2013–2014 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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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

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.

Scope of EQR Activities—Behavioral Health

The behavioral organizations 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 two 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 key indicators in 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. 2013 Standards and Guidelines for MBHOs and MCOs.

[1-4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Overall Conclusions

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

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

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

Physical Health Compliance Review Standards	Quality	Timeliness	Access
Coverage and Authorization of Services	✓	✓	✓
Access and Availability		✓	✓
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	✓	✓	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	✓		

Table 1-1—Assignment of Activities to Performance Domains for Physical Health Plans			
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Controlling High Blood Pressure	✓		
Comprehensive Diabetes Care	✓		✓
Annual Monitoring for Patients on Persistent Medications	✓		
Use of Imaging Studies for Low Back Pain	✓		
Pharmacotherapy Management of COPD Exacerbation	✓		
Use of Appropriate Medications for People With Asthma	✓		
Asthma Medication Ratio	✓		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	✓		
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	✓		
Ambulatory Care			✓
Inpatient Utilization—General Hospital/Acute Care			✓
Antibiotic Utilization			✓
Frequency of Selected Procedures(Procedures per 1,000 MM)			✓
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**
Coverage and Authorization of Services	✓	✓	✓
Access and Availability		✓	✓
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

HSAG's review of compliance monitoring standards determined that statewide performance in the quality domain by the physical health Medicaid plans was variable. Both Medicaid managed health care plans had adequate policies and procedures to guide utilization management decisions. DHMC demonstrated it consistently applied established criteria and required procedures to make authorization decisions, while RMHP was less consistent in following its established policies.

Of the 52 rates from the 28 quality-related HEDIS measures, 12 benchmarked at or above the national HEDIS Medicaid 90th percentiles whereas three were at or below the 10th percentiles. Twenty rates showed statistically significant improvement from the previous year. Improvement was noted in all the preventive screening measures, *Appropriate Testing for Children with Pharyngitis, Annual Monitoring for Patients on Persistent Medications—Total,* and most of the *Childhood Immunization Status* and *Comprehensive Diabetes Care* measures. Rate increases observed for *Childhood Immunization Status* may be due to a change in the data collection methodology required by the Department between the two years. Three rates (both indicators from the *Anti-depressant Medication Management* measure and the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* indicator) reported a significant rate decline from the previous year. Two of these measures, together with the *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* indicator, also benchmarked below the national HEDIS Medicaid 10th percentile and suggested statewide opportunities for improvement.

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

All of the measures within the CAHPS survey addressed quality. Because DHMC and RMHP were not required to administer a CAHPS survey to their adult Medicaid populations in FY 2012–2013, HSAG compared the current year's rates to the FY 2011–2012 rates. While RMHP did not see any substantial changes in its rates, DHMC experienced substantial decreases in rates for two measures (*Rating of All Health Care* and *Rating of Health Plan*) and substantial increases in rates for three measures (*Getting Needed* Care, *Getting Care* Quickly, and *Customer Service*). Comparison of the current year's child Medicaid results to the FY 2012–2013 results showed that both DHMC and RMHP experienced substantial rate decreases in *Getting Needed Care* and *Shared Decision Making*. DHMC also experienced substantial decreases for the *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* measures and a substantial rate increase in the *Getting Care Quickly* measure.

Quality—Behavioral Health

HSAG's review of compliance monitoring standards determined that Colorado's BHOs demonstrated strong performance in the quality domain, with three of the five BHOs achieving full compliance scores of 100 percent in Standard I—Coverage and Authorization of Services. All five BHOs had comprehensive utilization management (UM) programs and each employed a variety of mechanisms to ensure consistent standards where applied when making authorization decisions. A majority of denial records reviewed demonstrated that qualified clinicians were making determinations based on criteria, and NOAs included required content. Two of the five BHOs were required to revise applicable policies and templates to accurately and clearly describe a member's right to file a grievance (not an appeal) if he or she disagreed with a decision to extend the authorization decision time frame.

Percent of Members with Serious Mental Illness (SMI) with a Focal Point of Behavioral Health Care and *Hospital Recidivism* were the only HEDIS quality measures reported for this year. Statewide performance on both of these measures showed a very slight change from the previous year (no more than a 1.5 percentage-point change). Wide rate variation (more than 5 percentage points) by BHOs, as noted in 30-day and 90-day *Hospital Recidivism* for non-state and all hospitals, suggested room for continued statewide improvement.

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

Timeliness—Physical Health

Statewide experience in the timeliness domain also demonstrated variable results. While RMHP experienced minor issues related to timeliness, overall performance was good. It communicated appointment availability standards and HSAG's survey confirmed appointment availability within the required time frames for 100 percent of the calls made. Although DHMC's policies and procedures and its communication to its providers included accurate time frames for appointment availability, focus group and HSAG survey processes determined that DHMC did not consistently meet these standards. In addition, DMHC did not have an adequate process to track the length of time that members remained on the wait list for appointments.

Of the 20 rates from the eight timeliness-related HEDIS measures, four benchmarked at or above the national HEDIS Medicaid 90th percentiles. Six rates, all under *Childhood Immunization Status*, reported statistically significant improvement from the previous year. This rate increase may be due to a change in the data collection methodology required by the Department between the two years. Only one rate (*Follow-up Care for Children Prescribed ADHD Medication—Initiation*) reported a significant decline from the previous year. This indicator was also benchmarked at or below the 10th percentile and presented opportunities for statewide improvement.

HSAG assigned the *Getting Care Quickly* CAHPS measure to the timeliness domain. While RMHP did not experience a substantial change in rates for either its adult population or its child population, DHMC experienced a substantial increase for both its adult population (5.9 percentage-point increase over the FY 2011–2012 rate) and its child population (7.6 percentage-point increase over the FY 2012–2013 rate).

Timeliness—Behavioral Health

Similar to the quality domain, BHOs demonstrated strong performance in the timeliness domain. Of the 47 denial records that HSAG reviewed, only two included an NOA that was sent outside of the required time frame. Furthermore, HSAG found ample evidence that all five of the BHOs notified both providers and members of the appointment standards and conducted monitoring to ensure compliance with those standards.

The *Follow-Up After Hospitalization for Mental Illness* measure was the only timeliness measure this year. Statewide performance on this measure showed some slight decline from the previous year's results. The decline in the rate was no more than 3 percentage points. The variations in rates by BHO were above 10 percentage points for all indicators, suggesting room for continued statewide improvement.

Access—Physical Health

Some of the rural areas within the RMHP service area are designated as primary care shortage areas, as reflected in RMHP's provider network adequacy reports. However, RMHP implemented various mechanisms to address these shortages and ensure adequate access for all of its members. While DHMC's network adequacy reports demonstrated adequate provider network coverage, HSAG obtained information that indicated the Denver Health clinic system was operating at

capacity, thereby requiring that DHMC's new adult Medicaid members be put on a waiting list for appointments. Although DHMC's policies allow for members to be granted access to out-of-network providers when in-network services are not available, HSAG did not find any evidence that out-of-network services were offered or provided to members on the wait list.

Of the eight access-related measures, four were population-based (*Prenatal Care and Postpartum Care, Children's and Adolescents' Access to Primary Care Practitioners (PCPs), Adults' Access to Preventive/Ambulatory Health Services,* and *Comprehensive Diabetes Care*) and related to a total of 16 rates. Four of these rates, all under *Comprehensive Diabetes Care,* benchmarked at or above the national HEDIS Medicaid 90th percentiles. In general, the *Comprehensive Diabetes Care* measure reported statistically significant improvement from the previous year. On the other hand, three indicators under *Children's and Adolescents' Access to Primary Care Practitioners (PCPs)* and the *Adults' Access to Preventive/Ambulatory Health Services* measures reported significant rate declines. Both children/adolescent and adult access measures were below the national HEDIS Medicaid 25th percentile. These measures suggested statewide opportunities for improvement. Although *Ambulatory Care, Inpatient Utilization—General Hospital/Acute Care, Antibiotic Utilization, and Frequency of Selected Procedures* were related to beneficiary's access to care, these are utilization-based measures without risk adjustment. Statewide rates for these measures should be used for information only.

HSAG assigned only one CAHPS survey measure to the access domain—*Getting Needed Care*. Both DHMC and RMHP experienced substantial decreases in this measure for the child population (11.3 and 8.2 percentage points, respectfully); however, DHMC experienced a substantial increase of 5.4 percentage points between the current rate and the FY 2011–2012 rate for its adult population.

Access—Behavioral Health

Colorado BHO performance in the access domain was exceptional. All five of the BHOs demonstrated robust provider networks and comprehensive programs to ensure availability of culturally competent services. Each organization demonstrated willingness to provide out-of-network services to meet a member's unique treatment or cultural needs and when requested services were not available in-network.

Overall, statewide BHO performance in the domain of access for performance measures was very similar to last year's performance, with the exception of *Improving Physical Healthcare Access,* where a 16.5 percentage-point improvement was observed. Although all *Penetration Rate* indicators showed either similar performance or a decline in performance compared to the previous year, none had a change in rate of more than 1.5 percentage points.

Statewide performance on the utilization-based measures was similar to the prior year, with change in rates no more than 10 percent from the previous year's results. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the BHOs can use to further assess barriers or patterns of utilization when evaluating improvement interventions. BHO rate variations were greatest in *Hospital Average Length of Stay* for all hospitals, where the range between the lowest and highest average length of stay was 11.4 days.

2. External Quality Review (EQR) Activities

Physical Health

HSAG conducted four EQR activities for the physical health plans: compliance monitoring site reviews, validation of performance measures, validation of PIPs, and summarizing of the CAHPS results. HSAG conducted each activity in accordance with Centers for Medicare & Medicaid Services (CMS) Protocols, Version 2.0, September 2012). 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 the CMS Protocols, Version 2.0, September 2012). Details of how HSAG conducted the compliance monitoring site reviews, validation of performance measures, and validation of PIPs are given 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 physical health plan's strengths and opportunities for improvement derived from the results of the EQR activities. Also included are HSAG's recommendations for improving the health plans' performance. In addition, this section includes a summary assessment related to the quality and timeliness of, and access to, services furnished by each health plan, and a summary of overall statewide performance related to the quality, timeliness, and access to services.

Compliance Monitoring Site Reviews

For the FY 2013–2014 site review process, the Department requested a review of two areas of performance that had not been reviewed within the previous two fiscal years. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. To determine compliance, HSAG conducted a desk review of materials submitted prior to the on-site review activities; reviewed records, documents, and materials provided on-site; and conducted on-site interviews of key personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to health plan service and claims denials. In addition, HSAG conducted a high-level review of each health plan's authorization processes through a demonstration of the electronic system used to document and process requests for services.

The health plan's administrative records were reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action (NOAs). Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 15 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. For the records reviewed, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also calculated an overall record review score separately.

For DHMC, the Department requested that HSAG conduct a focus group with DHMC community partners to gather information related to experiences with access and availability of Denver Health providers and services. Results of the focus group were included in the DHMC compliance monitoring report and considered in the recommendations regarding access and availability.

HSAG determined which standards contained requirements that related to the domains of quality, timeliness, or access, as shown 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 I—Coverage and Authorization of Services	✓	✓	✓
Standard II—Access and Availability		✓	✓

Denver Health Medicaid Choice

Findings

Table 3-2 and Table 3-3 present the number of elements for each of the two 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 2013–2014).

Table 3-2—Summary of Scores for the Standards for FY 2013–2014 *for* DHMC							
Standard	**# of Elements**	**# of Applicable Elements**	**# *Met***	**# *Partially Met***	**# *Not Met***	**# *Not Applicable***	**Score (% of *Met* Elements)**
Standard I—Coverage and Authorization of Services	34	34	31	3	0	0	91%
Standard II—Access and Availability	21	20	16	4	0	1	80%
Totals	**55**	**54**	**47**	**7**	**0**	**1**	**87%***

*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)**
Denials	110	60	59	1	50	98%
Total	**110**	**60**	**59**	**1**	**50**	**98%**

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

Strengths

DHMC had a comprehensive Utilization Management (UM) Program Description that outlined the goals and responsibilities of the program, structure of the department responsible for making authorization determinations, clinical expertise of individuals who make determinations, and medical management and oversight of the program. Pediatric and adult guidelines delineated which services may be limited at Denver Health and Hospital Authority (DHHA) clinics and, therefore,

may be approved as out-of-network services. DHMC's processes included extensive interrater reliability training.

DHMC's Behavioral Health and Wellness Services Program Description delineated preventive health services and a continuum of care for members with alcohol and tobacco use disorders, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes, weight management issues, and depression and anxiety. The program included creative and community-based programs such as interactive education and exercise classes, distribution of DVDs, shopping and cooking classes, and individualized telephonic coaching, counseling, or case management.

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:

Coverage and Authorization of Services

DHMC staff members acknowledged that the DHHA schedulers must prioritize scheduling of member populations due to limited appointment availability. They stated that existing clinic patients, children, and pregnant women were prioritized over new adult Medicaid members when scheduling routine appointments. DHMC must evaluate appointment capacity in the DHHA provider system and develop a mechanism to accommodate all Medicaid members within the required appointment standards by either improving capacity in the DHHA system of providers (see Standard II) or authorizing out-of-network providers as required by federal regulations.

Although only one of the 10 records reviewed on-site contained an NOA that was sent outside the required time frames, DHMC must ensure that all NOAs are sent within the required time frames.

DHMC's member handbook stated that DHMC is not responsible for payment if the emergency provider determines that the incident was not an emergency. DHMC must revise member handbook language to clarify that DHMC uses a prudent layperson standard to determine payment for emergency services.

Access and Availability

Related to the scheduling wait list for newly enrolled adult Medicaid members, the significant number of grievances related to appointment delay and wait times, and low member satisfaction survey results (CAHPS), DHMC was required to develop mechanisms to fully explore and resolve provider appointment scheduling problems for Medicaid members as follows:

- DHMC was required to develop a process to specifically track, by individual, the length of time a member remains on the wait list.
- DHMC was required to work with the Department to determine solutions to barriers that create the need for the wait list.
- DHMC was required to develop mechanisms to ensure that new adult Medicaid members are not on a wait list beyond the required access to care standards.

- DHMC reports that all providers have an "open panel," which connotes that members may have immediate assignment to a PCP and access to appointments without the wait list process. DHMC must further define what it means by "open panel" and more accurately describe the processes for access into the DHHA clinic system.
- Although the Strategic Access Report and DHMC's policies clearly stated that members may have access to out-of-network providers if providers are unavailable within the network, focus group discussions and on-site interviews described processes whereby members are placed on an appointment scheduling wait list when access into the DHHA "closed system" is limited, rather than looking to either contracted or out-of-network providers to fill the need. DHMC must either implement policies to provide out-of-network care when necessary, or consider options to expand the network through the DHHA provider system or through contracts with non-DHHA providers.
- DHMC must determine what information exists within the DHHA system that can be used to monitor appointment access and compliance with access and availability standards. DHMC must develop an effective process to monitor scheduling wait times, identify barriers to complying with Medicaid contract appointment guidelines, and take appropriate action to ensure that appointment scheduling standards are met.

