plans that will help to improve the quality of care provided to Medicaid members. These recommendations included more clearly defining services available and the expectation that the requirements are met, updating member information related to behavioral health care, and addressing the availability of clinical practice guidelines to members and the public.

HSAG assigned 18 of the 21 HEDIS measures reported in 2013 to the quality domain. Statewide rates on the indicators fluctuated considerably. Colorado experienced statistically significant improvement in seven submeasures (indicators) related to quality and a statistically significant decline in five submeasures related to quality. However, Colorado ranked above the national Medicaid 90th percentile for eight of the 39 submeasures related to quality and below the national Medicaid 10th percentile for only one.

HSAG assigned all PIPs to the quality domain. Three of the four PIPs reviewed by HSAG earned a validation status of *Met*, with scores of 100 percent for critical elements *Met*, and scores ranging from 88 percent to 100 percent for all evaluation elements *Met*. One PIP received a validation status of *Partially Met* with a score of 90 percent for critical elements *Met*, and a score of 96 percent for all evaluation elements *Met*. Colorado's physical health plans have demonstrated a strong understanding and implementation of the CMS PIP protocols.

All of the measures within the CAHPS survey addressed quality. For FY 2012–2013, DHMC and RMHP conducted CAHPS surveys of their general child Medicaid populations. For the statewide general child Medicaid population, the rates for seven of the eight comparable measures increased from FY 2011–2012 to FY 2012–2013. For one of these measures, *Getting Needed Care*, the rate increased substantially (7.9 percentage points). One measure, *Rating of Health Plan*, demonstrated a slight decrease.

Quality—Behavioral Health

All four compliance standards contained requirements that pertained to the quality domain, and statewide performance was excellent. All BHOs had processes to ensure that each member had a primary source of behavioral health care and was assigned a person responsible for coordinating care. They had robust policies and practices for the protection of member privacy and confidentially of member records, as well as policies and practices to ensure members are not discriminated against. All BHOs had a health information system with the ability to collect, analyze, and report data essential to the development of effective quality initiatives. The BHOs' credentialing/recredentialing programs ensured that there was medical director input in the credentialing process, and the BHOs performed initial and ongoing monitoring of provider sanctions to ensure providers in the network met the quality standards. Quality assessment and performance improvement (QAPI) programs were comprehensive and included clinical practice guidelines, methods to detect over- and underutilization of services, and mechanisms to evaluate member perceptions of the adequacy of services.

Percent of Members with SMI with a Focal Point of Behavioral Health Care and *Hospital Recidivism* were the only performance measures this year that related to the quality domain. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. A wide range of rates among the BHOs were noted for this measure, with a difference of nearly 15 percentage points between the BHOs with the lowest and highest rates. Statewide BHO performance on the *Hospital Recidivism* indicators (submeasures) did not change very much from last year's results. Each of the six submeasures reported a minor decline in rate (an improvement in performance), though none of these rates improved by more than 3 percentage points. *Hospital Recidivism—Non-State Hospitals* and *All Hospitals* rates were similar. BHO variations in rates were smallest for *All Hospitals—7 Days* (2.5 percentage points) and largest for *Non-State Hospitals—90 Days* (8.9 percentage points). These results suggest that the BHOs should look to their existing interventions to continue improving *Hospital Recidivism* rates.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. All five PIPs validated by HSAG earned a *Met* validation status. A *Met* validation status demonstrates that each health plan exhibited a strong understanding and implementation of processes required to conduct a valid study.

Timeliness—Physical Health

HSAG assigned one compliance standard (Coordination and Continuity of Care) to the timeliness domain, and overall performance was good. Both health plans had strong care coordination programs that included processes to ensure timely access to service, particularly during transitions of care. One health plan was asked to enhance its processes for screening Medicaid members for the presence of special health care needs following enrollment with the health plan, which could impact the timeliness of identification of members with specific needs.

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. However, four of the nine *Childhood Immunization Status* submeasures experienced statistically significant increases, and five *Childhood Immunization Status* submeasures ranked within the national Medicaid 90th percentile.

HSAG assigned the *Getting Care Quickly* CAHPS measure to the timeliness domain. The adult measure experienced a decrease of 0.5 percentage points; however, this variation was not statistically significant.

Timeliness—Behavioral Health

Coordination and Continuity of Care was the only standard determined to have requirements that could impact the timeliness domain, and overall performance was very good. Each of the BHOs had processes to ensure that members had comprehensive assessments, which contributes to timely identification of member needs. HSAG found ample evidence at each BHO of referral to and

coordination with a variety of providers including community-based providers, also contributing to timely access to services, particularly during transitions of care.

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, with incremental improvement of less than 2 percentage points among each of the four submeasures. The variation in rates by BHO was smallest for *Non-State Hospitals—30 Days* (9.0 percentage points) and largest for *All Hospitals—7 Days* (16.8 percentage points). These wide variations suggest that the BHOs have room for continued improvement.

Access—Physical Health

The three compliance monitoring standards associated with the access domain were (1) Coordination and Continuity of Care, (2) Member Rights and Protections, and (3) Credentialing and Recredentialing. Both health plans had processes that allowed members with special health care needs direct access to specialists. Both health plans also had comprehensive credentialing programs that ensured access to a wide range of qualified providers. One health plan was asked to revise member communication to ensure members are made aware of Medicaid State plan-covered services that were not available through the health plan, such as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. This health plan was also asked to enhance its processes for screening Medicaid members for the presence of special health care needs following enrollment with the health plan, which could impact member access to services such as the care coordination programs.

Statewide results for performance measures assigned to the access domain were consistent with last year's results, with most of the measures showing changes of less than 5 percentage points. However, Colorado experienced a statistically significant decline in rates for the *Adults' Access to Preventive/Ambulatory Health Services* and two of the indicators for *Children's and Adolescents' Access to Primary Care Practitioners*. Colorado fell below the national Medicaid 10th percentile for *Children's and Adolescents' Access to Primary Care Practitioner—Ages 25 Months to 6 Years.*

HSAG assigned only one CAHPS survey measure to the access domain—*Getting Needed Care*. The child Medicaid population experienced a statistically significant increase of 7.9 percentage points.

Access—Behavioral Health

The BHOs also performed well in the access domain. Five of five BHOs had processes for providing mental health services on-site at nursing facilities, or coordinating transportation services to the community mental health centers (CMHCs). All BHOs used a variety of methods to inform members and providers of members' rights to access services and which services are available. All BHO's had NCQA-compliant credentialing and recredentialing programs that ensured access to a broad range of providers and services. All five BHOs employed several methods to monitor member perception of the adequacy of and access to services, and four of five provided evidence of follow-up on results of these surveys and information.

Overall, statewide BHO performance in the access domain for performance measures was similar to last year's performance. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. Although all *Penetration Rate* submeasures showed either similar performance or a decline in performance compared to last year, none had a change in rate of more than 1.5 percentage points.

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 includes a summary assessment of each health plan's strengths and opportunities for improvement derived from the results of the EQR activities conducted. Also included are HSAG's recommendations for improving the health plans' performance. This section also includes, for each health plan, a summary assessment related to the quality, timeliness of, and access to services furnished, and a summary of overall statewide performance related to the quality, timeliness, and access to services.

Compliance Monitoring Site Reviews

For the FY 2012–2013 site review process, the Department requested review of four areas of performance: coordination and continuity of care, member rights and protections, credentialing and recredentialing, and quality assessment and performance improvement. 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.

The health plan's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal managed care regulations and contract requirements was evaluated through review of the four standards. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

HSAG determined which standards contained requirements that related to the domains of Quality, Timeliness, or Access, as displayed in Table 3–1. Appendix A contains further details about the methodology used to conduct the EQR compliance monitoring site review activities.

Table 3–1—Standards Containing Requirements related to Performance Domains			
Standards	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓	✓	✓
Standard IV—Member Rights and Protections	✓		✓
Standard VIII—Credentialing and Recredentialing	✓		✓
Standard X—Quality Assessment and Performance Improvement	✓		

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 2012–2013).

Table 3–2—Summary of Scores for the Standards for FY 2012–2013 *for* DHMC							
Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard III—Coordination and Continuity of Care	15	15	14	0	1	0	93%
Standard IV—Member Rights and Protections	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	49	47	44	3	0	2	94%
Standard X—Quality Assessment and Performance Improvement	13	13	11	2	0	0	85%
Totals	**82**	**80**	**74**	**5**	**1**	**2**	**93%**

*The overall score is 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*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	80	80	80	0	0	100%
Recredentialing	80	78	78	0	2	100%
Total	**160**	**158**	**158**	**0**	**2**	**100%**

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

Strengths

DHMC maintained experienced, qualified staff to perform case management and care coordination functions. In addition, organizing the utilization management, care support, and complex case management staff within one department facilitated efficiency and communications regarding care coordination for members. The availability of case management personnel in the Denver Health and Hospital Authority (DHHA) specialty clinics enhanced the overall complex case management capabilities within the delivery system.

The Altruista Guiding Care case management software was a powerful program and resource to ensure consistent and complete documentation of complex case management. DHMC staff took the initiative to add customized information to the auto-generated features of the system to ensure a more individualized plan of care. Integration of the Guiding Care system with the DHMC health information system and the DHHA clinical information system enhanced the sharing of case management information with DHHA providers and ancillary departments. When necessary, DHMC obtained member-signed release of information forms to specifically allow for care coordination with external agencies and providers, including mental health providers.

DHMC staff had a variety of methods for keeping the topic of member rights visible to staff and providers. Methods included periodic discussions and trainings in DHHA provider meetings and DHMC leadership meetings and availability of rights lists on the Web site and staff portal. Staff members also reported that customer service and grievance staff members are encouraged to take the opportunity to explain member rights during member-initiated telephone calls to ensure member understanding. In addition, a reminder about member rights was published in the member newsletter at least once each year.

DHMC's credentialing and recredentialing files were well organized and provided clear evidence that primary source verification and recredentialing activities occurred well within the prescribed time frames. Although DHMC is a line of business within DHHA, DHMC entered into an interdepartmental memorandum of understanding (MOU) with DHHA's medical staff office (MSO) to document the relationship and ensure compliance with NCQA standards for credentialing. DHMC performed delegation oversight and monitoring activities, as required when credentialing activities are delegated.

DHMC had a comprehensive Quality Improvement (QI) Program Description that incorporated multiple QI monitoring components. The QI Impact Analysis Report was well organized and comprehensive, and it included summarized findings, opportunities for improvement, and actions taken related to each major QI program component. Many QI activities were conducted in conjunction with the QI activities performed in the DHHA delivery system, which enhances the integration of quality of care for DHMC members into the overall DHHA delivery system. This integration was facilitated through the participation of staff and providers in the QI committees and efforts of both DHMC and DHHA staff. Staff members described the activities of the DHHA Practice Guidelines Committee and the DHHA Access Committee as examples of these efforts.

Recommendations

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

Coordination and Continuity of Care

- DHMC must develop and approve a policy and procedure that outlines the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening package and methods to ensure that screening requirements are met.

Credentialing and Recredentialing

- Although the Medical Staff Bylaws stated that the bylaws applied to allied health professionals (AHPs), they did not delineate processes used for the AHPs. During the on-site interview, DHMC and DHHA staff members explained that AHPs are credentialed using different processes and a separate credentialing committee. DHMC must either revise the Medical Staff Bylaws or develop policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA AHPs.
- The Credentialing and Recredentialing of Practitioners policy included the applicant's right to receive notification of applicant rights. The Medical Staff Bylaws did not address notification to applicants regarding their rights under the credentialing program. DHMC must develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.
- The Medical Staff Bylaws addressed the notification to the provider that an action will be taken, the process for the hearing, and the types of actions available to DHHA; but grounds for actions did not include quality of care reasons. DHMC must revise or develop documents that describe the range of actions available to DHHA for changing the conditions of a practitioner's status based on quality reasons.

Quality Assessment and Performance Improvement

- DHMC must include a summary or statement of the overall impact and effectiveness of the QI program in the annual QI Impact Analysis Report.
- DHMC must communicate to members the availability of clinical practice guidelines and inform members how to access or request them.

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: DHMC performed very well in the quality domain. It demonstrated a well-defined comprehensive care management program that helped ensure that its members with the most complex needs received needs assessments and care plans. DHMC had processes to ensure that members had an ongoing source of primary care and a designated person responsible for coordinating care. DHMC employed several methods to make sure member rights were taken into consideration by all staff and providers and that members were aware of their rights. The

credentialing program was consistent with NCQA requirements and included ongoing monitoring of providers for sanction activity to ensure a robust network of qualified providers. The quality assessment and improvement program included a variety of mechanisms to monitor the provision of services and to evaluate the impact of quality initiatives on care and services. DHMC also had mechanisms to review clinical practice guidelines and to monitor member perceptions of the access to and adequacy of service. DHMC's health information system had the capability to monitor over- and underutilization of services and report data essential to development of quality initiatives.

Timeliness: DHMC's performance as it related to timeliness was very good. DHMC communicated to its providers their responsibility to coordinate member care. Members with complex needs were also assigned a care manager to assist the provider with ensuring the member's needs were met in a timely manner. On-site review of records demonstrated that DHMC coordinated with other providers to ensure timely services during transitions of care.

Access: DHMC also performed very well in the access domain. Its procedures allowed members with special health care needs direct access to specialists, and DHMC staffed specialty clinics with case management personnel. DHMC used a variety of methods to remind its members and providers of members' rights to access care, and DHMC's robust credentialing program ensured its members had access to qualified providers.

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 2012–2013).

Table 3–4—Summary of Scores for the Standards for FY 2012–2013 *for* RMHP

	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard III—Coordination and Continuity of Care	15	15	9	5	1	0	60%
Standard IV—Member Rights and Protections	5	5	4	1	0	0	80%
Standard VIII—Credentialing and Recredentialing	49	47	47	0	0	2	100%
Standard X—Quality Assessment and Performance Improvement	13	13	10	3	0	0	77%
Totals	**82**	**80**	**70**	**9**	**1**	**2**	**88%**

*The overall score is 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*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	80	76	76	0	4	100%
Recredentialing	80	75	75	0	5	100%
Total	**160**	**151**	**151**	**0**	**9**	**100%**

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

Strengths

RMHP had a well-trained, experienced case management staff of licensed registered nurses who were actively engaged in providing diverse support to members and families and coordinating services with multiple providers and entities. The RMHP case management program was supported by a comprehensive, well-organized electronic documentation software system for ongoing case monitoring. The system supported individualized goals and interventions driven by the case manager's critical thinking skills rather than pre-programmed system algorithms. Tools and formats within the system, such as the comprehensive assessment and care plan, were aligned with the

regulatory and contractual requirements but were flexible enough to encourage customized and detailed documentation of the member's needs and progress. RMHP was using multiple data-driven and referral avenues to identify members with the potential need for complex care management services. These avenues included data-driven cost reports, utilization and member risk levels, multiple sources of direct referral, and an outreach screening process for Medicaid members.

On-site, the staff described a project recently initiated whereby the RMHP Member Experience Advisory Committee (MEAC) will evaluate customer "touch points" (defined as points within the RMHP system where members will interact in some way with RMHP or its staff members) to evaluate members' experience with RMHP and opportunities to improve it. The staff reported that this project involves all departments and regions served by RMHP and could impact members within all lines of business.

RMHP's policies and processes were well organized and NCQA-compliant. RMHP's processes for maintaining documents obtained for credentialing and recredentialing provided secure record-keeping and easy access to the staff for processing and accessing provider files, as needed. RMHP's medical practice review committees (MPRCs), which served as RMHP's geographical area-specific peer review and credentialing committees, incorporated the RMHP medical director, or a qualified designee, and included a variety of provider types.

Credentialing Committee/MPRC meeting minutes demonstrated the role of the medical director consistent with the RMHP policy and that the committee reviewed files that did not initially meet criteria. The credentialing committees also reviewed ongoing monitoring for sanction activity, quality of care issues, and delegates' reports of credentialing activities.

Practitioner credentialing and recredentialing files were comprehensive and very well organized, as were organizational provider records. Practitioner and provider records demonstrated RMHP's performance of all required credentialing and recredentialing activities.

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:

Coordination and Continuity of Care

The RMHP provider manual and the Medicaid member handbook communicated most, but not all, of the wraparound services available under the EPSDT program. The explanation of EPSDT services in the member handbook was confusing. The services were not consistently identified as EPSDT and were communicated throughout various sections of the handbook rather than in one section. RMHP must revise or reformat the handbook to clearly define the services available under the EPSDT program and where and how to obtain them.

RMHP must correct its provider communications regarding EPSDT to include:

- The complete listing of Medicaid wraparound services.
- The periodicity schedules for screening services.

- Referral to a dentist beginning at 1 year of age.
- Information on how providers may refer members for wraparound services and inform providers of the availability of EPSDT support services through the local public health departments.
- The correct age range for eligibility of EPSDT services.

RMHP must also implement a process to ensure that all Medicaid members receive an initial screening for special health care needs after enrollment. RMHP must develop and approve a policy describing its screening package and the methods used to assure that screening requirements are met.

Member Rights and Protections

Although member rights were listed on the Web site and in the member handbook, information on the Web site related to behavioral health services was outdated by more than seven years. RMHP must work with its behavioral health organization partner to ensure accurate presentation of mental health/behavioral health information on RMHP's Web site. In addition, the member handbook posted on the Web site was not the current one. RMHP must update its Web site and develop processes to ensure members who choose to use the RMHP Web site receive the most accurate information, and that information available online does not conflict with previous hard copy information the member may have received.

The annual Medicaid enrollment letter (provided on-site) did not inform members of their right to receive a copy of the member handbook upon request; staff members had stated on-site that the letter did include this information. As this was a previous corrective action, HSAG continues to recommend that RMHP evaluate its systems and processes for implementing corrective actions and following through with processes. In order for members to fully understand benefits guaranteed under the Medicaid program and rights associated with these benefit programs, members must receive accurate and timely information because conflicting information from various sources is confusing. RMHP must also ensure that members are notified annually of their right to request and receive a copy of the member handbook.

Quality Assessment and Performance Improvement

- RMHP must include an assessment of the overall impact and effectiveness of the QI program in the QI annual report.
- RMHP must modify its policies and processes to ensure that CPGs applicable to Medicaid members are reviewed and approved annually.
- RMHP must perform and document an audit of a statistically valid sample of Medicaid encounter claims that includes verification of claims information against medical record documentation.

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: RMHP's performance, as it relates to the quality domain, was mixed. RMHP clearly communicated with its providers the expectation that primary care providers (PCPs) serve as care coordinators and ensured every member was assigned to a PCP. RMHP had comprehensive processes to protect the privacy and confidentiality of medical records, and member materials included a definitive statement that articulated RMHP's intention to provide equal opportunity and to prevent discrimination; however, RMHP did not annually inform members of their right to receive a copy of the member handbook upon request. RMHP had a comprehensive credentialing and recredentialing program that ensured its members have access to a network of qualified providers. RMHP had a comprehensive quality assurance and performance improvement (QAPI) program that included effective use of its health information system data to evaluate over- and underutilization of services and report data essential to the development of quality initiatives.

Timeliness: Coordination and Continuity of Care was the only standard HSAG determined to have requirements that could impact the timeliness domain, and RMHP's performance was mixed. The care coordination program included mechanisms for coordinating with multiple providers to ensure timely access to services during transitions of care. Once referred to the care management program, members received a comprehensive needs assessment, individual care coordination plan, an active case manager, and frequent follow-up.

Access: RMHP's performance as it relates to the access domain was also mixed. RMHP's processes allowed members with special health care needs direct access to specialists, and the RMHP network of providers appeared to be comprehensive. HSAG found that RMHP did not communicate to its members or providers all of the services available, and member materials included inaccurate, outdated information regarding how to access behavioral health services. Not knowing which services are available and where to obtain them can pose a significant barrier to members' access to services.

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. Appendix F 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 2012–2013 Statewide Average***
Standard III—Coordination and Continuity of Care	77%
Standard IV—Member Rights and Protections	90%
Standard VIII—Credentialing and Recredentialing	97%
Standard X—Quality Assessment and Performance Improvement	81%
Total	**90%**

* Statewide average rates are calculated by dividing the sum of the individual numerators by the sum of the individual denominators for the standard scores.

Table 3–7—Summary of Data From the Record Reviews	
Standards	**FY 2012–2013 Statewide Average***
Credentialing	100%
Recredentialing	100%
	100%

* Statewide average rates calculated by dividing the sum of the individual numerators by the sum of the individual denominators for the record review scores.

Summary Assessment Related to Quality, Timeliness, and Access

Quality: All four standards reviewed had requirements that impacted the quality domain. Several aspects of the quality domain were essential to providing quality care to members for which both health plans performed well. These program features included robust policies and practices for the protection of member privacy and confidentially of member records and policies and practices to ensure members are not discriminated against. Both health plans had a powerful health information system with the ability to document and support care coordination efforts and collect, analyze, and report data essential to evaluating the quality of services furnished. In addition, both health plans had comprehensive and NCQA-compliant credentialing programs that ensured medical director input in credentialing decisions, as well as initial and ongoing monitoring of provider sanctions to ensure providers in the network met the quality standards. Both health plans were asked to include an overall statement regarding the impact of their quality program in the annual quality program analysis report.

Timeliness: Statewide performance as it relates to the timeliness domain was good overall. Both health plans had strong care coordination programs that included processes to ensure timely access to service, particularly during transitions of care.

Access: Both health plans had processes that allowed members with special health care needs direct access to specialists. Both health plans also had comprehensive credentialing programs that ensured access to a wide range of qualified providers.

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 2012–2013 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	✓		
Appropriate Testing for Children with Pharyngitis	✓		
Prenatal Care and *Postpartum Care*	✓	✓	✓
Children's and Adolescents' Access to Primary Care Providers (PCPs)			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Chlamydia Screening in Women	✓		
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Adult BMI Assessment	✓		
Anti-depressant Medication Management	✓		
Follow-up Care for Children Prescribed ADHD Medication	✓	✓	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	
Controlling High Blood Pressure	✓		

Table 3–8—FY 2012–2013 Performance Measures Required for Validation			
Measure	Quality	Timeliness	Access
Comprehensive Diabetes Care	✓		✓
Annual Monitoring for Patients on Persistent Medications	✓		
Ambulatory Care			✓

The Department required that 21 performance measures be validated in FY 2012–2013 based on HEDIS 2013 specifications. Several measures were also validated in FY 2011–2012. HSAG made comparisons between the previous year's and the current year's results, when possible.

Denver Health Medicaid Choice

Compliance With Information Systems (IS) Standards

DHMC was fully compliant with all IS Standards relevant to the scope of the performance measure validation. The auditor noted that DHMC had some challenges working with its software vendor in capturing complete membership data. Issues were identified by DHMC and the vendor during the initial file loads. The auditor, in conjunction with an NCQA representative, assessed that there were communication issues between the plan and the vendor. Specifically, the issue was which membership files needed to be created and normalized to the vendor's software, and how to accomplish this. Once these issues were identified and corrected, the membership was successfully and accurately captured.[3-1] The auditor recommended in the Final Audit Report that DHMC should consider extracting data from the electronic medical record to be used as a supplemental data source and reducing medical record chart review processes. If implemented, this extraction should follow the new supplemental data guidelines, which impact the completion data and primary source documentation required.

Pediatric Care Performance Measures

Table 3–9 displays the DHMC HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results 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 Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Childhood Immunization Status—Combination 2	84.18%	81.22%	75th–89th	R
Childhood Immunization Status—Combination 3	83.70%	80.87%	75th–89th	R
Childhood Immunization Status—Combination 4	51.58%	**80.73%**	≥90th	R
Childhood Immunization Status—Combination 5	70.32%	65.75%	≥90th	R
Childhood Immunization Status—Combination 6	73.24%	69.76%	≥90th	R
Childhood Immunization Status—Combination 7	45.26%	**65.61%**	≥90th	R

[3-1] HEDIS Compliance Audit, Final Audit Report, Denver Health Medical Plan, Inc., July 2013.

Table 3–9—Review Results and Audit Designation for Pediatric Care Performance Measures *for* DHMC				
Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Childhood Immunization Status—Combination 8	46.96%	**69.69%**	≥90th	R
Childhood Immunization Status—Combination 9	62.04%	56.96%	≥90th	R
Childhood Immunization Status—Combination 10	41.12%	**56.89%**	≥90th	R
Immunizations for Adolescents—Combination 1	82.34%[2]	79.54%	75th–89th	R
Well-Child Visits in the First 15 Months of Life—Zero Visits	0.97%	1.22%	50th–74th[3]	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	51.34%	**69.10%**	50th–74th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.57%	66.91%	25th–49th	R
Adolescent Well-Care Visits	51.09%	49.15%	25th–49th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	85.16%	87.83%	≥90th	R
Counseling for Nutrition: Total	80.29%	75.18%	75th–89th	R
Counseling for Physical Activity: Total	61.31%	58.39%	75th–89th	R
Appropriate Testing for Children with Pharyngitis	—	70.30%	50th–74th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] The rate displayed reflects administrative data only. DHMC reported a hybrid rate of 86.1 percent for the *Immunizations for Adolescents—Combination 1* indicator for HEDIS 2012.

[3] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

Strengths

The auditor noted that DHMC had a very organized process to capture medical record abstracted data thoroughly and accurately. DHMC was also instrumental in working with the state Medicaid office to correctly identify membership for twin births.

All DHMC performance measures within the pediatric care performance domain received an audit result of *Reportable (R)* for 2013. DHMC had a statistically significant increase in rate of nearly 18 percentage points for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator. While four *Childhood Immunization Status* indicators also showed statistically significant increases of more than 15 percentage points, HSAG cannot ascertain if the rate increases reflect performance improvement, as there was a change in reporting requirements by the Department and a change in

dosing requirements for hepatitis A, a vaccine that is related to *Combinations 4, 7, 8,* and *10*. Nonetheless, DHMC's performance on most of the *Childhood Immunization Status* indicators benchmarked at or above the national HEDIS Medicaid 90th percentile.

Recommendations

HSAG recommends that DHMC focus its improvement efforts on the two indicators with a decrease in rate of more than 5 percentage points. These indicators are *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition: Total* and *Childhood Immunization Status—Combination 9*.

Although DHMC's *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* rates did not report a statistically significant decline from the prior year, these rates were below the federal EPSDT mandate of 80 percent. HSAG recommends that DHMC work with the Department's EPSDT Outreach (Healthy Communities) program to explore ways to increase the percentage of children who receive at least one visit per year.

Access to Care and Preventive Screening Performance Measures

Table 3–10 shows the DHMC HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for each performance measure for "Access to Care" and "Preventive Screening."

Table 3–10—Rates and Audit Results for Access to Care and Preventive Screening Performance Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.45%	85.40%	25th–49th	R
Postpartum Care	59.61%	54.99%	10th–24th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	94.98%	**92.28%**	<10th	R
Ages 25 Months to 6 Years	81.18%	**78.88%**	<10th	R
Ages 7 to 11 Years	83.99%	83.64%	10th–24th	R
Ages 12 to 19 Years	85.19%	85.82%	10th–24th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	73.52%	**70.11%**	<10th	R

Table 3–10—Rates and Audit Results for Access to Care and Preventive Screening Performance Measures *for* DHMC				
Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Preventive Screening				
Chlamydia Screening in Women—Total	67.80%	**72.35%**	≥90th	R
Breast Cancer Screening	—	49.16%	25th–49th	R
Cervical Cancer Screening	—	51.13%	<10th	R
Adult BMI Assessment	84.91%	86.86%	≥90th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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 rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

Strengths

All of DHMC's performance measures received an audit result of *Reportable (R)* for 2013 for the "Access to Care" and "Preventive Screening" performance measures. DHMC had a significant increase of nearly 5 percentage points for the *Chlamydia Screening in Women—Total* indicator, while most other measures had performances similar to last year's performance. Two measures ranked above the national HEDIS Medicaid 90th percentile.

Recommendations

HSAG recommends that DHMC focus its improvement efforts on measures that ranked below the national HEDIS Medicaid 10th percentile. These measures include the *Cervical Cancer Screening* measure as well as two of the *Children's and Adolescents' Access to Primary Care Practitioners* indicators and the *Adults' Access to Preventive/Ambulatory Health Services—Total* indicator, where these three "Access to Care" indicators also reported a significant decrease in rate from last year.

Mental/Behavioral Health Performance Measures

Table 3–11 shows the DHMC HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for the "Mental/Behavioral Health" performance measures.

Table 3–11—Rates and Audit Results for Mental/Behavioral Health Performance Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Anti-depressant Medication Management				
Effective Acute Phase Treatment	—	57.14%	75th–89th	R
Effective Continuation Phase Treatment	—	45.05%	≥90th	R
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	—	24.55%	10th–24th	R
Continuation	—	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	—	47.14%	75th–89th	R
Engagement	—	3.31%	10th–24th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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.

NA is shown when the health plan followed HEDIS specifications but the denominator is too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

Strengths

Although none of the "Mental/Behavioral Health" Performance Measures were reported in last year's technical report, the *Anti-depressant Medication Management—Effective Continuation Phase Treatment* indicator met or exceeded the national HEDIS Medicaid 90th percentile.

Recommendations

HSAG recommends that DHMC focus its improvement efforts on measures that ranked below the national HEDIS 25th percentile. These indicators include the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* and the *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement* indicators.

Living With Illness and Use of Services Performance Measures

Table 3–12 shows the DHMC HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for the "Living with Illness" and "Use of Services" performance measures.

Table 3–12—Rates and Audit Results for Living With Illness and Use of Services Performance Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Living with Illness				
Controlling High Blood Pressure	—	70.07%	≥90th	R
Comprehensive Diabetes Care				
HbA1c Testing	84.91%	83.21%	50th–74th	R
HbA1c Poor Control (>9.0%)	37.71%	33.58%	10th–24th[2]	R
HbA1c Control (<8.0%)	46.72%	51.09%	50th–74th	R
Eye Exam	56.20%	50.12%	25th–49th	R
LDL-C Screening	75.43%	70.32%	10th–24th	R
LDL-C Level <100 mg/dL	54.01%	50.36%	≥90th	R
Medical Attention for Nephropathy	79.32%	80.78%	50th–74th	R
Blood Pressure Controlled <140/80 mm Hg	55.47%	50.61%	75th–89th	R
Blood Pressure Controlled <140/90 mm Hg	71.05%	70.07%	75th–89th	R
Annual Monitoring for Patients on Persistent Medications—Total	86.05%	**84.14%**	25th–49th	R
Use of Services[3]				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	40.48	44.56	10th–24th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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 rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

[3] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

All of DHMC's performance measures in the "Living with Illness" domain received an audit result of *Reportable (R)* for 2013. The *Controlling High Blood Pressure* measure and the *Comprehensive*

Diabetes Care—LDL-C Level <100 mg/dL indicator exceeded the national HEDIS Medicaid 90th percentile. Though not statistically significant, the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* indicator had a rate increase of more than 4 percentage points from last year.