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 had comprehensive utilization management policies that adequately addressed clinical criteria and guidelines used to make utilization decisions. HSAG found evidence that DHMC consistently used established criteria and a medical necessity standard to make authorization determinations. Although HSAG identified minor issues with the clarity of information DHMC shared with its members, overall, DHMC performed well in the quality domain.

Timeliness: Policies and procedures and communication to members and providers indicated that DHMC met the scheduling guidelines requirement; however, focus group information and open shopper calls strongly suggested that scheduling standards were not consistently met. DHMC staff members acknowledged that new adult Medicaid members were put on a wait list due to lack of capacity in primary care clinics. DHMC was required to develop a process to specifically track, by individual, the length of time a member remains on the wait list.

Access: Although DHMC's Strategic Access Report stated that 99.8 percent of DHMC members are within 30 miles of a DHHA clinic and DHMC's written policies and procedures were compliant with all requirements, input from the focus group and open shopper calls indicated that DHMC's performance in the access domain needed significant improvement related to capacity issues. Scheduling wait lists were used for newly enrolled Medicaid members and members unable to obtain an appointment were not offered the option of using out-of-network providers. In addition, members who did see out-of-network providers did not have access to diagnostic tests or specialist care within the DHHA system, since only DHHA providers were permitted to order diagnostic tests within the DHHA network and diagnostic tests performed by out-of-network facilities were not covered by DHMC.

Rocky Mountain Health Plans

Findings

Table 3-4 and Table 3-5 present the number of elements for each of the two 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 2013–2014).

Table 3-4—Summary of Scores for the Standards for FY 2013–2014 *for* RMHP

	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	34	34	29	5	0	0	85%
Standard II—Access and Availability	22	21	19	2	0	1	90%
Totals	**56**	**55**	**48**	**7**	**0**	**1**	**87%**

*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)
Denials	100	59	51	8	41	86%
Total	**100**	**59**	**51**	**8**	**41**	**86%**

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

Strengths

RMHP staff members described and demonstrated the processes used to ensure that professionals with the appropriate expertise make authorization or denial decisions. Nurses may authorize services and physician reviewers make denial determinations in consultation with board-certified specialists and the requesting provider, as appropriate. Staff members demonstrated a new on-line program through which physicians may obtain access to the UM authorization system, enter the data required, and obtain immediate authorization. This program is in the pilot phase with a limited number of providers; it could expedite authorizations and significantly improve both provider and member satisfaction with obtaining services.

RMHP had an established network of providers that included contracts with nearly all available providers in the service area. In addition, RMHP consolidated all lines of business into one provider contract, thereby simplifying requirements for providers. RMHP stated that all contracted providers are required to participate in serving all RMHP contracted populations.

RMHP determined that the culture of poverty is the most prevalent cultural concern impacting the health and health care of populations in the service area. Therefore, RMHP implemented the Bridges out of Poverty Program, which addresses the attitudes, communication styles, and behaviors associated with poverty. The training program has been extended to network provider offices and RMHP staff members reported that it has been enthusiastically embraced and integrated by providers and their staffs. Bridges out of Poverty has significantly enhanced RMHP's comprehensive efforts to promote the delivery of services in a culturally competent manner.

Recommendations

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

Coverage and Authorization of Services

- RMHP was required to revise the preauthorization policy to clarify that all authorization decisions will be made within the required time frames from the date of the request for service, unless extended. Although only one Medicaid denial notification was sent outside the required time frame, RMHP must ensure that NOAs are sent within the time frames required by *10 CCR 2505-10, Section 8. 209*.
- RMHP was required to revise the CHP+ member handbook to remove the statement that RMHP may deny payment of emergency claims for untimely filing.
- RMHP was required to develop a mechanism to ensure that Medicaid-covered services are not denied for payment with NOAs being sent to the member when the issue is provider coding.
- RMHP was required to ensure that members are not held liable for untimely filed claims.
- RMHP was required to ensure that clinical language or medical jargon used in denial letters is kept to a minimum, and that it is explained to the member wherever possible (i.e., RMHP should strive for the 6th grade reading level).
- RMHP was required to ensure that claims denials clearly state the service that is being denied and provide complete and accurate information so that members may know how to obtain services covered under Medicaid but not under the managed care contract.
- RMHP was required to remove any language from template NOA letters that indicates members will be held liable for payment of Medicaid services (unless the conditions are met that require members to pay for services—i.e., written agreement between the member and the provider to receive noncovered or out-of-network services available in the network).
- RMHP was required to evaluate the letters being used for denials of new requests, as well as for claims denials, and revise processes to ensure that all NOAs (denials) include each of the requirements.

Access and Availability

- Although RMHP has mechanisms to periodically obtain feedback about member dissatisfaction with scheduling times, it must implement an effective mechanism that monitors providers regularly to determine compliance with scheduling standards, and it must take appropriate corrective action.

- Although use of Bridges out of Poverty was a clear strength, RMHP was required to develop policies and procedures to address cultural characteristics broader than poverty issues and linguistics, such as providing programs and services that incorporate the beliefs, attitudes, and practices of specific cultures, as well as perform outreach to specific cultures for prevention and treatment of diseases prevalent in those groups. In addition, RMHP was required to develop policies and procedures that ensure compliance with the laws applicable to persons with physical and developmental disabilities.

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 demonstrated the electronic authorization system used to ensure that criteria are applied consistently to all RMHP pre-service requests. However, results of the on-site denial record reviews demonstrated that claims denial decisions did not consistently follow established criteria. HSAG identified several issues that resulted in inappropriate denials of claims payment, or notifications to members that were confusing and inaccurate or that held members inappropriately responsible for payment. These issues indicated poor performance in the quality domain.

Timeliness: Overall, RMHP performed well in the timeliness domain. RMHP's preauthorization policy included a slight misrepresentation of time frames for decisions in instances when additional information was requested. While RMHP's policies included the appropriate time frame for sending NOAs, one of the denial records reviewed included an NOA that was not sent within the required time frames. RMHP communicated physician access requirements, such as hours of operation and appointment availability standards, to providers and to members. HSAG conducted a provider appointment survey through open shopper calls prior to the site visit, which confirmed appointment availability within the required time frames for 100 percent of the calls made by the HSAG staff.

Access: Policies and procedures, the provider contract, and access plans and analysis substantiated that RMHP's provider network was adequately configured to meet the majority of Medicaid provider network requirements. An analysis noted that some rural areas have a Medicaid provider shortage and that much of the RMHP service area is considered a primary care shortage area. Staff members stated that RMHP has contracts with nearly all qualified providers, including essential community providers, in the service area

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

As part of its processes, HSAG analyzes recommendations across plans to identify potential areas for statewide focus. Table 3-6 and Table 3-7 show the overall statewide average for each standard and denial record review. Appendix E contains summary tables showing the detailed site review scores for the standards and record reviews by health plan, as well as the statewide average.

Table 3-6—Summary of Data From the Review of Standards	
Standards	**FY 2013–2014 Statewide Average***
Standard I—Coverage and Authorization of Services	88%
Standard II—Access and Availability	85%
Total	**87%***

* 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 2013–2014 Statewide Average***
Denials	92%
	92%

* Statewide average rates are 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: Statewide performance in the quality domain by the Medicaid physical health plans was variable. Both Medicaid managed care plans had adequate policies and procedures to guide utilization management decisions. DHMC demonstrated it consistently applied established criteria and required procedures to make authorization decisions, while RMHP was less consistent in following its established policies.

Timeliness: Statewide experience in the timeliness domain also demonstrated variable results. While RMHP experienced minor issues related to timeliness, overall performance was good. It communicated appointment availability standards and HSAG's survey confirmed appointment availability within the required time frames for 100 percent of the calls made. Although DHMC's policies and procedures and communication to its providers included accurate time frames for appointment availability, focus group and HSAG survey processes determined that DHMC did not consistently meet these standards. In addition, DHMC did not have an adequate process to track the length of time members remained on the wait list for appointments.

Access: Some of the rural areas within the RMHP service area are designated as primary care shortage areas, as reflected in RMHP's provider network adequacy reports. However, RMHP implemented various mechanisms to address these shortages and ensure adequate access for all of its members. While DHMC's network adequacy reports demonstrated adequate provider network coverage, HSAG obtained information that indicated the Denver Health clinic system was operating at capacity, thereby requiring that DHMC's new adult Medicaid members be on a wait list for appointments. Although DHMC's policies allow for members to be granted access to out-of-network providers when in-network services are not available, HSAG did not find any evidence that out-of-network services were offered or provided to members on the wait list.

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 HEDIS auditors. Although HSAG did not audit DHMC and RMHP, it 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. Appendix B contains further details about the NCQA audit process and the methodology used to conduct the EQR validation of performance measure activities.

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 shown in Table 3-8. Additionally, Table 3-8 shows the data collection methodology, as required by the Department. An asterisk denotes a change in the data collection methodology required by the Department from last year.

Table 3-8—FY 2013–2014 Performance Measures Required for Validation

Measure	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Childhood Immunization Status	Hybrid*	✓	✓	
Immunizations for Adolescents	Hybrid*	✓	✓	
Well-Child Visits in the First 15 Months of Life	Hybrid	✓	✓	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Hybrid	✓	✓	
Adolescent Well-Care Visits	Hybrid	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Hybrid	✓		
Appropriate Testing for Children with Pharyngitis	Administrative	✓		
Prenatal Care and *Postpartum Care*	Hybrid	✓	✓	✓
Children's and Adolescents' Access to Primary Care Providers (PCPs)	Administrative			✓
Adults' Access to Preventive/Ambulatory Health Services	Administrative			✓
Chlamydia Screening in Women	Administrative	✓		
Breast Cancer Screening	Administrative	✓		
Cervical Cancer Screening	Hybrid*	✓		

Table 3-8—FY 2013–2014 Performance Measures Required for Validation

Measure	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Adult BMI Assessment	Hybrid	✓		
Antidepressant Medication Management	Administrative	✓		
Follow-up Care for Children Prescribed ADHD Medication	Administrative	✓	✓	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Administrative	✓	✓	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Administrative	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Administrative	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	Administrative	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Administrative	✓		
Controlling High Blood Pressure	Hybrid	✓		
Comprehensive Diabetes Care	Hybrid	✓		✓
Annual Monitoring for Patients on Persistent Medications	Administrative	✓		
Use of Imaging Studies for Low Back Pain	Administrative	✓		
Pharmacotherapy Management of COPD Exacerbation	Administrative	✓		
Use of Appropriate Medications for People With Asthma	Administrative	✓		
Asthma Medication Ratio	Administrative	✓		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Administrative	✓		
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	Administrative	✓		
Ambulatory Care	Administrative			✓
Inpatient Utilization—General Hospital/Acute Care	Administrative			✓
Antibiotic Utilization	Administrative			✓
Frequency of Selected Procedures(Procedures per 1,000 MM)	Administrative			✓

The Department required that 34 performance measures be validated in FY 2013–2014 based on HEDIS 2014 specifications; 12 measures were reported as new for this year. For measures that were validated in FY 2012–2013, HSAG also made comparisons between the previous year's and the current year's results.

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 progress from the previous audit in the area of medical record data collection and the use of supplemental data. No fewer than six supplemental data sources were used to aid in the capture of data, including the State immunization registry, lab results, an internal immunization database, and medical record review data from the previous year. The organization critically looked at the measures and was able to improve some of the rates by including different measures for chart review from previous years. The auditor noted that DHMC changed its claims processing system and continued to have challenges in reconciling Child Health Plan *Plus* (CHP+) membership with the State. Nonetheless, this challenge did not appear to impact processing of the Medicaid members. The auditor commended DHMC for using HEDIS reports to monitor overall progress toward the measure and to improve care.

Pediatric Care Performance Measures

Table 3-9 shows the DHMC HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for each Pediatric Care performance measure.

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

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Childhood Immunization Status				
Combination 2	81.22%[2]	78.35%	50th–74th	R
Combination 3	80.87%[2]	78.10%	50th–74th	R
Combination 4	80.73%[2]	77.62%	75th–89th	R
Combination 5	65.75%[2]	62.04%	75th–89th	R
Combination 6	69.76%[2]	**63.50%**	≥90th	R
Combination 7	65.61%[2]	62.04%	75th–89th	R
Combination 8	69.69%[2]	**63.26%**	≥90th	R
Combination 9	56.96%[2]	53.53%	≥90th	R
Combination 10	56.89%[2]	53.53%	≥90th	R
Immunizations for Adolescents—Combination 1	79.54%[2]	83.21%	75th–89th	R

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

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Well-Child Visits in the First 15 Months of Life				
*Zero Visits***	1.22%	2.68%	75th–89th	R
Six or More Visits	69.10%	63.50%	25th–49th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.91%	62.04%	10th–24th	R
Adolescent Well-Care Visits	49.15%	49.88%	50th–74th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	87.83%	91.73%	≥90th	R
Counseling for Nutrition: Total	75.18%	79.32%	≥90th	R
Counseling for Physical Activity: Total	58.39%	64.48%	75th–89th	R
Appropriate Testing for Children with Pharyngitis	70.30%	70.06%	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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

— 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.

** 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). When the percentile benchmarks were properly aligned with this inverse measure, the HEDIS 2014 rate actually ranked below the 25th percentile (10th–24th percentile).

[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] The Department's required data collection methodology for the *Childhood Immunization Status* measure in HEDIS 2013 was administrative. DHMC followed this requirement; the rates displayed here were the HMO's final rates.

Strengths

The auditor noted that DHMC looked at the measures critically and was able to improve some of the rates by including different measures for chart review from previous years.

All DHMC performance measures within the pediatric care performance domain received an audit result of *Reportable (R)* for HEDIS 2014. Although none of the measures reported an increase in rate, six indicators benchmarked at or above the national HEDIS Medicaid 90th percentile. These indicators are under *Childhood Immunization Status* (*Combinations 6, 8, 9,* and *10*) and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent* (*BMI Assessment—Total* and *Counseling for Nutrition—Total*).

Recommendations

HSAG recommends that DHMC focus its improvement efforts on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Well-Child Visits in the First 15 Months of Life—Zero Visits* measures. In 2014, the HEDIS 2014 rates for these measures benchmarked below the national HEDIS Medicaid 25th percentile. These measures as well as the *Adolescent Well-Care Visits* measure also performed below the federal EPSDT mandate of 80 percent. HSAG recommends that

DHMC continue to work with the Department's EPSDT outreach (Healthy Communities) program to explore ways to increase the percentage of children who attend at least one visit per year.

Access to Care and Preventive Screening Performance Measures

Table 3-10 shows the DHMC HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for each *Access to Care* and *Preventive Screening* performance measure.

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 2014 Audit Results
	2013	2014		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	85.40%	89.29%	50th–74th	R
Postpartum Care	54.99%	57.42%	10th–24th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	92.28%	92.24%	<10th	R
Ages 25 Months to 6 Years	78.88%	**74.69%**	<10th	R
Ages 7 to 11 Years	83.64%	**80.82%**	<10th	R
Ages 12 to 19 Years	85.82%	**82.32%**	10th–24th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	70.11%	71.00%	<10th	R
Preventive Screening				
Chlamydia Screening in Women—Total	72.35%	**68.49%**	75th–89th	R
Breast Cancer Screening	49.16%	**54.59%**	50th–74th	R
Cervical Cancer Screening	51.13%[2]	**67.15%**	50th–74th	R
Adult BMI Assessment	86.86%	90.51%	≥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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

— 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 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] The Department's required data collection methodology for this measure in HEDIS 2013 was administrative. DHMC followed this requirement; the rate displayed here was the HMO's final rate. Due to a change in the Department's reporting requirement (from administrative to hybrid in HEDIS 2014) and significant measure specification revisions, rate changes between these two years do not accurately reflect performance improvement or decline. Performance ranking based on HEDIS 2013 percentiles is presented for information only. HSAG suggests that the HEDIS 2014 *Cervical Cancer Screening* rate be treated as a baseline rate for future trending.

Strengths

All of DHMC's *Access to Care* and *Preventive Screening* performance measures received an audit result of *Reportable (R)* for HEDIS 2014. DHMC had a significant rate increase in the *Breast Cancer Screening* and *Cervical Cancer Screening* measures. Additionally, the *Adult BMI*

Assessment measure benchmarked at or above the national HEDIS Medicaid 90th percentile. The increase in *Cervical Cancer Screening* could be related to a change in the required data collection methodology from administrative to hybrid and significant measure specification changes. Consequently, the rate increase may not represent real performance improvement. Performance ranking based on HEDIS 2013 percentiles is presented for information only. HSAG suggests that the HEDIS 2014 *Cervical Cancer Screening* rate be treated as a baseline rate for future trending.

Recommendations

HSAG recommends that DHMC focus its improvement efforts on the *Children's and Adolescents' Access to Primary Care Practitioners* and the *Adults' Access to Preventive/Ambulatory Health Services—Total* measures. These measures ranked below the national HEDIS Medicaid 25th percentile.

Mental/Behavioral Health Performance Measures

Table 3-11 shows the DHMC HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 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 2014 Audit Results
	2013	2014		
Antidepressant Medication Management				
Effective Acute Phase Treatment	57.14%	**41.58%**	<10th	R
Effective Continuation Phase Treatment	45.05%	**30.43%**	10th–24th	R
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	24.55%	14.81%	<10th	R
Continuation	NA	NA	NA	NA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	47.14%	45.39%	75th–89th	R
Engagement	3.31%	3.50%	10th–24th	R
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	64.02%	50th–74th	R
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	—	89.67%	≥90th	R
Diabetes Monitoring for People With Diabetes and Schizophrenia	—	70.97%	50th–74th	R
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	—	NA	NA	NA

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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

— 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 ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

Strengths

Although none of the *Mental/Behavioral Health* performance measures reported a significant increase in rates from the previous year, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* met or exceeded the national HEDIS Medicaid 90th percentile.

Recommendations

HSAG recommended that DHMC focus its improvement efforts on improving the rates for the two indicators under *Antidepressant Medication Management*, where both had a significant rate decline. Additionally, DHMC should also focus on the *Follow-up Care for Children Prescribed ADHD Medication* measure, where the initiation phase indicator ranked below the national HEDIS Medicaid 10th percentile.

Living With Illness Performance Measures

Table 3-12 shows the DHMC HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for the *Living with Illness* performance measures.

Table 3-12—Rates and Audit Results for Living With Illness Performance Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Controlling High Blood Pressure	70.07%	66.42%	75th–89th	R
Comprehensive Diabetes Care				
HbA1c Testing	83.21%	**88.81%**	75th–89th	R
*HbA1c Poor Control (>9.0%)***	33.58%	31.87%	10th–24th	R
HbA1c Control (<8.0%)	51.09%	**58.39%**	75th–89th	R
Eye Exam	50.12%	49.64%	25th–49th	R
LDL–C Screening	70.32%	**76.64%**	50th–74th	R
LDL–C Level <100 mg/dL	50.36%	55.23%	≥90th	R
Medical Attention for Nephropathy	80.78%	82.48%	50th–74th	R
Blood Pressure Controlled <140/80 mm Hg	50.61%	56.20%	≥90th	R
Blood Pressure Controlled <140/90 mm Hg	70.07%	72.99%	75th–89th	R
Annual Monitoring for Patients on Persistent Medications—Total	84.14%	84.74%	25th–49th	R
Use of Imaging Studies for Low Back Pain	—	81.12%	75th–89th	R
Pharmacotherapy Management of COPD Exacerbation				
Systemic corticosteroid	—	64.90%	25th–49th	R
Bronchodilator	—	76.92%	10th–24th	R

Table 3-12—Rates and Audit Results for Living With Illness Performance Measures *for* DHMC				
Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Use of Appropriate Medications for People With Asthma—Total	—	78.61%	10th–24th	R
Asthma Medication Ratio—Total	—	53.60%	25th–49th	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	—	30.26%	25th–49th	R
Disease Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	—	81.48%	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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

— 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.

** 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). When the percentile benchmarks are re–aligned with this inverse measure, the HEDIS 2014 rate actually ranked above the national 75th percentile (75th–89th percentile).

[1] Percentile ratings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

Strengths

All of DHMC's performance measures in the living with illness domain received an audit result of *Reportable (R)* for HEDIS 2014. Three indicators under *Comprehensive Diabetes Care* had a significant rate increase (*HbA1c Testing*, *HbA1c Control < 8.0%*, and *LDL-C Screening*). Additionally, two other indicators benchmarked at or above the national HEDIS Medicaid 90th percentile (*LDL-C level < 100 mg/dL* and *Blood Pressure Controlled < 140/80 mm Hg*).

Recommendations

Although none of the performance measures in the living with illness domain had a significant rate decline or ranked below the national HEDIS Medicaid 10th percentile, improvement opportunities exist for two indicators where DHMC's performance benchmarked below the national 25th percentile. These are *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* and *Use of Appropriate Medications for People With Asthma—Total*.

Use of Services Observations

Table 3-13 shows the DHMC HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for the *Use of Services* measures. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2013 and 2014 may not denote actual improvement or decline in performance. Percentile rankings are assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations, and they are presented for information only.

Table 3-13—Rates and Audit Results for Use of Services Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Rankings	HEDIS 2014 Audit Results
	2013	2014		
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	—	225.92	<10th	R
Emergency Department Visits	44.56	44.05	<10th	R
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 MM (Total Inpatient)	—	5.53	<10th	R
Days per 1,000 MM (Total Inpatient)	—	21.84	10th–24th	R
Average Length of Stay (Total Inpatient)	—	3.95	50th–74th	R
Discharges per 1,000 MM (Medicine)	—	4.27	50th–74th	R
Days per 1,000 MM (Medicine)	—	14.41	50th–74th	R
Average Length of Stay (Medicine)	—	3.37	25th–49th	R
Discharges per 1,000 MM (Surgery)	—	1.17	25th–49th	R
Days per 1,000 MM (Surgery)	—	7.21	25th–49th	R
Average Length of Stay (Surgery)	—	6.15	25th–49th	R
Discharges per 1,000 MM (Maternity)	—	0.15	<10th	R
Days per 1,000 MM (Maternity)	—	0.40	<10th	R
Average Length of Stay (Maternity)	—	2.61	25th–49th	R
Antibiotic Utilization				
Average Scrips for PMPY for Antibiotics (All Ages)	—	0.35	<10th	R
Averages Days Supplied per Antibiotic Scrip (All Ages)	—	9.54	10th–24th	R
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.10	50th–74th	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips (All Ages)	—	27.65%	50th–74th	R
Frequency of Selected Procedures(Procedures per 1,000 MM)				
Bariatric weight loss surgery (0–19 Male)	NR	0.00	*	R
Bariatric weight loss surgery (0–19 Female)	NR	0.00	<95th	R
Bariatric weight loss surgery (20–44 Male)	NR	0.00	10th–49th	R
Bariatric weight loss surgery (20–44 Female)	NR	0.05	25th–49th	R
Bariatric weight loss surgery (45–64 Male)	NR	0.00	10th–74th	R
Bariatric weight loss surgery (45–64 Female)	NR	0.03	25th–49th	R
Tonsillectomy (0–9 Male & Female)	NR	0.36	10th–24th	R
Tonsillectomy (10–19 Male & Female)	NR	0.19	10th–24th	R
Hysterectomy, Abdominal (15–44 Female)	NR	0.06	10th–24th	R

Table 3-13—Rates and Audit Results for Use of Services Measures *for* DHMC

Performance Measures	HEDIS Rate		Percentile Rankings	HEDIS 2014 Audit Results
	2013	2014		
Hysterectomy, Abdominal (45–64 Female)	NR	0.12	<10th	R
Hysterectomy, Vaginal (15–44 Female)	NR	0.09	25th–49th	R
Hysterectomy, Vaginal (45–64 Female)	NR	0.15	25th–49th	R
Cholecystectomy, Open (30–64 Male)	NR	0.05	50th–74th	R
Cholecystectomy, Open (15–44 Female)	NR	0.05	≥90th	R
Cholecystectomy, Open (45–64 Female)	NR	0.06	50th–74th	R
Cholecystectomy(laparoscopic) (30–64 Male)	NR	0.20	10th–24th	R
Cholecystectomy(laparoscopic) (15–44 Female)	NR	0.55	10th–24th	R
Cholecystectomy(laparoscopic) (45–64 Female)	NR	0.36	<10th	R
Back Surgery (20–44 Male)	NR	0.06	<10th	R
Back Surgery (20–44 Female)	NR	0.04	<10th	R
Back Surgery (45–64 Male)	NR	0.09	<10th	R
Back Surgery (45–64 Female)	NR	0.15	<10th	R
Mastectomy (15–44 Female)	NR	0.02	50th–74th	R
Mastectomy (45–64 Female)	NR	0.03	10th–24th	R
Lumpectomy (15–44 Female)	NR	0.09	10th–24th	R
Lumpectomy (45–64 Female)	NR	0.27	10th–24th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
NR is shown when the plan chose not to report the rate.
* "0.00" is displayed for all the percentiles listed in the NCQA Means, Ratios, and Percentiles document for this indicator. This means that all the plan rates used by NCQA to create the percentiles are either the same or very similar at two decimal places. In this case, assigning percentile rank for a particular plan becomes meaningless.

Only *Emergency Department Visits* under *Ambulatory Care (per 1,000 Member Months)* was also reported in HEDIS 2013. The rate was fairly stable when compared to the previous year. Since the reported rates in the use of service domain 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 health plan's utilization results provide additional information that the health plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

Quality: Of the 52 rates from the 28 quality-related measures, 10 benchmarked at or above the national HEDIS Medicaid 90th percentiles and two were at or below the 10th percentiles. Five rates showed statistically significant improvement from the previous year. Improvement was noted in *Breast Cancer Screening, Cervical Cancer Screening*, and three indicators under *Comprehensive Diabetes Care (HbA1c*

testing, HbA1c <8% Control, and *LDL-C Screening*). For the *Cervical Cancer Screening* measure, the rate change may be related both to a change in the Department's reporting requirement from administrative to hybrid and significant measure specification revisions. Consequently, the rate increase may not accurately reflect performance improvement. Performance ranking based on HEDIS 2013 percentiles is presented for information only. HSAG suggests that the HEDIS 2014 *Cervical Cancer Screening* rate be treated as a baseline rate for future trending. Five rates (two under *Childhood Immunization Status, Chlamydia Screening in Women—Total*, and both indicators under *Antidepressant Medication Management*) showed significant rate declines from the previous year. The rates for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Follow-up Care for Children Prescribed ADHD Medication—Initiation* indicators were at or below the national HEDIS Medicaid 10th percentiles. These measures, together with those reporting significant declines, presented opportunities for improvement.

Timeliness: Of the 20 rates from the eight timeliness-related measures, four benchmarked at or above the national HEDIS Medicaid 90th percentiles. None showed statistically significant improvement from the previous year. Two rates (*Childhood Immunization Status—Combinations 6* and *8*) showed a significant decline from the previous year. Although they benchmarked at or above the 90th percentile, these indicators presented opportunities for improvement for DHMC.

Access: Of the eight access-related measures, four were population-based (*Prenatal and Postpartum Care, Children's and Adolescents' Access to Primary Care Practitioners, Adults' Access to Preventive/Ambulatory Health Services,* and *Comprehensive Diabetes Care*) and related to a total of 16 rates. Two of these rates, both under *Comprehensive Diabetes Care*, benchmarked at or above the national HEDIS Medicaid 90th percentiles. Three indicators under *Comprehensive Diabetes Care (HbA1c Testing, HbA1c <8% Control,* and *LDL-C Screening*) also showed statistically significant improvement from the previous year. On the other hand, three indicators under *Children's and Adolescents' Access to Primary Care Practitioners* showed a significant rate decline. The entire children/adolescent access measure and the adult access measure were also below the national HEDIS Medicaid 25th percentile. These measures suggested opportunities for improvement for DHMC. Although *Ambulatory Care, Inpatient Utilization, Antibiotic Utilization,* and *Frequency of Selected Procedures* were related to beneficiaries' access to care, these are utilization-based measures without any risk adjustment. The rates for these measures should be used for information only.

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 that had any negative impact on HEDIS reporting. The auditor had no recommendations for RMHP.

Pediatric Care Performance Measures

Table 3-14 shows the RMHP HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for each *Pediatric Care* performance measure.

Table 3-14—Rates and Audit Results for Pediatric Care Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Childhood Immunization Status				
Combination 2	51.45%[2]	77.70%	50th–74th	R
Combination 3	49.62%[2]	73.95%	50th–74th	R
Combination 4	9.19%[2]	66.23%	50th–74th	R
Combination 5	40.89%[2]	60.71%	50th–74th	R
Combination 6	31.39%[2]	51.66%	75th–89th	R
Combination 7	8.27%[2]	57.17%	50th–74th	R
Combination 8	5.82%[2]	48.12%	75th–89th	R
Combination 9	27.11%[2]	43.93%	75th–89th	R
Combination 10	5.51%[2]	41.94%	75th–89th	R
Immunizations for Adolescents—Combination 1	53.79%	59.65%	25th–49th	R
Well–Child Visits in the First 15 Months of Life				
*Zero Visits***	0.23%[3]	0.36%	10th–24th	R
Six or More Visits	82.64%[3]	80.73%	≥90th	R
Well–Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.75%	66.01%	10th–24th	R
Adolescent Well–Care Visits	42.82%[3]	45.58%	25th–49th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	72.65%	80.90%	≥90th	R
Counseling for Nutrition: Total	63.45%	63.15%	50th–74th	R
Counseling for Physical Activity: Total	56.73%	62.47%	75th–89th	R
Appropriate Testing for Children with Pharyngitis	89.90%	90.86%	≥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 blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

— 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.

** 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). When the percentile benchmarks are realigned with this inverse indicator, the HEDIS 2014 rate ranked above the national 75th percentile (75th–90th percentile).