Recommendations

HSAG recommends that DHMC focus its improvement efforts on the *Annual Monitoring for Patients on Persistent Medications—Total* indicator, which demonstrated a statistically significantly decrease in performance from last year. The two *Comprehensive Diabetes Care* indicators with a rate decrease of more than 5 percentage points (*Eye Exam* and *LDL-C Screening*) may also present opportunities for improvement. The *LDL-C Screening* indicator also ranked below the national HEDIS Medicaid 25th percentile.

Utilization Observations

The utilization indicator *Emergency Department Visits per 1,000 Member Months* under *Ambulatory Care* had a rate increase of over four visits per 1,000 member months. Since the rate 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 the majority of the quality-related measures. The indicator *Chlamydia Screening in Women—Total* had a significant rate increase in HEDIS 2013 of 4.55 percentage points. A statistically significant increase in rate of over 17 percentage points was also observed for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator. Although a few of the *Comprehensive Diabetes Care* indicators had rate declines of more than 5 percentage points from last year's rate, *Annual Monitoring for Patients on Persistent Medications—Total* was the only quality measure with a significant rate decrease. For newly reported measures, the *Cervical Cancer Screening* measure ranked below the national HEDIS Medicaid 10th percentile, presenting an opportunity for improvement for DHMC. However, the *Anti-depressant Medication Management—Effective Continuation Phase Treatment* indicator had high performance, benchmarking above the national HEDIS Medicaid 90th percentile.

Timeliness: Although a majority of the timeliness-related measures performed consistently compared to last year, a significant improvement of more than 17 percentage points was observed for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator.

Access: DHMC had sustained performance in a majority of the access-related measures, with only slight changes in performance between HEDIS 2012 and HEDIS 2013. Two *Children's and Adolescents' Access to Primary Care Practitioners* indicators (*Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*) and the indicator *Adults' Access to Preventive/Ambulatory Health Services—Total* had significant declines from HEDIS 2012.

Rocky Mountain Health Plans

Compliance With Information Systems Standards

- RMHP was fully compliant with all IS Standards relevant to the scope of the performance measure validation. The auditor did not identify any notable issues during the review of the standards that had any negative impact on HEDIS reporting. The auditor had no recommendations for RMHP.

Pediatric Care Performance Measures

Table 3–13 shows the RMHP HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for each performance measure for "Pediatric Care." It is important to note that RMHP chose to rotate the *Childhood Immunization Status* measure for HEDIS 2013, which means the rates in the HEDIS Rate—2012 and 2013 are from the same measurement year (2011). Although RMHP reported the same *Childhood Immunization Status* rates for both years, due to a change in reporting requirements from the Department, values displayed in the HEDIS 2012 and 2013 columns reflect different data collection methods. Statistical tests were also not performed for this measure.

Table 3–13—Rates and Audit Results for Pediatric Care Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Childhood Immunization Status—Combination 2	78.24%	51.45%[2, 3]	<10th	R
Childhood Immunization Status—Combination 3	76.16%	49.62%[2, 3]	<10th	R
Childhood Immunization Status—Combination 4	12.73%	9.19%[2, 3]	<10th	R
Childhood Immunization Status—Combination 5	63.43%	40.89%[2, 3]	10th–24th	R
Childhood Immunization Status—Combination 6	52.08%	31.39%[2, 3]	25th–49th	R
Childhood Immunization Status—Combination 7	11.34%	8.27%[2, 3]	<10th	R
Childhood Immunization Status—Combination 8	9.03%	5.82%[2, 3]	<10th	R
Childhood Immunization Status—Combination 9	44.91%	27.11%[2, 3]	25th–49th	R
Childhood Immunization Status—Combination 10	8.10%	5.51%[2, 3]	<10th	R
Immunizations for Adolescents—Combination 1	47.95%	53.79%	25th–49th	R
Well-Child Visits in the First 15 Months of Life—Zero Visits	0.23%	0.23%[3]	<10th[4]	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	82.64%	82.64%[3]	≥90th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.86%	66.75%	25th–49th	R
Adolescent Well-Care Visits	42.82%	42.82%[3]	25th–49th	R

Table 3–13—Rates and Audit Results for Pediatric Care Performance Measures *for* RMHP				
Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	71.06%	72.65%	75th–89th	R
Counseling for Nutrition: Total	62.96%	63.45%	50th–74th	R
Counseling for Physical Activity: Total	56.71%	56.73%	75th–89th	R
Appropriate Testing for Children with Pharyngitis	—	89.90%	≥90th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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 rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] RMHP chose to rotate the *Childhood Immunization Status* measure for HEDIS 2013. Therefore, the results in the HEDIS 2012 and 2013 columns are from the same measurement year (2011). A hybrid rate was reported for HEDIS 2012. The rate displayed for HEDIS 2013 reflects administrative data extrapolated from HEDIS 2012 rate.

[3] 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 2013 *Technical Specifications for Health Plans, Volume 2*.

[4] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

Strengths

All of RMHP's pediatric care performance measures received an audit result of *Reportable (R)* for 2013. Although 12 measures/indicators were rotated and the performance cannot be compared between 2012 and 2013, the *Immunizations for Adolescents—Combination 1* indicator had the highest rate increase of 5.84 percentage points. In addition, the *Appropriate Testing for Children with Pharyngitis* and *Well-Child Visits in the First 15 Months of Life—6+ Visits* measures performed above the national HEDIS Medicaid 90th percentile.

Recommendations

HSAG recommends that RMHP focus its improvement efforts on the *Childhood Immunization Status* measures, especially the six combinations that ranked below the national HEDIS Medicaid 10th percentile.

Although RMHP reported a slight increase in its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* rate, the rate was still below the federal EPSDT mandate of 80 percent. Likewise, RMHP's *Adolescent Well-Care Visits* rate also fell short of the 80-percent threshold. HSAG recommends that RMHP work with the Department's EPSDT Outreach (Healthy Communities) program to explore ways to increase the percentage of children who receive at least one visit per year.

Access to Care and Preventive Screening Performance Measures

Table 3–14 shows the RMHP HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for each performance measure for "Access to Care" and "Preventive Screening."

Table 3–14—Rates and Audit Results for Access to Care and Preventive Screening Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	96.95%	95.64%	≥90th	R
Postpartum Care	77.44%	73.83%	75th–89th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	98.54%	**96.90%**	25th–49th	R
Ages 25 Months to 6 Years	89.04%	**87.14%**	25th–49th	R
Ages 7 to 11 Years	92.08%	90.90%	50th–74th	R
Ages 12 to 19 Years	91.57%	89.99%	50th–74th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	89.76%	88.81%	75th–89th	R
Preventive Screening				
Chlamydia Screening in Women—Total	45.41%	46.15%	<10th	R
Breast Cancer Screening	—	47.79%	25th–49th	R
Cervical Cancer Screening	—	55.02%[2]	10th–24th	R
Adult BMI Assessment	69.91%	**80.26%**	≥90th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.
R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] The rate displayed reflects administrative data only. RMHP reported a rotated hybrid rate of 68.48 percent for the *Cervical Cancer Screening* measure for HEDIS 2013.

Strengths

All of RMHP's performance measures received an audit result of *Reportable (R)* for 2013. Improvement was seen for two of the "Preventive Screening" measures, with a significant increase in performance of 10.35 percentage points for *Adult BMI Assessment*. This measure and the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator were above the national HEDIS Medicaid 90th percentile.

Recommendations

HSAG recommends that RMHP focus its improvement efforts on the two *Children's and Adolescents' Access to Primary Care Practitioners* indicators (i.e., *Ages 12 to 24 Months* and *Ages 25 Months to 6 Years)* where significant decreases in rates were noted. In addition, the *Chlamydia Screening in Women—Total* measure ranked below the 10th percentile of the national HEDIS Medicaid performance.

Mental/Behavioral Health Performance Measures

Table 3–15 shows the RMHP HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for the "Mental/Behavioral Health" performance measures.

Table 3–15—Rates and Audit Results for Mental/Behavioral Health Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Anti-depressant Medication Management				
Effective Acute Phase Treatment	—	NB	NB	NB
Effective Continuation Phase Treatment	—	NB	NB	NB
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	—	43.56%	50th–74th	R
Continuation	—	40.63%	25th–49th	R
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	—	NB	NB	NB
Engagement	—	NB	NB	NB

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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 rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

Strengths

Since all of the "Mental/Behavioral Health" performance measures were new in HEDIS 2013, no particular strength was identified under this domain.

Recommendations

Since all of the "Mental/Behavioral Health" performance measures were new in HEDIS 2013 and the rates of the reportable measures were comparable to the national benchmark, HSAG did not make any recommendations under this domain.

Living With Illness and Use of Services Performance Measures

Table 3–16 shows the RMHP HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for "Living with Illness" and "Use of Services" performance measures.

Table 3–16—Rates and Audit Results for Living With Illness and Use of Services Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Living with Illness				
Controlling High Blood Pressure	—	73.38%	≥90th	R
Comprehensive Diabetes Care				
HbA1c Testing	92.20%	92.20%[2]	≥90th	R
HbA1c Poor Control (>9.0%)	19.24%	19.24%[2]	<10th[3]	R
HbA1c Control (<8.0%)	72.23%	72.23%[2]	≥90th	R
Eye Exam	60.80%	62.73%	75th–89th	R
LDL-C Screening	74.59%	75.55%	25th–49th	R
LDL-C Level <100 mg/dL	47.73%	44.86%	75th–89th	R
Medical Attention for Nephropathy	75.86%	76.22%	25th–49th	R
Blood Pressure Controlled <140/80 mm Hg	61.52%	61.52%[2]	≥90th	R
Blood Pressure Controlled <140/90 mm Hg	79.85%	79.85%[2]	≥90th	R
Annual Monitoring for Patients on Persistent Medications—Total	85.03%	86.03%	50th–74th	R
Use of Services[4]				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	62.90	62.73	25th–49th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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 rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[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 2013 *Technical Specifications for Health Plans, Volume 2*.

[3] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

[4] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

All of RMHP's performance measures received an audit result of *Reportable (R)* for HEDIS 2013. RMHP's efforts in managing members' blood pressure as well as HbA1c status had resulted in having six "Living with Illness" indicators ranking among the top 10th percentile of the national HEDIS performance.

Recommendations

HSAG recommends that RMHP focus its improvement efforts on the two *Comprehensive Diabetes Care* indicators that ranked below the national HEDIS Medicaid 50th percentile. These indicators were *LDL-C Screening* and *Medical Attention for Nephropathy.*

Utilization Observations

Compared to last year, RMHP reported minor variation in rate for the utilization measure. Since the rate 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 2013. The following is a summary assessment of RMHP's performance measure results related to the domains of quality, timeliness, and access.

Quality: RMHP performed consistently for many of the quality-related measures, although the measure *Adult BMI Assessment* had a significant rate increase of over 10 percentage points in HEDIS 2013. The newly reported measure *Appropriate Testing for Children with Pharyngitis* ranked above the national HEDIS Medicaid 90th percentile. An opportunity for improvement for RMHP included the newly reported measure *Cervical Cancer Screening,* which scored below the national HEDIS Medicaid 25th percentile. *Childhood Immunization Status*, *Well-Child Visits in the First 15 Months of Life*, *Adolescent Well-Care Visits*, and some of the *Comprehensive Diabetes Care* indicators were rotated measures and could not be compared between HEDIS 2012 and HEDIS 2013. This included six *Childhood Immunization Status* indicators that fell below the national HEDIS Medicaid 10th percentile. However, the rotated *Well-Child Visits in the First 15 Months of Life* measure and the rotated *Comprehensive Diabetes Care* indicators ranked in the top national HEDIS Medicaid percentile.

Timeliness: The majority of the timeliness-related measures performed consistently from last year, although the *Immunizations for Adolescents* measure had a slight improvement in performance of 5.84 percentage points. There was a decrease in rate for both of the *Prenatal and Postpartum Care* indicators, although neither had a significant decline. The rotated *Childhood Immunization Status* indicators served as an opportunity for improvement as six of RMHP's rates ranked below the national HEDIS Medicaid 10th percentile. However, the *Well-Child Visits in the First 15 Months of Life* indicators both ranked in the top national HEDIS Medicaid performance.

Access: For the majority of the access-related measures, RMHP had sustained performance levels in HEDIS 2013. The *Children's and Adolescents' Access to Primary Care Practitioners* indicators all had rate decreases compared to last year's rates, although only the *Ages 12 to 24 Months* and the *Ages 25 Months to 6 Years* indicators had significant rate declines. All of the rotated *Comprehensive Diabetes Care* indicators ranked in the top national HEDIS Medicaid performance.

Primary Care Physician Program

HSAG conducted an NCQA HEDIS Compliance Audit for PCPP. The NCQA HEDIS Compliance Audit followed the 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 2012
Certified Software Report	CY 2012
Performance Measure Reports	CY 2012
Supporting Documentation	CY 2012
On-site Interviews and Information Systems Demonstrations	CY 2012

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

PCPP was fully compliant with all NCQA-defined IS standards relevant to the scope of the performance measure validation, except for IS 1.0.[3-2] As in years past, during calendar year 2012, the Department continued to experience challenges with data completeness associated with services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) due to the current set-up of the mechanized claims processing and information retrieval system, Medicaid Management Information System (MMIS). According to the Department, these centers were reimbursed by submitting revenue codes. However, MMIS allowed claims submitted by these centers to adjudicate without requiring sufficient diagnosis and procedure details behind the claims. More specifically, additional claim lines populated with procedure code details beyond the revenue code were "denied" by MMIS. When these centers realized that these claims lines were rejected, this information was omitted in subsequent claim submissions. At the end of the audit, the

[3-2] HEDIS 2013 Compliance Audit, Final Report of Findings for Colorado Department of Health Care Policy and Financing, July 2013.

Department was still awaiting a solution to this issue as the Customer Service Request (CSR) was being processed. The auditor determined that this issue resulted in a minimal impact on HEDIS reporting and recommended that the Department investigate ways to follow NQCA's latest guidelines to acquire supplemental data from these centers, if possible.

Pediatric Care Performance Measures

Table 3–18 shows the PCPP HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for each performance measure for "Pediatric Care."

Table 3–18—Rates and Audit Results for Pediatric Care Performance Measures *for* PCPP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Childhood Immunization Status—Combination 2	76.64%	74.25%	25th–49th	R
Childhood Immunization Status—Combination 3	76.12%	72.62%	50th–74th	R
Childhood Immunization Status—Combination 4	53.28%	**72.39%**	≥90th	R
Childhood Immunization Status—Combination 5	58.27%	58.70%	50th–74th	R
Childhood Immunization Status—Combination 6	38.32%	**45.94%**	75th–89th	R
Childhood Immunization Status—Combination 7	41.21%	**58.47%**	≥90th	R
Childhood Immunization Status—Combination 8	27.82%	**45.94%**	≥90th	R
Childhood Immunization Status—Combination 9	31.23%	**38.05%**	50th–74th	R
Childhood Immunization Status—Combination 10	22.57%	**38.05%**	≥90th	R
Immunizations for Adolescents—Combination 1	64.16%	**70.66%**	50th–74th	R
Well-Child Visits in the First 15 Months of Life—Zero Visits	1.06%	2.67%	75th–89th[2]	R
Well-Child Visits in the First 15 Months of Life—6+ Visits	61.38%	62.00%	25th–49th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.07%	61.56%	10th–24th	R
Adolescent Well-Care Visits	47.93%	**39.42%**	10th–24th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	55.47%	**77.86%**	≥90th	R
Counseling for Nutrition: Total	55.23%	61.56%	50th–74th	R
Counseling for Physical Activity: Total	51.09%	**63.99%**	75th–89th	R
Appropriate Testing for Children with Pharyngitis	—	68.16%	25th–49th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.
— 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 rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.
[2] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

Strengths

PCPP's performance measures received an audit designation of *Reportable (R)* for 2013. The *Immunizations for Adolescents—Combination 1* indicator and two indicators (*BMI Assessment: Total* and *Counseling for Physical Activity: Total*) for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* had significantly improved performance, with increases of greater than 6 percentage points. The highest improvement was for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total* indicator which improved by over 22 percentage points and was above the national HEDIS Medicaid 90th percentile. Additionally, six indicators for the *Childhood Immunization Status* measure had significant increases in rates, although these increases should be interpreted with caution as there was a change in the data collection methodology and a change in the dosing requirement for hepatitis A, a vaccine that is related to *Combination 4, 7, 8,* and *10*.

Recommendations

The *Adolescent Well-Care Visits* measure had a statistically significant decline of 8.51 percentage points from last year and was well below the EPSDT mandate of 80 percent. Although PCPP showed a slight increase in its *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* rate, it also fell below the federal mandate. These measures presented opportunities for improvement.

Access to Care and Preventive Screening Performance Measures

Table 3–19 shows the PCPP HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for each performance measure for "Access to Care" and "Preventive Screening".

Table 3–19—Rates and Audit Results for Access to Care and Preventive Screening Performance Measures *for* PCPP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	80.26%	**86.34%**	50th–74th	R
Postpartum Care	69.58%	69.67%	50th–74th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	97.04%	97.86%	50th–74th	R
Ages 25 Months to 6 Years	85.80%	86.55%	10th–24th	R
Ages 7 to 11 Years	90.19%	89.61%	25th–49th	R
Ages 12 to 19 Years	90.05%	88.78%	25th–49th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	83.89%	83.02%	25th–49th	R

Table 3–19—Rates and Audit Results for Access to Care and Preventive Screening Performance Measures *for* PCPP				
Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Preventive Screening				
Chlamydia Screening in Women—Total	26.11%	28.75%	<10th	R
Breast Cancer Screening	—	30.36%	<10th	R
Cervical Cancer Screening	—	27.66%	<10th	R
Adult BMI Assessment	50.85%	**71.05%**	75th–89th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.
R is shown when the rate was reportable, according to NCQA standards.
[1] Percentile rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

Strengths

All of PCPP's "Access to Care" and "Preventive Screening" performance measures received an audit result of *Reportable (R)* for HEDIS 2013. PCPP had significant increases in the rates for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Adult BMI Assessment* measures. The *Adult BMI Assessment* measure had an improvement of 20.20 percentage points.

Recommendations

PCPP should consider implementing a performance improvement strategy for the *Chlamydia Screening in Women—Total*, *Breast Cancer Screening*, and *Cervical Cancer Screening* measures due to their ranking below the national HEDIS Medicaid 10th percentile.

Mental/Behavioral Health Performance Measures

Table 3–20 shows the PCPP HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for the "Mental/Behavioral Health" performance measures.

Table 3–20—Rates and Audit Results for Mental/Behavioral Health Performance Measures *for* PCPP				
Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Anti-depressant Medication Management				
Effective Acute Phase Treatment	—	65.35%	≥90th	R
Effective Continuation Phase Treatment	—	48.51%	≥90th	R

Table 3–20—Rates and Audit Results for Mental/Behavioral Health Performance Measures *for* PCPP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	—	35.96%	25th–49th	R
Continuation	—	30.95%	10th–24th	R
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	—	25.90%	<10th	R
Engagement	—	3.01%	10th–24th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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 rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

Strengths

While all of the "Mental/Behavioral Health" performance measures were new in HEDIS 2013, all of PCPP's performance measures received an audit result of *Reportable (R)* for HEDIS 2013. The two *Anti-depressant Medication Management* indicators ranked above the national HEDIS Medicaid 90th percentile.

Recommendations

The indicator *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation* ranked below the national HEDIS Medicaid 10th percentile. PCPP should consider targeting its improvement efforts on this indicator.

Living With Illness and Use of Services Performance Measures

Table 3–21 shows the PCPP HEDIS 2012 and HEDIS 2013 rates, the percentile rankings for HEDIS 2013 rates, and HEDIS 2013 audit results for "Living with Illness" and "Use of Services" measures and indicators.

Table 3–21—Rates and Audit Results for Living With Illness and Use of Services Performance Measures *for* PCPP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2013 Audit Results
	2012	2013		
Living with Illness				
Controlling High Blood Pressure	—	46.47%	10th–24th	R
Comprehensive Diabetes Care				
HbA1c Testing	65.69%	71.29%	<10th	R
HbA1c Poor Control (>9.0%)	63.75%	57.66%	75th–89th[2]	R
HbA1c Control (<8.0%)	32.60%	36.98%	10th–24th	R
Eye Exam	45.74%	50.36%	25th–49th	R
LDL-C Screening	56.45%	57.91%	<10th	R
LDL-C Level <100 mg/dL	25.30%	30.66%	25th–49th	R
Medical Attention for Nephropathy	68.13%	66.67%	<10th	R
Blood Pressure Controlled <140/80 mm Hg	27.74%	**39.66%**	50th–74th	R
Blood Pressure Controlled <140/90 mm Hg	40.88%	**54.26%**	10th–24th	R
Annual Monitoring for Patients on Persistent Medications—Total	71.93%	**66.77%**	<10th	R
Use of Services[3]				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	55.52	57.84	25th–49th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— 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 rankings were assigned to the HEDIS 2012 reported rates based on HEDIS 2011 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

[3] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

All of PCPP's performance measures received an audit result of *Reportable (R)* for HEDIS 2013. Two *Comprehensive Diabetes Care* indicators (*Blood Pressure Controlled <140/80 mm Hg* and *Blood Pressure Controlled <140/90 mm Hg*) had significant improvement in performance, with more than an 11 percentage point increase in rates.

Recommendations

The rate for *Annual Monitoring for Patients on Persistent Medications—Total* significantly declined by 5.16 percentage points. In addition, this indicator and three *Comprehensive Diabetes Care* indicators (*HbA1c Testing*, *LDL-C Screening*, and *Medical Attention for Nephropathy*) fell below the 10th percentile of the national HEDIS Medicaid performance, which represent opportunities for improvement.

Utilization Observations

Compared to last year, PCPP exhibited minor variation in the utilization measure rate for *Ambulatory Care*. Since the rate does 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 HEDIS 2013. 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 performance varied for a number of measures. Statistically significant improvement was observed for *Childhood Immunization Status* (*Combinations 4, 6, 7, 8, 9,* and *10*), *Immunizations for Adolescents—Combination 1*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (*BMI Assessment: Total* and *Counseling for Physical Activity: Total*), *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, *Adult BMI Assessment*, and *Comprehensive Diabetes Care* (*Blood Pressure Controlled <140/80 mm Hg* and *Blood Pressure Controlled <140/90 mm Hg*). Please note the rate increases for four *Childhood Immunization Status* indicators (*Combinations 4, 7, 8,* and *10*) may not reflect the performance improvement due to changes in the dosing requirement for hepatitis A in the measure specification. Several measures reported significant rate declines, including *Adolescent Well-Care Visits* and *Annual Monitoring for Patients on Persistent Medications—Total*. Among the newly reported measures, *Chlamydia Screening in Women—Total, Breast Cancer Screening, Cervical Cancer Screening*, and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation* measures served as opportunities for improvement for PCPP as they ranked below the national HEDIS Medicaid 10th percentile. However, both *Anti-depressant Medication Management* indicators ranked in the national HEDIS Medicaid 90th percentile.

Timeliness: For measures related to timeliness, there were notable changes observed as well as measures that performed consistently with last year. Six indicators for *Childhood Immunization Status* (*Combinations 4, 6, 7, 8, 9,* and *10*), *Immunizations for Adolescents*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* had significant improvement in performance. As discussed above, the rate increases for four *Childhood Immunization Status* indicators (*Combinations 4, 7, 8,* and *10*) should be interpreted with caution. The *Adolescent Well-Care Visits* measure had a significant rate decline of over 8 percentage points, and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation* ranked below the national HEDIS Medicaid 10th percentile.

Access: For measures related to access, there were notable changes observed as well as measures that performed very similar with last year. Statistically significant improvements in rates were seen for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and the *Blood Pressure Controlled <140/80 mm Hg* and *Blood Pressure Controlled <140/90 mm Hg* indicators for the *Comprehensive Diabetes Care* measure.

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

Table 3–22 shows the statewide weighted averages for 2012 and 2013 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 Rankings[1]
	2012	2013	
Childhood Immunization Status—Combination 2	81.44%	**72.27%**	25th–49th
Childhood Immunization Status—Combination 3	80.53%	**71.31%**	25th–49th
Childhood Immunization Status—Combination 4	41.57%	**60.65%**	≥90th
Childhood Immunization Status—Combination 5	66.63%	**58.06%**	50th–74th
Childhood Immunization Status—Combination 6	62.23%	**55.67%**	75th–89th
Childhood Immunization Status—Combination 7	35.66%	**49.44%**	≥90th
Childhood Immunization Status—Combination 8	33.96%	**48.96%**	≥90th
Childhood Immunization Status—Combination 9	52.74%	**45.93%**	≥90th
Childhood Immunization Status—Combination 10	29.51%	**40.26%**	≥90th
Immunizations for Adolescents—Combination 1	69.48%	71.60%	75th–89th
Well-Child Visits in the First 15 Months of Life—Zero Visits	0.75%	1.05%	25th–49th[2]
Well-Child Visits in the First 15 Months of Life—6+ Visits	62.55%	**72.83%**	75th–89th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.98%	65.91%	25th–49th
Adolescent Well-Care Visits	48.24%	45.22%	25th–49th

Table 3–22—Statewide Summary of Rates for Pediatric Care Performance Measures			
Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2012	2013	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment: Total	74.79%	**81.82%**	≥90th
Counseling for Nutrition: Total	70.13%	69.24%	75th–89th
Counseling for Physical Activity: Total	57.81%	59.20%	75th–89th
Appropriate Testing for Children with Pharyngitis	—	80.26%	75th–89th

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.

[1] Percentile rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

Strengths

The *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator had a significant rate increase of more than 10 percentage points. In addition, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents— BMI Assessment: Total* indicator had a significant improvement of 7.03 percentage points and benchmarked above the national HEDIS Medicaid 90th percentile. While four of the *Childhood Immunization Status* indicators (*Combinations 4, 7, 8,* and *10)* had significant increases in rates, the increases should be interpreted with caution as there was a change in the data collection methodology and a change in the dosing requirements for hepatitis A, a vaccine related to *Combinations 4, 7, 8,* and *10*.

Recommendations

Five of the *Childhood Immunization Status* indicators (*Combinations 2, 3, 5, 6,* and *9)* had rates that decreased more than 6 percentage points between 2012 and 2013. However, the decrease in rates should be interpreted with caution since the data collection methodology was changed from the hybrid method in HEDIS 2012 to the administrative method in HEDIS 2013.

Access to Care and Preventive Screening Performance Measures

Table 3–23 displays the statewide weighted averages for HEDIS 2012 and HEDIS 2013 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 Rankings[1]
	2012	2013	
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	88.65%	89.66%	50th–74th
Postpartum Care	68.58%	65.10%	50th–74th
Children's and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	96.25%	**94.42%**	10th–24th
Ages 25 Months to 6 Years	83.99%	**82.33%**	<10th
Ages 7 to 11 Years	87.17%	86.48%	10th–24th
Ages 12 to 19 Years	88.03%	87.56%	25th–49th
Adults' Access to Preventive/Ambulatory Health Services—Total	80.62%	**78.53%**	10th–24th
Preventive Screening			
Chlamydia Screening in Women—Total	52.01%	54.38%	25th–49th
Breast Cancer Screening	—	41.96%	10th–24th
Cervical Cancer Screening	—	45.78%	<10th
Adult BMI Assessment	69.02%	**80.19%**	≥90th

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.

[1] Percentile rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

Strengths

HSAG observed notable improvement in the *Adult BMI Assessment* measure, which had a rate increase of 11.17 percentage points and performed above the national HEDIS Medicaid 90th percentile.

Recommendations

Three indicators, *Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months*, *Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years,* and *Adults' Access to Preventive/Ambulatory Health Services—Total* exhibited a significant

rate decrease from 2012 to 2013, although none had a rate decrease of more than 3 percentage points. In addition, the *Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* indicator and *Cervical Cancer Screening* measure fell below the national HEDIS Medicaid 10th percentile. Improvement efforts should be targeted on these measures.

Mental/Behavioral Health Performance Measures

Table 3–24 shows the statewide weighted averages for HEDIS 2013 and the percentile rankings for the "Mental/Behavioral Health" performance measures.

Table 3–24—Statewide Summary of Rates for Mental/Behavioral Health Performance Measures

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2012	2013	
Anti-depressant Medication Management			
Effective Acute Phase Treatment	—	60.07%	75th-89th
Effective Continuation Phase Treatment	—	46.29%	≥90th
Follow-up Care for Children Prescribed ADHD Medication			
Initiation	—	34.46%	25th–49th
Continuation	—	29.90%	10th–24th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			
Initiation	—	42.03%	50th–74th
Engagement	—	3.24%	10th–24th

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.

[1] Percentile rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

Strengths

Although none of the rates for the "Mental/Behavioral Health" performance measures were reported in HEDIS 2012, the indicators for the *Anti-depressant Medication Management* measure had strong performance. Both indicators were above the national HEDIS Medicaid 75th percentile, with the *Effective Continuation Phase Treatment* indicator above the 90th percentile.

Recommendations

The *Follow-up Care for Children Prescribed ADHD Medication—Continuation* and *Initiation* and *Engagement of Alcohol and Other Drug Dependence Treatment— Engagement* indicators had performance that ranked below the national HEDIS Medicaid 25th percentile. The focus should be on these indicators to improve performance.

Living With Illness and Use of Services Measures

Table 3–25 shows the statewide weighted averages for HEDIS 2012 and HEDIS 2013 and the percentile rankings for each performance measure for "Living with Illness" and "Use of Services."