[1] Percentile rankings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] RMHP chose to rotate the *Childhood Immunization Status* measure for HEDIS 2013, Since the Department required this measure to be reported administratively in HEDIS 2013, the rate displayed here for HEDIS 2013 reflects administrative data extrapolated from RMHP's HEDIS 2012 rate. For this measure, RMHP reported a rotated hybrid rate of 78.24 percent (Combination 2), 76.16 percent (Combination 3), 12.73 percent (Combination 4), 63.43 percent (Combination 5), 52.08 percent (Combination 6), 11.34 percent (Combination 7), 9.03 percent (Combination 8), 44.91 percent (Combination 9), and 8.10 percent (Combination 10) for HEDIS 2013.

[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 2014 *Technical Specifications for Health Plans, Volume 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

All of RMHP's *Pediatric Care* performance measures received an audit result of *Reportable (R)*. All indicators under *Childhood Immunization Status* and *BMI Assessment* under *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* had significant rate increases. Additionally, the *BMI Assessment* indicator and two other measures (*Well-Child Visits in the First 15 Months of Life—6+ Visits* and *Appropriate Testing for Children with Pharyngitis*) benchmarked at or exceeded the national HEDIS Medicaid 90th percentiles. The rate increase observed for the *Childhood Immunization Status* measure may be related to a change in the data collection methodology from administrative to hybrid and may not denote actual performance improvement.

Recommendations

Although none of the *Pediatric Care* measures ranked below the national HEDIS Medicaid 10th percentile, opportunities for improvement exist for those ranked below the 25th percentile. RMHP should focus on improving the performance for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. This measure and the *Adolescent Well-Care Visits* measure performed below the federal EPSDT mandate of 80 percent. HSAG recommends that RMHP continue to work with the Department's EPSDT outreach (Healthy Communities) program to explore ways to increase the percentage of children who attend at least one visit per year.

Access to Care and Preventive Screening Performance Measures

Table 3-15 shows the RMHP HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for each *Access to Care* and *Preventive Screening* performance measure.

Table 3-15—Rates and Audit Results for Access to Care and Preventive Screening Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	95.64%	95.64%[2]	≥90th	R
Postpartum Care	73.83%	73.83%[2]	≥90th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	96.90%	97.85%	75th–89th	R
Ages 25 Months to 6 Years	87.14%	86.29%	10th–24th	R
Ages 7 to 11 Years	90.90%	89.55%	25th–49th	R
Ages 12 to 19 Years	89.99%	**87.88%**	25th–49th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	88.81%	88.33%	75th–89th	R

Table 3-15—Rates and Audit Results for Access to Care and Preventive Screening Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Preventive Screening				
Chlamydia Screening in Women—Total	46.15%	45.32%	<10th	R
Breast Cancer Screening	47.79%	51.96%	50th–74th	R
Cervical Cancer Screening	55.02%[3]	**70.25%**	50th–74th	R
Adult BMI Assessment	80.26%	85.81%	≥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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.
R is shown when the rate was reportable, according to NCQA standards.

[1] Percentile rankings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] The plan chose to rotate the measure; the HEDIS 2013 rates were rotated for HEDIS 2014. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the HEDIS 2014 *Technical Specifications for Health Plans, Volume 2*.

[3] 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. Due to a change in the Department's reporting requirement (from administrative to hybrid in HEDIS 2014) and significant measure specification revisions, rate changes between these two years do not accurately reflect performance improvement or decline. HSAG suggests that the HEDIS 2014 *Cervical Cancer Screening* rate be treated as a baseline rate for future trending. Performance ranking based on HEDIS 2013 percentiles should be used for information only.

Strengths

All of RMHP's performance measures received an audit result of *Reportable (R)* for HEDIS 2014. The *Prenatal and Postpartum Care* measure and the *Adult BMI Assessment* measure ranked at or above the national HEDIS Medicaid 90th percentile. Although a significant rate increase was noted for the *Cervical Cancer Screening* measure, the increase was related to a change in data collection methodology from administrative to hybrid (as required by the Department) as well as significant measure specification changes. Consequently, the rate increase may not reflect actual performance measure improvement. Performance ranking based on HEDIS 2013 percentiles for this measure should be used for information only. HSAG suggests that the HEDIS 2014 *Cervical Cancer Screening* rate be treated as a baseline rate for future trending.

Recommendations

HSAG recommended that RMHP focus its improvement efforts on the measures with significant rate declines or that ranked below the national HEDIS Medicaid 25th percentile. These measures include *Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Chlamydia Screening in Women—Total*.

Mental/Behavioral Health Performance Measures

Table 3-16 shows the RMHP HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for the *Mental/Behavioral Health* performance measures.

Table 3-16—Rates and Audit Results for Mental/Behavioral Health Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Antidepressant Medication Management				
Effective Acute Phase Treatment	NB*	NB*	NB*	NB*
Effective Continuation Phase Treatment	NB*	NB*	NB*	NB*
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	43.56%	31.67%	25th–49th	R
Continuation	40.63%	35.90%	25th–49th	R
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	NB*	NB*	NB*	NB*
Engagement	NB*	NB*	NB*	NB*
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	NB*	NB*	NB*
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	—	NB*	NB*	NB*
Diabetes Monitoring for People With Diabetes and Schizophrenia	—	NR	NR	NR
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	—	NR	NR	NR

— 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 in RMHP's HEDIS 2013 and 2014 IDSS, indicating that the health plan did not offer the benefit required by the measure. Nonetheless, as these measures do not require behavioral health services, the audit designations approved by the MCO's auditors should have been *NR* (plan chose not to report) rather than *NB* (no benefits offered). HSAG recommends that RMHP work with their auditors and the Department to ensure that the most accurate audit designations be assigned for these measures.
NR is shown because RMHP was not required to report the measure.
[1] Percentile rankings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

Strengths

The only *Mental/Behavioral Health* measure reported by RMHP—*Follow-up Care for Children Prescribed ADHD Medication*—did not show any improvement or rank above the national HEDIS Medicaid 90th percentile. No particular strength was identified under this domain.

Recommendations

Follow-up Care for Children Prescribed ADHD Medication was the only measure reported by RMHP in this domain. Both indicators under this measure reported a decline in rate, although the decline was not significant. RMHP should focus on improving the rates for these indicators.

RMHP indicated in its IDSS submission that an *NB* (benefits not offered) was assigned to four of the seven measures in this domain (i.e., *Antidepressant Medication Management*, *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Adherence to Antipsychotic Medications for Individuals With Schizophrenia,* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*). Nonetheless, as these measures do not require behavioral health services, the audit designations approved by the MCO's auditors should have been *NR* (plan chose not to report) rather than *NB* (no benefits offered). HSAG recommends that RMHP work with their auditors and the Department to ensure that the most accurate audit designations be assigned for these measures.

Living With Illness Performance Measures

Table 3-17 shows the RMHP HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for *Living with Illness* performance measures.

Table 3-17—Rates and Audit Results for Living With Illness Performance Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Controlling High Blood Pressure[2]	73.38%	73.38%[2]	≥90th	R
Comprehensive Diabetes Care				
HbA1c Testing	92.20%[2]	89.37%	75th–89th	R
*HbA1c Poor Control (>9.0%)***	19.24%[2]	**26.41%**	<10th	R
HbA1c Control (<8.0%)	72.23%[2]	**65.61%**	≥90th	R
Eye Exam	62.73%	63.62%	75th–89th	R
LDL–C Screening	75.55%	72.09%	25th–49th	R
LDL–C Level <100 mg/dL	44.86%	43.19%	75th–89th	R
Medical Attention for Nephropathy	76.22%	75.58%	25th–49th	R
Blood Pressure Controlled <140/80 mm Hg	61.52%[2]	**55.15%**	≥90th	R
Blood Pressure Controlled <140/90 mm Hg	79.85%[2]	76.74%	≥90th	R
Annual Monitoring for Patients on Persistent Medications—Total	86.03%	83.22%	25th–49th	R
Use of Imaging Studies for Low Back Pain		74.15%	25th–49th	R
Pharmacotherapy Management of COPD Exacerbation				
Systemic corticosteroid		32.53%	<10th	R
Bronchodilator		48.19%	<10th	R

Table 3-17—Rates and Audit Results for Living With Illness Performance Measures *for* RMHP				
Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2014 Audit Results
	2013	2014		
Use of Appropriate Medications for People With Asthma—Total		85.94%	50th–74th	R
Asthma Medication Ratio—Total		62.35%	50th–74th	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		29.59%	25th–49th	R
Disease Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis		52.54%	<10th	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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.
— 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.
** 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). When the percentile benchmarks are re-aligned with this inverse indicator, the HEDIS 2014 rate ranked above the national 90th percentile, putting the HMO within the top 10 percent of national performance.
[1] Percentile rankings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.
[2] The plan chose to rotate the measure. Measure rotation allows the health plan to use the audited and reportable rate from the previous year as specified by NCQA in the HEDIS 2014 *Technical Specifications for Health Plans, Volume 2*.

Strengths

All of RMHP's performance measures received an audit result of *Reportable (R)* for HEDIS 2014. RMHP continued to demonstrate strengths in managing its members' blood pressure and HbA1c values, resulting in having five *Living with Illness* indicators ranking among the top 10th percentile of the national HEDIS performance.

Recommendations

HSAG recommended that RMHP focus its improvement efforts on measures with significant declines in performance or that ranked below the national HEDIS Medicaid 10th percentile. Three of the *Comprehensive Diabetes Care* indicators [*HbA1c Poor Control (>9/0%), HbA1c Control (<8.0%),* and *Blood Pressure Controlled < 140/80 mm Hg*] ranked at or above the top 10th percentile of national performance. These indicators reported a significant performance decline from last year and presented opportunities for improvement. Additionally, RMHP should focus its effort on the *Pharmacotherapy Management of COPD Exacerbation* and *Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis* measures, where their HEDIS 2014 rates ranked below the national HEDIS Medicaid 10th percentile.

Use of Services Observations

Table 3-18 shows the RMHP HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and the HEDIS 2014 audit results for the *Use of Services* measures. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2013 and 2014 may not denote actual improvement or a decline in performance. Percentile rankings are assigned to the

HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations and are presented for information only.

Table 3-18—Rates and Audit Results for Use of Services Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings	HEDIS 2014 Audit Results
	2013	2014		
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	—	401.91	50th–74th	R
Emergency Department Visits	62.73	58.85	25th–49th	R
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 MM (Total Inpatient)	—	9.25	75th–89th	R
Days per 1,000 MM (Total Inpatient)	—	32.87	50th–74th	R
Average Length of Stay (Total Inpatient)	—	3.55	25th–49th	R
Discharges per 1,000 MM (Medicine)	—	4.08	50th–74th	R
Days per 1,000 MM (Medicine)	—	16.74	75th–89th	R
Average Length of Stay (Medicine)	—	4.10	75th–89th	R
Discharges per 1,000 MM (Surgery)	—	1.73	75th–89th	R
Days per 1,000 MM (Surgery)	—	8.86	50th–74th	R
Average Length of Stay (Surgery)	—	5.13	10th–24th	R
Discharges per 1,000 MM (Maternity)	—	6.14	50th–74th	R
Days per 1,000 MM (Maternity)	—	12.94	50th–74th	R
Average Length of Stay (Maternity)	—	2.11	<10th	R
Antibiotic Utilization				
Average Scrips for PMPY for Antibiotics (All Ages)	—	1.01	25th–49th	R
Averages Days Supplied per Antibiotic Scrip (All Ages)	—	9.71	75th–89th	R
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.36	10th–24th	R
Percentage of Antibiotics of Concern of all Antibiotic Scrips (All Ages)	—	35.93%	10th–24th	R
Frequency of Selected Procedures(Procedures per 1,000 MM)				
Bariatric weight loss surgery (0–19 Male)	0.00	0.00	*	R
Bariatric weight loss surgery (0–19 Female)	0.00	0.00	<95th	R
Bariatric weight loss surgery (20–44 Male)	0.07	0.07	≥90th	R
Bariatric weight loss surgery (20–44 Female)	0.23	0.23	75th–89th	R
Bariatric weight loss surgery (45–64 Male)	0.00	0.00	10th–74th	R
Bariatric weight loss surgery (45–64 Female)	0.13	0.53	≥90th	R

Table 3-18—Rates and Audit Results for Use of Services Measures *for* RMHP

Performance Measures	HEDIS Rate		Percentile Rankings	HEDIS 2014 Audit Results
	2013	2014		
Tonsillectomy (0–9 Male & Female)	1.20	1.31	≥90th	R
Tonsillectomy (10–19 Male & Female)	0.99	0.92	≥90th	R
Hysterectomy, Abdominal (15–44 Female)	0.35	0.29	75th–89th	R
Hysterectomy, Abdominal (45–64 Female)	0.63	0.13	<10th	R
Hysterectomy, Vaginal (15–44 Female)	0.91	0.60	≥90th	R
Hysterectomy, Vaginal (45–64 Female)	0.21	0.20	50th–74th	R
Cholecystectomy, Open (30–64 Male)	0.17	0.05	50th–74th	R
Cholecystectomy, Open (15–44 Female)	0.02	0.00	10th–24th	R
Cholecystectomy, Open (45–64 Female)	0.00	0.07	50th–74th	R
Cholecystectomy(laparoscopic) (30–64 Male)	0.44	0.94	≥90th	R
Cholecystectomy(laparoscopic) (15–44 Female)	1.52	1.36	≥90th	R
Cholecystectomy(laparoscopic) (45–64 Female)	1.67	1.60	≥90th	R
Back Surgery (20–44 Male)	0.58	0.63	≥90th	R
Back Surgery (20–44 Female)	0.32	0.23	50th–74th	R
Back Surgery (45–64 Male)	0.56	0.95	75th–89th	R
Back Surgery (45–64 Female)	1.81	0.73	50th–74th	R
Mastectomy (15–44 Female)	0.09	0.04	75th–89th	R
Mastectomy (45–64 Female)	0.28	0.07	10th–24th	R
Lumpectomy (15–44 Female)	0.32	0.30	≥90th	R
Lumpectomy (45–64 Female)	0.35	0.53	50th–74th	R

— is shown when no data were available or the measure was not reported in last year's technical report or HEDIS aggregate report.
R is shown when the rate was reportable, according to NCQA standards.
* "0.00" is shown for all percentiles listed in the NCQA Means, Ratios, and Percentiles document for this indicator. This means that all the plan rates used by NCQA to create the percentiles are either the same or very similar at two decimal places. In this case, assigning percentile rank for a particular plan becomes meaningless.

Compared to the prior year, RMHP reported some variations in the *Emergency Department Visits per 1,000 Member Months* under *Ambulatory Care* and specific procedures under the *Frequency of Selected Procedures* measure. Since the reported rates in the use of service domain 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 health plan's utilization results provide additional information that the health plans can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: Of the 44 valid rates from the 24 quality-related measures, 11 benchmarked at or above the national HEDIS Medicaid 90th percentiles. On the other hand, four rates (*Chlamydia Screening in Women—Total,* two indicators under *Pharmacotherapy Management of COPD Exacerbation,* and *Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis*) were at or below the 10th percentiles. Eleven rates reported statistically significant improvement from the previous year. Improvement was noted in *Childhood Immunization Status, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent—BMI Assessment,* and *Cervical Cancer Screening*. Rate increases observed for *Childhood Immunization Status* and *Cervical Cancer Screening* may be due to a change in the data collection methodology required by the Department between the two years. For the *Cervical Cancer Screening* measure in particular, the rate change also may be due to significant measure specification revisions. Consequently, the rate increase may not accurately reflect performance improvement. HSAG suggests that the HEDIS 2014 *Cervical Cancer Screening* rate be treated as a baseline rate for future trending. Performance ranking based on HEDIS 2013 percentiles should be used for information only. Three rates, all under *Comprehensive Diabetes Care* (*HbA1c Poor Control, HbA1c <8% Control,* and *Blood Pressure Controlled <140/80 mm Hg*) showed significant rate declines from the previous year. These measures, coupled with those benchmarking below the national HEDIS Medicaid 10th percentiles, suggested opportunities for improvement.

Timeliness: Of the 18 valid rates from the eight timeliness-related measures, three benchmarked at or above the national HEDIS Medicaid 90th percentiles. All indicators under *Childhood Immunization Status* experienced statistically significant improvements from the previous year. This rate increase may be due to a change in the data collection methodology required by the Department between the two years. None of the timeliness-related measures reported a significant decline from the previous year or benchmarked below the national HEDIS Medicaid 10th percentile. Nonetheless, opportunities for improvement existed for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, where the HEDIS 2014 rate was below the national 25th percentile.

Access: Of the eight access-related measures, four were population-based (*Prenatal and Postpartum Care, Children's and Adolescents' Access to Primary Care Practitioners, Adults' Access to Preventive/Ambulatory Health Services,* and *Comprehensive Diabetes Care*) and related to a total of 16 rates. Six of these rates (two under *Prenatal and Postpartum Care* and four under *Comprehensive Diabetes Care*) benchmarked at or above the national HEDIS Medicaid 90th percentiles. None of the access-related population-based measures had statistically significant improvement from the previous year. On the other hand, four rates (*Children's and Adolescents' Access to Primary Care Providers—Ages 12 to 19 Years* and three indicators under *Comprehensive Diabetes Care*) reported significant rate declines. These measures suggested opportunities for improvement for RMHP. Although *Ambulatory Care, Inpatient Utilization, Antibiotic Utilization,* and *Frequency of Selected Procedures* were related to beneficiaries' access to care, these are utilization-based measures without any risk adjustment. The rates should be used for information only.

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

Table 3-19 shows the statewide weighted averages for 2013 and 2014 and the percentile rankings for each *Pediatric Care* performance measure. Please note that, unlike the HEDIS 2013 rates, the HEDIS 2014 statewide rates represent the aggregate rates from the two MCOs and did not include Medicaid recipients enrolled in the Primary Care Physician Program.

Table 3-19—Statewide Rates for Pediatric Care Performance Measures

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2013	2014	
Childhood Immunization Status			
Combination 2	72.27%	**78.13%**	50th–74th
Combination 3	71.31%	**76.70%**	50th–74th
Combination 4	60.65%	**73.77%**	75th–89th
Combination 5	58.06%	61.59%	50th–74th
Combination 6	55.67%	59.50%	≥90th
Combination 7	49.44%	**60.40%**	75th–89th
Combination 8	48.96%	**58.15%**	≥90th
Combination 9	45.93%	50.29%	≥90th
Combination 10	40.26%	**49.61%**	≥90th
Immunizations for Adolescents—Combination 1	71.60%	76.13%	50th–74th
Well–Child Visits in the First 15 Months of Life			
*Zero Visits***	1.05%	1.94%	50th–74th
Six or More Visits	72.83%	68.97%	50th–74th
Well–Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.91%	63.35%	10th–24th
Adolescent Well–Care Visits	45.22%	48.50%	50th–74th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment: Total	81.82%	**87.94%**	≥90th
Counseling for Nutrition: Total	69.24%	73.66%	75th–89th
Counseling for Physical Activity: Total	59.20%	63.78%	75th–89th
Appropriate Testing for Children with Pharyngitis	80.26%	**85.51%**	≥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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

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

** 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). When the percentile benchmarks are re–aligned with this inverse indicator, the HEDIS 2014 statewide rate was below the national 50th percentile (25th–49th percentile).

[1] Percentile rankings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

Strengths

Although six of the nine indicators under *Childhood Immunization Status* reported significant rate increases, these increases may be related to a change in the data collection methodology required by the Department, from administrative in HEDIS 2013 to hybrid in HEDIS 2014. Two additional *Pediatric Care* performance measures (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total,* and *Appropriate Testing for Children with Pharyngitis*) also reported significant rate increases. These two measures, and four other indicators under *Childhood Immunization Status*, ranked at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Although none of the *Pediatric Care* measures ranked below the national HEDIS Medicaid 10th percentile, opportunities for improvement were noted for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of Life* measure, where the statewide rate ranked below the 25th percentile. Additionally, this measure and the *Adolescent Well-Care Visits* measure performed below the federal EPSDT mandate of 80 percent. HSAG recommends that all MCOs work with the Department's EPSDT outreach (Healthy Communities) program to explore ways to increase the percentage of children who attend at least one visit per year.

Access to Care and Preventive Screening Performance Measures

Table 3-20 shows the statewide weighted averages for HEDIS 2013 and HEDIS 2014 and the percentile rankings for each *Access to Care* and *Preventive Screening* performance measure.

Table 3-20—Statewide Summary of Rates for Access to Care and Preventive Screening Performance Measures

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2013	2014	
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	89.66%	92.06%	75th–89th
Postpartum Care	65.10%	64.57%	50th–74th
Children's and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	94.42%	93.99%	10th–24th
Ages 25 Months to 6 Years	82.33%	**78.52%**	<10th
Ages 7 to 11 Years	86.48%	**83.32%**	<10th
Ages 12 to 19 Years	87.56%	**84.07%**	10th–24th
Adults' Access to Preventive/Ambulatory Health Services—Total	78.53%	**76.83%**	10th–24th

Table 3-20—Statewide Summary of Rates for Access to Care and Preventive Screening Performance Measures			
Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2013	2014	
Preventive Screening			
Chlamydia Screening in Women—Total	54.38%	**59.43%**	50th–74th
Breast Cancer Screening	41.96%	**53.73%**	50th–74th
Cervical Cancer Screening[2]	45.78%	**68.28%**	50th–74th
Adult BMI Assessment	80.19%	**88.73%**	≥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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

— 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 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

[2] Due to a change in the Department's reporting requirement (from administrative to hybrid in HEDIS 2014) and significant measure specification revisions, rate changes between these two years do not accurately reflect performance improvement or decline. HSAG suggests that the HEDIS 2014 *Cervical Cancer Screening* rate be treated as a baseline rate for future trending. Performance ranking based on HEDIS 2013 percentiles should be used for information only.

Strengths

HSAG observed a significant rate increase in all of the *Preventive Screening* measures, although the increase in *Cervical Cancer Screening* could be related both to a change in data collection methodology required by the Department (from administrative in HEDIS 2013 to hybrid in HEDIS 2014) and significant measure specification changes. Consequently, the rate increase may not reflect actual performance improvement. Performance ranking based on HEDIS 2013 percentiles is presented for information only. HSAG suggests that the HEDIS 2014 *Cervical Cancer Screening* rate be treated as a baseline rate for future trending. Additionally, the *Adult BMI Assessment* measure continued to rank at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Three rates (two under *Children's and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months* and *Ages 25 Months to 6 Years,* and one under *Adults' Access to Preventive/Ambulatory Health Services—Total*) continued to show significant rate decreases. The first two rates also benchmarked below the national HEDIS Medicaid 10th percentile. These three indicators presented statewide opportunities for improvement.

Mental/Behavioral Health Performance Measures

Table 3-21 shows the statewide weighted averages for HEDIS 2013 and HEDIS 2014 and the percentile rankings for the *Mental/Behavioral Health* performance measures.

Table 3-21—Statewide Summary of Rates for Mental/Behavioral Health Performance Measures

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2013	2014	
Antidepressant Medication Management			
Effective Acute Phase Treatment	60.07%	**41.58%**	<10th
Effective Continuation Phase Treatment	46.29%	**30.43%**	10th–24th
Follow–up Care for Children Prescribed ADHD Medication			
Initiation	34.46%	**23.68%**	<10th
Continuation	29.90%	30.16%	10th–24th
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			
Initiation	42.03%	45.39%	75th–89th
Engagement	3.24%	3.50%	10th–24th
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	64.02%	50th–74th
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	—	89.67%	≥90th
Diabetes Monitoring for People With Diabetes and Schizophrenia	—	70.97%	50th–74th
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	—	NA	NA

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. Measures shaded in blue with a black font indicate that the data collection methodology was administrative for HEDIS 2013 and was hybrid for HEDIS 2014.

— 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.

Strengths

Even though this is the first year for the health plans to report the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* measure, the statewide rate ranked at or above the national HEDIS Medicaid 90th percentile.

Recommendations

HSAG noted that the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* indicator and the *Antidepressant Medication Management* measures had significant rate declines. These indicators also ranked below the 25th percentile, suggesting statewide opportunities for improvement.

Living with Illness Measures

Table 3-22 shows the statewide weighted averages for HEDIS 2013 and HEDIS 2014 and the percentile rankings for each *Living with Illness* performance measure.

Table 3-22—Statewide Rates for Living With Illness Performance Measures

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2013	2014	
Controlling High Blood Pressure	63.20%	68.56%	75th–89th
Comprehensive Diabetes Care			
HbA1c Testing	81.00%	**88.98%**	75th–89th
*HbA1c Poor Control (>9.0%)***	38.76%	**30.21%**	<10th
HbA1c Control (<8.0%)	50.47%	**60.60%**	≥90th
Eye Exam	52.68%	53.90%	25th–49th
LDL–C Screening	67.31%	**75.26%**	25th–49th
LDL–C Level <100 mg/dL	42.87%	**51.56%**	≥90th
Medical Attention for Nephropathy	75.29%	80.38%	50th–74th
Blood Pressure Controlled <140/80 mm Hg	49.09%	**55.88%**	≥90th
Blood Pressure Controlled <140/90 mm Hg	66.74%	**74.14%**	75th–89th
Annual Monitoring for Patients on Persistent Medications—Total	80.33%	**84.40%**	25th–49th
Use of Imaging Studies for Low Back Pain	—	78.49%	50th–74th
Pharmacotherapy Management of COPD Exacerbation			
Systemic corticosteroid	—	55.67%	10th–24th
Bronchodilator	—	68.73%	<10th
Use of Appropriate Medications for People With Asthma—Total	—	80.79%	25th–49th
Asthma Medication Ratio—Total	—	56.22%	25th–49th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	—	30.03%	25th–49th
Disease Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	—	69.29%	25th–49th

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.

— 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 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

** 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). When the percentile benchmarks are re-aligned with this inverse indicator, the HEDIS 2014 rate ranked above the national 90th percentile, which means the statewide rate was among the top 10 percent of national performance.

Strengths

Eight of the *Living with Illness* indicators, including seven under *Comprehensive Diabetes Care*, reported a significant rate increase from last year. This suggests that all plans demonstrated efforts

to improve the quality of diabetes care. Additionally, three of the *Comprehensive Diabetes Care* indicators ranked within the top 10 percent of national performance.

Recommendations

One indicator (*Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*) ranked below the national HEDIS Medicaid 10th percentile and presented statewide opportunities for improvement.

Use of Services Observations

Table 3-23 shows the statewide HEDIS 2013 and HEDIS 2014 rates, the percentile rankings for HEDIS 2014 rates, and HEDIS 2014 audit results for the *Use of Services* measures. Percentile rankings are assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations and are presented for information only.

Table 3-23—Statewide Rates and Percentile Ranking for Use of Services Measures

Measures	HEDIS Rate		Percentile Rankings[1]
	2013	2014	
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	—	280.29	10th–24th
Emergency Department Visits	52.15	48.62	10th–24th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 MM (Total Inpatient)	—	6.68	10th–24th
Days per 1,000 MM (Total Inpatient)	—	25.25	25th–49th
Average Length of Stay (Total Inpatient)	—	3.78	50th–74th
Discharges per 1,000 MM (Medicine)	—	4.21	50th–74th
Days per 1,000 MM (Medicine)	—	15.13	50th–74th
Average Length of Stay (Medicine)	—	3.59	50th–74th
Discharges per 1,000 MM (Surgery)	—	1.34	25th–49th
Days per 1,000 MM (Surgery)	—	7.72	25th–49th
Average Length of Stay (Surgery)	—	5.75	25th–49th
Discharges per 1,000 MM (Maternity)	—	2.02	10th–24th
Days per 1,000 MM (Maternity)	—	4.31	<10th
Average Length of Stay (Maternity)	—	2.13	<10th
Antibiotic Utilization			
Average Scrips for PMPY for Antibiotics (All Ages)	—	0.55	<10th
Averages Days Supplied per Antibiotic Scrip (All Ages)	—	9.63	75th–89th
Average Scrips PMPY for Antibiotics of Concern (All Ages)	—	0.18	<10th

Table 3-23—Statewide Rates and Percentile Ranking for Use of Services Measures

Measures	HEDIS Rate		Percentile Rankings[1]
	2013	2014	
Percentage of Antibiotics of Concern of all Antibiotic Scrips (All Ages)	—	32.24%	<10th
Frequency of Selected Procedures(Procedures per 1,000 MM)			
Bariatric weight loss surgery (0–19 Male)	0.00	0.00	*
Bariatric weight loss surgery (0–19 Female)	0.00	0.00	<95th
Bariatric weight loss surgery (20–44 Male)	0.06	0.02	50th–74th
Bariatric weight loss surgery (20–44 Female)	0.15	0.12	50th–74th
Bariatric weight loss surgery (45–64 Male)	0.00	0.00	10th–74th
Bariatric weight loss surgery (45–64 Female)	0.11	0.19	75th–89th
Tonsillectomy (0–9 Male & Female)	0.94	0.65	25th–49th
Tonsillectomy (10–19 Male & Female)	0.72	0.40	50th–74th
Hysterectomy, Abdominal (15–44 Female)	0.23	0.14	25th–49th
Hysterectomy, Abdominal (45–64 Female)	0.44	0.13	<10th
Hysterectomy, Vaginal (15–44 Female)	0.60	0.27	75th–89th
Hysterectomy, Vaginal (45–64 Female)	0.17	0.17	25th–49th
Cholecystectomy, Open (30–64 Male)	0.15	0.05	50th–74th
Cholecystectomy, Open (15–44 Female)	0.01	0.03	≥90th
Cholecystectomy, Open (45–64 Female)	0.00	0.06	50th–74th
Cholecystectomy(laparoscopic) (30–64 Male)	0.42	0.39	50th–74th
Cholecystectomy(laparoscopic) (15–44 Female)	1.11	0.83	50th–74th
Cholecystectomy(laparoscopic) (45–64 Female)	1.16	0.75	50th–74th
Back Surgery (20–44 Male)	0.37	0.22	25th–49th
Back Surgery (20–44 Female)	0.28	0.11	10th–24th
Back Surgery (45–64 Male)	0.50	0.29	10th–24th
Back Surgery (45–64 Female)	1.10	0.33	10th–24th
Mastectomy (15–44 Female)	0.05	0.03	50th–74th
Mastectomy (45–64 Female)	0.17	0.04	10th–24th
Lumpectomy (15–44 Female)	0.23	0.16	50th–74th
Lumpectomy (45–64 Female)	0.25	0.35	10th–24th

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

* "0.00" is shown for all the percentiles listed in the NCQA Means, Ratios, and Percentiles document for this indicator. This means that all the plan rates used by NCQA to create the percentiles are either the same or very similar at two decimal places. In this case, assigning percentile rank for a particular plan becomes meaningless.