Table 3–25—Statewide Summary of Rates for Living With Illness and Use of Services Performance Measures

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2012	2013	
Living with Illness			
Controlling High Blood Pressure	—	63.20%	50th–74th
Comprehensive Diabetes Care			
HbA1c Testing	79.19%	81.00%	25th–49th
HbA1c Poor Control (>9.0%)	43.77%	38.76%	25th–49th[2]
HbA1c Control (<8.0%)	46.47%	50.47%	50th–74th
Eye Exam	53.21%	52.68%	25th–49th
LDL-C Screening	68.21%	67.31%	10th–24th
LDL-C Level <100 mg/dL	42.11%	42.87%	75th–89th
Medical Attention for Nephropathy	74.48%	75.29%	25th–49th
Blood Pressure Controlled <140/80 mm Hg	46.35%	49.09%	75th–89th
Blood Pressure Controlled <140/90 mm Hg	61.55%	66.74%	50th–74th
Annual Monitoring for Patients on Persistent Medications—Total	82.17%	80.33%	10th–24th
Use of Services[3]			
Ambulatory Care (Per 1,000 Member Months)			
Emergency Department Visits	49.41	52.15	10th–24th

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year. Rates shaded in red with a red font indicate a statistically significant decline in performance from the prior year. Rates shaded in gray with a black font indicate that the data collection methodology was hybrid for HEDIS 2012 and was administrative for HEDIS 2013. Rates shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2012 and was hybrid for HEDIS 2013.

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.

[1] Percentile rankings were assigned to the HEDIS 2013 reported rates based on HEDIS 2012 ratios and percentiles for Medicaid populations. Because NCQA published the Medicaid HEDIS 2012 means, percentiles, and ratios with two decimal places, the HEDIS 2012 and HEDIS 2013 rates in this table were displayed with two decimal places.

[2] For this indicator, a lower rate indicates better performance (e.g., a rate in the 10th percentile is better than a rate in the 90th percentile).

[3] Since the reported rates for measures under Use of Services are not risk-adjusted, rate changes observed between HEDIS 2012 and 2013 may not denote improvement or decline in performance. Percentile ranking based on HEDIS 2013 rates are also for information only.

Strengths

Three *Comprehensive Diabetes Care* indicators, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Blood Pressure Controlled <140/90 mm Hg* had improved rates of at least 4 percentage points from the previous year.

Recommendations

Two indicators (*Comprehensive Diabetes Care—LDL-C Screening* and *Annual Monitoring for Patients on Persistent Medications—Total*) fell below the national HEDIS Medicaid 25th percentile. They presented opportunities to improve.

Utilization Observations

Compared to HEDIS 2012, there was a small variation in the rate for the utilization measure *Ambulatory Care*. Since the rate 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 certain measures and a slight decline for other measures. The following is a summary assessment of statewide performance measures related to the domains of quality, timeliness, and access.

Quality: Statewide performance on quality-related measures was mixed. *Well-Child Visits in the First 15 Months of Life—6+ Visits*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total*, and *Adult BMI Assessment* had significant improvements. In addition, the newly reported measure *Anti-depressant Medication Management—Effective Continuation Phase Treatment* ranked above the national HEDIS Medicaid 90th percentile. Significant increases in rates were observed for four *Childhood Immunization Status* indicators (*Combinations 4, 7, 8,* and *10*), while significant declines in performance were reported for indicators *Combinations 2, 3, 5, 6,* and *9*. Due to changes in reporting requirements by the Department and changes in measure specifications, HSAG cannot comment if these rate changes indicate improvements or declines in performance. The newly reported measure *Cervical Cancer Screening* reported a rate that fell below the national HEDIS Medicaid 10th percentile. This measure presents an opportunity for improvement.

Timeliness: Statewide performance on timeliness-related measures was mixed, with significant increase in rates for four *Childhood Immunization Status* indicators (*Combinations 4, 7, 8,* and *10*) but significant decrease in rates for five *Childhood Immunization Status* indicators (*Combinations 2, 3, 5, 6,* and *9*). As discussed above, HSAG cannot comment if these rate changes indicate improvements or declines in performance for *Childhood Immunization Status* indicators. The indicator *Well-Child Visits in the First 15 Months of Life—6+ Visits* also had a significant rate increase. Other measures, such as *Comprehensive Diabetes Care*, were fairly consistent between 2012 and 2013 with very little variation in rates.

Access: Statewide performance on access-related measures exhibited more of a decline during HEDIS 2013. All of the *Children's and Adolescents' Access to Primary Care Practitioners* indicators had a rate decline between 2012 and 2013, although the decline in performance was only significant for the indicators *Ages 12 to 24 Months* and *Ages 25 Months to 6 Years*. In addition, the measure *Adults' Access to Preventive/Ambulatory Health Services—Total* had a significant decline of over 2 percentage points. These measures 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 2012–2013, 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.

Table 3–26 below lists the PIP topics identified by each MCO.

Table 3–26—Summary of Each MCO's PIPs

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

Appendix D, EQR Activities—Validation of Performance Improvement Projects, describes how the PIP activities were validated and how the resulting data were aggregated and analyzed by HSAG.

Denver Health Medicaid Choice

Findings

DHMC conducted two PIPs, *Adults Access to Preventive/Ambulatory Health Services* and *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*. 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 contribute to improved health outcomes and overall quality of life. It may also reduce members' inappropriate use of emergency department (ED) services. This was the second year for the *Adults Access to Preventive/Ambulatory Health Services* PIP, and DHMC completed Activities I through IV and VI through VIII and reported baseline data.

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 fourth year for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. DHMC completed Activities I through X and reported Remeasurement 2 results.

Table 3–27 provides a summary of DHMC's *Adults Access to Preventive/Ambulatory Health Services* PIP validation results for the FY 2012–2013 validation cycle.

Table 3–27—FY12–13 Performance Improvement Project Validation Results *for* DHMC					
PIP#1: *Adults Access to Preventive/Ambulatory Health Services*					
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% (2/2)	0% (0/2)	0% (0/2)
	IV.	Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Sampling Techniques	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (10/10)	0% (0/10)	0% (0/10)
Implementation	VII.	Data Analysis and Interpretation	100% (4/4)	0% (0/4)	0% (0/4)
	VIII.	Interventions and Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total			100% (6/6)	0% (0/6)	0% (0/6)
Outcomes	IX.	Real Improvement	*Not Assessed*		
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			*Not Assessed*		
Percent Score of Applicable Evaluation Elements *Met*			**100% (16/16)**		

The DHMC *Adults Access to Preventive/Ambulatory Health Services* PIP demonstrated strength in its study design (Activities I–VI) and study implementation (Activities VII and VIII) by receiving *Met* scores for all applicable evaluation elements. The plan documented a solid study design, which is essential to producing methodologically sound results. The DHMC *Adults Access to Preventive/Ambulatory Health Services* PIP's overall score for applicable evaluation elements *Met* was 100 percent wherein 16 of 16 elements received a *Met* score. The Percent Score of Applicable Evaluation Elements *Met* was the same for the 2011–2012 and 2012–2013 PIP submissions, 100 percent.

Table 3–28 provides a summary of DHMC's *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP validation results for the FY 2012–2013 validation cycle.

Table 3–28—FY12–13 Performance Improvement Project Validation Results *for* DHMC					
PIP#2: *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*					
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% (5/5)	0% (0/5)	0% (0/5)
	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	91% (10/11)	9% (1/11)	0% (0/11)
Design Total			91% (29/32)	3% (1/32)	6% (2/32)
Implementation	VII.	Interventions and Improvement Strategies	75% (3/4)	25% (1/4)	0% (0/4)
	VIII.	Data Analysis and Interpretation	89% (8/9)	0% (0/9)	11% (1/9)
Implementation Total			84% (11/13)	8% (1/13)	8% (1/13)
Outcomes	IX.	Real Improvement	75% (3/4)	25% (1/4)	0% (0/4)
	X.	Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total			80% (4/5)	20% (1/5)	0% (0/5)
Percent Score of Applicable Evaluation Elements *Met*			**88% (44/50)**		

The DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP demonstrated strength in the selection of study topic, design of study question, definition of study indicator, and definition of study population (Activities I through IV) by receiving *Met* scores for all applicable evaluation elements. The plan implemented QI processes and interventions based on barriers identified through data analysis and QI processes. The DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP's overall score for applicable evaluation elements *Met* was 88 percent wherein 44 of 50 elements received a *Met* score. With the progression of the PIP, the Percent Score of Applicable Evaluation Elements *Met* decreased from 94 percent in the 2011–2012 PIP submission, to 88 percent in the 2012–2013 PIP submission.

Table 3–29 provides a summary of DHMC's PIP-specific outcomes for the FY 2012–2013 validation cycle.

Table 3–29—FY12–13 Performance Improvement Project-Specific Outcomes *for* DHMC

PIP#1: *Adults Access to Preventive/Ambulatory Health Services*					
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Remeasurement 2**	**Percentage Point Change**	**Statistical Significance (*p* value)**
The number of members age 20 and older who had an ambulatory or preventive care visit during the measurement year.	73.5%	*	*	*	*
PIP#2: *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*					
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Remeasurement 2**	**Percentage Point Change**	**Statistical Significance (*p* value)**
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%	73.4%	1.9↑	*p=0.2365 Not Statistically Significant*
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%	48.7%	16.7↑	*p<0.0001♦ Statistically Significant*
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%	74.7%	3.6↑	*p=0.2961 Not Statistically Significant*
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%	70.9%	1.9↑	*p=0.3096 Not Statistically Significant*

*The PIP has not progressed past reporting baseline results.

♦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.

DHMC completed Activities I through IV and VI through VIII of the *Adults Access to Preventive/Ambulatory Health Services* PIP and reported baseline data for January 1, 2012, through December 31, 2012. The baseline results showed a rate of 73.5 percent. The plan reported a statistically significant increase above the baseline rate as the Remeasurement 1 goal.

For the Remeasurement 2 period, the DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP showed that for Study Indicator 1, 73.4 percent of members diagnosed with an SMI who were 21 years of age and older had at least one primary care visit in an outpatient setting. Although this result exceeded the Remeasurement 1 rate by 1.9 percentage points, the Remeasurement 2 increase was not statistically significant and remained below the baseline rate of 79.6 percent. For Study Indicators 2a and 2b, DHMC documented that 48.7 percent and 74.7 percent of members had documentation of behavioral health information and medication reconciliation in their medical record, respectively. Study Indicator 2a was the only indicator that demonstrated statistically significant improvement between Remeasurement 1 and Remeasurement 2. The Study Indicator 2a rate exceeded the baseline rate by 13.6 percentage points; however, another measurement period must be reported for Study Indicator 2a before it can be assessed for sustained improvement. The rate increase for Study Indicator 2b, from 71.1 percent to 74.7 percent, was not statistically significant. Although the rates for Study Indicators 1 and 2b increased during Remeasurement 2, the increases were not statistically significant and the current remeasurement rates remained below the baseline rates. Study Indicator 3 was the only study indicator that demonstrated sustained improvement. Study Indicators 1, 2a, and 2b could not be assessed for sustained improvement during this measurement period.

Strengths

The DHMC *Adults Access to Preventive/Ambulatory Health Services* PIP demonstrated strength in Activities I–IV and VI–VIII by receiving *Met* scores for all applicable evaluation elements. The plan documented a solid study design and implementation, which is essential to producing methodologically sound results. The intervention and improvement strategies were linked to the barriers identified by the plan. DHMC documented that the Denver Health Access Committee meets monthly to discuss the HEDIS measure associated with the PIP and related access issues for patients. The plan conducted a secret shopper study that identified long wait times in care facilities, geographic locations of clinics, and gaps in member education about preventive health care resources as primary contributors to member dissatisfaction. Subsequently, DHMC identified four barriers for the PIP. The interventions developed by DHMC were appropriately linked to the barriers identified. All of the baseline interventions were implemented and monitored by the DHMP QI intervention manager and special projects specialist.

The DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP demonstrated strength in its study design (Activities I–IV) by receiving *Met* scores for all applicable evaluation elements. DHMC identified barriers based on outcomes from the plan's original focus study on this topic and further causal/barrier analysis. DHMC provided a fishbone diagram that included 11 barriers in five barrier-type categories. The plan selected three priority barriers and documented that most of the interventions implemented were based on the barriers identified and involve system changes that are likely to induce permanent, sustained improvement. DHMC also noted that it planned to evaluate interventions quarterly to ensure effectiveness.

Interventions

DHMC included four interventions in the *Adults Access to Preventive/Ambulatory Health Services* PIP. Two of the four interventions, access to the care transportation program and adult birthday cards, were implemented prior to the start of the PIP. The remaining interventions included scheduled dates for diabetic eye exams and a partnership with Walgreens' Take Care Clinic. Additionally, DHMC documented the implementation of interventions with outcomes that cannot be captured through administrative data collection. For example, to increase member access to care, the plan developed the following interventions: a telephonic depression treatment, a phone-in nurse advice line, and a remote diabetes control program. The plan noted that the interventions are considered ongoing with annual minor modifications.

The DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP included 14 interventions implemented from 2009 through 2011:

- Established a collaborative data exchange process.
- Developed a systematic outreach protocol.
- Created a master contact list.
- Updated DHMC's tracking database.
- Outreached members for a signed Request for Information.
- Gave providers access to secure communication.
- Streamlined pharmacy claims and authorization processes.
- Disseminated information to providers about medication reconciliation.
- Created a master medication/diagnosis list.
- Co-located a Denver health provider in the Mental Health Center of Denver (MHCD) clinic for easier member access to a PCP.
- Increased the number of patient navigators.
- Implemented a new Web-based system for integrated claims data.
- Moved a nursing position into the pharmacy for more clinical oversight.
- Developed criteria for standardization of prior authorization procedures.

Recommendations

For DHMC's *Adults Access to Preventive/Ambulatory Health Services* PIP, it is conceivable that the interventions with outcomes the plan cannot monitor through administrative data collection may influence a member's decision to access preventive/ambulatory health services. DHMC should monitor these interventions through alternate means other than administrative data collection. The plan should examine the impact that the "many" dual eligible, fee-for-service members it referenced are having on the outcomes. Any steps taken by DHMC to correct the claims issues identified should be documented. The plan should monitor all of the implemented interventions regularly, evaluate the efficacy of the interventions, and standardize and monitor successful interventions. Unsuccessful interventions should be revised or discontinued. In future submissions, the plan should document any changes made to the interventions and discuss the success of the interventions related to the PIP outcomes. The plan should also conduct an annual causal/barrier analysis to determine if the original barriers identified are still relevant.

DHMC should revisit its causal/barrier analysis process for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, as the barriers identified at the start of this PIP may have changed. The plan should regularly monitor and evaluate interventions to determine which interventions were successful. Finally, DHMC should standardize its successful interventions and monitor the standardized interventions to ensure their continued success.

Rocky Mountain Health Plans

Findings

RMHP conducted two PIPs, *Adult BMI Assessment* and *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*. The RMHP *Adult BMI Assessment* PIP focused on improving the rate of BMI documentation in member medical records. This was the second validation year for the *Adult BMI Assessment* PIP, and RMHP completed Activities I through VIII. The plan reported a baseline data collection period of calendar year 2012.

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 ED visits. This was the fifth year for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. RMHP completed Activities I through IV and VI through X and reported Remeasurement 4 data.

Table 3–30 and Table 3–31 show RMHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3–30—FY12–13 Performance Improvement Project Validation Results *for* RMHP

PIP #1:*Adult BMI Assessment*					
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% (2/2)	0% (0/2)	0% (0/2)
	IV.	Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Sampling Techniques	100% (6/6)	0% (0/6)	0% (0/6)
	VI.	Data Collection	100% (5/5)	0% (0/5)	0% (0/5)
Design Total			100% (17/17)	0% (0/17)	0% (0/17)
Implementation	VII.	Data Analysis and Interpretation	80% (4/5)	20% (1/5)	0% (0/5)
	VIII.	Interventions and Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total			86% (6/7)	14% (1/7)	0% (0/7)
Outcomes	IX.	Real Improvement	*Not Assessed*		
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			*Not Assessed*		
Combined Percent Score of Applicable Evaluation Elements Met			**96% (23/24)**		

RMHP documented a solid study design, which is essential to producing methodologically sound results, and received *Met* scores for all applicable evaluation elements in Activities I through VI. The RMHP *Adult BMI Assessment* PIP's overall score for applicable evaluation elements *Met* was 96 percent wherein 23 of 24 elements received a *Met* score. The PIP received a *Partially Met* overall validation status. The Percent Score of Applicable Evaluation Elements Met decreased from 100 percent in the 2011–2012 PIP submission, to 96 percent in the 2012–2013 PIP submission. For the 2012–2013 validation cycle, the plan progressed to reporting baseline results, and HSAG validated Activities I through VIII.

Table 3–31—FY12–13 Performance Improvement Project Validation Results *for* RMHP

PIP #2: Coordination of Care Between Medicaid Physical and Behavioral Health Providers

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% (5/5)	0% (0/5)	0% (0/5)
	IV.	Study Population	100% (3/3)	0% (0/3)	0% (0/3)
	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	25% (1/4)	0% (0/4)	75% (3/4)
	X.	Sustained Improvement	0% (0/1)	0% (0/1)	100% (1/1)
Outcomes Total			20% (1/5)	0% (0/5)	80% (4/5)
Combined Percent Score of Applicable Evaluation Elements Met			**89% (32/36)**		

RMHP's *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP demonstrated a solid foundation for data collection, analysis, and interpretation by receiving *Met* scores for all evaluation elements in Activities I through IV and VI through VIII. RMHP's overall score for applicable evaluation elements *Met* was 89 percent wherein 32 of 36 elements received a *Met* score. All of RMHP's *Not Met* scores occurred in Activities IX and X. In Activity IX, both study indicators demonstrated a decline in performance; therefore, improvement could not be linked to the implemented interventions. Additionally, the Remeasurement 4 rates for both study indicators did not demonstrate sustained improvement over baseline. With the progression of the PIP, the Percent Score of Applicable Evaluation Elements *Met* increased from 86 percent in the 2011–2012 PIP submission, to 89 percent in the 2012–2013 PIP submission.

Table 3–32 provides a summary of RMHP's PIP indicator outcomes for the FY 2012–2013 validation cycle.

Table 3–32—FY12–13 Performance Improvement Project-Specific Outcomes *for* RMHP

PIP#1: *Adult BMI Assessment*

PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Remeasurement 4	Percentage Point Change	Statistical Significance (*p* value)	Sustained Improvement
The percentage of the eligible population with BMI percentile documentation during the measurement year or year prior to the measurement year.	69.9%	*	*	*	*	*	*	*

PIP#2: *Coordination of Care Between Medicaid Physical and Behavioral Health Providers*

PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Remeasurement 4	Percentage Point Change	Statistical Significance (*p* value)	Sustained Improvement
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%	77.2%	6.1↓	*p*=0.0433♦ Statistically Significant	No
Study Indicator 2: The total number of members who had at least one emergency room visit during the measurement year.^	40%	47.1%	49.7%	40.2%	41.5%	1.3↑^	*p*=0.7579 Not Statistically Significant	No

*The PIP has not progressed past reporting baseline results.
^Lower rates indicate better performance for this study indicator.
♦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.

During the baseline measurement of the *Adult BMI Assessment* PIP, RMHP reported that 69.9 percent of members had evidence of BMI percentile documentation during the measurement year or the year prior to the measurement year. The plan set a Remeasurement 1 goal of increasing the baseline rate by 5 percent.

The Remeasurement 4 rate for Study Indicator 1 of the RMHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP showed a decline of 6.1 percentage points, from 83.3 percent of members who had at least one visit to a primary care provider in an

ambulatory setting, to 77.2 percent. This decrease was statistically significant ($p = 0.0433$) and was 8 percentage points below the baseline rate of 85.2 percent. For Study Indicator 2, which is an inverse study indicator, the plan reported a decline in performance with the percentage of members who had at least one ER visit increasing 1.3 percentage points from 40.2 percent during Remeasurement 3 to 41.5 percent during Remeasurement 4. The Remeasurement 4 rate for Study Indicator 2 was 1.5 percentage points higher than the baseline rate.

Strengths

The RMHP *Adult BMI Assessment* PIP established a solid study design, which is essential to producing methodologically sound results. The plan documented a multi-step causal/barrier analysis. The RMHP HEDIS Improvement Team (HIT) cataloged and reviewed current adult BMI measure interventions, and the QI Department facilitated intradepartmental discussions about possible study barriers and past intervention efforts. RMHP submitted one fishbone diagram that identified 21 barriers. RMHP selected three priority barriers: one member-based and two provider/practice-based barriers.

The RMHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP Study Design (Activities I–IV) and Data Collection and Analysis (Activities VI and VIII) continued to perform well, indicating that the PIP was appropriately designed and implemented to measure outcomes and improvement. RMHP used interdepartmental teams, workgroups, and meetings with external agencies to develop interventions aimed at improving the coordination of care outcomes for members with behavioral health conditions. Barriers identified by the plan included, a lack of knowledge about integration of medical and behavioral health services, a lack of consistent use of primary care services by members, plans' lack of knowledge about ER utilization trends, a lack of physician knowledge about available case management services, a lack of provider knowledge about coordinating care for SMI members, a lack of member knowledge about urgent medical care, and a lack of staff knowledge about how to respond to mental health crises in the primary care setting.

Interventions

During the baseline measurement period, RMHP implemented four interventions for its *Adult BMI Assessment* PIP. Two of the interventions involved creating member brochures designed to promote preventive health services for women while the remaining two interventions were related to the Beacon project. RMHP described that it is currently working with the Beacon project on a meaningful use measure for BMI documentation. Beacon project business analysts work with staff to assess the capabilities of the electronic medical record (EMR) at RMHP practices, including how BMI is documented. Interventions related to the Beacon project included (1) Beacon project staff consulting with provider/practice staff about EMR capacity, and (2) Beacon project quality improvement associates partnering with provider/practice staff on improving workflows for collecting BMI documentation.

In the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, RMHP documented that the interventions were designed to address the identified barriers. The interventions implemented by RMHP in the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP were member-, system-, and provider-based. The member-based interventions were educational and included radio ads, brochures, articles, and newsletters. The

system-based interventions included analysis of ER utilization trends, development of an interdepartmental ER utilization workgroup, improved case management outreach procedures, and coordination with behavioral health providers. The provider-based interventions implemented by RMHP included staff trainings and first aid education. The plan did not implement any new interventions during remeasurement periods 3 and 4, but it did document that previously implemented interventions were ongoing.

Recommendations

For its *Adult BMI Assessment* PIP, RMHP should document how it will ensure that successful Beacon project interventions are implemented systemwide to include non-Beacon project practices. Improving BMI documentation in member records is a provider- and practice-based PIP topic. HSAG recommends that RMHP consider implementing interventions designed to address the specific provider- and practice-based barriers it identified in its causal/barrier analysis such as a lack of time at intake to calculate BMI, limited time and resources available to address healthy weight issues with members, and adult BMI not being calculated.

For the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, RMHP should examine the interventions that were ongoing for the duration of the PIP to determine if any of the interventions were successful. Interventions deemed successful by the plan should be standardized and monitored to help RMHP achieve improved results during the next phase of the study. HSAG further suggests that the plan increase the focus on provider- and system-based interventions for improving coordination of care. Member-based interventions are not likely to have a strong impact on coordination of care outcomes and will not impact how information is exchanged between behavioral and medical health providers.

In the future, HSAG suggests that RMHP regularly monitor improvement efforts to ensure that the improvement efforts are having the desired effect. If the improvement efforts are not successful, they should be revised or discontinued. The plan should also revisit the causal/barrier analysis process annually, at a minimum, to ensure that the correct barriers are being addressed. Finally, in light of the Remeasurement 4 outcomes for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, RMHP should consider performing a causal/barrier analysis for the next phase of the study to avoid repeating intervention and improvement efforts that were unsuccessful during the current phase of the study.

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

Table 3–33 shows the health plans' overall performance based on HSAG's validation of the FY 2012–2013 PIPs that were submitted for validation.

Table 3–33—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*	88%	100%	*Met*
RMHP	*Adult BMI Assessment*	96%	90%	*Partially Met*
RMHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	89%	100%	*Met*

Three of the four PIPs reviewed by HSAG received a *Met* validation status. Each health plan had one PIP that had not progressed past reporting baseline results.

Table 3–34 shows a comparison of the health plans' improvement results.

Table 3–34—Statewide Summary of Improvement

	DHMC	RMHP
Number of comparable rates (previous measurement to current measurement)	4*	2*
Number of rates that improved	100% (4/4)	0% (0/2)
Number of rates that declined	0% (0/4)	100% (2/2)
Number of rates that showed statistically significant improvement over the previous measurement period	25% (1/4)	0% (0/2)
Number of rates that showed statistically significant improvement over baseline	25% (1/4)	0% (0/2)

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

All of the DHMC *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP rates improved; however, only one rate improved by a statistically significant amount. The DHMC *Adults Access to Preventive/Ambulatory Health Services* PIP only included baseline data; therefore, a comparison between measurement periods could not be performed. None of the RMHP rates for the RMHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP improved over the previous measurement period. The RMHP *Adult BMI Assessment* PIP included baseline only; therefore, a comparison between measurement periods could not be performed.

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-3]

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 four of the five composites (*Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Customer Service*), the rates were based on responses by members who chose a response of "Usually" or "Always." For one composite (*Shared Decision Making*), the rates were based on responses by members who chose a response of "A lot" or "Yes." For purposes of this report, results are reported for a CAHPS measure even when the minimum reporting of 100 respondents was not met; therefore, caution should be exercised when interpreting these results. Measures that did not meet the minimum number of 100 responses are denoted with a cross (+). Measures that could not be compared to the prior year's rates or NCQA CAHPS national averages are denoted as Not Comparable (NC).[3-4] Appendix E contains additional details about the technical methods of data collection and analysis of survey data and the 2012 NCQA CAHPS national averages.[3-5,3-6]

For FY 2012–2013, DHMC and RMHP did not conduct CAHPS surveys of their adult Medicaid populations; therefore, adult Medicaid results are presented for PCPP only. All health plans, however, did conduct CAHPS surveys of their child Medicaid populations; therefore, child Medicaid results are available for all health plans. The child Medicaid results presented in this report are for the general child population.

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.

[3-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[3-4] Due to changes to the *Shared Decision Making* composite measure, current year (FY 2012–2013) rates are not comparable to the prior year's (FY 2011–2012) rates. For detailed information on the changes to the composite measure, please refer to Appendix E of this report.
[3-5] Due to changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the comparisons of current year (FY 2012–2013) rates to the prior year's (FY 2011–2012) rates. For detailed information on the changes to the composite measure, please refer to Appendix E of this report.
[3-6] Due to changes in the NCQA CAHPS national averages available for composite measures, the FY 2011–2012 rates for each composite measure were recalculated for DHMC, RMHP, PCPP, and the Statewide average. Therefore, the FY 2011–2012 CAHPS results for all composite measures presented in this section will not match the previous year's report.

Denver Health Medicaid Choice

As previously noted, DHMC's adult Medicaid population was not surveyed during the current year (FY 2012–2013); therefore, results are presented for the child Medicaid population only.

Findings

Table 3–35 shows the general child Medicaid results achieved by DHMC for the current year (FY 2012–2013) and the prior year (FY 2011–2012).[7]

Table 3–35—General Child Medicaid Question Summary Rates and Global Proportions *for* DHMC

Measure	FY 2011–2012 Rate	FY 2012–2013 Rate
Getting Needed Care	65.9%	81.6%
Getting Care Quickly	79.0%	77.9%
How Well Doctors Communicate	91.6%	94.7%
Customer Service	79.2%	86.4%
Shared Decision Making	NC	61.0%
Rating of Personal Doctor	80.1%	82.1%
Rating of Specialist Seen Most Often	71.0%+	81.4%
Rating of All Health Care	64.9%	68.4%
Rating of Health Plan	71.9%	71.5%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

NC indicates that comparisons could not be performed for this measure.

Recommendations

DHMC did not have any substantial decreases in the rates for the general child Medicaid population; however, two measures showed slight decreases: *Getting Care Quickly* and *Rating of Health Plan*. 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 general child Medicaid population, three of the eight comparable measures' rates increased substantially: *Getting Needed Care* (15.7 percentage points), *Customer Service* (7.2 percentage points), and *Rating of Specialist Seen Most Often* (10.4 percentage points). None of the measures' rates decreased substantially. Four of the measures for the general child Medicaid population had the lowest rates among the health plans in FY 2012–2013: *Getting Needed Care*, *Getting Care*

[7] As previously noted, DHMC's FY 2011–2012 rates for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the FY 2011–2012 results for all composite measures presented in this section will not match the previous year's report.

Quickly, *How Well Doctors Communicate*, and *Customer Service*. Five of the measures, however, had the highest rates among the health plans in FY 2012–2013: *Shared Decision Making, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of All Health Care,* and *Rating of Health Plan*.

Rocky Mountain Health Plans

Findings

As previously noted, RMHP's adult Medicaid population was not surveyed during the current year (FY 2012–2013); therefore, results are presented for the child Medicaid population only. Table 3–36 shows the general child Medicaid results achieved by RMHP for the current year (FY 2012–2013) and the prior year (FY 2011–2012).[8]

Table 3–36—General Child Medicaid Question Summary Rates and Global Proportions *for* RMHP

Measure	FY 2011–2012 Rate	FY 2012–2013 Rate
Getting Needed Care	86.5%	93.1%
Getting Care Quickly	92.3%	93.6%
How Well Doctors Communicate	93.2%	97.3%
Customer Service	83.8%+	89.1%+
Shared Decision Making	NC	58.7%+
Rating of Personal Doctor	73.8%	74.5%
Rating of Specialist Seen Most Often	72.1%+	70.1%+
Rating of All Health Care	61.7%	64.6%
Rating of Health Plan	67.9%	67.3%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

NC indicates that comparisons could not be performed for this measure.

Recommendations

RMHP did not have any substantial decreases in the rates for the general child Medicaid population; however, the rates for two measures decreased slightly: *Rating of Specialist Seen Most Often* 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.

[8] As previously noted, RMHP's FY 2011–2012 rates for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the FY 2011–2012 results for all composite measures presented in this section will not match the previous year's report.