Compared to HEDIS 2013, there was a small decline in the rate for the utilization measure *Ambulatory Care*. Certain procedures under the *Frequency of Selected Procedures* measure also exhibited some rate fluctuations. Since the statewide rates in the use of service domain did not take into account the characteristics of the population from individual health plans, HSAG cannot draw conclusions on performance based on the utilization results.

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: Of the 52 rates from the 28 quality-related measures, 12 benchmarked at or above the national HEDIS Medicaid 90th percentiles whereas three were at or below the 10th percentiles. Twenty rates reported statistically significant improvement from the previous year. Improvement was noted in all the *Preventive Screening* measures, *Appropriate Testing for Children with Pharyngitis, Annual Monitoring for Patients on Persistent Medications—Total,* and most of the *Childhood Immunization Status* and *Comprehensive Diabetes Care* measures. The rate increase observed for *Childhood Immunization Status* may be due to a change in the data collection methodology between the two years, as required by the Department. Three rates (both indicators from the *Antidepressant Medication Management* measure and the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* indicator) reported significant rate declines from the previous year. Two of these measures, together with the *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* indicator, also benchmarked below the national HEDIS Medicaid 10th percentile and suggested opportunities for improvement.

Timeliness: Of the 20 rates from the eight timeliness-related measures, four benchmarked at or above the national HEDIS Medicaid 90th percentiles. Six rates, all under *Childhood Immunization Status*, reported statistically significant improvement from the previous year. This rate increase may be due to a change in the data collection methodology between the two years, as required by the Department. Only one rate (*Follow-up Care for Children Prescribed ADHD Medication—Initiation*) reported a significant decline from the previous year. This indicator also benchmarked at or below the 10th percentile and presented statewide opportunities for improvement.

Access: Of the eight access-related measures, four were population-based (*Prenatal and Postpartum Care, Children's and Adolescents' Access to Primary Care Practitioners, Adults' Access to Preventive/Ambulatory Health Services,* and *Comprehensive Diabetes Care*) and related to a total of 16 rates. Four of these rates, all under *Comprehensive Diabetes Care,* benchmarked at or above the national HEDIS Medicaid 90th percentiles. In general, the *Comprehensive Diabetes Care* measure reported statistically significant improvement from the previous year. On the other hand, three indicators under *Children's and Adolescents' Access to Primary Care Practitioners* and the *Adults' Access to Preventive/Ambulatory Health Services* measures reported significant rate declines. Both *Children/Adolescent* and *Adult Access* measures were below the national HEDIS Medicaid 25th percentile. These measures suggested statewide opportunities for improvement. Although *Ambulatory Care, Inpatient Utilization, Antibiotic Utilization, and Frequency of Selected Procedures* were related to beneficiaries' access to care, these are utilization-based measures without risk adjustment. Statewide rates for these measures should be used for information only.

Validation of Performance Improvement Projects

For FY 2013–2014, HSAG validated one PIP each for DHMC and RMHP. Table 3-24 lists the PIP topics identified by each plan.

Table 3-24—Summary of Each MCO's PIPs

Health Plan	PIP Study
Denver Health Medicaid Choice (DHMC)	*Adults Access to Preventive/Ambulatory Health Services*
Rocky Mountain Health Plans (RMHP)	*Adult BMI Assessment*

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 one clinical PIP, *Adults Access to Preventive/Ambulatory Health Services*. The 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 services. This was the third year for this PIP. DHMC completed Activities I through IV and VI through IX and reported baseline data.

Table 3-25 provides a summary of DHMC's *Adults Access to Preventive/Ambulatory Health Services* PIP validation results for the FY 2013–2014 validation cycle.

Table 3-25—FY 2013–2014 Performance Improvement Project Validation Results *for* DHMC

PIP Topic: *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	88% (7/8)	13% (1/8)	0% (0/8)
	VIII.	Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
		Implementation Total	92% (11/12)	8% (1/12)	0% (0/12)

Table 3-25—FY 2013–2014 Performance Improvement Project Validation Results *for* DHMC					
PIP Topic: ***Adults Access to Preventive/Ambulatory Health Services***					
Study Stage	**Activity**		**Percent of Applicable Elements**		
			Met	**Partially Met**	**Not Met**
Outcomes	IX.	Real Improvement	25% (1/4)	0% (0/4)	75% (3/4)
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			25% (1/4)	0% (0/4)	75% (3/4)
Percent Score of Applicable Evaluation Elements *Met*			**85% (22/26)**		

The DHMC *Adults Access to Preventive/Ambulatory Health Services* PIP demonstrated strong performance in study design (Activities I–VI), with all applicable evaluation elements receiving *Met* scores. A solid study design is essential to producing methodologically sound results. The health plan also demonstrated strength in its implementation of interventions and improvement strategies, receiving *Met* scores for all evaluation elements in Activity VIII. The PIP was scored down in Activity VII for errors in statistical testing and in Activity IX for lack of improvement in the study indicator rates. Overall, the PIP received a *Met* score for 85 percent of all applicable evaluation elements and 100 percent of all applicable critical evaluation elements, resulting in an overall *Met* validation status.

Table 3-26 provides a summary of DHMC's PIP-specific outcomes for the FY 2013–2014 validation cycle.

Table 3-26—FY 2013–2014 Performance Improvement Project-Specific Outcomes *for* DHMC				
PIP Topic: ***Adults Access to Preventive/Ambulatory Health Services***				
PIP Study Indicator	**Baseline**	**Remeasurement 1**	**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%	70.1%	3.4↓	*p*<0.0001 *Statistically Significant*

↓Denotes a decrease in the study indicator rate from the previous measurement period.

DHMC completed Activities I through IV and VII through IX of the *Adults Access to Preventive/Ambulatory Health Services* PIP and reported Remeasurement 1 data for January 1, 2013, through December 31, 2013. The Remeasurement 1 rate of 70.1 percent was a statistically significant decline of 3.4 percentage points from the baseline rate of 73.5 percent. DHMC did not reach its goal of achieving statistically significant improvement over the baseline rate for preventive/ambulatory care visits.

Strengths

The PIP demonstrated strong performance in Activities I through IV and Activities VI and VIII by receiving *Met* scores for all applicable evaluation elements. The health plan documented a solid study design and implementation, which is essential to producing methodologically sound results.

The interventions developed by DHMC were appropriately linked to the barriers identified. The health plan included an additional table in Activity VIII documenting the specific causal/barrier analysis tools and results supporting each identified barrier and associated intervention. The health plan also documented evaluation results for each intervention and next steps taken.

Interventions

DHMC reported six interventions for the current validation cycle. Three were continued from previous measurement periods, two were initiated during the Remeasurement 1 period, and one was initiated after the end of the Remeasurement 1 period. Ongoing interventions included free transportation to medical appointments for members, member birthday card preventive service reminders, and monthly dedicated diabetic eye exam dates at the Denver Health Eye Clinic. During the Remeasurement 1 period, DHMC implemented two interventions to expand availability of adult preventive/ambulatory appointments. In May 2013, members were able to begin obtaining services at 10 Walgreens Take Care Clinics located throughout the Denver area. Additionally, in September 2013, DHMC partnered with the Westside Family Health Center to expand adult clinic appointment times to include Saturday mornings.

Evaluation results show DHMC documented several revisions that will be made to ongoing interventions. While most members are eligible for the free transportation program, qualitative data suggested the current transportation service is unreliable in transporting members to appointments on time. For this reason, the health plan will monitor timeliness of the existing transportation provider more closely and supplement the program with a taxi service when timeliness issues arise. Quantitative analysis of the birthday card reminder intervention suggested that the response rate for scheduling a preventive visit fell below the health plan’s goal. Given this result, DHMC will be conducting further evaluation and supplementing the birthday cards with direct calls to improve appointment scheduling response rates. Results of the diabetic eye exam evaluation suggested that the monthly dedicated eye exam day did not accommodate member needs; therefore, an additional day each month will be blocked off for eye exam appointments. Finally, evaluation of the Walgreens Take Care Clinic partnership revealed that the Walgreens clinics accounted for only a minimal number of adult member visits during the Remeasurement 1 period; additional qualitative data suggested that additional outreach is necessary to ensure that members are aware of the partnership and the accessibility of these clinics for adult health services.

Recommendations

Based on the validation results of DHMC’s *Adults Access to Preventive/Ambulatory Health Services* PIP for the FY 2013–2014 validation cycle, HSAG offers several recommendations. First, when making comparisons between measurement periods to assess improvement achieved by a PIP, DHMC should revisit its statistical testing procedures to ensure that the results are being calculated accurately. The health plan should contact HSAG and request technical assistance, if needed, in order to understand the correct methods for obtaining accurate statistical testing results. Second, DHMC should continue to implement ongoing evaluations of each intervention to assess effectiveness. The health plan should use evaluation results and regularly revisit the causal/barrier analysis to clarify the root causes of lack of improvement in the study indicator. Interventions determined to be ineffective or unsuitable should be revised in order to improve outcomes more effectively.

Rocky Mountain Health Plans

Findings

RMHP submitted one clinical PIP, *Adult BMI Assessment*. The PIP focused on improving the rate of BMI documentation in member medical records. This was the third validation year for the *Adult BMI Assessment* PIP and RMHP completed Activities I through IX. The health plan reported Remeasurement 1 data from calendar year 2013.

Table 3-27 shows RMHP scores based on HSAG's validation. HSAG reviewed and evaluated each activity according to HSAG's validation methodology.

Table 3-27—FY 2013–2014 Performance Improvement Project Validation Results *for* RMHP

PIP Topic: *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	89% (8/9)	0% (0/9)	11% (1/9)
	VIII.	Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
		Implementation Total	92% (11/12)	0% (0/12)	8% (1/12)
Outcomes	IX.	Real Improvement	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement	*Not Assessed*		
		Outcomes Total	94% (15/16)	0% (0/16)	6% (1/16)
Combined Percent Score of Applicable Evaluation Elements Met			**97% (32/33)**		

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. At the first remeasurement, RMHP demonstrated strong performance in the implementation of improvement strategies (Activity VIII) and achieved statistically significant improvement in outcomes (Activity IX), receiving *Met* scores for all applicable evaluation elements in these activities. The health plan was scored down in evaluation element eight in Activity VII for a documentation omission. Overall, the RMHP *Adult BMI Assessment* PIP received a *Met* score for 97 percent of all applicable evaluation elements and 100 percent of all applicable critical evaluation elements.

Table 3-28 provides a summary of RMHP's PIP indicator outcomes for the FY 2013–2014 validation cycle.

Table 3-28—FY2013–2014 Performance Improvement Project-Specific Outcomes *for* RMHP					
PIP Topic: *Adult BMI Assessment*					
PIP Study Indicator	Baseline	Remeasurement 1	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%	80.3%	10.4↑	$p = 0.0006$ *Statistically Significant*	NA

↑ Denotes an increase in the study indicator rate from the previous measurement period.

At the first remeasurement of the *Adult BMI Assessment* PIP, RMHP reported that 80.3 percent of members had evidence of BMI percentile documentation during the measurement year or the year prior to the measurement year. The Remeasurement 1 rate was 10.4 percentage points above the baseline rate, which was a statistically significant increase ($p = 0.0006$). The Remeasurement 1 results exceeded the Remeasurement 1 goal of a 3.0 percent increase over the baseline rate.

Strengths

The RMHP *Adult BMI Assessment* PIP demonstrated strong performance in all three stages: study design, implementation, and outcomes. The health plan met all of the applicable evaluation elements in the design stage, Activities I–VI. The solid study design allowed RMHP to successfully progress to the implementation stage (Activities VII–VIII) and the outcomes stage (Activities IX–X). The health plan met all of the requirements related to implementation of improvement strategies in Activity VIII. In the outcomes stage, RMHP achieved statistically significant improvement over baseline at the first remeasurement.

Interventions

During the first remeasurement period, RMHP implemented four interventions to address member-, provider-, and practice-based barriers. The health plan continued implementing its baseline member-based interventions that involved brochure reminder mailings designed to promote preventive health services for women, and it documented that it was exploring expanding this intervention to include a brochure targeting male members. The health plan also implemented two provider- and practice-based interventions based on the principles and practices of the Beacon Consortium, a grant-supported partnership focused on improving health information infrastructure and making measurable improvements in health care quality, which formally ended in February 2012. Based on the success of the Beacon Consortium-related interventions during the baseline measurement period, RMHP partnered with practices to achieve two goals using Beacon strategies: (1) ensure electronic medical record meaningful use in documenting BMI, and (2) improve practice work flow to support BMI assessment and documentation. RMHP documented that it continued

three interventions beyond the Remeasurement 1 period. Additionally, the health plan reported two new interventions initiated after the end of the Remeasurement 1 period to address the newly identified barriers related to modes of communication with members.

Recommendations

Based on the results of RMHP's *Adult BMI Assessment* PIP validation for the FY 2013–2014 validation cycle, HSAG offered several recommendations. When comparing study indicator results between measurement periods, the health plan should take care to ensure rate changes are calculated correctly and noted consistently throughout the PIP documentation. Additionally, when developing improvement strategies, RMHP should target resources toward interventions that are likely to result in long-term change. The health plan should ensure that each intervention is accompanied by an ongoing evaluation of effectiveness and evaluation results should be used, in combination with updated causal/barrier analysis results, to continually refine improvement strategies in order to optimize desired impact on outcomes.

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

Table 3-29 shows the health plans' overall performance based on HSAG's validation of the FY 2013–2014 PIPs submitted for validation.

Table 3-29—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*	85%	100%	*Met*
RMHP	*Adult BMI Assessment*	97%	100%	*Met*

Both of the PIPs received a *Met* validation status. Both health plans progressed to reporting Remeasurement 1 data and completed applicable Activities I–IX.

Table 3-30 shows a comparison of the health plans' improvement results.

Table 3-30—Statewide Summary of Improvement		
	DHMC	RMHP
Number of comparable rates (previous measurement to current measurement)	1	1
Number of rates that improved	0	1
Number of rates that declined	1	0
Number of rates that showed statistically significant improvement over the previous measurement period	0	1
Number of rates that showed statistically significant improvement over baseline	0	1

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

For the DHMC *Adults Access to Preventive/Ambulatory Health Services* PIP, the study indicator rate declined from baseline to the first remeasurement. In contrast, there was a statistically significant improvement in the study indicator rate from baseline to the first remeasurement for the RMHP *Adult BMI Assessment* PIP.