For the general child Medicaid population, two of the eight comparable measures' rates increased substantially: *Getting Needed Care* (6.6 percentage points) and *Customer Service* (5.3 percentage points). Four of the measures demonstrated slight increases: *Getting Care Quickly, How Well Doctors Communicate, Rating of Personal Doctor,* and *Rating of All Health Care*. None of the measures decreased substantially. One of the measures for the general child Medicaid population had the lowest rate among the health plans in FY 2012–2013: *Rating of All Health Care*. Three of the measures had the highest rates among the health plans in FY 2012–2013: *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*.

Primary Care Physician Program

Findings

Table 3–37 shows the adult Medicaid results achieved by PCPP during the current year (FY 2012–2013) and the prior year (FY 2011–2012).

Table 3–37—Adult Medicaid Question Summary Rates and Global Proportions *for* PCPP

Measure	FY 2011–2012 Rate	FY 2012–2013 Rate
Getting Needed Care	84.5%	82.1%
Getting Care Quickly	85.6%	81.2%
How Well Doctors Communicate	90.0%	87.4%
Customer Service	80.5%+	84.4%
Shared Decision Making	NC	50.0%
Rating of Personal Doctor	67.1%	62.0%
Rating of Specialist Seen Most Often	63.4%	58.1%
Rating of All Health Care	51.4%	48.9%
Rating of Health Plan	58.2%	51.2%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

NC indicates that comparisons could not be performed for this measure.

Table 3–38 shows the general child Medicaid results achieved by PCPP for the current year (FY 2012–2013) and the prior year (FY 2011–2012).

Table 3–38—General Child Medicaid Question Summary Rates and Global Proportions *for* PCPP

Measure	FY 2011–2012 Rate	FY 2012–2013 Rate
Getting Needed Care	85.3%	86.7%
Getting Care Quickly	92.3%	93.7%
How Well Doctors Communicate	94.9%	95.5%
Customer Service	86.6%+	88.7%
Shared Decision Making	NC	57.8%+
Rating of Personal Doctor	71.9%	74.2%

Table 3–38—General Child Medicaid Question Summary Rates and Global Proportions *for* PCPP		
Measure	**FY 2011–2012 Rate**	**FY 2012–2013 Rate**
Rating of Specialist Seen Most Often	67.0%+	64.9%+
Rating of All Health Care	67.6%	65.7%
Rating of Health Plan	69.0%	63.7%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

NC indicates that comparisons could not be performed for this measure.

Recommendations

For the adult Medicaid population, PCPP demonstrated a substantial decrease for three measures' rates: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. For the child Medicaid survey, PCPP demonstrated a substantial rate decrease for one measure: *Rating of Health Plan.* 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 comparable measures showed a slight rate increase: *Customer Service*. The remaining comparable measures showed rate decreases; furthermore, three measures' rates decreased substantially: *Rating of Personal Doctor* (5.1 percentage points), *Rating of Specialist Seen Most Often* (5.3 percentage points), and *Rating of Health Plan* (7.0 percentage points).

For the child Medicaid population, five of the eight comparable measures demonstrated slight increases: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Personal Doctor*. One of the eight comparable measure's rate demonstrated a substantial decrease: *Rating of Health Plan* (5.3 percentage points). Two of the measures' rates decreased slightly: *Rating of Specialist Seen Most Often* and *Rating of All Health Care*. Four measures had the lowest rates among the health plans in FY 2012–2013: *Shared Decision Making, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Rating of Health Plan.* One measure had the highest rate among the health plans in FY 2012–2013: *Getting Care Quickly*.

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

Statewide averages for the adult Medicaid population are not presented in this section given that PCPP was the only health plan for which adult Medicaid results are available. The adult Medicaid statewide averages during the current year (FY 2012–2013) and the prior year (FY 2011–2012) will be equivalent to the adult Medicaid results presented for PCPP.

Table 3–39 shows the general child Medicaid statewide averages for the current year (FY 2012–2013) and the prior year (FY 2011–2012).

Table 3–39—General Child Medicaid Statewide Averages		
Measure	**FY 2011–2012 Rate**	**FY 2012–2013 Rate**
Getting Needed Care	79.2%	87.1%
Getting Care Quickly	87.9%	88.4%
How Well Doctors Communicate	93.2%	95.8%
Customer Service	83.2%	88.1%
Shared Decision Making	NC	59.2%
Rating of Personal Doctor	75.3%	76.9%
Rating of Specialist Seen Most Often	70.0%	72.1%
Rating of All Health Care	64.7%	66.2%
Rating of Health Plan	69.6%	67.5%

NC indicates comparisons could not be performed for this measure.

Summary Assessment Related to Quality, Timeliness, and Access

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

For the statewide general child Medicaid population, the rates for seven of the eight comparable measures increased from FY 2011–2012 to FY 2012–2013. For one of these measures, *Getting Needed Care*, the rate increased substantially (7.9 percentage points). One measure, *Rating of Health Plan,* demonstrated a slight decrease.

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
Health plans should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. Health plans should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner.
Health plans can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations. Access to free health assessments also can assist health plans in promoting patient health awareness and preventive health care efforts.
Health plans can assist providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible—a process call "max packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies can include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during the current scheduled visit, whenever possible.
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 physician are more informed about their health issues and are able to make deliberate choices about an appropriate course of action. By increasing the availability of language-concordant physicians, patients with limited English proficiency can schedule more frequent visits with their physicians and are better able to manage health conditions.
Streamlining the referral process allows health plan members to more readily obtain the specialty care they need. 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 collected in a timely manner from all parties involved (e.g., plans, patients, and providers).
Getting Care Quickly
Health plans can assist providers in examining patterns related to no-show appointments in order to determine the factors contributing to patient no-shows or an analysis of the specific types of appointments that are resulting in no-shows. Some findings have shown that follow-up visits account for a large percentage of no-shows. Thus, the health plan can assist providers in re-examining their return visit patterns and eliminate unnecessary follow-up appointments or find alternative methods to conduct follow-up care (e.g., telephone and/or e-mail follow-up). Additionally, follow-up appointments could be conducted by another health care professional such as nurse practitioners or physician assistants.
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. An online patient portal can aid in the use of electronic communication and provide a safe, secure location where patients and providers can communicate.

Table 3–40—Composite Measure Recommendations
A nurse advice help line can be implemented to direct members to the most appropriate level of care for their health problem. Members unsure if their health problem requires immediate care or a physician visit can be directed to the help line, where nurses can assess their situation and provide advice for receiving care and/or offer steps they can take to manage symptoms of minor conditions. Additionally, a 24-hour help line can improve members' perceptions of getting care quickly by providing quick, easy access to the resources and expertise of clinical staff.
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. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for 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 is often a result of bottlenecks and redundancies in the administrative and clinical patient flow processes (e.g., diagnostic tests, test results, treatments, hospital admission, and specialty services). To address these problems, it is necessary to identify these issues and determine the optimal resolution. Health plans can conduct a patient flow analysis to track a patient's experience throughout a visit or clinical service. Examples of steps that are tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.
How Well Doctors Communicate
Health plans can encourage patients to take a more active role in the management of their health care by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and health care goals and action planning forms that facilitate physician-patient communication. Furthermore, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.
Often, health information is presented to patients in a way that is too complex and technical, which can result in patient 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. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Furthermore, providing training for health care workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication. Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice.
Health plans can consider hiring interpreters that serve as full-time staff members at provider offices with a high volume of non-English speaking patients to ensure accurate communication among patients and physicians. Offering an in-office, interpretation service promotes the development of relationships between the patient and family members with their physician. With an interpreter present to translate, the physician will have a clearer understanding of how to best address the appropriate health issues and the patient will feel more at ease. Having an interpreter on-site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule.

Table 3–41—Global Rating Recommendations
Rating of Personal Doctor
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 visit. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it takes to complete the scheduled visit. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type and if appropriate changes can be made to scheduling templates to ensure patients are receiving prompt, adequate care. Additionally, by measuring the amount of time it takes to provide care, both health plans and physician offices can identify where streamlining opportunities exist.
Health plans can explore additional methods for obtaining direct patient feedback to improve patient satisfaction, such as comment cards. Comment cards can be provided to patients with their office visit discharge paperwork or via postal mail or e-mail. Comment card questions may prompt feedback regarding care received during a recent visit or other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest. Research suggests the addition of the question, "Would you recommend this physician's office to a friend?" greatly predicts overall patient satisfaction. 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.
Health plans should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans can create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication which involves allowing the patient to discuss and share in the decision-making process, as well as effectively communicating expectations and goals of health care treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication.
Health plans should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their health care. Therefore, one key to a successful shared decision-making model is ensuring that physicians are properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision-making process, ensuring that physicians understand the importance of taking each patient's values into consideration, and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.
Rating of Specialist Seen Most Often
Health plans should work with providers to encourage the implementation of systems that enhance the efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions that have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used by staff to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or various other prescribed reasons.
Health plans may want to explore the option of telemedicine with their provider networks to address issues with provider access in certain geographic areas. Telemedicine such as live, interactive videoconferencing allows providers to offer care from a remote location. Telemedicine consultation models allow the local provider to be more involved in the consultation process and more informed about the care the patient is receiving.

Table 3–41—Global Rating Recommendations
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 provider-patient communication. Training seminars can include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops can use case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.
Rating of All Health Care
Health plans should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. Standard practices and established protocols can assist in this process by ensuring access to care issues are handled consistently across all practices. For example, health plans can develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows staff to work quickly in providing timely access to care while following protocol.
Since both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when performing an evaluation of health care processes. Health plans should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource to health care processes. The councils' roles within a health plan organization can vary and responsibilities may include input into or involvement in program development, implementation, and evaluation; marketing of health care services; and design of new materials or tools that support the provider-patient relationship.
Rating of Health Plan
To achieve improved quality, timeliness, and access to care, health plans should engage in efforts that assist providers in examining and improving their systems' abilities to manage patient demand. As an example, health plans can test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments to increase physician availability. By finding alternatives to traditional one-on-one, in-office visits, health plans can assist in improving physician availability and ensuring patients receive immediate medical care and services.
It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." Health care microsystems include a team of health providers, patient/population to whom care is provided, environment that provides information to providers and patients, support staff, equipment, and office environment. The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. 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, health 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. Online interactive tools such as health discussion boards and health risk assessments can provide members instant feedback and education on the medical condition(s) specific to their health care needs.

Table 3–41—Global Rating Recommendations
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. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures to providers and staff, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, by monitoring and reporting the progress of QI efforts internally, health plans can assess whether QI initiatives have been effective in improving the quality of care delivered to members.

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

Introduction

The Department required each health plan to address recommendations and required actions following EQR activities conducted in FY 2011–2012. 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

Compliance Monitoring Site Reviews

DHMC achieved 100 percent compliance during the 2011–2012 site review and had no corrective actions requiring follow-up.

Validation of Performance Measures

Between HEDIS 2011 and HEDIS 2012, DHMC exhibited a decline in performance in 10 pediatric care performance measures. The *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator reported the greatest decline of more than 15 percentage points. HSAG recommended DHMC conduct a barrier analysis to help identify the source of the declines, as well as design and implement interventions to target them. DHMC also experienced slight declines in several of the access to care and preventive screening measures.

The HEDIS 2013 rates reflected statistically significant improvement in four of the *Childhood Immunization Status* indicators; however, HSAG cannot determine if this increase reflects performance improvement or if it was due to the change in dosing requirements for hepatitis A, a vaccine related to *Combinations 4, 7. 8,* and *10*. DHMC also had a statistically significant increase in rates of nearly 18 percentage points for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* indicator.

Validation of Performance Improvement Projects

DHMC conducted two PIPs in FY 2011–2012. Its *Adults Access to Preventive/Ambulatory Health Services* PIP had not progressed to baseline measurement; therefore, HSAG's only suggestion was that DHMC move forward to reporting baseline results. DHMC progressed the 2012–2013 *Adults Access to Preventive/Ambulatory Health Services* PIP to the baseline measurement and identified a goal for the Remeasurement 1 period. HSAG suggested that the plan monitor interventions through alternate means other than administrative data collection. HSAG also suggested that unsuccessful interventions be revised or discontinued and reminded DHMC to document any changes made to

the interventions and discuss the success of the interventions related to the PIP outcomes in future submissions.

The FY 2011–2012 *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP showed statistically significant declines in the rates for Study Indicators 1 and 2b. HSAG recommended that DHMC monitor its interventions to determine if they are addressing the identified barriers and having the desired effect on outcomes. Although DHMC's FY 2012–2013 submission of its *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* experienced a slight increase for Study Indicators 1 and 2b between Remeasurement 1 and Remeasurement 2, the increase was not statistically significant and remained below the baseline rate of 79.6 percent. HSAG suggested that DHMC revisit its causal/barrier analysis process as the barriers identified at the start of this PIP may have changed.

Consumer Assessment of Healthcare Providers and Systems

For FY 2012–2013, DHMC did not conduct CAHPS surveys of its adult Medicaid populations.

For the comparable child population measures between FY 2010–2011 and FY 2011–2012, DHMC had no substantial decreases; however, two measures experienced slight rate declines: *Getting Needed Care* and *Rating of Personal Doctor*. HSAG recommended that DHMC continue to direct quality improvement activities toward these measures. In FY 2012–2013, DHMC's *Getting Needed Care* rate increased by 15.7 percentage points. Although slight, DHMC also experienced an increase of 2 percentage points for *Rating of Personal Doctor*. These increases indicate an improvement in consumer satisfaction for these domains.

Rocky Mountain Health Plans

Compliance Monitoring Site Reviews

As a result of the FY 2011–2012 site review, RMHP was required to address 11 required actions related to member information, grievance system, and provider participation and program integrity. RMHP submitted its plan to address all required actions to HSAG and the Department in May 2012. HSAG and the Department required that adjustments be made to the plan. RMHP submitted a revised plan along with documents to demonstrate areas of completion in August, September, and December 2012. While RMHP was able to satisfy many of the requirements, at the time of the 2012–2013 site review, RMHP had one outstanding action from the 2011–2012 site review:

- The Explanation of Benefits auto-generated for claims denials had incorrect information and time frames.

Since this corrective action requires computer system programming time, RMHP did not have an estimated date of completion. HSAG and the Department will continue to work with RMHP until all corrective actions are implemented.

Validation of Performance Measures

Between HEDIS 2011 and HEDIS 2012, RMHP experienced a statistically significant decline in four indicators under *Childhood Immunization Status* measure (*Combinations 4, 7, 8,* and 10) and the *Adolescent Well Care Visits* measure. HSAG suggested RMHP conduct a barrier analysis to help identify the source of the declines and design and implement interventions to target them. Although not statistically significant, RMHP also experienced declines in three of the access to care and preventive screening performance measures. HSAG recommended that RMHP target its improvement efforts for measures with lower performance compared to the National HEDIS Medicaid performance, such as *Chlamydia Screening in Women*, which ranked below the 10th percentile.

RMHP chose to rotate the *Childhood Immunization Status* measure for HEDIS 2013. Therefore, the HEDIS 2013 rates are the same as those reported in HEDIS 2012. RMHP's rate for *Chlamydia Screening in Women—Total* rate increased slightly; however, it remained below the 10th percentile of the national HEDIS Medicaid performance.

Validation of Performance Improvement Projects

FY 2011–2012 was the first year for RMHP's *Adult BMI Assessment* PIP, and it had not yet progressed to baseline measurement. HSAG's only suggestion was that RMHP move forward to reporting baseline results. The 2012–2013 PIP submission reported a baseline data collection period of calendar year 2012 and set a goal of improving this rate by 5 percent. HSAG recommends that as RMHP progresses with this PIP, it consider implementing interventions designed to address the specific provider- and practice-based barriers identified in its causal/barrier analysis.

FY 2011–2012 was the fourth year for RMHP's *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. While RMHP documented a new focus, it did not document any new interventions. Also, RMHP did not document how it monitors implemented interventions to determine efficacy. HSAG recommended RMHP develop and implement new interventions to address its new focus and then evaluate those interventions to determine if the interventions are successful. RMHP's 2012–2013 PIP submission did not document any new interventions during Remeasurement periods 3 and 4, but the submission did document that previously implemented interventions were ongoing. HSAG recommended that RMHP perform a causal/barrier analysis for the next phase of the study to avoid repeating intervention and improvement efforts that were unsuccessful.

Consumer Assessment of Healthcare Providers and Systems

For FY 2012–2013, DHMC and RMHP did not conduct CAHPS surveys of their adult Medicaid populations.

For the child population measures between FY 2010–2011 and FY 2011–2012, HSAG did note that RMHP showed a substantial decline in one measure: *Shared Decision Making*. RMHP also experienced slight declines in rates for three measures: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of all Health Care*. HSAG recommended that RMHP direct quality

improvement activities toward these areas. Between FY 2011–2012 and FY 2012–2013, three of the four measures showed improvement: *How Well Doctors Communicate, 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*.

Primary Care Physician Program

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

Six measures showed a decline in performance from 2011 to 2012. PCPP experienced a decline of at least 5 percentage points for three indicators for the *Childhood Immunization Status (Combinations 2, 6,* and *9*) and the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. HSAG also noted that the PCPP rate for the *Chlamydia Screening in Women—Total* indicator ranked below the national HEDIS Medicaid 10th percentile. HSAG suggested that PCPP focus its efforts on improving the performance of these indicators.

PCPP's 2013 HEDIS rates showed a statistically significant increase in seven of 10 *Childhood Immunization Status* indicators, including *Combinations 6* and *9*. Although not statistically significant, PCPP also experienced a slight increase in its rate for the *Chlamydia Screening in Women—Total* indicator; however, this indicator still ranked below the national HEDIS Medicaid 10th percentile. HSAG suggested that PCPP continue its efforts to improve this rate.

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 2012 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*. HSAG recommended that PCPP continue to direct quality improvement activities toward these measures.

For the *Shared Decision Making* composite measure, changes were made to the CAHPS 5.0 Surveys question language, response options, and number of questions. Due to these changes,

comparisons to national data and prior years' rates could not be performed for the *Shared Decision Making* composite measure. Although not statistically significant, HSAG was able to determine a slight increase between the 2012 and 2013 child Medicaid survey *Rating of Personal Doctor* measure. While also not statistically significant, PCPP also experienced a further decline between the 2012 and 2013 adult Medicaid survey *How Well Doctors Communicate* measure. HSAG recommended that PCPP continue to direct quality improvement activities toward these measures.

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 EQR activities performed. Also included are HSAG's recommendations for improving the health plans' performance. 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 2012–2013 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 III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

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 Credentialing and Recredentialing standard, HSAG conducted a record review of 10 credentialing files and 10 recredentialing files. 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 determined which standards contained requirements that related to the domains of Quality, Timeliness, or Access. Table 5-1 displays which standards contain requirements related to each of the domains. 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—Standards Containing Requirements Related to Performance Domains			
Standards	Quality	Timeliness	Access
Coordination and Continuity of Care	✓	✓	✓
Member Rights and Protections	✓		✓
Credentialing and Recredentialing	✓		✓
Quality Assessment and Performance Improvement	✓		

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

Access Behavioral Care

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 2012–2013).

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 III—Coordination and Continuity of Care	8	8	8	0	0	0	100%
Standard IV—Member Rights and Protections	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	49	49	48	1	0	0	98%
Standard X—Quality Assessment and Performance Improvement	16	16	16	0	0	0	100%
Totals	**78**	**78**	**77**	**1**	**0**	**0**	**99%***

*The overall score is 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)
Credentialing	80	70	70	0	10	100%
Recredentialing	80	62	62	0	18	100%
Totals	**160**	**132**	**132**	**0**	**28**	**100%***

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

Strengths

Colorado Access had a well-defined care coordination program, with specialized care coordinators dedicated to support the ABC line of business and its members. ABC care management staff had a

collaborative relationship with the primary mental health providers, such as the Mental Health Center of Denver (MHCD), and high-volume skilled nursing facility (SNF) providers, which enhanced the monitoring of and planning for services for members with complex cultural, mental health, and physical health needs. The Altruista case management software documented all of the components of the comprehensive care coordination process and allowed for integration of the treatment record from the mental health provider. ABC audited provider medical records to ensure provider compliance with the member assessment and treatment plan requirements.

Colorado Access had processes for ensuring that members and providers understand member rights. Colorado Access also provided periodic communication that reminded staff, members, and providers about member rights and the need to ensure these rights are taken into consideration at all times. Processes for ensuring member rights are taken into account were consistent across all lines of business. Colorado Access provided frequent training for staff and employees. Colorado Access had several mechanisms to engage providers in a partnership (e.g., a user-friendly Web site; frequent provider newsletters available electronically; and an impressive number of trainings delivered in person and/or via Webinar, publicized through its Web site).

Credentials Committee minutes were detailed and demonstrated the role of the medical director consistent with the Colorado Access policy. The minutes also evidenced that the committee reviewed files that did not initially meet the required criteria. The Credentials Committee also reviewed ongoing monitoring for sanction activity, quality of care issues, and delegates' reports of credentialing activities. Practitioner credentialing and recredentialing files were comprehensive, neat, and very well organized, as were organizational provider records. Practitioner and provider records demonstrated Colorado Access' performance of all required credentialing and recredentialing activities.

ABC has experienced management staff to support the ABC line of business and quality improvement (QI) programs. Colorado Access has developed one quality assessment and performance improvement (QAPI) program applicable to all lines of business, which enables ABC to be well resourced with QI policies, staff, systems, and committees. Colorado Access has invested in the development of high-functioning health information systems, which integrate data and produce reports to support QI monitoring activities and initiatives. ABC has designed the comprehensive, detailed, and well-formatted QAPI Annual Evaluation report, which addresses all of the required elements. Medical Behavioral Quality Improvement Committee and QI Committee meeting minutes included discussion and recommendations related to reported QI activities and outcomes.

Recommendations

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

Credentialing and Recredentialing

While Colorado Access/ABC had numerous and appropriate methods to prevent discrimination during credentialing and recredentialing processes, there were no methods in place for monitoring to ensure nondiscriminatory credentialing practices, as required by the National Committee for

Quality Assurance (NCQA). Colorado Access must develop processes for monitoring to ensure nondiscriminatory credentialing practices.

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: HSAG determined that all four standards (Coordination and Continuity of Care, Member Rights and Protections, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement) had requirements that could impact the quality of services provided to members. ABC's performance in the quality domain was very strong. ABC had processes in place to ensure that members had an ongoing source of primary behavioral health care and had a mechanism to formally designate a person primarily responsible for coordinating members' care. Its Care Coordination program addressed service accessibility, continuity of care, and attention to individual needs for members with complex physical and behavioral health needs. ABC had effective procedures to ensure the privacy and confidentiality of protected health information and provided periodic communication to members about member rights. ABC's NCQA-compliant credentialing and recredentialing program ensured a broad base of qualified providers and included ongoing monitoring of providers for the quality and appropriateness of services provided. ABC's QAPI Program included clinical practice guidelines, methods to detect over- and underutilization of services, robust data reporting, and a variety of mechanisms to evaluate member perceptions of the access to and adequacy of services. ABC had effective processes in place to address instances when quality was less than expected.

Timeliness: Coordination and Continuity of Care is the only standard that HSAG determined to have requirements that could impact the timeliness domain. ABC performed very well in the timeliness domain. On-site presentation of a care coordination case demonstrated timely coordination of services between multiple providers during transitions of care. ABC's electronic care management system included comprehensive member assessment ensuring timely identification of member needs, and time-specific goals and interventions.

Access: HSAG determined that the Coordination and Continuity of Care, Member Rights and Protections, and Credentialing and Recredentialing standards contained requirements that could impact the access domain. ABC's performance as it related to the access domain also proved to be strong. On-site presentation of care coordination records demonstrated how the care coordination program at ABC assisted members in obtaining access to necessary services through referrals to specialists and community-based providers, and by providing coordination between providers. By sending periodic reminders of member rights to members, staff, and providers, ABC informed all parties of members' rights related to accessing services. ABC's credentialing and recredentialing program ensured a robust network of qualified providers.

Behavioral Healthcare, Inc.

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 2012–2013).

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 III—Coordination and Continuity of Care	8	8	8	0	0	0	100%
Standard IV—Member Rights and Protections	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	49	47	45	1	1	2	96%
Standard X—Quality Assessment and Performance Improvement	16	16	15	0	1	0	94%
Totals	**78**	**76**	**73**	**1**	**2**	**2**	**96%***

*The overall score is 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)
Credentialing	60	60	60	0	0	100%
Recredentialing	60	60	60	0	0	100%
Totals	**120**	**120**	**120**	**0**	**0**	**100%***

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

Strengths

BHI contracted with Colorado Access for the performance and management of care coordination services for members because of Colorado Access' established care coordination experience and system. BHI and Colorado Access have jointly established on-site care coordinators in each of the network community mental health centers (CMHCs). BHI provided policy oversight and guidance to the care coordinators regarding BHI members. This approach capitalized on the strengths of each participating entity and provided significant depth in the care coordination resources available to members with complex needs. The three cases selected by BHI for the care coordination presentation demonstrated that BHI engaged in coordinating care for members with very complex needs who required multiple providers and services. The care coordinators actively performed ongoing, hands-on care management and follow-up with members, families, providers, and agencies. Each case also demonstrated BHI's commitment to evaluate, pursue, and organize services to meet the care coordination challenges presented by members with complex needs.

BHI provided evidence of numerous member-focused programs designed to actively engage members in treatment, decision-making, and their own health and wellness, and to keep information about mental health benefits and rights visible to both members and providers. Programs included wellness classes; peer specialist programs; life skills trainings; the Recovery-based, Individualized Strengths-based Education (RISE) program; and the Whole Health Active Management (WHAM) program. Staff members described the active roles of both the Office of Member and Family Affairs (OMFA) and care management staff, located at the CMHCs, in these programs.

There was ample evidence of BHI's monitoring and oversight of Colorado Access. BHI had a good relationship with its delegate and a clear understanding of Colorado Access' processes and activities. On-site record review of contracted provider records demonstrated that primary source verification for credentialing and recredentialing was completed within the required time frames and that recredentialing was completed within the 36-month time frame. The delegate's credentialing records and BHI's on-site contracting files for each contracted provider were well organized. Organizational provider records were also well organized and contained the required information.

BHI had a well-defined QAPI Program that incorporated multiple data sources for monitoring and reporting, including performance indicators, utilization, grievances, focus studies, and quality of care concerns. Within the last year, BHI added staff to support the BHI QI program and re-introduced the Report Card process to its network CMHCs. Implementation of the BHI Report Card required the CMHCs to review many of the key quality monitoring parameters quarterly. BHI designated accountability for oversight of QI functions to internal executive and management leadership, the Provider Advisory Committee (PAC), the Program Evaluation and Outcomes (PEO) Committee, and the delegated QI committees of the CMHCs. BHI assigned development of clinical practice guidelines to the Standards of Practice (SOP) Committee, which reviews and adapts clinical guidelines while considering local member needs and provider expertise. BHI had a comprehensive integrated health information system, which provided both routine and ad-hoc reports for QI monitoring activities.

Recommendations

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

Credentialing and Recredentialing

Although BHI provided evidence of activities designed to prevent discriminatory credentialing processes, BHI must also develop a mechanism to monitor the credentialing/recredentialing program at least annually to ensure nondiscriminatory credentialing and recredentialing. The mechanism must be described in BHI's policies and procedures.

BHI provided evidence of assessment and subsequent reassessment of organizational providers; however, in four of the four applicable organizational provider files reviewed, reassessment had not occurred within the 36-month time frame required by NCQA. BHI must develop a mechanism to ensure that organizational providers are reassessed every three years (36 months).

Quality Assessment and Performance Improvement

BHI's quality program did not incorporate review of results from the Mental Health Statistics Improvement Program (MHSIP), Youth Services Surveys (YSS), and Youth Services Surveys for Families (YSS-F) member satisfaction surveys in 2012. BHI must incorporate review of future MHSIP, YSS, and YSS-F satisfaction survey results into the 2013 Quality Assurance Work Plan and provide evidence of review and action as needed by the appropriate QI oversight committees.

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: BHI performed very well in the quality domain. BHI's processes included assigning a care coordinator to each member who is responsible for assessing needs and coordinating care with behavioral health and primary care providers, community-based agencies, and other support services necessary. BHI developed collaborative initiatives with the county social services agencies to promote care coordination between providers and community-based organizations. BHI implemented numerous member-focused programs designed to engage members in treatment and decision-making. BHI had effective procedures to ensure the privacy and confidentiality of protected health information and had a variety of methods to inform staff, providers, and members of member rights and the need to ensure member rights are taken into account. BHI's NCQA-compliant credentialing and recredentialing program ensured a broad base of qualified providers and included ongoing monitoring of providers for the quality and appropriateness of services provided. BHI's QAPI Program included clinical practice guidelines, methods to detect over- and underutilization of services, effective data reporting, and mechanisms to evaluate member perceptions of the access to and adequacy of services. BHI had effective processes in place to address instances when quality was less than expected.

Timeliness: By making care coordinators accessible at the CMHCs, BHI helped ensure timely identification of member needs. BHI provided case review information that demonstrated timely assessment, care planning, and care coordination with community-based providers during transitions of care.

Access: HSAG determined that the Coordination and Continuity of Care, Member Rights and Protections, and Credentialing and Recredentialing standards contained requirements that could impact the access domain. By keeping member rights and protections at the forefront of business, BHI helped ensure members and providers were aware of members' rights to access services and which services are available. BHI's NCQA-compliant credentialing and recredentialing program ensured a robust network of qualified providers. Although BHI provided evidence of monitoring grievance and appeal data, HSAG recommended that BHI apply a more robust quality oversight and review of information obtained from member surveys (MHSIP, YSS-F, YSS) to use the data about member perception of access to services for program improvement.

Colorado Health Partnerships, LLC

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 2012–2013).

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 III—Coordination and Continuity of Care	8	8	8	0	0	0	100%
Standard IV—Member Rights and Protections	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	49	47	46	1	0	2	98%
Standard X—Quality Assessment and Performance Improvement	16	16	16	0	0	0	100%
Totals	**78**	**76**	**75**	**1**	**0**	**2**	**99%***

*The overall score is 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)
Credentialing	80	62	62	0	18	100%
Recredentialing	80	63	62	1	17	98%
Totals	**160**	**125**	**124**	**1**	**35**	**99%***

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

Strengths

CHP's partnership with ValueOptions (VO) was a clear strength for CHP with corporate support, processes, and software for tracking members and responding to their needs. Local staff members were well qualified, experienced, and familiar with Colorado requirements and the distinct needs of Colorado's Medicaid population. The CHP team demonstrated leadership and administrative skill in coordinating care for members with complex medical and behavioral health needs. CHP had planned innovative programs to improve the effectiveness of care coordination programs, such as the expansion of the peer specialist program to enhance the effectiveness of transitioning members from hospitalization to outpatient services. The care managers appeared well connected to the CMHC staff, as well as other providers and community service organizations that were participating in a member's care team. The care coordination process was well documented in the member's treatment record, as well as the electronic care coordination system.

Ongoing communication between the BHO and the CMHCs regarding member rights was accomplished by the OMFA representatives on-site at each of the CMHCs. CHP's OMFA director provided ongoing support and met periodically with the CMHCs' OMFA directors to clarify policies and assist with member needs.

VO's corporate policies and processes bring extensive experience and knowledge of NCQA requirements to CHP. VO's database for maintaining documents obtained for credentialing and recredentialing provides secure recordkeeping, while providing easy access to staff for processing and accessing provider files, as needed. VO's assignment of two credentialing specialists designated for Colorado provider applications ensured that Colorado-specific requirements were met. CHP's site visit tools and procedures for both individual practitioners and organizational providers were comprehensive and incorporated both NCQA and Colorado-specific requirements. CHP's credentialing committee, which served as the VO local credentialing committee, incorporated VO staff members and CMHC providers and included a variety of provider types.

The CHP/VO support staff and systems were supported by the national VO organization, thereby enhancing the experience and expertise available to CHP for QI activities. In addition, local staff members were experienced and had longevity with CHP. The QI process engaged many participating providers and departments in the component activities, as well as the functions of the Quality Improvement Steering Committee/Clinical Advisory Utilization Management Committee (QISC/CAUMC). QISC/CAUMC meeting minutes documented substantive discussion of the analysis and recommendations related to the review of a comprehensive base of QI activities and data.

Recommendations

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

Credentialing and Recredentialing

Although a delegation agreement may not be required because VO is a CHP partner, since there is a delegation agreement, it must be complete. The delegation agreement between VO and CHP did not include a provision that CHP retains the right to approve, suspend, and terminate individual practitioners and providers. This provision was present in the delegation agreement submitted for the 2010 site visit, but it had been removed from the most recently signed agreement. CHP must either revise the delegation agreement or use an addendum to include the required provision that CHP retains the right to approve, suspend, and terminate individual practitioners and providers.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: CHP performed very well in the quality domain. CHP had processes to ensure that each member was assigned a person responsible for coordinating care. An on-site presentation of care coordination cases demonstrated active coordination of information and services among providers; use of comprehensive assessments; and development of treatment plans with goals, progress

monitoring, and follow-up revisions to the individualized care plans. CHP had effective procedures to ensure the privacy and confidentiality of protected health information and had a variety of methods to inform staff, providers, and members of member rights and the need to ensure member rights are taken into account. CHP's credentialing and recredentialing program included monitoring providers for the quality and appropriateness of services provided. CHP's QAPI Program was comprehensive and included clinical practice guidelines, methods to detect over- and underutilization of services, and mechanisms to evaluate member perceptions of the access to and adequacy of services. CHP's health information system effectively reported data essential to development of quality initiatives.

Timeliness: CHP's processes included monitoring provider records for timeliness of assessment and treatment planning. Ensuring that each member is assessed provides timely identification of member needs.

Access: CHP demonstrated it provided mental health services on-site at nursing facilities, or provided transportation to services at CMHCs. CHP had a variety of methods to inform members and providers of members' rights to access services and which services are available. CHP's NCQA-compliant credentialing and recredentialing program ensured access to a broad range of providers and services. CHP employed several methods to monitor member perception of the adequacy of and access to services, with follow-up on results of these surveys and information.

Foothills Behavioral Health Partners, LLC

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 2012–2013).

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 III—Coordination and Continuity of Care	8	8	8	0	0	0	100%
Standard IV—Member Rights and Protections	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	49	47	47	0	0	2	100%
Standard X—Quality Assessment and Performance Improvement	16	16	16	0	0	0	100%
Totals	**78**	**76**	**76**	**0**	**0**	**2**	**100%***

*The overall score is 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)
Credentialing	61	61	61	0	0	100%
Recredentialing	60	60	59	1	0	98%
Totals	**121**	**121**	**120**	**1**	**0**	**99%***

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

Strengths

Care coordination needs were assessed and facilitated through the care managers assigned to the participating CMHCs. The CMHC electronic health record included comprehensive documentation of member needs assessment, treatment plan components, frequent progress notes, and updates to support the coordination and continuity of care requirements. Sample cases reviewed during the on-site visit provided verification of active case manager coordination of services with multiple providers and entities for a variety of complex cases.

The FBHP Member Information policy described the OMFA processes and responsibilities for ensuring the accuracy of member materials that describe member rights and timely distribution of those materials to members. FBHP staff members described the OMFA representatives' duties at

each network CMHC. OMFA representatives are a resource for members and providers at the CMHCs and provide presentations as needed during new employee orientations and annual training.

FBHP's partnership with VO and VO's corporate policies and processes bring extensive experience and knowledge of NCQA credentialing/recredentialing requirements to FBHP. VO's database for maintaining documents obtained for credentialing and recredentialing provides secure recordkeeping, while providing easy access to staff for processing and accessing provider files, as needed. VO's assignment of two credentialing specialists designated for Colorado provider applications ensured that Colorado-specific requirements were met. FBHP's site visit tools and procedures for both individual practitioners and organizational providers were comprehensive and incorporated both NCQA and Colorado-specific requirements. FBHP's credentialing committee, which served as the VO local credentialing committee, incorporated VO staff members and CMHC providers and included a variety of provider types.

FBHP, through its QI/Utilization Management Committee, CMHCs, and QI support staff, actively and regularly reviewed numerous data reports and ongoing performance indicators to monitor the quality and appropriateness of FBHP services. Data reports were analyzed by QI staff and presented in a meaningful way to the QI committees. Clinical practice guidelines were developed through the involvement of local providers with expertise in the clinical area under review. Clinical guidelines were then published in materials easy for members to understand in the form of diagnosis-specific "tips" for members and families.

Recommendations

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

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: FBHP's performance across the four standards was 100 percent, demonstrating very strong performance in the quality domain. FBHP had a mechanism to ensure that each member has a primary source of behavioral health care and a process for ensuring that care is coordinated. FBHP communicated requirements and expectations for medical records to providers, and FBHP demonstrated that it regularly monitored provider compliance with medical record content and with coordination and continuity of care requirements. On-site presentation of care coordination cases demonstrated coordination between providers and community-based service agencies. FBHP had effective methods for ensuring the privacy and confidentiality of protected health information and a variety of methods to inform members and providers about member rights and provider responsibilities regarding member rights. FBHP had robust credentialing and recredentialing processes and demonstrated compliance with NCQA requirements. The FBHP QI Program Description, QI Annual Evaluation, and QI Work Plan outlined multiple components of a comprehensive QI program that incorporated monitoring of over- and underutilization, quality performance indicators, member survey information, access metrics, grievance and appeal data, practice guidelines, and review of quality of care concerns.

Timeliness: FBHP performed exceptionally well in the timeliness domain. Its coordination and continuity of care process ensured that members were receiving needed services to maintain and improve their physical and mental health. Comprehensive assessments for members ensured timely identification of member needs.

Access: As with the other domains, FBHP demonstrated strong performance in the access domain as well. FBHP demonstrated it provided mental health services on-site at nursing facilities, or provided transportation to services at CMHCs. FBHP assigned each member to a care coordinator who is responsible for ensuring access to services. Clear, concise, and accurate member information helped ensure members were aware of available services and how to access them, and FBHP's credentialing program ensured access to a broad variety of qualified providers. FBHP also employed several methods to monitor member perception of the adequacy of and access to services, with follow-up on results of these surveys and information.

Northeast Behavioral Health Partnership, LLC

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 2012–2013).

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 III—Coordination and Continuity of Care	8	8	8	0	0	0	100%
Standard IV—Member Rights and Protections	5	5	5	0	0	0	100%
Standard VIII—Credentialing and Recredentialing	49	47	46	1	0	2	98%
Standard X—Quality Assessment and Performance Improvement	16	16	16	0	0	0	100%
Totals	**78**	**76**	**75**	**1**	**0**	**2**	**99%***

*The overall score is 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)
Credentialing	64	48	48	0	16	100%
Recredentialing	80	60	58	2	20	97
Totals	**144**	**108**	**106**	**2**	**36**	**98%***

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

Strengths

NBHP delegated care coordination activities to VO. VO demonstrated extensive experience in care management, provided well-qualified staff to support NBHP members and CMHCs, and maintained well-defined systems and processes to support care coordination. The VO team demonstrated leadership and administrative skill in coordination of care for members with complex medical and behavioral health needs. Discharge planners located at each of the CMHCs facilitated continuity of care when members were transitioning from one level of care to another. Collectively, NBHP and its partners demonstrated depth of resources committed to coordination and continuity of care for members. The CMHC electronic health record, used in case demonstration, appeared well configured to document and track the elements of coordination of care.

NBHP demonstrated that its members are continuously encouraged by therapists and during member groups to access their rights and to use processes available to them, such as the grievance and appeals processes. Staff stated that OMFA advocates, located at each network CMHC, are visible to members and support providers in helping members access the grievance and appeal system. NBHP staff use "Compliment & Complaint Help" business card-sized handouts, placed throughout the CMHCs, which are available for providers to distribute to members. The cards have the OMFA advocate names and contact information and remind members of their right to provide feedback, positive or negative, to the CMHCs.

VO's corporate policies and processes bring extensive experience and knowledge of NCQA requirements to NBHP. VO's database for maintaining documents obtained for credentialing and recredentialing provides secure recordkeeping, while providing easy access to staff for processing and accessing provider files, as needed. VO's assignment of two credentialing specialists designated for Colorado provider applications ensured that Colorado-specific requirements were met. NBHP's site visit tools and procedures for both individual practitioners and organizational providers were comprehensive and incorporated both NCQA and Colorado-specific requirements. NBHP's credentialing committee, which served as the VO local credentialing committee, incorporated VO staff members and CMHC providers and included a variety of provider types.

The NBHP staff was supported by the Colorado VO staff and systems, as well as the national VO organization, thereby enhancing the experience and expertise available to NBHP for QI activities. The QI process engaged many participating providers and departments in the component activities, as well as in the functions of the QI/Utilization Management Committee. The VO Health Information System was well developed and capable of producing numerous reports, which were used regularly to evaluate quality and appropriateness of care and to stimulate interventions and improvements. The NBHP medical director provided active leadership for the NBHP QI and UM programs.

Recommendations

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

Credentialing and Recredentialing

Although NBHP included VO as a member of the partnership, there was a delegation agreement between the partnership and VO (as required by the Department). The delegation agreement did not include a provision that NBHP retains the right to approve, suspend, and terminate individual practitioners and providers. This provision was present in the delegation agreement submitted for the 2010 site visit, but it had been removed from the most recently signed agreement. NBHP must either revise the delegation agreement or use an addendum to include the required provision that NBHP retains the right to approve, suspend, and terminate individual practitioners and providers.

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 performed very well in the quality domain. NBHP had processes to ensure that each member was assigned a person responsible for coordinating care. An on-site presentation of care coordination cases demonstrated active coordination of information and services among providers; use of comprehensive assessments; and development of treatment plans with goals, progress monitoring, and follow-up revisions to the individualized care plans. NBHP had effective procedures to ensure the privacy and confidentiality of protected health information and had a variety of methods to inform staff, providers, and members of member rights and the need to ensure member rights are taken into account. A particular strength for NBHP was the use of Compliment & Complaint Help business cards available at all sites and from therapists as a reminder to members of their grievance rights. NBHP's credentialing and recredentialing program included monitoring providers for the quality and appropriateness of services provided. NBHP's QAPI Program was comprehensive and included clinical practice guidelines, methods to detect over- and underutilization of services, and mechanisms to evaluate member perceptions of the access to and adequacy of services. NBHP's health information system effectively reported data essential to development of quality initiatives.

Timeliness: NBHP's processes included monitoring provider records for timeliness of assessment and treatment planning. Ensuring that each member is assessed provides timely identification of member needs.

Access: NBHP demonstrated it provided mental health services on-site at nursing facilities, or provided transportation to services at CMHCs. NBHP had a variety of methods to inform members and providers of members' rights to access services and which services are available. NBHP's NCQA-compliant credentialing and recredentialing program ensured access to a broad range of providers and services. NBHP employed several methods to monitor member perception of the adequacy of and access to services, with follow-up on results of these surveys and information.

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 F 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 2012–2013 Statewide Average***
Standard III—Coordination and Continuity of Care	**100%**
Standard IV—Member Rights and Protections	**100%**
Standard VIII—Credentialing and Recredentialing	**98%**
Standard X—Quality Assessment and Performance Improvement	**99%**
Overall Statewide Compliance Score	**98%***

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

Table 5-13—Statewide Score for Record Review	
Standards	**FY 2012–2013 Statewide Average***
Credentialing	**100%**
Recredentialing	**99%**
Overall Statewide Score for Record Reviews	**99%***

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

Quality: All four standards reviewed had requirements that impacted the quality domain. Statewide performance in the quality domain was excellent. All BHOs had processes to ensure that each member had a primary source of behavioral health care and was assigned a person responsible for coordinating care. All BHOs monitored providers for compliance with contract requirements such as medical record requirements or the completeness of assessments and care planning. Five of five BHOs had robust policies and practices for the protection of member privacy and confidentially of member records and policies and practices to ensure members are not discriminated against as well as mechanisms to inform staff, providers, and members of member rights and the need to ensure member rights are taken into account. All BHOs had a health information system with the ability to collect, analyze, and report data essential to the development of effective quality initiatives. In addition, five of five BHOs had robust credentialing/recredentialing programs that ensured medical director input in the credentialing program, and performed initial and ongoing monitoring of provider sanctions to ensure providers in the network met the quality standards. QAPI programs were comprehensive and included clinical practice guidelines, methods to detect over- and underutilization of services, and mechanisms to evaluate member perceptions of the access to and adequacy of services.

In addition, there were several enhancements to the BHOs' QAPI programs that were suggested but were not required. Four of five BHOs were asked to consider clearly documenting conclusions drawn and recommendations for actions in quality oversight committee meeting minutes rather than only documenting the results of quality activities. Three of the five BHOs were asked to consider including in the annual QI work plan, identification of which initiatives were continued from or related to the previous year's initiatives, to more effectively identify ongoing quality concerns. Two BHOs were asked to consider increasing the sample size of providers audited for compliance with medical record content and coordination of care requirements. Two BHOs were asked to consider including follow-up information in the quality oversight committee minutes when CMHCs were asked to address quality issues or results of quality studies or initiatives. One BHO was asked to increase the documentation of operational review and oversight of pertinent quality data and QI studies and findings.

Timeliness: Each of the BHOs had processes to ensure that members had comprehensive assessments, which contributes to timely identification of member needs. All BHOs also provided evidence of referral to and coordination with a variety of providers including community-based providers, also contributing to timely access to services particularly during transitions of care.

Access: Five of five BHOs had processes for providing mental health services on-site at nursing facilities, or coordinating transportation services to the CMHCs. All BHOs used a variety of methods to inform members and providers of members' rights to access services and which services are available. These included posters at facilities, Web site information, member and provider handbooks, member and provider newsletters, annual letters, and topic-specific flyers and brochures. All BHO's had NCQA-compliant credentialing and recredentialing programs that ensured access to a broad range of providers and services. Five of five BHOs employed several methods to monitor member perception of the adequacy of and access to services. Four of five BHOs provided evidence of follow-up on results of these surveys and information. One of five BHOs had a recommendation that could impact the Access domain; HSAG recommended that this BHO apply a more robust quality oversight and review of information obtained from member surveys (MHSIP, YSS-F, YSS) to use the data about member perception of access to services for program improvement.

Validation of Performance Measures

The Department required the collection and reporting of 11 performance measures for the FY 2012–2013 validation process. Five were HEDIS-like measures and six were developed by the Department and the BHOs. Some of these measures have multiple indicators (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 34 rates. All measures originated from claims/encounter data. The specifications for these measures were 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. Nine of the 11 measures were validated and reported in the previous year, and comparisons with last year's results are listed when available.

HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)* (Department of Health and Human Services, Centers for Medicare & Medicaid Services, Protocol 2, Version 2.0, September 2012). 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 contained documentation detailing the information systems used by the BHO and the Department for performance measure reporting activities, and was reviewed by auditors prior to the on-site visit. During the on-site visit, HSAG auditors completed 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 *Report*, *Not Reported*, or *No Benefit* 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 compliant. Consequently, it was possible that an error for a single element resulted in a designation of *Not Reported* (*NR*) because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it was also possible that several element errors had little impact on the reported rate; and HSAG gave the indicator a designation of *Report*.

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**
Percent of Members with SMI with a Focal Point of Behavioral Health Care	✓		✓
Improving Physical Healthcare 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

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 the files to the CMHC 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. Based on the contract, DST internally audited 2 percent of manually adjudicated claims and auto-adjudicated claims daily. DST sent the results to ABC daily, and summaries of the findings were sent monthly and quarterly. ABC performed two types of audits on DST. First, ABC reviewed a 7 percent sample of the audits performed by DST to ensure the quality of the internal audit conducted by DST. Second, internal auditors at Colorado Access audited 3 to 5 percent of claims processed daily.

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 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	—	96.1%	*Report*
Improving Physical Healthcare Access	—	59.1%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	5.0%	6.2%	*Report*
Adolescents 13 Through 17 Years of Age	14.9%	14.8%	*Report*
Adults 18 Through 64 Years of Age	19.4%	19.1%	*Report*
Adults 65 Years of Age or Older	6.5%	6.7%	*Report*
Penetration Rate by Service Category			
Inpatient Care	0.3%	0.3%	*Report*
Intensive Outpatient/Partial Hospitalization	0.05%	0.05%	*Report*
Ambulatory Care	8.9%	10.2%	*Report*
Overall Penetration Rates	10.9%	11.5%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	11.6%	10.9%	*Report*
AFDC/CWP Children	5.1%	6.1%	*Report*
AND/AB-SSI	32.9%	33.7%	*Report*
BC Children	4.9%	6.2%	*Report*
BC Women	13.1%	13.4%	*Report*
BCCP—Women Breast and Cervical Cancer	17.2%	16.4%	*Report*
Foster Care	39.7%	43.2%	*Report*
OAP-A	6.4%	6.6%	*Report*
OAP-B-SSI	22.6%	24.2%	*Report*
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	3.8%	4.3%	*Report*
30 Days	11.1%	11.5%	*Report*
90 Days	21.9%	18.4%	*Report*
All Hospitals—7 Days	3.7%	4.3%	*Report*
30 Days	10.7%	11.4%	*Report*
90 Days	21.1%	18.9%	*Report*
Hospital Average Length of Stay			
Non-State Hospitals	8.17	9.36	*Report*
All Hospitals	19.97	16.89	*Report*

Table 5-15—Review Results and Audit Designation *for* ABC			
Performance Measures	Rate		FY 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
Emergency Room Utilization (Rate/1000 Members, All Ages)	7.95	11.24	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	5.41	4.87	*Report*
All Hospitals	6.30	5.58	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	39.7%	42.6%	*Report*
30 Days	58.7%	62.1%	*Report*
All Hospitals—7 Days	40.4%	42.5%	*Report*
30 Days	59.1%	62.2%	*Report*

[1] For the *Hospital Recidivism* measure, an increase over last year's rates would suggest poorer performance.
— Indicates the measure was not calculated.

Strengths

ABC acted on the recommendations made by HSAG during the previous year's audit. ABC indicated that its system is ready for the ICD-10 conversion effective July 2013. ABC's performance measure reporting and process flow document is very detailed and is a valuable resource. The ABC performance measure team has retained its core team members for the past several years, adding to the reliability of processes in place.

ABC received a *Report* status for all audited performance measures. HSAG observed improvement in the *Overall Penetration Rates* and all *Follow-Up After Hospitalization for Mental Illness* submeasures. While all of the *Follow-Up After Hospitalization for Mental Illness* submeasures improved over the previous measurement period, none of the submeasures improved by more than 3.5 percentage points.

Recommendations

ABC should implement a rate validation process. 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. Also, HSAG noted that only one individual was responsible for the performance measure rate calculation process. ABC should implement a process to have other staff members serve as backup should the primary person be unavailable to perform his or her duties. Furthermore, as ABC begins the transition to a new transactional system, HSAG recommended that ABC thoroughly document the process, including any issues encountered along the way and how those issues were resolved.

HSAG noted that specific types of mental health practitioners were not specified in the scope document for Intensive Outpatient/Partial Hospitalization and Outpatient and ED services. This issue was communicated to the Department as a potential recommendation. ABC should begin capturing the rendering provider information from its CMHCs to ensure provider data completeness when the scope document is updated.

HSAG observed lack of improvement on many of the *Hospital Recidivism* measures.[5-1] Specifically, four of the six *Hospital Recidivism* category submeasures showed increased rates, indicating decreased performance. However, none of these rates increased by more than 1 percentage point. ABC should investigate reasons why the hospital recidivism performance has declined.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* were the only quality measures reported for this year. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. ABC's performance on measures in the *Hospital Recidivism* category demonstrated opportunities for improvement. Two of the six measures improved over the previous measurement period (i.e., reported a declining rate), and none of the measures reported a positive or negative change greater than 4 percentage points. In particular, the *Non-State Hospitals—90 Days* submeasure showed a decline in rate (suggesting improvement) of 3.5 percentage points.

Timeliness: *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported this year. ABC's performance on this measure demonstrated improvement for each of the four submeasures. In particular, the *Non-State Hospitals—30-Days* submeasure rate showed an increase of 3.4 percentage points.

Access: ABC's performance in the domain of access was mixed, with opportunities for improvement present for most of the measures. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. Two of the 17 *Penetration Rate* submeasures (*Penetration Rate by Service Category—Inpatient Care* and *Intensive Outpatient/Partial Hospitalization*) showed the same level of performance as the previous year. Four of the remaining 15 submeasures exhibited a decline, though none of these measures declined by more than 1 percentage point. Conversely, of the 11 *Penetration Rate* submeasures with higher performance in the current measurement period, none showed improvement in excess of 3.6 percentage points.

All utilization-based access measures except *Emergency Room Utilization* and *Hospital Average Length of Stay—Non-State Hospitals* experienced a decline in utilization, indicative of shorter inpatient stays and a lower rate of members using inpatient services. 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.

Findings—System and Reporting Capabilities

BHI contracted with Colorado Access to manage eligibility data processing. During the BHI and Colorado Access audit, 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 information technology (IT) department ensured that files met necessary requirements to be loaded into PowerSTEPP. Daily eligibility files were sent to the CMHCs, and 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. Colorado Access appeared to have a robust oversight process to its claims processing vendor, DST. Additionally, BHI conducted an annual claims validation audit using medical record review to ensure claims accuracy.

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 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	—	92.8%	*Report*
Improving Physical Healthcare Access	—	72.8%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	5.8%	6.4%	*Report*
Adolescents 13 Through 17 Years of Age	16.5%	16.7%	*Report*
Adults 18 Through 64 Years of Age	17.4%	18.3%	*Report*
Adults 65 Years of Age or Older	4.1%	4.6%	*Report*
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	*Report*
Intensive Outpatient/Partial Hospitalization	0.1%	0.1%	*Report*
Ambulatory Care	10.1%	10.9%	*Report*
Overall Penetration Rate	10.5%	11.3%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	11.8%	12.9%	*Report*
AFDC/CWP Children	6.3%	7.0%	*Report*
AND/AB-SSI	31.8%	32.9%	*Report*
BC Children	4.7%	5.4%	*Report*

Table 5-16—Review Results and Audit Designation *for* BHI			
Performance Measures	Rate		FY 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
BC Women	6.9%	9.1%	*Report*
BCCP—Women Breast and Cervical Cancer	9.3%	12.1%	*Report*
Foster Care	34.8%	36.7%	*Report*
OAP-A	4.1%	4.6%	*Report*
OAP-B-SSI	19.6%	21.3%	*Report*
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	2.9%	2.8%	*Report*
30 Days	11.5%	8.3%	*Report*
90 Days	18.0%	14.6%	*Report*
All Hospitals—7 Days	4.1%	3.0%	*Report*
30 Days	12.6%	8.8%	*Report*
90 Days	19.4%	15.1%	*Report*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	7.80	7.13	*Report*
All Hospitals	14.31	15.54	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	6.64	9.95	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.26	2.87	*Report*
All Hospitals	4.78	3.83	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	50.0%	57.8%	*Report*
30 Days	67.6%	70.8%	*Report*
All Hospitals—7 Days	51.0%	59.3%	*Report*
30 Days	67.4%	72.7%	*Report*

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

— Indicates the measure was not calculated.

Strengths

BHI continued to have a very collaborative relationship with Colorado Access, its administrative service organization (ASO). BHI collaborated with the BHOs and the Department in acting on the recommendations from the previous year's audit to revise the scope document. BHI maintained a team of experienced professionals who work together to ensure robust and accurate performance measure reporting.

BHI received a *Report* status for all audited performance measures. HSAG observed improvement of at least 3 percentage points among all four submeasures in the *Follow-Up After Hospitalization for Mental Illness* category. Additionally, minor improvement was observed among all *Hospital Recidivism* submeasures.

Recommendations

BHI should implement a rate validation process. 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 noted that one individual was responsible for the performance measure rate calculation process. BHI should implement a process to provide additional staff as backup for this process. Finally, as Colorado Access begins the transition of its claims processing to a new transactional system, BHI should make sure that this process is thoroughly documented, including any issues encountered along the way and how those issues were resolved.

HSAG noted that specific types of mental health practitioners were not specified in the scope document for Intensive Outpatient/Partial Hospitalization and Outpatient and ED services. This issue was communicated to the Department as a potential recommendation. BHI should begin capturing the rendering provider information from its CMHCs to ensure provider data completeness when the scope document is updated.

Although no statistically significant changes occurred for the 17 *Penetration Rate* submeasures, HSAG observed opportunities for improvement on almost all of the *Penetration Rate* submeasures, as none of the measures demonstrated more than 2.8 percentage points of improvement over the previous measurement period.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* were the only quality measures reported for this year. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. BHI's performance demonstrated some performance improvement, as all six *Hospital Recidivism* submeasures reported rate decreases compared to last year. However, none of the submeasures reported decreases of more than 5 percentage points.

Timeliness: The *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported this year. BHI's performance on this measure demonstrated improvement for each of the four submeasures. Specifically, performance on one submeasure (*Non-State Hospitals—30 Days*) reported improvement of 3.2 percentage points; and the remaining three submeasures reported rate increases of more than 5 percentage points.

Access: BHI's performance in the domain of access was mixed, with minor improvement among most penetration rate-related submeasures. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. Two of the 17 *Penetration Rate* submeasures (*Penetration Rate by Service Category—Inpatient Care* and *Intensive Outpatient/Partial Hospitalization*) showed the same level of performance as the previous year. Each of the remaining 15 submeasures exhibited an increased rate, though none of these increases exceeded 2.8 percentage points.

For the utilization-based access measures, all except the *Hospital Average Length of Stay, All Hospitals* and *Emergency Room Utilization* submeasures reported a decrease 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

Findings—System and Reporting Capabilities

HSAG had no concerns with CHP's process for receipt and processing of eligibility data from the State. There were no major changes in CHP processes compared to last year. CHP delegated information technology functions and administrative service functions to ValueOptions (VO). VO'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. Eligibility data were transferred to a Microsoft SQL server for reporting access. Eligibility updates from community mental health centers (CMHCs) were checked against the non-Medicaid files and capitation payment data to ensure eligibility. CHP also indicated that the issues associated with the 834 eligibility file occurred before the 5010 implementation, and no further related issues were reported.

HSAG also had no concerns regarding CHP's process for receiving and reporting claims and encounter data. There were no major changes in the 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 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	—	85.9%	*Report*
Improving Physical Healthcare Access	—	77.1%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.1%	7.3%	*Report*
Adolescents 13 Through 17 Years of Age	19.2%	18.7%	*Report*
Adults 18 Through 64 Years of Age	19.2%	19.9%	*Report*
Adults 65 Years of Age or Older	6.1%	6.9%	*Report*

Table 5-17—Review Results and Audit Designation *for* CHP			
Performance Measures	Rate		FY 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	*Report*
Intensive Outpatient/Partial Hospitalization	0.00%	0.00%	*Report*
Ambulatory Care	12.1%	12.7%	*Report*
Overall Penetration Rate	12.9%	13.4%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	15.1%	15.4%	*Report*
AFDC/CWP Children	8.2%	8.6%	*Report*
AND/AB-SSI	27.6%	28.9%	*Report*
BC Children	6.2%	6.1%	*Report*
BC Women	14.5%	14.4%	*Report*
BCCP—Women Breast and Cervical Cancer	16.4%	16.7%	*Report*
Foster Care	32.4%	31.6%	*Report*
OAP-A	6.1%	6.8%	*Report*
OAP-B-SSI	18.0%	20.0%	*Report*
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	4.8%	2.4%	*Report*
30 Days	12.0%	7.9%	*Report*
90 Days	22.3%	14.9%	*Report*
All Hospitals—7 Days	4.1%	2.3%	*Report*
30 Days	11.4%[3]	8.4%	*Report*
90 Days	21.6%	15.9%	*Report*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	6.57	6.63	*Report*
All Hospitals	10.38	9.49	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	10.02	10.18	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.39	3.15	*Report*
All Hospitals	5.03	4.61	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	46.0%	43.8%	*Report*
30–Days	65.6%	66.0%	*Report*
All Hospitals—7 Days	48.5%	48.5%	*Report*
30–Days	67.8%	70.0%	*Report*

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

— Indicates the measure was not calculated.

Strengths

Similar 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. With the exception of the new indicators, the same staff members were responsible for performance measure calculation. Prior to rate submission, CHP also developed a vigorous validation process that mimics the performance measure audit to ensure accuracy of the rates submitted.