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. Both of the PIPs earned a *Met* validation status, demonstrating 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®)

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 FY 2013–2014, the adult PCPP population was administered a modified version of the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set and survey questions from the Adult Clinician and Group CAHPS surveys with Patient-Centered Medical Home™ (PCMH™) items ("Adult CAHPS PCMH Survey"). The child PCPP population for the first time was administered the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item and survey questions from the Child Clinician and Group CAHPS surveys with PCMH™ items ("Child CAHPS PCMH Survey").[3-1,3-2] Therefore, the FY 2013–2014 adult and child Medicaid results for PCPP represent a baseline assessment and comparisons to prior year's rates could not be performed for these populations.

For DHMC and RMHP, 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 for the child population.

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 member responses of "Usually" or "Always." For one composite (*Shared Decision Making*), the rates were based on member responses 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).[3-3] Measures' rates that are not available are denoted

[3-1] Patient-Centered Medical Home™ (PCMH™) is a trademark of the National Committee for Quality Assurance (NCQA).
[3-2] It is important to note that for the adult and child PCPP CAHPS survey administration, the Department elected to modify the CAHPS 5.0 Medicaid Health Plan Surveys and remove the Rating of Health Plan global rating question and Customer Service composite measure survey questions; therefore, CAHPS survey results for the adult and child PCPP populations are limited to the three global ratings (Rating of All Heath Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Shared Decision Making).
[3-3] Due to changes to the *Shared Decision Making* composite measure, for DHMC and RMHP the current year's (FY 2013–2014) adult Medicaid rates are not comparable to the prior years' (FY 2011–2012) adult Medicaid rates. For information on the changes to the composite measure, please refer to Appendix E of this report.

as Not Available (NA). Appendix D contains additional details about the technical methods of data collection and analysis of survey data. [3-4, 3-5]

It is important to note that in FY 2013–2014, a modified version of the CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys with the HEDIS supplemental item sets were administered to PCPP's adult and child Medicaid populations, respectively, for the first time. For PCPP's adult Medicaid population, the CAHPS 5.0 Adult Survey was modified to include survey questions from the Adult Clinician and Group CAHPS surveys with PCMH™ items ("Adult CAHPS PCMH Survey"). For PCPP's child Medicaid population, the CAHPS 5.0 Child Medicaid Survey was modified to include survey questions from the Child Clinician and Group CAHPS surveys with PCMH™ items ("Child CAHPS PCMH Survey").[3-6, 3-7] As a result of the modifications to the survey instruments, comparisons to the prior year's results (FY 2012–2013) could not be performed for PCPP's adult and child Medicaid populations. Therefore, adult and child Medicaid results for PCPP are presented for FY 2013–2014 only.

In FY 2012–2013, DHMC and RMHP did not conduct CAHPS surveys of their adult Medicaid populations; therefore, for DHMC and RMHP, comparisons of prior year's adult Medicaid results involved a comparison of FY 2013–2014 to FY 2011–2012 CAHPS results. Both health plans, however, did conduct CAHPS surveys of their child Medicaid populations; therefore, FY 2013–2014 child Medicaid results were compared to FY 2012–2013 results. The FY 2012–2013 child Medicaid results presented in this report for DHMC and RMHP are for the general child population.

For DHMC's and RMHP's 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.

[3-4] Due to changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting the comparisons of DHMC's and RMHP's current year (FY 2013–2014) rates to the prior years' (FY 2011–2012) rates for the plans' adult Medicaid populations. For information on the changes to the composite measure, please refer to Appendix E of this report.

[3-5] Due to changes in the NCQA CAHPS national averages available for composite measures, the FY 2011–2012 adult Medicaid rates for each composite measure were recalculated for DHMC and RMHP, and the adult Medicaid Statewide average. Therefore, the FY 2011–2012 CAHPS adult Medicaid results for all composite measures presented in this section for DHMC, RMHP, and the statewide average will not match previous years' reports.

[3-6] Patient-Centered Medical Home™ (PCMH™) is a trademark of the National Committee for Quality Assurance (NCQA).

[3-7] It is important to note that for the adult and child PCPP CAHPS survey administration, the Department elected to modify the CAHPS 5.0 Medicaid Health Plan Surveys and remove the Rating of Health Plan global rating question and Customer Service composite measure survey questions; therefore, CAHPS survey results for the adult and child PCPP populations are limited to the three global ratings (Rating of All Heath Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Shared Decision Making).

Denver Health Medicaid Choice

Findings

Table 3-31 shows the adult Medicaid results achieved by DHMC for the current year (FY 2013–2014) and the prior year (FY 2011–2012).[3-8,3-9]

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

Measure	FY 2011–2012 Rate	FY 2013–2014 Rate
Getting Needed Care	64.9%	70.3%
Getting Care Quickly	68.4%	74.3%
How Well Doctors Communicate	89.0%	90.0%
Customer Service	66.3%+	83.5%
Shared Decision Making	NC	52.2%
Rating of Personal Doctor	67.3%	65.4%
Rating of Specialist Seen Most Often	57.0%	59.5%
Rating of All Health Care	49.7%	43.7%
Rating of Health Plan	59.3%	51.5%

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.

Table 3-32 shows the child Medicaid results achieved by DHMC for the current year (FY 2013–2014) and the prior year (FY 2012–2013).

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

Measure	FY 2012–2013 Rate	FY 2013–2014 Rate
Getting Needed Care	81.6%	73.5%
Getting Care Quickly	77.9%	85.5%
How Well Doctors Communicate	94.7%	94.3%
Customer Service	86.4%	86.1%
Shared Decision Making	61.0%	55.8%+
Rating of Personal Doctor	82.1%	75.4%
Rating of Specialist Seen Most Often	81.4%	73.8%+
Rating of All Health Care	68.4%	66.7%
Rating of Health Plan	71.5%	70.1%

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.

[3-8] DHMC's adult Medicaid population was not surveyed during FY 2012–2013.

[3-9] As previously noted, DHMC's FY 2011–2012 adult Medicaid 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 previous years' reports.

Recommendations

For the adult Medicaid population, two of the eight comparable measures' rates decreased substantially: *Rating of All Health Care* and *Rating of Health Plan*. For the child Medicaid population, four of the measures' rates decreased substantially: *Getting Needed Care*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. DHMC should continue to direct quality improvement activities toward these measures.

Summary Assessment Related to Quality, Timeliness, and Access

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

For the adult Medicaid population, three of the eight comparable measures' rates increased substantially: *Getting Needed Care* (5.4 percentage points), *Getting Care Quickly* (5.9 percentage points), and *Customer Service* (17.2 percentage points). Two of the eight comparable measures' rates decreased substantially: *Rating of All Health Care* (6.0 percentage points) and *Rating of Health Plan* (7.8 percentage points). Three of the measures for the adult Medicaid population had the highest rates among the health plans in FY 2013–2014: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. One of the measures for the adult Medicaid population— *Shared Decision Making*—had the lowest rate among the health plans in FY 2013–2014

For the child Medicaid population, the rate for *Getting Care Quickly,* increased substantially (7.6 percentage points). Four measures' rates decreased substantially: *Getting Needed Care* (8.1 percentage points), *Shared Decision Making* (5.2 percentage points), *Rating of Personal Doctor* (6.7 percentage points), and *Rating of Specialist Seen Most Often* (7.6 percentage points). Two of the measures for the child Medicaid population had the highest rates among the health plans in FY 2013–2014: *How Well Doctors Communicate* and *Customer Service*. Four of the measures had the lowest rates among the health plans in FY 2013–2014: *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*.

Rocky Mountain Health Plans

Findings

Table 3-33 shows the adult Medicaid results achieved by RMHP for the current year (FY 2013–2014) and the prior year (FY 2011–2012).[3-10]

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

Measure	FY 2011–2012 Rate	FY 2013–2014 Rate
Getting Needed Care	88.4%	84.9%
Getting Care Quickly	86.8%	83.2%
How Well Doctors Communicate	91.5%	89.4%
Customer Service	82.5%+	84.3%+
Shared Decision Making	NC	50.1%
Rating of Personal Doctor	64.4%	67.1%
Rating of Specialist Seen Most Often	64.7%	61.9%
Rating of All Health Care	50.0%	53.8%
Rating of Health Plan	64.0%	59.1%

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 3-34 shows the child Medicaid results achieved by RMHP for the current year (FY 2013–2014) and the prior year (FY 2012–2013).

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

Measure	FY 2012–2013 Rate	FY 2013–2014 Rate
Getting Needed Care	93.1%	92.6%
Getting Care Quickly	93.6%	91.8%
How Well Doctors Communicate	97.3%	94.5%
Customer Service	89.1%+	87.7%+
Shared Decision Making	58.7%+	52.1%+
Rating of Personal Doctor	74.5%	71.3%
Rating of Specialist Seen Most Often	70.1%+	69.2%+
Rating of All Health Care	64.6%	60.2%
Rating of Health Plan	67.3%	68.5%

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.

[3-10] As previously noted, RMHP's FY 2012–2013 adult Medicaid rates for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the FY 2012–2013 adult Medicaid results for all composite measures presented in this section for RMHP will not match previous years' reports.

Recommendations

RMHP had no substantial decreases in the rates for the adult Medicaid population. For the child Medicaid population, however, the rate for one measure decreased substantially: *Shared Decision Making*. RMHP should continue to direct quality improvement activities toward this measure.

Summary Assessment Related to Quality, Timeliness, and Access

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

For the adult Medicaid population, none of the measures increased or decreased substantially. One of the measures for the adult Medicaid population had the highest rate among the health plans in FY 2013–2014: *How Well Doctors Communicate*. Three of the measures for the adult Medicaid population had the lowest rates among the health plans in FY 2013–2014: *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*.

For the child Medicaid population, one measure's rate decreased substantially: *Shared Decision Making* (6.6 percentage points). No measures increased substantially. Three of the measures for the child Medicaid population had the highest rate among the health plans in FY 2013–2014: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. One of the measures for the child Medicaid population had the lowest rate among the health plans in FY 2013–2014: *Shared Decision Making*.

Primary Care Physician Program

Findings

Table 3-35 shows the adult Medicaid results achieved by PCPP during the current year (FY 2013–2014).

Table 3-35—Adult Medicaid Question Summary Rates and Global Proportions *for* PCPP	
Measure	**FY 2013–2014 Rate**
Getting Needed Care	80.2%
Getting Care Quickly	80.0%
How Well Doctors Communicate	88.9%
Customer Service	NA
Shared Decision Making	54.2%
Rating of Personal Doctor	61.0%
Rating of Specialist Seen Most Often	59.3%
Rating of All Health Care	49.7%
Rating of Health Plan	NA

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.

NA indicates CAHPS survey results are not available for the CAHPS measure.

Table 3-36 shows the child Medicaid results achieved by PCPP for the current year (FY 2013–2014).

Table 3-36—Child Medicaid Question Summary Rates and Global Proportions *for* PCPP	
Measure	**FY 2013–2014 Rate**
Getting Needed Care	86.6%
Getting Care Quickly	92.4%
How Well Doctors Communicate	92.1%
Customer Service	NA
Shared Decision Making	56.8%+
Rating of Personal Doctor	72.8%
Rating of Specialist Seen Most Often	67.7%+
Rating of All Health Care	65.7%
Rating of Health Plan	NA

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.

NA indicates CAHPS survey results are not available for the CAHPS measure.

Recommendations

As previously noted, for PCPP's adult Medicaid population, the CAHPS 5.0 Adult Medicaid Health Plan Survey administered in FY 2013–2014 was modified to include survey questions from Adult CAHPS PCMH Survey. For PCPP's child Medicaid population, the CAHPS 5.0 Child Medicaid Health Plan Survey was modified to include survey questions from the Child CAHPS PCMH Survey. Since this was the first year HSAG administered the modified survey to the PCPP's adult and child Medicaid populations, direct comparisons cannot be made to prior years' results. However, rates for the *How Well Doctors Communicate* and *Rating of Specialist Seen Most Often* measures were slightly lower than the rates achieved by the other plans for both child and adult populations. For the adult Medicaid population, PCPP also had the lowest rate among the health plans in FY 2013–2014—for *Rating of Personal Doctor*.

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.

Although HSAG was unable to make direct comparisons to prior years' PCPP results or to results observed by other plans, results observed for PCPP are similar to those observed in prior years and by the other plans. While there is always room for improvement, the PCPP performance as it relates to quality, timeliness, and access is similar to what was expected.

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

Given the modifications to the CAHPS Adult and Child Medicaid Health Plan Surveys administered to PCPP's adult Medicaid population, the statewide averages presented in this section are derived from the combined adult Medicaid results for DHMC and RMHP (i.e., they do not include results for adult Medicaid PCPP). Therefore, the FY 2011–2012 CAHPS adult Medicaid statewide averages presented in this section will not match previous years' reports. Table 3-37 shows the adult Medicaid statewide averages for the current year (FY 2013–2014) and the prior year (FY 2011–2012).[3-11]

Table 3-37—Adult Medicaid Statewide Averages

Measure	FY 2011–2012 Rate	FY 2013–2014 Rate
Getting Needed Care	77.6%	78.3%
Getting Care Quickly	77.2%	78.9%
How Well Doctors Communicate	90.2%	89.6%
Customer Service	73.2%	83.8%
Shared Decision Making	NC	51.0%
Rating of Personal Doctor	65.8%	66.3%
Rating of Specialist Seen Most Often	61.4%	60.9%
Rating of All Health Care	49.8%	49.0%
Rating of Health Plan	61.5%	55.2%

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

[3-11] DHMC's and RMHP's adult Medicaid population were not surveyed in FY 2012-2013.

The statewide averages presented in this section are derived from the combined child Medicaid results for DHMC and RMHP (i.e., they do not include results for child Medicaid PCPP). Therefore, the FY 2011–2012 CAHPS child Medicaid statewide averages presented in this section will not match previous years' reports. Table 3-38 shows the child Medicaid statewide averages for the current year (FY 2013–2014) and the prior year (FY 2012–2013).

Table 3-38—Child Medicaid Statewide Averages

Measure	FY 2012–2013 Rate	FY 2013–2014 Rate
Getting Needed Care	85.7%	82.1%
Getting Care Quickly	82.7%	88.3%
How Well Doctors Communicate	95.6%	94.4%
Customer Service	87.0%	86.6%
Shared Decision Making	60.2%	53.8%
Rating of Personal Doctor	79.7%	73.4%
Rating of Specialist Seen Most Often	76.5%	71.7%
Rating of All Health Care	67.2%	63.7%
Rating of Health Plan	70.4%	69.4%

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.

Recommendations

The statewide adult Medicaid population showed a substantial decrease in rate for one of the eight comparable measures, *Rating of Health Plan*. For the statewide child Medicaid population, a substantial decrease in rate was shown for one measure, *Shared Decision Making*.

Summary Assessment Related to Quality, Timeliness, and Access

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

For the statewide adult Medicaid population, one of the eight comparable measures' rates decreased substantially: *Rating of Health Plan* (6.3 percentage points) from FY 2011–2012 to FY 2013–2014. The statewide adult Medicaid population also experienced a slight decrease in rates for two measures: *How Well Doctors Communicate* and *Rating of Specialist Seen Most Often*. The rates for the remaining five comparable measures increased from FY 2011–2012 to FY 2013–2014. For one of these measures, *Customer Service*, the rate increased substantially (10.6 percentage points).