CHP also demonstrated good oversight of its CMHCs and received all claims/encounters data electronically. Once VO loaded the encounters into its system, it maintained a quick turnaround time to notify CHP's CMHCs of any errors or previously held encounters and to allow the CMHCs to resubmit data before the Department's required submission deadline. This minimizes any additional void or replacements that are required once the data are submitted to the Department. As discussed with the Department, HSAG found that the amount of encounters submitted by CHP that were rejected was very low, indicating CHP has complete and accurate encounter data.

CHP received a *Report* status for all audited performance measures. HSAG observed improvement in the *Hospital Recidivism* submeasures. However, CHP demonstrated mixed performance for *Penetration Rate* and *Follow-Up After Hospitalization for Mental Illness* measures, with improved performance among selected submeasures.

Recommendations

CHP should implement adjudication edits on secondary diagnoses, focusing on specificity checks, and notify providers via warning messages. This approach will not delay payment to providers but will alert them of submitting secondary diagnoses with coding details that are required for some of the performance measures. HSAG also recommended that CHP ensure that the length of stay for same-day discharge is accurately calculated in its source code.

Although none of the measures with decreased performance reported a decline of more than 3 percentage points in their rates, CHP's performance presented opportunities for improvement. Specifically, the *Non-State Hospitals—7 Days* submeasure under *Follow-Up After Hospitalization for Mental Illness* reported a 2.2 percentage point decrease from last year. CHP should investigate reasons why this particular follow-up rate decreased while the *All Hospitals—7 Days* rate remained the same.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* were the only quality measures reported this year. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. CHP's performance on the *Hospital Recidivism* measures reflected a concerted effort to improve rates since the previous measurement period. Each of the six

submeasures reported improvements, and two submeasures' rates (*Non-State Hospitals—90 Days*, and *All Hospitals—90 Days)* increased by more than 5 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. Within this category, one submeasure showed a small improvement (*All Hospitals—30 Days*, 2.2 percentage points), and another showing a small decline (*Non-State Hospitals—7 Days*, 2.2 percentage points).

Access: CHP's performance in the domain of access suggested targeted opportunities for improvement. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. Nine *Penetration Rate* submeasures reported an improvement of less than 1 percentage point over last year's rates, and two submeasures reported an unchanged rate as compared to the previous measurement period. Among those *Penetration Rate* submeasures that reported a decline, each reported a rate change of less than 1 percentage point.

For utilization-based measures, HSAG observed that the *All Hospitals* submeasure of the *Hospital Average Length of Stay* reported a shorter average length of stay when compared to last year. Both *Inpatient Utilization* submeasures reported an increase in utilization of more than 5, but less than 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

Findings—System and Reporting Capabilities

HSAG had no concerns with FBHP's process for receipt and processing of eligibility data from the State. There were no major changes in FBHP processes compared to last year. FBHP delegated information technology functions and administrative service functions to ValueOptions (VO). VO'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. Eligibility data were transferred to a Microsoft SQL server for reporting access. Eligibility updates from CMHCs were checked against the non-Medicaid files and capitation payment data to ensure eligibility. VO indicated that the issues associated with the 834 eligibility file occurred before the 5010 implementation. No further related issues were reported.

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. In reviewing the data report card associated with the

measurement year, HSAG found that one federally qualified health center (FQHC), Clinica, had a very high non-submittable rate. Further discussion with FBHP and VO revealed that this FQHC sent not only the behavioral health claims but also physical health claims and claims for non-Medicaid members and relied on VO to assist with sorting out behavioral health claims/encounters for the Medicaid members. Based on this discussion, HSAG had no concerns with how FBHP/VO processed its claims and encounters.

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 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	—	91.1%	*Report*
Improving Physical Healthcare Access	—	73.1%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	13.8%	12.9%	*Report*
Adolescents 13 Through 17 Years of Age	28.6%	26.3%	*Report*
Adults 18 Through 64 Years of Age	25.8%	24.4%	*Report*
Adults 65 Years of Age or Older	11.3%	7.3%	*Report*
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	*Report*
Intensive Outpatient/Partial Hospitalization	0.04%	0.02%	*Report*
Ambulatory Care	15.6%	15.0%	*Report*
Overall Penetration Rate	19.5%	18.2%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	20.0%	17.4%	*Report*
AFDC/CWP Children	15.6%	14.8%	*Report*
AND/AB-SSI	35.8%	35.8%	*Report*
BC Children	11.8%	8.6%	*Report*
BC Women	21.7%	15.7%	*Report*
BCCP—Women Breast and Cervical Cancer	24.7%	15.8%	*Report*
Foster Care	37.5%	38.8%	*Report*
OAP-A	11.2%	7.2%	*Report*
OAP-B-SSI	27.5%	26.8%	*Report*
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	3.2%	4.5%	*Report*
30 Days	8.8%	9.9%	*Report*
90 Days	15.2%	19.7%	*Report*
All Hospitals—7 Days	3.3%	4.0%	*Report*

Table 5-18—Review Results and Audit Designation *for* FBHP			
Performance Measures	Rate		FY 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
30 Days	11.1%	10.8%	*Report*
90 Days	18.3%	19.5%	*Report*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	6.27	7.00	*Report*
All Hospitals	14.63	19.05	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	6.30	9.68	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.34	3.11	*Report*
All Hospitals	5.56	5.28	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	53.6%	54.0%	*Report*
30 Days	70.5%	71.1%	*Report*
All Hospitals—7 Days	55.5%	57.7%	*Report*
30 Days	74.7%	75.5%	*Report*

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

— Indicates the measure was not calculated.

Strengths

Similar to prior years, 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 also demonstrated good oversight of its CMHCs and received all claims/encounter data electronically. FBHP had an extra layer of validation and reconciliation processes for encounter data completeness and accuracy. FBHP issued a reconciliation report quarterly to CMHCs and made sure all encounters sent could be reconciled before submission to the State. Additionally, FBHP also reconciled the encounter data between its 837 file submission with the flat file submission to the Department. Furthermore, FBHP sent all encounters (Medicaid and non-Medicaid) to VO to ensure that VO had complete data. (This helped for retro-enrollments to ensure that encounters were already submitted.) The amount of encounter data rejection to the Department was very low, indicating FBHP has complete and accurate encounter data.

FBHP received a *Report* status for all audited performance measures. FBHP's performance showed a minor improvement (no more than 2.2 percentage points) on each of the four submeasures under *Follow-Up After Hospitalization for Mental Illness*. Declines of more than 5 percentage points were also noted for two *Penetration Rate by Medicaid Eligibility Category* submeasures (*BC Women* and *BCCP—Women Breast and Cervical Cancer*).

Recommendations

FBHP should implement a rate validation process. 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 also recommended that FBHP ensure the length of stay for same-day discharge is accurately calculated in its source code.

FBHP's performance suggested targeted room for improvement on *Penetration Rate* and *Hospital Recidivism* measures. HSAG observed an overall decline in rate for almost all *Penetration Rate* submeasures, with two submeasures reporting the same rate as reported during the previous measurement period, and two submeasures reporting a decline of more than 5 percentage points. Five of the six *Hospital Recidivism* submeasures showed a decline in performance, with one submeasure (*Non-State Hospitals—90 Days*) having a rate increase of 4.5 percentage points, indicating a decline in performance.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* were the only quality measures reported for this year. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. FBHP's performance on the six *Hospital Recidivism* submeasures demonstrated opportunities for improvement. Specifically, only one submeasure (*All Hospitals—30 Days*) improved by less than half a percentage point (i.e., reported a decline in rate), and all other submeasures reported decreased performance (i.e., increased rates).

Timeliness: FBHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) reflected a continued effort toward improvement. All four submeasures under *Follow-Up After Hospitalization for Mental Illness* reported increased performance since last year, though none of the submeasures increased by more than 2.2 percentage points.

Access: FBHP's overall performance in the domain of access was poorer than last year's performance, with only one *Penetration Rate* submeasure and two utilization-related submeasures exhibiting improvement. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. Among those submeasures showing a decline, two *Penetration Rate* submeasures demonstrated a performance decline of more than 5 percentage points from last year's rates.

For the utilization-based measures, *Inpatient Utilization* for both *Non-State Hospitals* and *All Hospitals* reported declines of approximately 5 percent, with the lower rates indicating fewer members requiring inpatient hospitalizations. Both *Hospital Average Length of Stay (All Ages)* submeasures reported an increase in the average length of hospital stays and the *Emergency Room Utilization* submeasure also reported an increased rate. In particular, the *Hospital Average Length of Stay—All Hospitals* submeasure exhibited a 30.2 percent increase in the length of stay, signaling that the average length of a hospital stay during this year was approximately 4.5 days longer than

during the previous measurement period. It is important to assess utilization based on the characteristics of FBHP'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.

Northeast Behavioral Health Partnership, LLC

Findings—System and Reporting Capabilities

HSAG had no concerns with NBHP's process for receipt and processing of eligibility data from the State. There were no major changes in NBHP processes compared to last year. NBHP delegated information technology functions and administrative service functions to ValueOptions (VO). VO'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. Eligibility data were transferred to a Microsoft SQL server for reporting access. Eligibility updates from CMHCs were checked against the non-Medicaid files and capitation payment data to ensure eligibility. NBHP also indicated that the issues associated with the 834 eligibility file occurred before the 5010 implementation, and no further related issues were reported.

HSAG had no concerns regarding NBHP'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 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 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	—	81.3%	*Report*
Improving Physical Healthcare Access	—	74.7%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.0%	6.9%	*Report*
Adolescents 13 Through 17 Years of Age	22.0%	20.2%	*Report*
Adults 18 Through 64 Years of Age	18.8%	19.5%	*Report*
Adults 65 Years of Age or Older	5.7%	5.9%	*Report*

Table 5-19—Review Results and Audit Designation *for* NBHP			
Performance Measures	Rate		FY 2012–2013 Audit Designation
	FY 2011–2012	FY 2012–2013	
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.3%	*Report*
Intensive Outpatient/Partial Hospitalization	0.01%	0.00%	*Report*
Ambulatory Care	12.2%	12.2%	*Report*
Overall Penetration Rate	12.6%	12.7%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	13.6%	13.9%	*Report*
AFDC/CWP Children	8.6%	8.7%	*Report*
AND/AB-SSI	31.8%	32.3%	*Report*
BC Children	5.8%	4.7%	*Report*
BC Women	8.8%	10.3%	*Report*
BCCP—Women Breast and Cervical Cancer	11.9%	10.1%	*Report*
Foster Care	35.7%	35.1%	*Report*
OAP-A	5.7%	5.9%	*Report*
OAP-B-SSI	22.8%	22.8%	*Report*
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	0.3%	1.6%	*Report*
30 Days	2.3%	5.9%	*Report*
90 Days	7.1%	10.9%	*Report*
All Hospitals—7 Days	0.3%	1.8%	*Report*
30 Days	2.4%	5.9%	*Report*
90 Days	7.4%	11.7%	*Report*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	5.74	6.48	*Report*
All Hospitals	8.88	7.83	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	5.40	10.23	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	4.29	4.09	*Report*
All Hospitals	4.65	4.33	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	55.3%	51.4%	*Report*
30–Days	75.3%	70.2%	*Report*
All Hospitals—7 Days	55.3%	51.9%	*Report*
30 Days	74.8%	71.0%	*Report*

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

— Indicates the measure was not calculated.

Strengths

Similar 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. With the exception of the new indicators, the staff members responsible for performance measure calculation and reporting were the same staff members 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 all encounter data electronically. Once VO loaded the encounters into its system, it maintained a quick turnaround time to notify NBHP's CMHCs of any errors or previously held encounters and to allow the CMHCs to resubmit data before the Department's required submission deadline. This minimizes any additional void or replacements that are required when the data are submitted 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 *Report* status for all audited performance measures. NBHP's performance showed improvement of less than 2 percentage points on nine of the *Penetration Rate* submeasures.

Recommendations

NBHP should implement adjudication edits on secondary diagnoses, focusing on specificity checks, and notify providers via warning notes. This approach will not delay payment to providers but will alert them of submitting secondary diagnoses with coding details that are required for some of the performance measures. HSAG also recommended that NBHP ensure the length of stay for same-day discharge is accurately calculated in its source code.

NBHP's performance suggested widespread opportunities for improvement, with declines among all six *Hospital Recidivism* submeasures. Additionally, each of the four submeasures in the *Follow-Up After Hospitalization for Mental Illness* category reported a decreased rate since the previous measurement period, and the rate for one submeasure declined more than 5 percentage points.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* were the only quality measures reported for this year. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. NBHP's performance on measures in the *Hospital Recidivism* category demonstrated opportunities for improvement. Specifically, performance for all six submeasures declined since the previous measurement period (i.e., reported an increased rate), though none of the submeasures reported rate increases greater than 5 percentage points.

Timeliness: NBHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) demonstrated declines over the previous measurement period. All submeasures

reported decreased performance rates of at least 3.4 percentage points, and one submeasure (*Non-State Hospitals—30 Days*) declined by 5.1 percentage points.

Access: NBHP's performance in the domain of access showed mixed performance when compared to last year's results. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. Nine of the seventeen *Penetration Rate* submeasures showed improvement of no more than 1.5 percentage points, two submeasures remained the same, and the remaining six submeasures reported a decline of no more than 2 percentage points.

For the utilization-based measures, *Inpatient Utilization* and *Emergency Room Utilization* each differed from the previous measurement period: both *Inpatient Utilization* submeasures reported lower rates, while there was a large, 89.4 percent increase in the rate of *Emergency Room Utilization*. The *Hospital Average Length of Stay* submeasure for *Non-State Hospitals* reported longer average stays by more than 12 percent over last year's results. However, the average length of stay for *All Hospitals* declined by nearly 12 percent. The increase in the *Emergency Room Utilization* measure reflects that the rate of emergency room visits was nearly twice as large as during the previous measurement period. 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 2012–2013 and the prior year.

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

Performance Measures	Rate		BHO FY 2012–2013 Rate Variations
	FY 2011–2012	FY 2012–2013	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	—	89.9%	81.3%–96.1%
Improving Physical Healthcare Access	—	72.8%	59.1%–77.1%
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.1%	7.4%	6.2%–12.9%
Adolescents 13 Through 17 Years of age	19.3%	18.7%	14.8%–26.3%
Adults 18 Through 64 Years of age	19.6%	19.9%	18.3%–24.4%
Adults 65 Years of Age or Older	6.4%	6.3%	4.6%–7.3%
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	0.2%–0.3%
Intensive Outpatient/Partial Hospitalization	0.03%	0.03%	0.003%–0.07%

Table 5-20—Statewide Weighted Average Rates for the Performance Measures			
	Rate		
Performance Measures	FY 2011–2012	FY 2012–2013	BHO FY 2012–2013 Rate Variations
Ambulatory Care	11.5%	12.0%	10.2%–15.0%
Overall Penetration Rate	12.7%	13.0%	11.3%–18.2%
Penetration Rate by Medicaid Eligibility			
AFDC/CWP Adults	14.2%	14.2%	10.9%–17.4%
AFDC/CWP Children	8.0%	8.4%	6.1%–14.8%
AND/AB–SSI	30.9%	31.8%	28.9%–35.8%
BC Children	6.1%	6.0%	4.7%–8.6%
BC Women	12.6%	12.5%	9.1%–15.7%
BCCP—Women Breast and Cervical Cancer	16.1%	15.0%	10.0%–16.7%
Foster Care	35.1%	35.9%	31.6%–43.3%
OAP-A	6.4%	6.2%	4.6%–7.2%
OAP-B-SSI	21.0%	22.3%	20.0%–26.8%
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	3.4%	3.0%	1.6%–4.5%
30 Days	10.0%	8.8%	5.9%–11.5%
90 Days	18.4%	15.6%	10.9%–19.7%
All Hospitals—7 Days	3.5%	3.0%	1.8%–4.3%
30 Days	10.4%	9.1%	5.9%–11.4%
90 Days	19.0%	16.3%	11.7%–19.5%
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	7.07	7.39	6.48–9.36
All Hospitals	13.60	13.29	7.83–19.05
Emergency Room Utilization (Rate/1000 Members, All Ages)	7.84	10.25	9.68–11.24
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.82	3.49	2.87–4.87
All Hospitals	5.20	4.63	3.83–5.58
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	47.4%	48.3%	42.6%–57.7%
30 Days	66.3%	67.1%	62.1%–71.1%
All Hospitals—7 Days	49.0%	50.9%	42.5%–59.3%
30 Days	67.7%	69.7%	62.1%–75.5%

[1] 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 validation finding of *Report*. Eighteen of the 27 non-utilization submeasures with both prior year and current year rates (eight *Penetration Rate* submeasures, six *Hospital Recidivism* submeasures, and four *Follow-Up After Hospitalization for Mental Illness* submeasures) demonstrated performance improvement with rate changes of no more than 3 percentage points from the previous year. Performance of three additional submeasures, both related to *Penetration Rate*, stayed the same from last year. While these changes indicate incremental improvement, no single non-utilization submeasure improved to such a degree as to be highlighted as a strength among the statewide results.

Statewide Recommendations

HSAG recommended that all of the BHOs continue to work with the Department and each other to address and resolve issues identified in the scope document, such as clarifying the type of mental health practitioners required and required diagnoses for select measures.

HSAG observed that while statewide improvement was noted on each of the six *Hospital Recidivism* submeasures and all four *Follow-Up After Hospitalization for Mental Illness* submeasures, the reported rate changes were less than 3 percentage points for each submeasure. Additionally, there was wide variation by BHO in *Follow-Up After Hospitalization for Mental Illness* rates. The Department should consider exploring longer-range trends in performance measure rates to identify performance measures with persistently low rates or rates that have been slow to improve over time. The Department could then consider developing statewide performance improvement projects to improve these rates and reduce variation in performance among the BHOs.

Quality: *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* were the only quality measures reported for this year. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. However, it is important to note the wide range of rates among the BHOs for this measure, with a difference of nearly 15 percentage points between the BHOs with the lowest and highest rates. Statewide BHO performance on the *Hospital Recidivism* submeasures did not change very much from last year's results. Each of the six submeasures reported a minor decline in rate (an improvement in performance), though none of these rates improved by more than 3 percentage points. BHO variations in rates were smallest for *All Hospitals—7 Days* (2.5 percentage points) and largest for *Non-State Hospitals—90 Days* (8.8 percentage points). These results suggest that the BHOs should look to their existing interventions to continue improving *Hospital Recidivism* rates.

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, with incremental improvement of no more than 2 percentage points among each of the four submeasures. The variation in rates by BHO was smallest for *Non-State Hospitals—30 Days* (9.0 percentage points) and largest for *All Hospitals—7 Days* (16.8 percentage points). These wide variations suggest that the BHOs have room for continued improvement.

Access: Overall, statewide BHO performance in the domain of access for performance measures was very similar to last year's performance. Since the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure is new during this reporting period, comparable data are not available. Although all *Penetration Rate* submeasures showed either similar performance or a decline in performance compared to last year, none had a change in rate of more than 1.5 percentage points.

Statewide performance on the utilization-based measures was characterized by a 30.8 percent increase in the rate for *Emergency Room Utilization*, indicating decreased performance. However, rates for both *Inpatient Utilization* submeasures improved by more than 8 percent (i.e., the rates declined, indicating improved performance). Utilization rates were mixed for the *Hospital Average Length of Stay* submeasures, with the rate for *Non-State Hospitals* declining by 4.5 percent and the rate for *All Hospitals* improving by 2.3 percent. The increase in the *Emergency Room Utilization* measure among the aggregated BHOs reflects the increase ER utilization rates reported by four of the five BHOs, increasing the statewide rate from 7.84 to 10.25 ER visits per 1,000 members between the two measurement periods. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Validation of Performance Improvement Projects

For FY 2012–2013, the Department offered each BHO the option of conducting two PIPs, or one PIP and one focused study that included interventions. All five BHOs chose to conduct one PIP and one focused study. The Department evaluated the focused studies, and those results can be found in Section 7.

Table 5-21 below lists the PIP topics identified by each BHO.

Table 5-21—FY12–13 PIP Topics Selected by BHOs

BHO	PIP Topic
Access Behavioral Care (ABC)	*Increasing Access to Mental Health Services for Youth*
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, LLC (FBHP)	*Reducing Overall Hospital 90-Day Recidivism*
Northeast Behavioral Health Partnership, LLC (NBHP)	*Increasing Penetration for Medicaid Member Aged 65+*

Appendix D, EQR Activities—Validation of Performance Improvement Projects, describes how the PIPs were validated and how the resulting data were aggregated and analyzed by HSAG.

Access Behavioral Care

Findings

The ABC *Increasing Access to Mental Health Services for Youth* PIP focused on improving access to mental health services for the Medicaid youth population ages 5–17. The goals of the study were to improve processes related to service access and to increase treatment utilization. This was the first year for the *Increasing Access to Mental Health Services for Youth* PIP, and ABC completed Activities I through IV, VI, and VII. The plan reported baseline results.

Table 5-22 provides a summary of ABC's combined PIP validation results for the FY 2012–2013 validation cycle.

Table 5-22—FY12–13 Performance Improvement Project Validation Results *for* ABC (n=1PIP)					
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 Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Sampling Techniques	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (10/10)	0% (0/10)	0% (0/10)
Implementation	VII.	Data Analysis and Interpretation	100% (4/4)	0% (0/4)	0% (0/4)
	VIII.	Interventions and Improvement Strategies	*Not Assessed*	*Not Assessed*	*Not Assessed*
Implementation Total			100% (4/4)	0% (0/4)	0% (0/4)
Outcomes	IX.	Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X.	Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			*Not Assessed*	*Not Assessed*	*Not Assessed*
Percent Score of Applicable Evaluation Elements *Met*			**100% (14/14)**		

ABC demonstrated strength by receiving *Met* scores for all applicable evaluation elements for Activities I through IV, VI, and VII. The plan documented a solid study design which is essential to producing methodologically sound results. The interpretation of the PIP results was appropriate. The ABC overall score for applicable evaluation elements *Met* was 100 percent wherein 14 of 14 evaluation elements received a *Met* score. The ABC PIP received a *Met* validation status.

Table 5-23 provides a summary of ABC's PIP specific outcomes for the FY 2012–2013 validation cycle.

Table 5-23—FY12–13 Performance Improvement Project Specific Outcomes *for* ABC (n=1 PIP)				
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Rate or Percentage Point Change**	**Statistical Significance (*p* value)**
PIP#1: *Increasing Access to Mental Health Services for Youth*				
Percent of BHO members ages 5–17 with at least one mental health service contact in the measurement year.	10.19%	*	*	*

*The PIP did not progress past reporting baseline.

For the ABC *Increasing Access to Mental Health Services for Youth* PIP, the baseline results indicated that 4,290 out of 42,115 members, or 10.19 percent, had at least one mental health service contact in the baseline measurement year. ABC indicated that the Remeasurement 1 goal is a statistically significant increase over the baseline rate.

Strengths

ABC documented that it will use baseline results to develop a benchmark by which remeasurement will be gauged. ABC stated that the goals for this PIP were to improve processes related to service access and to increase treatment utilization.

Interventions

ABC noted that focused interventions will be designed to increase access to, and engagement in, all levels of care and service including screening, referral, assessment, and treatment.

Recommendations

Barriers identified by the plan should be prioritized to ensure that the barriers most likely to impact the outcomes are appropriately addressed. ABC should demonstrate a concrete link between its prioritized barriers and implemented interventions. In its next annual submission, the plan should discuss how it will evaluate interventions to determine the overall success of the interventions and the effect they are having on the outcomes.

Behavioral Healthcare, Inc.

Findings

This was the second 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 VIII and reported baseline results.

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—FY12–13 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	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Sampling Techniques	100% (6/6)	0% (0/6)	0% (0/6)
	VI.	Data Collection	100% (5/5)	0% (0/5)	0% (0/5)
Design Total			100% (18/18)	0% (0/18)	0% (0/18)
Implementation	VII.	Data Analysis and Interpretation	100% (5/5)	0% (0/5)	0% (0/5)
	VIII.	Interventions and Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total			100% (7/7)	0% (0/7)	0% (0/7)

Table 5-24—FY12–13 Performance Improvement Project Validation Results *for* BHI (n=1 PIP)					
Study Stage	**Activity**		**Percent of Applicable Elements**		
			Met	**Partially Met**	**Not Met**
Outcomes	IX.	Real Improvement	Not Assessed	Not Assessed	Not Assessed
	X.	Sustained Improvement	Not Assessed	Not Assessed	Not Assessed
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements *Met*			**100% (25/25)**		

BHI's overall score for applicable evaluation elements *Met* was 100 percent wherein 25 of 25 evaluation elements received a *Met* score. BHI's *Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics* PIP did not progress past reporting baseline; thus, rates for subsequent measurement periods were not available. The Percent Score of Applicable Evaluation Elements *Met* increased from 86 percent in the 2011–2012 PIP submission to 100 percent in the 2012–2013 PIP submission.

Table 5-25 provides a summary of BHI's PIP-specific outcomes for the FY 2012–2013 validation cycle.

Table 5-25—FY12–13 Performance Improvement Project Specific Outcomes *for* BHI (n=1 PIP)				
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**Rate or Percentage Point Change**	**Statistical Significance (*p* value)**
PIP#1: *Increasing Access to Mental Health Services for Youth*				
Study Indicator 1a: Percentage of documented fasting plasma glucose lab results within 30 days prior to or up to 30 days after initiating a new atypical antipsychotic.	6.71%	*	*	*
Study Indicator 1b: Percentage of documented follow-up for abnormal lab results within 30 days from the date of lab documentation.	NA	*	*	*
Study Indicator 2a: Percentage of documented fasting lipid panel lab results within 30 days prior to or 30 days after initiating a new atypical antipsychotic.	4.69%	*	*	*
Study Indicator 2b: Percentage of documented follow-up for abnormal lab results within 30 days from the date of the lab documentation.	57.14%	*	*	*

*The PIP did not progress past reporting baseline.

BHI set a goal of increasing the study indicators' baseline results by 5, 10, 2, and 10 percentage points, respectively, for Remeasurement 1. For Study Indicator 1b, the plan reported that out of the 20 consumers who received a plasma glucose lab, there were no abnormal plasma glucose results; therefore, the baseline results for Study Indicator 1b were not applicable (NA).

Strengths

BHI demonstrated strength in Activities I through VIII by receiving *Met* scores for all applicable evaluation elements. The plan documented a solid study design, which is essential to producing methodologically sound results. The intervention and improvement strategies were designed to improve outcomes and change behavior at an institutional, practitioner, or consumer level.

The plan documented a causal/barrier analysis process that included BHI QI team meetings with the QI departments from each of the CMHCs. The fishbone diagram submitted by BHI included nine barriers grouped into three main categories: clients, logistics, and prescribers. The plan stated that it linked its planned Remeasurement 1 interventions to the prioritized barriers. There were no interventions implemented during the baseline measurement period.

Interventions

BHI listed 10 interventions to be implemented during Remeasurement 1. Five interventions were linked to the prescriber barrier: labs not being ordered. One intervention was linked to the logistics barrier: losing the lab/referral slip. Four of the interventions were linked to the client barrier: lack of client education about the importance of labs. The interventions included updates to the Web site, online training and staff education about the practice guideline revisions, a consumer mailer about the importance of labs, and research about provider lab referral processes.

Recommendations

BHI documented that the PIP is designed to improve system- and provider-based processes such as timely metabolic lab documentation, timely review of lab results, and appropriate follow-up for clients. HSAG suggested that BHI focus on implementing interventions aimed specifically at the system- and provider-based barriers it identified in its causal/barrier analysis. BHI should conduct a causal/barrier analysis annually to ensure the original barriers identified are still applicable. HSAG recommended that BHI monitor the implemented interventions regularly to gauge the effect the interventions are having on the outcomes. Unsuccessful interventions should be discontinued. Successful interventions that initially may not have been implemented systemwide should be standardized. Monitoring of standardized interventions is recommended to ensure the continued success of the interventions.

Colorado Health Partnerships, LLC

Findings

This was the sixth 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 4 results.

Table 5-26 shows CHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 5-26—FY12–13 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)
Implementation	VII.	Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
	VIII.	Data Analysis and Interpretation	100% (9/9)	0% (0/9)	0% (0/9)
Implementation Total			100% (13/13)	0% (0/13)	0% (0/13)
Outcomes	IX.	Real Improvement	25% (1/4)	75% (3/4)	0% (0/4)
	X.	Sustained Improvement	0% (0/1)	100% (1/1)	0% (0/1)
Outcomes Total			20% (1/5)	80% (4/5)	0% (0/5)
Percent Score of Applicable Evaluation Elements *Met*			**92% (45/49)**		

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 92 percent wherein 45 of 49 elements received a *Met* score. CHP's *Partially Met* scores in Activity IX and X were due to the statistically significant rate decline for Study Indicator 2, which did not point toward improvement in outcomes during the current measurement period or sustained improvement. CHP received a *Met* validation status. With the progression of the PIP, the Percent Score of Applicable evaluation elements *Met* decreased from 94 percent in the 2011–2012 PIP submission, to 92 percent in the 2012–2013 PIP submission.

Table 5-27 provides a summary of CHP's PIP specific outcomes for the FY 2012–2013 validation cycle.

Table 5-27—FY12–13 Performance Improvement Project Specific Outcomes *for* CHP (n=1 PIP)

PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Remeasurement 4	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%	85.0%	2.1↑	*p*=0.0417* statistically significant	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%	49.4%	21.7↓	*p*<0.0001* statistically significant	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.

The CHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP reported Remeasurement 4 results. During Remeasurement 4, CHP reported an increase in the Study Indicator 1 rate from 82.9 percent to 85 percent. The rate increase was statistically significant with a *p* value of 0.0417, and the plan met the Study Indicator 1 goal. The Study Indicator 2 rate decreased from 71.1 percent in Remeasurement 3 to 49.4 percent in Remeasurement 4. The rate decrease was statistically significant with a *p* value <0.0001. The Remeasurement 4 rate for Study Indicator 2 was 35.6 percentage points lower than the goal. Although the Study Indicator 2 rate was 3.5 percentage points higher than the baseline rate of 45.9 percent, the change was not statistically significant. During this measurement period, only Study Indicator 1 (penetration rate) achieved sustained improvement. Study Indicator 2 (documentation rate) did not achieve sustained improvement due to a statistically significant decline from Remeasurement 3 to Remeasurement 4.

Strengths

The CHP *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP demonstrated strength in Activities I through VIII by receiving *Met* scores for all applicable evaluation elements. The plan documented a solid study design and implementation, which is essential to producing methodologically sound results. The data analysis and interpretation of the PIP results were appropriate and adhered to the statistical analysis techniques used.

At the start of the study, the plan documented that the CHP Quality/Clinical Committee and PIP Task Group collectively reviewed policies and procedures across providers within the CHP network

and determined that there were three priority barriers to successful coordination of care between Medicaid physical and behavioral health providers. The barriers identified by the plan were member- and system-based barriers.

Interventions

CHP implemented nine interventions from baseline through Remeasurement 4. The plan instituted a new coordination of care policy and procedure that required behavioral health providers to coordinate care with physical health providers. The policy included specific time frame and documentation requirements aimed at promoting coordination of care with physical health providers. The coordination of care policy was reviewed annually at a Clinical and Quality Committee meeting that included representatives from behavioral health agencies. CHP also developed a standardized coordination of care form, addressed the lack of provider adherence to the new policy, sent a letter to providers stressing the importance of communicating with physical health providers, and conducted discussions with providers to ensure the coordination of care policy was implemented properly.

Additionally, CHP hosted face-to-face provider forums throughout the State, provided ongoing documentation training to providers, and requested behavioral health agencies to submit corrective action plans for improving coordination of care documentation. The plan updated its annual contract compliance audit activity to include a review of the coordination of care policy and documentation of evidence that mental health agencies are distributing information related to coordination of care. Finally, the plan documented that it performed data mining activities and data analysis during the remeasurement periods to pinpoint areas needing improvement.

Recommendations

HSAG recommends that CHP monitor the implemented interventions regularly to evaluate the effect the interventions are having on the outcomes. The coordination of care topic is a provider/system-based topic. Consumer-based interventions are unlikely to have a measurable effect on the outcomes or impact how information is exchanged between behavioral and medical health providers. Unsuccessful interventions should be discontinued. Successful interventions that initially may not have been implemented systemwide should be standardized. Monitoring of standardized interventions is recommended to ensure the continued success of the interventions. Additionally, the plan should conduct a causal/barrier analysis annually to determine if the barriers identified at the start of the PIP are still applicable.

Foothills Behavioral Health Partners, LLC

Findings

The FBHP *Reducing Overall 90-Day Hospital Recidivism* PIP focused on reducing the percent of hospital readmissions 90 days after discharge for hospitalization of a covered mental health disorder. FBHP noted that it believes reducing readmissions will help improve consumer recovery efforts, increase opportunities for consumers to develop a healthy lifestyle, and improve consumers' overall functioning and outcomes. This was the first year FBHP submitted this study for validation. FBHP completed Activities I through IV and VI through VIII and reported baseline results.

Table 5-28 shows FBHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 5-28—FY12–13 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% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Study Indicator	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Sampling Techniques	Not Applicable	Not Applicable	Not Applicable
	VI.	Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (10/10)	0% (0/10)	0% (0/10)
Implementation	VII.	Data Analysis and Interpretation	100% (4/4)	0% (0/4)	0% (0/4)
	VIII.	Interventions and Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total			100% (6/6)	0% (0/6)	0% (0/6)
Outcomes	IX.	Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X.	Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			*Not Assessed*	*Not Assessed*	*Not Assessed*
Percent Score of Applicable Evaluation Elements Met			**100% (16/16)**		

FBHP's strong performance in Activities I through IV and VI 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 100 percent wherein 16 of 16 elements received a *Met* score. The FBHP *Reducing Overall 90-Day Hospital Recidivism* PIP received a *Met* validation status.

Table 5-29 provides a summary of FBHP's PIP specific outcomes for the FY 2012–2013 validation cycle.

Table 5-29—FY12–13 Performance Improvement Project Specific Outcomes *for* FBHP (n=1 PIP)

PIP Study Indicator	Baseline	Remeasurement 1	Percentage Point Change	Statistical Significance (*p* value)
PIP#1: *Reducing Overall 90 Day Hospital Recidivism*				
The percent of all hospital consumer discharges, for treatment of a covered mental health diagnosis, which does not result in a re-hospitalization within 24 hours, with a readmission for another hospital episode for treatment of a covered mental health diagnosis, within 90 days after the date of discharge.^	19.53%	*	*	*

^Lower rates indicate better performance for this PIP.
*The PIP did not progress past reporting baseline.

For baseline, FBHP reported that 74 of 379 consumers, or 19.53 percent of consumers, were readmitted to the hospital within 30 days of discharge. The rate for this PIP is inverted, and a decrease in the rate represents an improvement in the outcomes. The plan estimated that its Remeasurement 1 goal of a statistically significant reduction from the baseline rate would result in a Remeasurement 1 rate of 15.3 percent.

Strengths

FBHP demonstrated strength in its study design and study implementation phase by receiving *Met* scores for all applicable evaluation elements for Activities I through IV and VI through VIII. The plan documented a solid study design and implementation, which is essential to producing methodologically sound results. The intervention and improvement strategies were designed to improve outcomes and change behavior at the provider and system level.

FBHP documented that the PIP committee, QI teams, key staff members at each CMHC, and the FBHP QI team met monthly to discuss the causal/barrier analysis and appropriate interventions. The FBHP QI team conducted an analysis of barriers and determined there were seven priority barriers. The barriers identified by the plan were provider- and system-based barriers.

Interventions

Beginning in October 2011, the plan implemented seven interventions linked to the identified priority barriers. FBHP developed and implemented discharge follow-up guidelines, implemented same- or next-day prescriber appointments for discharged consumers, standardized procedures for follow-up and outreach, hired additional staff (a mobile clinician, hospital liaisons, and a care coordinator), implemented guidelines to ensure discharge/crisis/self-care plans are completed or reviewed at discharge, and discussed how to improve communication with the treating hospitals. The interventions implemented by the plan were provider- and system-based interventions, and the plan documented a concrete link between the barriers identified and the interventions implemented. FBHP stated that care process issues may be contributing to increasing hospital recidivism and will be monitored ad hoc for potential improvement opportunities.

Recommendations

HSAG recommended that FBHP monitor the implemented interventions regularly to evaluate the effect the interventions are having on the outcomes. Unsuccessful interventions should be discontinued. Successful interventions that initially may not have been implemented systemwide should be standardized. HSAG recommended that FBHP monitor standardized interventions to ensure the continued success of the interventions. Additionally, the plan should conduct a causal/barrier analysis annually to determine if the barriers identified at the start of the PIP are still applicable.

Northeast Behavioral Health Partnership, LLC

Findings

The purpose of the NBHP *Increasing Penetration for Medicaid Members Aged 65+* PIP was to evaluate if improving the penetration rate will lead to increased access to needed mental health services. The goal of the study was to increase the number of members receiving a mental health service during the measurement year. This was the first year this PIP was submitted for validation, and NBHP completed Activities I through IV and VI through VIII. The plan reported baseline results.

Table 5-30 shows NBHP scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 5-30—FY12–13 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% (2/2)	0% (0/2)	0% (0/2)
	II.	Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Study Indicator	100% (1/1)	0% (0/1)	0% (0/1)
	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% (4/4)	0% (0/4)	0% (0/4)
Design Total			100% (10/10)	0% (0/10)	0% (0/10)
Implementation	VII.	Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
	VIII.	Data Analysis and Interpretation	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total			100% (6/6)	0% (0/6)	0% (0/6)
Outcomes	IX.	Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X.	Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			*Not Assessed*	*Not Assessed*	*Not Assessed*
Percent Score of Applicable Evaluation Elements Met			**100% (16/16)**		

For the FY 2012–2013 validation cycle, HSAG validated Activities I through IV and VI through VIII for the baseline measurement period. The overall score for applicable evaluation elements *Met* was 100 percent wherein 16 of 16 elements received a *Met* score. NBHP received a *Not Met* validation status.

Table 5-31 provides a summary of NBHP's PIP specific outcomes for the FY 2012–2013 validation cycle.

Table 5-31—FY12–13 Performance Improvement Project Specific Outcomes *for* NBHP (n=1 PIP)

PIP Study Indicator	Baseline	Remeasurement 1	Percentage Point Change	Statistical Significance (*p* value)
PIP#1: Coordination of Care Between Medicaid Physical and Behavioral Health Providers				
The percentage of individuals eligible for services who actually received one or more services during a specified time period.	5.93%	*	*	*

*The PIP did not progress past reporting baseline.

The baseline results for the *Increasing Penetration for Medicaid Members Aged 65+* PIP showed that 5.93 percent, or 296 of 4,989 eligible NBHP members aged 65 and older, had at least one mental health service during the measurement year. NBHP reported a Remeasurement 1 goal of a statistically significant increase in the penetration rate for adults aged 65 and older.

Strengths

NBHP received *Met* scores for Activities I through IV and VI through VIII for all applicable evaluation elements. The selected PIP topic was representative of the entire Medicaid-enrolled population to which the study indicator applied, and the PIP study indicator was developed to track performance or improvement over time. NBHP demonstrated a sound study design, which is essential to producing methodologically sound results. The intervention and improvement strategies were appropriately designed to improve outcomes.

NBHP documented that a causal/barrier analysis was conducted; and the PIP Committee, including administrators and clinicians, discussed the issues, causes, and barriers associated with the PIP topic. The plan provided a fishbone diagram with its PIP submission that included six distinct barriers. The plan stated that its first priority was to address members' lack of knowledge about available services and mental health symptoms by distributing mental health services information and contacts.

Interventions

NBHP did not institute any interventions during the baseline measurement period. The plan listed seven interventions with start dates during Remeasurement 1. Each of the planned Remeasurement 1 interventions was linked to an identified barrier. A brochure and a fact sheet were sent to eligible members in December 2012. NBHP also sent the brochure and fact sheet to agencies/locations where senior citizens were likely to be present, such as senior centers. Additionally, in February 2013, NBHP included the brochure and fact sheet in the new member monthly mailing sent to all

new eligible members from the month of January 2013. The remaining five interventions documented by the plan had an implementation start date of March 2013 and included either the distribution of the brochure and fact sheet to senior centers, or the mailing of the brochure and fact sheet to new members.

NBHP documented three interventions with start dates to be determined. The plan documented that it would provide training to providers with large volumes of Medicaid clients in an effort to reduce stereotypes. The training would also be available on the NBHP Web site. The NBHP quality director will offer to visit physical health providers to provide additional training about recognizing mental health symptoms and improving awareness of mental health issues.

Recommendations

HSAG encouraged NBHP to perform a causal/barrier analysis at least annually to determine if the barriers identified in the original causal/barrier analysis and fishbone diagram are still applicable. Interventions should be designed to change long-term behavior at the system, provider, or member level. Although effective in the short-term, reminder letters, brochures, and mass mailings are unlikely to induce permanent change. NBHP should evaluate all of the implemented interventions regularly to determine their efficacy. In future submissions, the plan should describe the data analysis it performed to determine if the mailings/informational packets were effective. NBHP should describe its conclusions about the effectiveness of each intervention implemented. In future submissions, the plan should document any changes made to the interventions and discuss the success of each intervention in relation to the PIP outcomes.

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

Table 5-32 shows the health plans' overall performance based on HSAG's validation of the FY 2012–2013 PIPs that were submitted for validation.

Table 5-32—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	*Increasing Access to Mental Health Services for Youth*	100%	100%	*Met*
BHI	*Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics*	100%	100%	*Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	92%	100%	*Met*
FBHP	*Reducing Overall Hospital 90-Day Recidivism*	100%	100%	*Met*
NBHP	*Increasing Penetration for Medicaid Member Aged 65+*	100%	100%	*Met*

All five of the BHO PIPs reviewed by HSAG received a *Met* validation status, suggesting a thorough application of the PIP's design.

Table 5-33 shows a comparison of the BHO plans' improvement results.

Table 5-33—Statewide Summary of BHO Improvement

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

*The PIP did not progress past reporting baseline.

CHP reported a statistically significant increase in the Study Indicator 1 rate and a statistically significant decrease in the Study Indicator 2 rate. CHP documented that during this measurement period, only Study Indicator 1 (penetration rate) achieved sustained improvement. The ABC, BHI, FBHP, and NBHP PIPs had not progressed past reporting baseline.

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 five PIPs validated by HSAG earned a *Met* validation status. A *Met* validation status demonstrates that each health plan exhibited a strong understanding and implementation of processes required to conduct a valid study.

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 2011–2012. 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 2011–2012 compliance review, ABC was required to revise its member handbook and other member communications to specify accurate time frames related to State fair hearings. ABC submitted a corrective action plan (CAP) to HSAG and the Department in March 2012. After requesting and receiving additional information regarding the details, HSAG and the Department approved the plan. ABC submitted documents demonstrating it had implemented the CAP to HSAG and the Department in July 2012. After careful review, HSAG and the Department determined ABC had successfully addressed all of the FY 2011–2012 required actions.

Performance Measures

During the FY 2011–2012 audit, HSAG recommended that, as ABC begins the transition to a new transactional system, it should thoroughly document the process, including any issues encountered and how those issues were resolved. HSAG also recommended that ABC continue to collaborate with the Department and other BHOs regarding the scope document. HSAG found evidence during the FY 2012–2013 audit that ABC acted upon both recommendations.

HSAG observed a decrease in rate of more than 5 percentage points on several of ABC's *Penetration Rate by Medicaid Eligibility Category* submeasures. HSAG suggested ABC investigate the reasons for the decline. The 2012–2013 audit showed that most of these rates increased slightly; however, none of the increases were statistically significant. HSAG encourages ABC to continue its investigation.

Performance Improvement Projects

For the FY 2011–2012 validation cycle, ABC completed two PIPs: *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* and *Coordination of Care Between Psychiatric Emergency Services and Outpatient Treatment*. At the conclusion of the FY 2011–2012 validation cycle, the Department and HSAG determined both PIPs met the maximum project length of time (5 years) and were validated through Activity X for both years 4 and 5. The Department granted ABC's request to retire both PIPs.

Behavioral Healthcare, Inc.

Compliance Monitoring Site Reviews

As a result of the 2011–2012 site review, BHI was required to address 12 elements that received scores less than *Met*. The required actions included making revisions to its member materials related to time frames associated with the grievance system. BHI was also required to develop corrective actions related to the provision of ongoing monitoring and formal review of its delegates. BHI submitted its CAP to the Department and HSAG in February 2012. In August 2012, BHI submitted documents to the Department and HSAG demonstrating that it had implemented the CAP. After requiring additional edits to a few of the documents, HSAG and the Department determined that BHI successfully completed all of the FY 2011–2012 required actions.

Performance Measures

Based on the FY 2011–2012 performance measure validation audit, HSAG recommended that BHI collaborate with the Department and other BHOs regarding the scope document, such as indicating required continuous enrollment, when needed. HSAG found evidence during the FY 2012–2013 audit that the issues with the scope document had been addressed through a collaborative effort between BHI, the Department, and the other BHOs.

Although not statistically significant, BHI's *Penetration Rate* submeasures experienced some increase in rates and *Hospital Recidivism* submeasures showed slight decreases (indicating improvement). HSAG suggested BHI research the cause of these rate changes.

Performance Improvement Projects

FY 2011–2012 was the first year for BHI's *Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics* PIP. BHI's overall score for applicable evaluation elements *Met* was 86 percent. BHI's only *Partially Met* score occurred in Activity IV, for a critical element, and resulted in BHI receiving an overall *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. HSAG recommended that BHI ensure that all members included in the PIP denominator(s) have the opportunity to be measured in the numerator(s). HSAG's FY 2012–2013 validation of the PIP demonstrated that BHI addressed HSAG's recommendation. The Percent Score of Applicable Evaluation Elements *Met* increased from 86 percent in the 2011–2012 PIP submission to 100 percent in the 2012–2013 PIP submission.

Colorado Health Partnerships, LLC

Compliance Monitoring Site Reviews

As a result of the FY 2011–2012 site review, CHP was required to make relatively minor edits to its member materials related to annual notice of the right to request information. CHP's member participation agreements needed to be revised to include an omitted clause. CHP also was required to make revisions to its policies and procedures related to the continuation of previously authorized services during an appeal or State fair hearing.

CHP submitted its CAP to HSAG and the Department in March 2012. HSAG and the Department reviewed and approved the plan. CHP submitted documents demonstrating that it had implemented its plan, as written, in June 2012. After careful review, HSAG and the Department notified CHP that it had successfully completed all required actions.

Performance Measures

After the FY 2011–2012 audit, HSAG recommended that CHP continue working with the Department and BHOs to address issues with the scope document. HSAG suggested that the BHOs and the Department provide the list of medications for various measures and update the list at least annually to ensure that all BHOs are using the same list of medications for the measures. HSAG found the scope document vastly improved over the prior year.

Although none of CHP's measures reported a decline in performance of more than 5 percentage points, 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. HSAG recommended that CHP investigate reasons why this particular recidivism rate increased. All of CHP's FY 2012–2013 *Hospital Recidivism* submeasures improved, most notably the *Non-State Hospitals—90 Days* submeasure, which improved by 7.4 percentage points.

Performance Improvement Projects

Based on its FY 2011–2012 review of the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP, HSAG recommended that CHP routinely monitor implemented interventions on an interim basis to determine if the interventions are successful. HSAG also recommended that CHP conduct a drill-down analysis to identify specific barriers that impede improvement for a particular subgroup. HSAG's FY 2012–2013 review showed that CHP documented that it performed data mining activities and data analysis during the remeasurement periods to pinpoint areas needing improvement. Indicator 1 experienced a statistically significant increase, and CHP met the goal it set for this indicator. Unfortunately, the Remeasurement 4 rate for Study Indicator 2 was 35.6 percentage points lower than the goal. HSAG suggested that CHP conduct a causal/barrier analysis annually to determine if the barriers identified at the start of the PIP are still applicable.

Foothills Behavioral Health Partners, LLC

Compliance Monitoring Site Reviews

As a result of the FY 2011–2012 site review, FBHP was required to address five required actions. Examples of these actions included the requirement to revise its member handbook to accurately describe the resolution time frame for standard appeals. FBHP was required to ensure individuals who make clinical decisions related to grievances and appeals have clinical expertise in treating the condition. FBHP submitted its corrective action plan in March 2012, which was reviewed and approved by HSAG and the Department. In June 2012, FBHP submitted documents demonstrating that it had completed the required action. HSAG and the Department determined that FBHP successfully addressed all required actions.

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 2012–2013 audit that FBHP had worked with the Department and the other BHOs to address the formatting issues with the scope document.

FBHP's FY 2011–2012 performance suggested room for improvement on *Penetration Rate*, *Hospital Recidivism*, and *Follow-Up After Hospitalization for Mental Illness* measures. HSAG observed decline in rates of more than 5 percentage points in 10 submeasures. Unfortunately, FBHP's declines continued in FY 2012–2013 with almost all of the *Penetration Rate* submeasures exhibiting further declines and two of the *Penetration Rate by Medicaid Eligibility Category* submeasures experiencing a decline of more than 5 percentage points. Although not statistically significant, FBHP also experienced poorer performance in four of its six *Hospital Recidivism* submeasure rates.

Performance Improvement Projects

For the FY 2011–2012 validation cycle, HSAG reviewed FBHP's *Reducing ED Utilization for Youth* PIP. After exhibiting strong performance in quality outcomes with demonstrated sustained improvement in its Study Indicator 1 rate, FBHP retired this PIP at completion of the FY 2011–2012 validation cycle.

Northeast Behavioral Health Partnership, LLC

Compliance Monitoring Site Reviews

During the 2011–2012 site review, NBHP was required to develop corrective actions for five requirements that received scores of *Partially Met*. These required actions were related to time frames for expedited appeal resolution and continuation of previously authorized services. NBHP was also required to include a provision that had been omitted from its delegation contract with VO. NBHP submitted its CAP to HSAG and the Department in March 2012. HSAG and the Department approved NBHP's plan. NBHP submitted documents to the Department and HSAG in June 2012 demonstrating it had implemented the corrective actions. HSAG and the Department reviewed NBHP's documents and determined that NBHP had successfully addressed all of the required actions.

Performance Measures

Based on the FY 2011–2012 audit, HSAG recommended that NBHP continue to collaborate with the Department and other BHOs to address the challenges with formatting in the scope document. HSAG found evidence during the FY 2012–2013 audit that NBHP had worked with the Department and the other BHOs to address the formatting issues with the scope document.

NBHP's FY 2011–2012 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 5 percentage points. FY 2012–2013 performance for these measures remained mostly the same, with very few submeasures exhibiting an increase or decrease of more than 1 percentage point.

Performance Improvement Projects

In FY 2011–2012, NBHP submitted one PIP for validation: *Coordination of Care Between Psychiatric Providers and Physical Health Providers*. The plan's reported rates implied 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. NBHP retired this PIP at completion of the FY 2011–2012 validation cycle.

Introduction

For fiscal year (FY) 2012–2013, the Department offered each behavioral and physical health plan the option of conducting two PIPs, or one PIP and one focused study with an intervention. Access Behavioral Care (ABC), Behavioral Healthcare, Inc. (BHI), Colorado Health Partnerships, LLC (CHP), Foothills Behavioral Health Partners, LLC (FBHP), and Northeast Behavioral Health Partnership, LLC (NBHP) opted to conduct one PIP and one focused study. The Department evaluated the focused studies and those results are presented here.

Access Behavioral Care

Study Topic and Goal

The study topic was selected after review of the 2011 Regional Care Collaborative Organization (RCCO) attribution data that highlighted the need for securing a medical home for unattributed behavioral health consumers shared by ABC and RCCO Region 5 (Denver). Attribution refers to assignment of a Primary Care Medical Provider (PCMP). This topic reflects a potentially high-risk issue for members who have co-morbid medical and behavioral health conditions and who may not be receiving timely, coordinated medical care. This is a high-risk population due to medical conditions that may not be diagnosed or treated, or due to complications from medication contraindications. The goal of this pilot project was to determine if targeted interventions resulted in an increase in the number of active ABC behavioral health consumers connected to a RCCO PCMP.

Methodology

The study focused on Medicaid Behavioral Health Consumers who received mental health/behavioral services through ABC's partner, the Mental Health Center of Denver (MHCD) as of July 1, 2012, who did not have an assigned PCMP. Data were pulled from Colorado Access claims data and monthly state RCCO enrollment and roster files. Data matching between these files was a complex process due to the continuously changing enrollment, eligibility, and attribution status of consumers.

Targeted activities included several steps. The RCCO Contract Manager (at the Department) sent MHCD the monthly enrollment file with information about newly enrolled Accountable Care Collaborative (ACC) members who had behavioral health claims with MHCD. The designated coordinator at MHCD reviewed these files to determine if the member was showing as attributed or unattributed to a PCMP. If the member was unattributed, then the coordinator forwarded this information to the assigned MHCD Case Manager (CM), along with a Medicaid ACC Program PCMP Choice Form. The CM was then able to offer assistance to the member regarding choice and selection of a PCMP, including assistance contacting Health Colorado (the enrollment broker) using

the fax form or via telephone call. It should be noted that Medicaid consumers received mailings from the Department at the time of enrollment in the ACC Program including a description of the program, information about how to select a PCMP, and a PCMP Provider Directory. RCCO 5 also mailed out a Welcome Packet 30 days after notification of the member enrollment. Members received interactive voice response (IVR) telephone messaging to encourage PCMP selection, and the Colorado Access Coordinated Clinical Services Team made efforts to on-board members.

Summary and Findings

There were 226 Adult Medicaid enrollees in the study as of July 1, 2012. Data were collected over a six-month period to track and calculate attribution. Of the original study population, 41 members became dis-enrolled during the study period. Of the 185 members still eligible and active in the program, 55 percent (102) became attributed to a Primary Care Medical Provider (PCMP), and 45 percent (83) had not selected a PCMP by the end of the study period (Attachment 1). There is no comparative baseline data, so it is not possible to draw comparisons to a cohort group.

Conclusion and Recommendations

This project has demonstrated promising results despite the complexity of enrollment and eligibility tracking. Members may need varying levels of assistance in getting attributed to a PCMP. RCCO Region 5 and ABC will continue to engage Community Mental Health Providers (CMHPs) in assisting common members to find a medical home.

It is recommended that a task group be convened to increase collaboration between RCCO, ABC, and CMHPs to maximize outreach and attribution efforts on behalf of Medicaid Behavioral Health Consumers.

Behavioral Healthcare, Inc.

Study Topic and Goal

The purpose of this study is to identify BHI member demographics and utilization patterns of mental health services including emergency department visits, inpatient hospitalization stays, and outpatient services received. This study will identify individuals by Medicaid eligibility category, age, ethnicity, and gender. This study hopes to present information on areas of improvement for mental health services and to identify areas where early prevention and intervention are needed. BHI will examine the data analysis results and determine appropriate interventions and changes in practice for population-based care.

Methodology

BHI members eligible for the study will be identified through BHI Medicaid Eligibility files, enrolled for nine out of twelve months during the study period, FY 2012 (July 1, 2011–June 30, 2012). BHI encounter files will be used to identify members with at least one mental health service as well members who used ED, inpatient, and outpatient services in the study period. GraphPad will be used to calculate the Chi-square value and determine if there is a significant difference between the demographic category that used an ED, inpatient, or outpatient service in FY 2012 and the total population of members who received any service during FY 2012 for the same demographic category.

Summary and Findings

The results were calculated using GraphPad's Chi-square 2x2 contingency table. The results produced a Chi-square value and significance level for each category. Each demographic category (from the FY 2012 services—ED, Inpatient, and Outpatient) was compared to the same demographic category for all individuals who received a service in FY 2012 and met eligibility criteria.

BHI found that there were fewer inpatient claims for children and more for adolescents than in the overall population, and more inpatient claims for Aid to Needy, Disabled, Blind eligibility than in the overall population. Similarly, there were fewer emergency department claims for children and more claims for adolescents and adults than in the overall population. There were fewer emergency department claims for AFDC-C (children) eligibility and more claims for AFDC-A (adult) eligibility, mirroring the age category findings. In addition, there were more ED claims for women and fewer for men than in the overall population.

Conclusions and Recommendations

Because the study was exploratory, the results are not presented in terms of identified goals and benchmarks. The study was successful because BHI identified which demographic groups are using ED, inpatient, and outpatient services for mental health care. The results demonstrate that BHI members utilize services at similar rates across service categories, with some differences among age groups, gender, and Medicaid eligibility.

Colorado Health Partnerships, LLC

Study Topic and Goal

Within the realm of public health care programs such as Medicaid, public policy and legislation are dynamically affecting criteria for public health care eligibility and promoting systemic health care integration among service providers. Since the beginning of FY 2009 (July 1, 2009, through June 30, 2012), the average number of eligible Medicaid beneficiaries within CHP has increased 36.2 percent. In addition, CHP has undertaken efforts to initiate and sustain coordination of care for Medicaid beneficiaries receiving behavioral and physical healthcare services. These efforts have ranged from increased education about and documentation of care coordination among service providers, to education for Medicaid beneficiaries about the myriad of services available to serve their behavioral health care needs and where to access them. A specific area of focus for CHP has been Medicaid beneficiaries utilizing hospital emergency rooms for behavioral health crisis services. CHP's focused study was examining if there are common factors that contribute to Adult Medicaid beneficiaries' decisions to choose emergency room services over alternative services when seeking care for non-life-threatening concerns

Methodology

A standardized paper survey will be used in the collection of member survey responses. Paid emergency room claims data will be extracted from the ValueOptions' (CHP's delegate for data processing and quality management) data warehouse to identify survey recipients. The survey will consist of approximately 8–12 questions and is designed to collect a standardized set of responses. Survey responses will be compiled and analyzed by a qualified staff member of the Quality Management Department at ValueOptions, under the supervision of the Quality Management director.

Summary and Findings

Due to the survey time frame, analysis will not be available until September 2013.

Foothills Behavioral Health Partners, LLC

Study Topic and Goal

The intent of this focus study is to complete efforts, begun in a FY 2012 focus study, "Design of a Healthcare Management (HCM) Program" to establish and implement a best practice for health care coordination/care management, within a behavioral health home, for individuals with severe mental illness at risk for metabolic syndrome and resultant cardiovascular disease and type 2 diabetes. Individuals with severe mental illness, specifically those with schizophrenia or bipolar illness, have a significantly shorter life span than the general population because these individuals are more likely to develop chronic medical conditions, including cardiovascular disease (CVD) and diabetes and are more likely than the general population to have lifestyle issues, including smoking, lack of exercise, and poor dietary habits that lead to "at risk" factors for CVD and diabetes, including obesity and metabolic syndrome.[7-1] In addition, antipsychotic medication, in particular some of the atypical antipsychotics, used to treat individuals with schizophrenia and increasingly for those with bipolar disorder, have been shown to increase rates of obesity and type 2 Diabetes.[7-2]

Methodology

Measures

To assess gaps in adherence to the Healthcare Management (HCM) Guideline as documented in the study population and to identify necessary enhancements to the Partner Mental Health Center (PMHC) electronic medical record (EMR), a reliable Checklist Instrument was developed to conduct a Medical Record Audit. Below are the steps that were taken to develop this instrument:

1. As a first step, the project team agreed on the care elements of the HCM program which were required to significantly improve members' health behaviors and ultimately their health. Six minimum elements were identified, including at least:
   - An annual screening of four medical indices (blood pressure, body mass index [BMI], blood glucose, and lipids) and family/personal health history factors.
   - An annual determination, based on screening information, of at-risk status for diabetes or cardiovascular disease.
   - Conduct, annually, specific coordination of care activities with the PCP.
   - Provide, annually, health education information.

   For members identified as "at risk" for diabetes or cardiovascular disease:
   - Annual development/revision and implementation of a health plan.
   - Prescriber and health plan follow-up every three months.

[7-1] American Diabetes Association et al., 2004; Brown, Inskip & Barraclough, 2000; Goff et al., 2005; McIntyre et al., 2005; Osby et al., 2001; Sokal et al., 2004.
[7-2] Allison et al., 1999; Jones et al., 2001.

2. The team worked with each partner mental health center to verify where in the medical record these elements would be documented. This information was added to the audit tool under the column "chart location."
3. Once the audit tool was drafted, the project team tested the item for clarity, with each team member auditing 3–4 charts with this checklist, revising as needed the definition and/or chart location.

Summary and Findings

Due to the survey time frame, analysis will not be available until September.

Northeast Behavioral Health Partnership, LLC

Topic and Goal

NBHP's topic for this focused study is "ACF Perceptions of Mental Health Center (MHC) Services." The purpose of this focused study is to begin a process of addressing the complex needs of Community Mental Health Support (CMHS) waiver beneficiaries through a better understanding of perceptions and barriers to MHC and Alternative Care Facility (ACF) collaboration. The focused study aims to explore perceptions and knowledge of ACF staff regarding MHC services provided to CMHS Medicaid waiver beneficiaries. The information obtained will be used to assess opportunities for improvement projects that focus on the MHC/ACF alliance and to inform the development of new systems for collaboration and coordinated care. The study questions were:

1. Do differences exist in the frequencies of negative and positive responses as they relate to specific survey questions regarding ACF staff satisfaction with MHC services and relationship?
2. Do differences exist in the frequencies of negative and positive responses as they relate to specific survey questions regarding ACF staff knowledge of MHC services offered?
3. What proportion of the staff members surveyed has no knowledge of the MHC in their area?

Methodology

CMHS Medicaid Waiver Program beneficiaries were identified using the quarterly CMHS waiver data file from the Department of Health Care Policy and Financing. The ACFs that provided services to these clients were identified. A survey asking five questions about ACF knowledge of MHC and five questions about ACF satisfaction with MHC was disseminated to identify respondents at the ACFs. Quantitative responses were tallied to identify areas for improvement. Qualitative responses were reviewed for more specific information and possible concerns.

Summary of Findings

Study Indicators and Results
1. Frequencies of negative vs. positive responses for specific survey questions are within the satisfaction domain. Frequencies of negative responses for 3 of 5 questions about satisfaction were higher than positive responses. These frequencies show a need to improve ACF satisfaction with MHC in the areas of: MHC responsiveness to requests for services, and MHC collaboration with the ACFs on residents' treatment or transition plan. ACFs are also generally dissatisfied with the MHCs.
2. Frequencies of negative vs. positive responses for specific survey questions are within the knowledge domain. Frequencies of negative responses for 3 of 5 questions about knowledge were also higher than positive responses. These frequencies indicate need for improvement in providing information to the ACFs on the crisis phone number for the local MHC, possibly sharing the MHC training calendars with the ACFs, and disseminating information to the ACFs on MHC family support groups.
3. The proportion of facilities surveyed reporting no knowledge of a local MHC. Of the five ACFs surveyed, some staff from only one ACF-Park Regency reported no knowledge of a local MHC. This result is misleading as some staff at Park Regency also reported knowledge of the local MHC.

Conclusion and Recommendations (Interventions)

NBHP considers this study to be very successful. In spite of the survey return rate of 53.1 percent, the results were very detailed and included qualitative responses that supported the quantitative responses. The following areas were clearly identified as areas for improvement that will be addressed in future projects/intervention with ACFs:

1. Improve MHC responsiveness to ACF request for services.
2. Increase MHC collaboration on resident treatment and transition plan.
3. Provide MHC crisis telephone number to ACFs.
4. MHCs' training calendars will be shared with the ACFs.
5. MHC will make ACFs aware of family support programs.

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 2012–2013 site review process, the Department requested a review of four areas of performance: coordination and continuity of care, member rights and protections, credentialing and recredentialing, and quality assessment and performance improvement. HSAG developed a review strategy that corresponded with the four areas identified by the Department.

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. The site review processes were developed to ensure consistency with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs),* as the site review process was initiated prior to the CMS release of updated protocols. HSAG reviewed its processes to ensure that the 2012–2013 site review processes were also consistent with *CMS EQR Protocol 1, Version 2.0, September 2012.*

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 VIII—Credentialing and Recredentialing for both physical health plans and BHOs, HSAG conducted an on-site review of 10 credentialing records, 10 recredentialing records, and 5 organizational credentialing 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 2012–2013.

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 2012–2013 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 2012–2013 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. 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 2013 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) 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 2013 (CY 2012) 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 enrollment/eligibility data. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation for Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September, 2012 (CMS Performance Measure Validation Protocol). 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 provided by the Department, 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 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.
  - Evaluation of system compliance, including a review of the information systems assessment, focusing on the processing of claims, encounter, member, and provider data. HSAG performed primary source verification on a random sample of members, validating enrollment and encounter data for a given date of service within both the membership and encounter data system. Additionally, HSAG evaluated the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, 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 discussion and observation of source code logic and a review of how all data sources were combined. The data file was produced for the reporting of the selected performance measures. HSAG performed primary source verification to further validate the output files, and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures 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 2012
Certified Software Report	CY 2012
Performance Measure Reports	CY 2012
Supporting Documentation	CY 2012
On-site Interviews and Demonstrations	CY 2012

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 the BHOs, and was used to determine compliance with the performance measure definitions.
- **Previous Performance Measure Reports:** These were obtained from the Department and each BHO and were 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 2011–2012
Source code (programming language) for performance measures (from the Department)	FY 2011–2012
Previous year's performance measure reports	FY 2011–2012
Current performance measure results (from BHOs and the Department)	FY 2011–2012
Supporting documentation (from BHOs and the Department)	FY 2011–2012
On-site interviews and demonstrations (from BHOs and the Department)	FY 2011–2012

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

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

HSAG determined results for each performance measure based on the validation activities previously described. After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for PCPP. HSAG forwarded this report to the Department and PCPP. The health plans forwarded their final audit reports and final IDSS to the Department. HSAG reviewed and evaluated all data sources to assess health plan compliance with the HEDIS Compliance Audit Standards. The information system (IS) standards are listed as follows:

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

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

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS protocol, HSAG gave a validation finding of *Report*, *Not Reported*, or *No Benefit* 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 non-compliant. Consequently, it was possible that an error for a single element resulted in a designation of *Not Reported* 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 *Report*.

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 2012 Percentiles

Performance Measures	P10	P25	P50	P75	P90
Pediatric Care					
Childhood Immunization Status—Combination 2	64.23%	69.10%	75.35%	80.79%	84.18%
Childhood Immunization Status—Combination 3	58.88%	64.72%	71.93%	77.49%	82.48%
Childhood Immunization Status—Combination 4	20.92%	27.78%	33.92%	40.39%	46.93%
Childhood Immunization Status—Combination 5	36.50%	46.47%	52.92%	59.76%	64.68%
Childhood Immunization Status—Combination 6	20.19%	30.90%	37.57%	45.50%	56.20%
Childhood Immunization Status—Combination 7	15.29%	20.92%	26.03%	33.33%	38.50%
Childhood Immunization Status—Combination 8	10.90%	14.36%	20.88%	25.69%	31.25%
Childhood Immunization Status—Combination 9	14.81%	22.87%	29.79%	38.19%	45.05%
Childhood Immunization Status—Combination 10	8.10%	11.54%	16.51%	21.41%	27.49%
Immunizations for Adolescents—Combination 1	39.77%	50.36%	62.29%	70.83%	80.91%
*Well-Child Visits in the First 15 Months of Life—Zero Visits**	0.46%	0.72%	1.22%	2.43%	3.89%
Well-Child Visits in the First 15 Months of Life—6+ Visits	43.80%	54.31%	62.95%	70.70%	77.31%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.07%	65.51%	72.26%	79.32%	83.04%
Adolescent Well-Care Visits	35.52%	42.11%	49.65%	57.61%	64.72%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Assessment: Total	1.55%	29.20%	47.45%	66.67%	77.13%
Counseling for Nutrition: Total	0.82%	42.82%	54.88%	67.15%	77.61%
Counseling for Physical Activity: Total	0.16%	31.63%	43.29%	56.20%	64.87%
Appropriate Testing for Children with Pharyngitis	49.98%	58.50%	70.00%	76.37%	83.86%
Access to Care					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	72.02%	80.54%	86.13%	90.39%	93.33%
Postpartum Care	52.43%	58.70%	64.98%	71.05%	74.73%
Children's and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	93.06%	95.56%	97.02%	97.88%	98.39%
Ages 25 Months to 6 Years	83.16%	86.62%	89.19%	91.40%	92.63%
Ages 7 to 11 Years	83.37%	87.56%	90.58%	92.88%	94.51%
Ages 12 to 19 Years	81.78%	86.04%	89.21%	91.59%	93.01%
Adults' Access to Preventive/Ambulatory Health Services—Total	70.66%	79.85%	83.90%	86.67%	89.41%
Preventive Screening					
Chlamydia Screening in Women—Total	47.62%	52.70%	58.40%	63.89%	68.83%
Breast Cancer Screening	36.80%	44.82%	50.46%	56.58%	62.76%
Cervical Cancer Screening	51.85%	61.81%	69.10%	73.24%	78.51%
Adult BMI Assessment	4.41%	46.90%	57.94%	70.60%	78.35%

Performance Measures	P10	P25	P50	P75	P90
Mental/Behavioral Health					
Anti-depressant Medication Management					
Effective Acute Phase Treatment	43.40%	46.98%	49.42%	52.74%	61.58%
Effective Continuation Phase Treatment	26.73%	29.96%	32.42%	37.31%	42.94%
Follow-up Care for Children Prescribed ADHD Medication					
Initiation	22.97%	32.93%	39.19%	44.46%	52.48%
Continuation	21.79%	38.36%	47.09%	56.10%	63.11%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					
Initiation	29.93%	34.30%	38.80%	43.62%	49.44%
Engagement	2.41%	5.84%	11.72%	18.56%	21.24%
Living With Illness					
Controlling High Blood Pressure	42.22%	50.00%	57.52%	63.65%	69.11%
Comprehensive Diabetes Care					
HbA1c Testing	74.90%	78.54%	82.38%	87.01%	91.13%
*HbA1c Poor Control (>9.0%)**	28.95%	34.33%	41.68%	50.31%	58.24%
HbA1c Control (<8.0%)	35.04%	42.09%	48.72%	55.70%	59.37%
Eye Exam	36.25%	45.03%	52.88%	61.75%	69.72%
LDL-C Screening	64.38%	70.34%	76.16%	80.88%	83.45%
LDL-C Level <100 mg/dL	23.06%	28.47%	35.86%	41.02%	46.44%
Medical Attention for Nephropathy	68.43%	73.48%	78.71%	83.03%	86.93%
Blood Pressure Controlled <140/80 mm Hg	27.31%	33.09%	39.10%	46.20%	54.99%
Blood Pressure Controlled <140/90 mm Hg	47.02%	54.48%	63.50%	69.82%	75.44%
Annual Monitoring for Patients on Persistent Medications—Total	78.45%	81.16%	84.81%	87.02%	88.55%
Use of Services					
Ambulatory Care (Per 1,000 Member Months)					
Emergency Department Visits	42.03	52.45	63.15	72.77	80.04

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

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 five PIPs for the behavioral health organizations (BHOs) and four PIPs for the physical health plans. For the BHOs, HSAG performed validation activities on one PIP for each of the 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)	*Increasing Access to Mental Health Services for Youth*
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*

Table D-1—Summary of Each BHO's PIP	
BHO	**PIP Study**
Foothills Behavioral Health Partners, LLC (FBHP)	*Reducing Overall Hospital 90-Day Recidivism*
Northeast Behavioral Health Partnership, LLC (NBHP)	*Increasing Penetration for Medicaid Members Aged 65+*

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 started before September 2012 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] The methodology used to validate PIPs started after September 2012 was based on CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[D-2] Using these protocols, HSAG, in collaboration with the Department, developed the PIP Summary Forms, which each BHO and each MCO completed and submitted to HSAG for review and validation. The PIP Summary Forms 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:

[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.

[D-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

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

* To ensure that health plans analyzed and interpreted data prior to identifying and implementing interventions, HSAG reversed the order of Activities VII and VIII in the PIP Summary Form 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 followed by a description of planned interventions and improvement strategies in Activity VIII.

♦ In accordance with updated CMS protocol, the reporting order for Activities III and IV in the PIP Summary Form was reversed. For all PIPs developed after September 2012, health plans are required to provide a description of the representative and generalizable study population in Activity III, followed by a description of the study indicator(s) in Activity IV.

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 2012–2013

Data Aggregation, Analysis, and How Conclusions Were Drawn

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. HSAG designates some of the evaluation elements deemed pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all of the critical elements must receive a score of *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a score of *Partially Met* or *Not Met* will result in a corresponding overall PIP validation status of *Partially Met* or *Not Met*.

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 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set for the adult population, and the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item and the children with chronic conditions (CCC) measurement sets for the child population. The surveys include a set of standardized items (57 items for the CAHPS 5.0 Adult Medicaid Health Plan Survey and 83 items for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set) that assess patient perspectives on care. To support the reliability and validity of the findings, standardized 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 denoted with a cross (+).

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 three categories: (1) "Never," "Sometimes," "Usually," and "Always;" (2) "Not at all," "A little," "Some," and "A lot;" or (3) "No" and "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "A lot/Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

It is important to note that the CAHPS 5.0 Medicaid Health Plan Surveys were released by the Agency for Healthcare Research and Quality (AHRQ) in 2012. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the adult and child CAHPS Health Plan Surveys in August 2012. The following is a summary of the changes resulting from the transition to the CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys.

With the transition from the CAHPS 4.0 to 5.0 Surveys, there were no changes made to the four CAHPS global ratings: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. The question language, response options, and placement of the global ratings remain the same; therefore, comparisons to national data and prior year's rates were performed for all four global ratings.

For three of the five composite measures (*Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), minor to no changes were made to the question language; therefore, comparisons to national data and prior year's rates were performed for these composite measures. For the *Getting Needed Care* composite measure, changes were made to the question language and placement of questions included in the composite. While comparisons to national data and prior year's rates were performed for this composite measure, the changes to the question language and reordering of questions may impact survey results; therefore, caution should be exercised when interpreting the results of the *Getting Needed Care* composite measure. For the *Shared Decision Making* composite measure, changes were made to the question language, response options, and number of questions. All items in the composite measure were reworded to ask about "starting or stopping a prescription medicine," whereas previously the items asked about "choices for your treatment of health care." Response options for these questions were revised to accommodate the new question language. Also, one question was added to the composite. Due to these changes, comparisons to national data and prior year's rates could not be performed for the *Shared Decision Making* composite measure.

Description of Data Obtained

For 2013, DHMC's and RMHP's adult Medicaid populations were not surveyed; therefore, survey results for the adult population are limited to PCPP. However, all health plans administered CAHPS surveys to their child Medicaid populations. Table E-1 through Table E-4 present the question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for the surveyed adult population (i.e., PCPP) and child populations.

Table E-1 and Table E-2 present the question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for the 2013 global ratings and 2013 composite scores, respectively, for PCPP. Measures at or above the 2012 NCQA national averages are highlighted in yellow.

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

Measure of Member Satisfaction	Adult Medicaid 2013	
	2012 NCQA CAHPS National Averages	PCPP
Rating of Personal Doctor	61.9%	62.0%
Rating of Specialist Seen Most Often	62.1%	58.1%
Rating of All Health Care	49.8%	48.9%
Rating of Health Plan	55.6%	51.2%

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

Indicates a rate is at or above the 2012 NCQA CAHPS national average.

Table E-2—NCQA National Averages and Global Proportions for Composite Scores

Measure of Member Satisfaction	Adult Medicaid 2013	
	2012 NCQA CAHPS National Averages	PCPP
Getting Needed Care	75.6%	82.1%
Getting Care Quickly	80.4%	81.2%
How Well Doctors Communicate	87.8%	87.4%
Customer Service	80.4%	84.4%
Shared Decision Making	NC	50.0%

A global proportion is the percentage of respondents offering a positive response ("A lot" or "Yes").

Due to changes to the *Shared Decision Making* composite score measure, comparisons to national data could not be performed for 2013. This is denoted as Not Comparable (NC) in the table above.

Indicates a rate is at or above the 2012 NCQA CAHPS national average.

Table E-3 and Table E-4 present the question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for the 2013 global ratings and 2013 composite scores, respectively, for the child population. 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 5.0H Child Medicaid Health Plan Survey for DHMC and RMHP, respectively. The health plans reported that NCQA methodology was followed in calculating these results. Measures at or above the 2012 NCQA national averages are highlighted in yellow.

Table E-3—NCQA National Averages and Question Summary Rates for Global Ratings

Measure of Member Satisfaction	Child Medicaid 2013			
	2012 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Rating of Personal Doctor	72.1%	82.1%	74.5%	74.2%
Rating of Specialist Seen Most Often	67.3%	81.4%	70.1%+	64.9%+
Rating of All Health Care	64.1%	68.4%	64.6%	65.7%
Rating of Health Plan	67.4%	71.5%	67.3%	63.7%

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

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Indicates a rate is at or above the 2012 NCQA CAHPS national average.

Table E-4—NCQA National Averages and Global Proportions for Composite Scores

Measure of Member Satisfaction	Child Medicaid 2013			
	2012 NCQA CAHPS National Averages	DHMC	RMHP	PCPP
Getting Needed Care	79.3%	81.6%	93.1%	86.7%
Getting Care Quickly	87.3%	77.9%	93.6%	93.7%
How Well Doctors Communicate	91.8%	94.7%	97.3%	95.5%
Customer Service	83.0%	86.4%	89.1%+	88.7%
Shared Decision Making	NC	61.0%	58.7%+	57.8%+

A global proportion is the percentage of respondents offering a positive response ("Usually/Always" or "A lot/Yes").

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.

Due to changes to the *Shared Decision Making* composite score measure, comparisons to national data could not be performed for 2013. This is denoted as Not Comparable (NC) in the table above.

Indicates a rate that is at or above the 2012 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 2012–2013.

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 2012–2013 Standard Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services (2011)	85%	81%	83%
Standard II—Access and Availability (2011)	85%	100%	92%
Standard III—Coordination and Continuity of Care (2013)	93%	60%	77%
Standard IV—Member Rights and Protections (2013)	100%	80%	90%
Standard V—Member Information (2012)	100%	90%	95%
Standard VI—Grievance System (2012)	100%	73%	87%
Standard VII—Provider Participation and Program Integrity (2012)	100%	85%	92%
Standard VIII—Credentialing and Recredentialing (2013)	94%	100%	97%
Standard IX—Subcontracts and Delegation (2012)	100%	100%	100%
Standard X—Quality Assessment and Performance Improvement (2013)	85%	77%	81%

Standards presented in blue text were reviewed in 2011.
Standards presented in green text were reviewed in 2012.
Standards presented in black text were reviewed in 2013.

Table F-2—FY 2012–2013 Record Review Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Denials (2011)	98%	56%	77%
Appeals (2012)	93%	92%	93%
Credentialing (2013)	100%	100%	100%
Recredentialing (2013)	100%	100%	100%

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 2012–2013 Standard Scores for the BHOs

Description of Component	ABC	BHI	CHP	FBHP	NBHP	Statewide Average
Standard I—Coverage and Authorization of Services (2011)	94%	91%	94%	97%	97%	95%
Standard II—Access and Availability (2011)	100%	100%	100%	100%	100%	100%
Standard III—Coordination and Continuity of Care (2013)	100%	100%	100%	100%	100%	100%
Standard IV—Member Rights and Protections (2013)	100%	100%	100%	100%	100%	100%
Standard V—Member Information (2012)	95%	84%	89%	89%	95%	91%
Standard VI—Grievance System (2012)	92%	76%	85%	92%	88%	87%
Standard VII—Provider Participation and Program Integrity (2012)	100%	93%	100%	100%	100%	99%
Standard VIII—Credentialing and Recredentialing (2013)	98%	96%	98%	100%	98%	98%
Standard IX— Subcontracts and Delegation (2012)	100%	75%	86%	86%	86%	86%
Standard X—Quality Assessment and Performance Improvement (2013)	100%	94%	100%	100%	100%	99%

Standards presented in blue text were reviewed in 2011.
Standards presented in green text were reviewed in 2012.
Standards presented in black text were reviewed in 2013.

Table F-4—FY 2012–2013 Record Review Scores for the BHOs

Description of Component	ABC	BHI	CHP	FBHP	NBHP	Statewide Average
Denials (2011)	95%	71%	99%	100%	100%	93%
Appeals (2012)	100%	81%	100%	100%	100%	97%
Credentialing (2013)	100%	100%	100%	100%	100%	100%
Recredentialing (2013)	100%	100%	98%	98%	97%	99%

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	81.22%	51.45%	74.25%	72.27%
Childhood Immunization Status—Combination 3	80.87%	49.62%	72.62%	71.31%
Childhood Immunization Status—Combination 4	80.73%	9.19%	72.39%	60.65%
Childhood Immunization Status—Combination 5	65.75%	40.89%	58.70%	58.06%
Childhood Immunization Status—Combination 6	69.76%	31.39%	45.94%	55.67%
Childhood Immunization Status—Combination 7	65.61%	8.27%	58.47%	49.44%
Childhood Immunization Status—Combination 8	69.69%	5.82%	45.94%	48.96%
Childhood Immunization Status—Combination 9	56.96%	27.11%	38.05%	45.93%
Childhood Immunization Status—Combination 10	56.89%	5.51%	38.05%	40.26%
Immunizations for Adolescents—Combination 1	79.54%	53.79%	70.66%	71.60%
Well-Child Visits in the First 15 Months of Life—Zero Visits	1.22%	0.23%	2.67%	1.05%
Well-Child Visits in the First 15 Months of Life—6+ Visits	69.10%	82.64%	62.00%	72.83%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.91%	66.75%	61.56%	65.91%
Adolescent Well-Care Visits	49.15%	42.82%	39.42%	45.22%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	87.83%	72.65%	77.86%	81.82%
Counseling for Nutrition: Total	75.18%	63.45%	61.56%	69.24%
Counseling for Physical Activity: Total	58.39%	56.73%	63.99%	59.20%
Appropriate Testing for Children with Pharyngitis	70.30%	89.90%	68.16%	80.26%

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	85.40%	95.64%	86.34%	89.66%
Postpartum Care	54.99%	73.83%	69.67%	65.10%
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	92.28%	96.90%	97.86%	94.42%
Ages 25 Months to 6 Years	78.88%	87.14%	86.55%	82.33%
Ages 7 to 11 Years	83.64%	90.90%	89.61%	86.48%
Ages 12 to 19 Years	85.82%	89.99%	88.78%	87.56%
Adults' Access to Preventive/Ambulatory Health Services—Total	70.11%	88.81%	83.02%	78.53%
Preventive Screening				
Chlamydia Screening in Women—Total	72.35%	46.15%	28.75%	54.38%
Breast Cancer Screening	49.16%	47.79%	30.36%	41.96%
Cervical Cancer Screening	51.13%	55.02%2	27.66%	45.78%
Adult BMI Assessment	86.86%	80.26%	71.05%	80.19%

Table F-7 presents mental/behavioral health performance scores for each physical health plan and the statewide average.

Table F-7—Mental/Behavioral Health Performance Measures for Physical Health Plans and Statewide Average				
Performance Measures	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Anti-depressant Medication Management				
Effective Acute Phase Treatment	57.14%	NB	65.35%	60.07%
Effective Continuation Phase Treatment	45.05%	NB	48.51%	46.29%
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	24.55%	43.56%	35.96%	34.46%
Continuation	NA	40.63%	30.95%	29.90%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	47.14%	NB	25.90%	42.03%
Engagement	3.31%	NB	3.01%	3.24%

NB—indicates that this benefit was not offered by this health plan.

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

Table F-8—Living With Illness Performance Measures for Physical Health Plans and Statewide Average				
Performance Measures	**DHMC**	**RMHP**	**PCPP**	**Statewide Average**
Controlling High Blood Pressure	70.07%	73.38%	46.47%	63.20%
Comprehensive Diabetes Care				
HbA1c Testing	83.21%	92.20%	71.29%	81.00%
HbA1c Poor Control (>9.0%)	33.58%	19.24%	57.66%	38.76%
HbA1c Control (<8.0%)	51.09%	72.23%	36.98%	50.47%
Eye Exam	50.12%	62.73%	50.36%	52.68%
LDL-C Screening	70.32%	75.55%	57.91%	67.31%
LDL-C Level <100 mg/dL	50.36%	44.86%	30.66%	42.87%
Medical Attention for Nephropathy	80.78%	76.22%	66.67%	75.29%
Blood Pressure Controlled <140/80 mm Hg	50.61%	61.52%	39.66%	49.09%
Blood Pressure Controlled <140/90 mm Hg	70.07%	79.85%	54.26%	66.74%
Annual Monitoring for Patients on Persistent Medications—Total	84.14%	86.03%	66.77%	80.33%
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
Emergency Department Visits	44.56	62.73	57.84	52.15

Table F-9 includes FY 2012–2013 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	FBHP	NBHP	Statewide Average
Percent of Members with SMI with a Focal Point of Behavioral Health Care	96.1%	92.8%	85.9%	91.1%	81.3%	89.9%
Improving Physical Healthcare Access	59.1%	72.8%	77.1%	73.0%	74.7%	72.8%
Penetration Rate by Age Category						
Children 12 Years of Age and Younger	6.2%	6.4%	7.3%	12.9%	6.9%	7.4%
Adolescents 13 Through 17 Years of Age	14.8%	16.7%	18.7%	26.3%	20.2%	18.7%
Adults 18 Through 64 Years of Age	19.1%	18.3%	19.9%	24.4%	19.3%	19.9%
Adults 65 Years of Age or Older	6.7%	4.6%	6.89%	7.3%	5.9%	6.3%
Penetration Rate by Service Category						
Inpatient Care	0.3%	0.2%	0.2%	0.2%	0.3%%	0.2%
Intensive Outpatient/Partial Hospitalization	0.05%	0.1%	0.00%	0.02%	0.00%	0.03%
Ambulatory Care	10.2%	10.9%	12.7%	15.0%	12.2%	12.0%
Overall Penetration Rate	11.5%	11.3%	13.4%	18.2%	12.7%	13.0%
Penetration Rate by Medicaid Eligibility Category						
AFDC/CWP Adults	10.9%	12.9%	15.4%	17.4%	13.9%	14.2%
AFDC/CWP Children	6.1%	7.0%	8.6%	14.8%	8.7%	8.4%
AND/AB-SSI	33.7%	32.9%	28.9%	35.8%	32.3%	31.8%
BC Children	6.2%	5.4%	6.1%	8.6%	4.7%	6.0%
BC Women	13.4%	9.1%	14.4%	15.7%	10.3%	12.5%
BCCP—Women Breast and Cervical Cancer	16.4%	12.1%	16.7%	15.8%	10.1%	15.0%
Foster Care	43.2%	36.7%	31.6%	38.8%	35.1%	35.9%
OAP-A	6.6%	4.6%	6.8%	7.2%	5.9%	6.2%
OAP-B-SSI	24.2%	21.3%	20.0%	26.8%	22.8%	22.3%
Hospital Recidivism						
Non-State Hospitals—7 Days	4.3%	2.8%	2.4%	4.5%	1.6%	3.0%
30 Days	11.5%	8.3%	7.9%	9.9%	5.9%	8.8%
90 Days	18.4%	14.6%	14.9%	19.7%	10.9%	15.6%
All Hospitals—7 Days	4.3%	3.0%	2.3%	4.0%	1.8%	3.0%
30 Days	11.4%	8.8%	8.4%	10.8%	5.9%	9.1%
90 Days	18.9%	15.1%	15.9%	19.5%	11.7%	16.3%
Hospital Average Length of Stay						
Non-State Hospitals	9.36	7.13	6.63	7.00	6.48	7.39
All Hospitals	16.89	15.54	9.49	19.05	7.83	13.29
Emergency Room Utilization (Rate/1000 Members, All Ages)	11.24	9.95	10.18	9.68	10.23	10.25

Table F-9—2011–2012 Performance Measure Results for BHOs						
Performance Measures	**ABC**	**BHI**	**CHP**	**FBHP**	**NBHP**	**Statewide Average**
Inpatient Utilization (Rate/1000 Members, All Ages)						
Non-State Hospitals	4.87	2.87	3.15	3.11	4.09	3.49
All Hospitals	5.58	3.83	4.61	5.28	4.33	4.63
Follow-Up After Hospitalization for Mental Illness						
Non-State Hospitals—7 Days	42.6%	57.8%	43.8%	54.0%	51.4%	48.3%
30 Days	62.1%	70.8%	66.0%	71.1%	70.2%	67.1%
All Hospitals—7 Days	42.5%	59.3%	48.5%	57.7%	51.9%	50.9%
30 Days	62.2%	72.7%	70.0%	75.5%	71.0%	69.7%

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*	88%	100%	*Met*
RMHP	*Adult BMI Assessment*	96%	90%	*Partially Met*
RMHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	89%	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	*Increasing Access to Mental Health Services for Youth*	100%	100%	*Met*
BHI	*Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics*	100%	100%	*Met*
CHP	*Coordination of Care Between Medicaid Physical and Behavioral Health Providers*	92%	100%	*Met*
FBHP	*Reducing Overall Hospital 90-Day Recidivism*	100%	100%	*Met*
NBHP	*Increasing Penetration for Medicaid Member Aged 65+*	100%	100%	*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. For FY 2012–2013, DHMC and RMHP did not conduct CAHPS surveys of their adult Medicaid populations; therefore, adult Medicaid results are presented for PCPP only.

Table F-12—Adult Medicaid Question Summary Rates and Global Proportions

Measure	DHMC	RMHP	PCPP	Statewide Average
Getting Needed Care	—	—	82.1%	82.1%
Getting Care Quickly	—	—	81.2%	81.2%
How Well Doctors Communicate	—	—	87.4%	87.4%
Customer Service	—	—	84.4%	84.4%
Shared Decision Making	—	—	50.0%	50.0%
Rating of Personal Doctor	—	—	62.0%	62.0%
Rating of Specialist Seen Most Often	—	—	58.1%	58.1%
Rating of All Health Care	—	—	48.9%	48.9%
Rating of Health Plan	—	—	51.2%	51.2%

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	81.6%	93.1%	86.7%	87.1%
Getting Care Quickly	77.9%	93.6%	93.7%	88.4%
How Well Doctors Communicate	94.7%	97.3%	95.5%	95.8%
Customer Service	86.4%	89.1%+	88.7%	88.1%
Shared Decision Making	61.0%	58.7%+	57.8%+	59.2%
Rating of Personal Doctor	82.1%	74.5%	74.2%	76.9%
Rating of Specialist Seen Most Often	81.4%	70.1%+	64.9%+	72.1%
Rating of All Health Care	68.4%	64.6%	65.7%	66.2%
Rating of Health Plan	71.5%	67.3%	63.7%	67.5%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.