For the statewide child Medicaid population, the rates for eight of the nine measures decreased from FY 2012–2013 to FY 2013–2014. For one of these measures, *Shared Decision Making*, the rate decreased substantially (6.2 percentage points). For the remaining measure, *Getting Care Quickly*, the rate increased substantially (5.6 percentage points).

For the child Medicaid population, two of the measures' rates decreased substantially: *Getting Needed Care* (8.2 percentage points) and *Shared Decision Making* (6.6 percentage points). None of the measures increased substantially. Three of the measures for the child Medicaid population had

the highest rates among the health plans in FY 2013–2014: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. One of the measures for the child Medicaid population had the lowest rate among the health plans in FY 2013–2014: *Shared Decision Making*.

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 3-39 and Table 3-40, respectively.

Table 3-39—Composite Measure Recommendations
Getting Needed Care
Health plans should ensure that patients are receiving care from the 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 systems that allow for as many of the patient's needs as possible to be met during one office visit when feasible—a process called "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 physicians 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 email follow-up). Additionally, follow-up appointments could be conducted by another health care professional such as nurse practitioners or physician assistants.

Table 3-39—Composite Measure Recommendations
Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who 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.
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 to their physicians any questions, concerns, or expectations 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 non-adherence and poor health outcomes. To address this issue, health plans should consider revising existing print materials and creating new ones 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 who 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 3-40—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 email. 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, and customer service. Research suggests that 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 that 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 that 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 who have routine appointments, a reminder system could be implemented to ensure they are receiving the appropriate attention at the appropriate time. This triggering system could be used by the staff to prompt general follow-up contact or specific interaction with patients to ensure they have necessary tests completed before an appointment or for 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 3-40—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 and improve provider-patient communication. Training seminars can include sessions on improving communication skills with different cultures, as well as on 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's 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 patients being late. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows the staff to work quickly in providing timely access to care while following protocol.
Since both patients and families have the direct experience of having an illness or interacting with a 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 that 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 members who provide services to members) that provide the health plan's health care "products." Health care microsystems include a team of health providers; the patient/population to whom care is provided; an environment that provides information to providers and patients; and support staff, equipment, and office environment. The goal of the microsystems' approach is to focus on small, replicable, functional service systems that enable the health plan's 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 gives members easy access to an array of health plan and health care information and services particular to their needs and interests. To help increase members' satisfaction with their health plans, the 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 3-40—Global Rating Recommendations
Implementation of organization-wide quality improvement (QI) initiatives are most successful when health plan staff members 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 2012–2013. This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations or required actions from the FY 2012–2013 site EQR activities.

Denver Health Medicaid Choice

Compliance Monitoring Site Reviews

As a result of the FY 2012–2013 site review, DHMC was required to implement corrective actions related to three of the four standards reviewed: coordination and continuity of care, credentialing and recredentialing, and quality assessment and performance improvement. Required actions included:

- ♦ Develop or revise policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for Denver Health and Hospital Authority (DHHA) allied health professionals.
- ♦ Develop or revise documents to address notifying applicants of rights under the credentialing program and that describe the range of actions available to DHHA for changing the conditions of a practitioner's status based on quality reasons.
- ♦ Revise policies to allow the public to access its clinical practice guidelines (CPGs) at no cost. DHMC was also required to communicate to members the availability of CPGs and how to access or request them.
- ♦ 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.
- ♦ Include a summary or statement of the overall impact and effectiveness of the quality improvement (QI) program in the annual QI Impact Analysis Report.

DHMC submitted its CAP to HSAG and the Department in May 2013. After careful review, HSAG and the Department determined that, if implemented as written, DHMC would achieve full compliance. DHMC submitted documentation demonstrating that it had implemented its plan, and in October 2013, HSAG and the Department determined that DHMC had successfully addressed all required actions.

Validation of Performance Measures

Based on its FY 2012–2013 review, HSAG recommended that DHMC focus its improvement efforts on indicators that either demonstrated a decrease in rate of more than 5 percentage points or benchmarked below the national Medicaid HEDIS 10th or 25th percentiles. These indicators were:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition: Total*
- *Childhood Immunization Status—Combination 9*
- *Cervical Cancer Screening*
- *Children's and Adolescents' Access to Primary Care Practitioners (12–24 Months and 25 Months–6 Years)*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Follow-up Care for Children Prescribed ADHD Medication—Initiation*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement*
- *Annual Monitoring for Patients on Persistent Medications—Total*
- *Comprehensive Diabetes Care (Eye Exam* and *LDL-C Screening)*

DHMC's HEDIS 2014 rates showed statistically significant improvement in *Cervical Cancer Screening* and *Comprehensive Diabetes Care—LDL-C Screening*. Improvement in *Cervical Cancer Screening* may be related to the Department changing the data collection methodology requirements from administrative to hybrid in HEDIS 2014 and not due to any specific improvement efforts from DHMC. Nonetheless, the rate increase in *Comprehensive Diabetes Care—LDL-C Screening* may suggest improvement efforts made by DHMC to improve care. The *Children's and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* indicator reported a significant decline from HEDIS 2013. Rates for the remaining measures showed some changes, but they were not significant. This suggested that DHMC's performance remained stable for these measures.

Validation of Performance Improvement Projects

DHMC submitted two PIPs for validation in FY 2012–2013: the *Adults Access to Preventive/Ambulatory Health Services* PIP and the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. The *Coordination of Care* PIP was retired at the conclusion of the FY 2012–2013 validation cycle with the completion of the second remeasurement period and with an overall *Met* validation status for Activities I through X.

In FY 2012–2013, DHMC reported baseline data for the *Adults Access to Preventive/Ambulatory Health Services* PIP. Validated for Activities I through VIII, the PIP received a *Met* score for 100 percent of the applicable evaluation elements and an overall *Met* validation status. There were no identified deficiencies or recommendations made.

Consumer Assessment of Healthcare Providers and Systems

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

For the comparable child population measures between FY 2011–2012 and FY 2012–2013, DHMC had no substantial decreases; however, two measures experienced slight rate declines: *Getting Care Quickly* and *Rating of Health Plan*. HSAG recommended that DHMC continue to direct quality improvement activities toward these measures. In FY 2013–2014, DHMC's *Getting Care Quickly* rate increased by 7.6 percentage points. This increase indicates an improvement in consumer satisfaction for this domain. Although slight, DHMC experienced a decrease of 1.4 percentage points for *Rating of Health Plan*.

Rocky Mountain Health Plans

Compliance Monitoring Site Reviews

As a result of the FY 2012–2013 site review, RMHP was required to implement corrective actions related to three of the four standards reviewed: coordination and continuity of care, member rights and protections, and quality assessment and performance improvement. Required actions included:

- Revise and reformat the member handbook to clearly define the services available under the EPSDT program, as well as wrap-around services, and where and how to obtain them. RMHP was also required to correct its provider communications regarding EPSDT and wrap-around services.
- 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 ensure that screening requirements are met.
- Work with its behavioral health organization partner to ensure accurate presentation of mental health/behavioral health information on RMHP's Web site.
- Evaluate its systems and processes for implementing corrective actions and following through with the processes. This was a previous corrective action and HSAG once again made this recommendation.
- Ensure that members are notified annually of their right to request and receive a copy of the member handbook.
- Include an assessment of the overall impact and effectiveness of the quality improvement program in the quality improvement annual report and modify policies and processes to ensure that clinical practice guidelines are reviewed and approved annually.
- Perform an audit of a statistically significant sample of Medicaid encounter claims and include verification of claims information against medical record information.

RMHP submitted a CAP to HSAG and the Department in July 2013. After requiring that RMHP make several revisions to its plans, HSAG and the Department agreed in September 2013 that, if implemented as written, RMHP would achieve full compliance with all applicable requirements. In

October 2013, RMHP began submitting documents to HSAG and the Department to demonstrate implementation of its plan. In June 2014, HSAG and the Department determined that RMHP had achieved compliance with the requirements reviewed during the FY 2012-2013 site review.

In addition, RMHP had one corrective action continued from the FY 2011–2012 site review process. The explanation of benefits auto-generated for claims denials depicted incorrect information and time frames. RMHP submitted revised language in April 2013, which was approved by the Department. During the 2013–2014 site review, HSAG reviewed denials records. Claims denials sent after June 2013 included accurate information and time frames. HSAG determined that this required action was completed.

Validation of Performance Measures

Based on its FY 2012–2013 review, HSAG recommended that RMHP focus its improvement efforts on indicators that either demonstrated a decrease in rates of more than 5 percentage points or benchmarked below the national Medicaid HEDIS 10th or 25th percentiles. These indicators were:

- *Childhood Immunization Status—Combinations 2, 3, 4, 7, 8, and 10*
- *Children's and Adolescents' Access to Primary Care Practitioners (12-24 Months* and *25 Months—6 Years)*
- *Chlamydia Screening in Women—Total*
- *Comprehensive Diabetes Care* (*LDL-C Screening* and *Medical Attention for Nephropathy)*

RMHP's HEDIS 2014 rates showed statistically significant improvement in the *Childhood Immunization Status* measure. Improvement observed in this measure may be related to the Department changing the data collection methodology requirements from administrative to hybrid in HEDIS 2014 and not due to any specific improvement efforts from RMHP. Rates for the remaining measures showed some changes but they were not significant. This suggested that RMHP's performance remained stable for these measures.

Validation of Performance Improvement Projects

RMHP submitted two PIPs for validation in FY 2012–2013: the *Adult BMI Assessment* PIP and the *Improving Coordination of Care for Members with Behavioral Health Conditions* PIP. The *Improving Coordination of Care* PIP was retired at the conclusion of the FY 2012–2013 validation cycle with the completion of the fourth remeasurement period and with an overall *Met* validation status for Activities I through X.

For the *Adult BMI Assessment* PIP, RMHP reported baseline data in FY 2012–2013 and the PIP was validated for Activities I through VIII. The PIP received a *Met* score for 23 out of 24 (96 percent) applicable evaluation elements. The overall validation status was *Partially Met* because the PIP received a *Partially Met* score for one critical evaluation element in Activity VII (data analysis and interpretation). The *Partially Met* score in Activity VII was due to a discrepancy in the documentation of the numerator, denominator, and baseline rate for the study indicator. RMHP

documented the correct baseline rate but the incorrect numerator and denominator. In FY 2013–2014, RMHP corrected the documentation errors for the baseline numerator and denominator.

Consumer Assessment of Healthcare Providers and Systems

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

For the comparable child population measures between FY 2011–2012 and FY 2012–2013, RMHP had no substantial decreases; however, two measures experienced slight rate declines: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. HSAG recommended that RMHP direct quality improvement activities toward these areas. Between FY 2012–2013 and FY 2013–2014, one measure showed a slight improvement: *Rating of Health Plan*. This increase may indicate an improvement in consumer satisfaction for this domain.

HSAG HEALTH SERVICES ADVISORY GROUP

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. Also included are HSAG's recommendations for improving the BHOs' performance. The BHO-specific findings from the three EQR activities are detailed in the applicable subpart of this section, titled Compliance Monitoring Site Reviews, Validation of Performance Measures, and Validation of Performance Improvement Projects. This section also includes a summary of overall statewide performance related to the quality and timeliness of, and access to, care and services for each activity.

Compliance Monitoring Site Reviews

For the FY 2013–2014 site review process, the Department requested a review of two areas of performance that had not been reviewed within the previous two fiscal years: Standard I—Coverage and Authorization of Services, and Standard II—Access and Availability.

In developing the data collection tools and in reviewing the two standards, HSAG used the BHOs' 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; a review of records, documents, and materials provided on-site; and on-site interviews of key BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO service and claims denials. In addition, HSAG conducted a high-level review of the BHOs' authorization processes through a demonstration of each BHO's electronic system used to document and process requests for behavioral health services.

A sample of a BHO's administrative records related to Medicaid service and claims denials was also reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action (NOAs). Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 15 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. For the record review, the BHO received a score of *C* (Compliant), *NC* (Not Compliant), or *NA* (Not Applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

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 shows 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
Standard I—Coverage and Authorization of Services	✓	✓	✓
Standard II—Access and Availability		✓	✓

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

Access Behavioral Care (ABC)

Findings

Table 5-2 presents the number of elements for each of the standards; the number of elements assigned a score of *Met, Partially Met, Not Met,* or *Not Applicable*; and the overall compliance score for the current year (FY 2013–2014).

Table 5-2—Summary of Scores for ABC

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	31	31	30	1	0	0	97%
Standard II—Access and Availability	15	15	14	1	0	0	93%
Totals	**46**	**46**	**44**	**2**	**0**	**0**	**96%***

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

Table 5-3—Summary of Scores for ABC's Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	70	44	44	0	26	100%
Totals	**70**	**44**	**44**	**0**	**26**	**100%**

Strengths

For Standard I—Coverage and Authorization of Services, ABC's policies addressed each of the requirements. Policies and procedures described processes to ensure utilization review criteria were

applied consistently. During the on-site interview, ABC staff members described extensive interrater reliability training and testing. HSAG's on-site review of the denial records demonstrated that the staff implemented the policies as written.

While reviewing documents related to Standard II—Access and Availability, HSAG found that ABC's policies and procedures, member handbook, and provider manual included accurate and complete information regarding how to obtain emergency, urgently needed, and poststabilization services. On-site discussion with staff members demonstrated that ABC's staff had a clear understanding of poststabilization rules and requirements.

Recommendations

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

Coverage and Authorization of Services

- ABC was required to revise its applicable policies and templates to accurately describe the member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination.

Access and Availability

- ABC was required to require its providers to maintain hours of operation for Medicaid members that are no less than hours of operation for commercial members.

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 assigned Standard I—Coverage and Authorization of Services to the quality domain. The provider manual included accurate and complete information about ABC's utilization management (UM) program. ABC's policies and procedures were comprehensive and staff members appeared well-informed. ABC used the English and Spanish versions of the Health Literacy Advisor tool to assess and improve the readability of its member information.

Timeliness: Both standards included aspects that pertained to the timeliness domain and ABC's performance was very good. HSAG's on-site review of denial records demonstrated that ABC consistently met all time frame requirements. Also, ABC communicated all required appointment standards to providers and documented active monitoring of appointment and access to care requirements through multiple data sources.

Access: ABC had an adequate network with a variety of provider types and specialties to meet member needs. Furthermore, ABC routinely assessed members' distance to providers, provider-to-member ratios, and geographic distribution of network providers. ABC's provider manual required providers to be available 24 hours a day, seven days a week to respond to emergencies. ABC

provided a 24-hour crisis line for its members and communicated the availability of the line to its members.

Behavioral Healthcare, Inc. (BHI)

Findings

Table 5-4 presents the number of elements for each of the standards; the number of elements assigned a score of *Met, Partially Met, Not Met,* or *Not Applicable*; and the overall compliance score for the current year (FY 2013–2014).

Table 5-4—Summary of Scores for BHI

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	31	31	25	5	1	0	81%
Standard II—Access and Availability	15	15	15	0	0	0	100%
Totals	**46**	**46**	**40**	**5**	**1**	**0**	**87%***

*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)
Denials	150	102	94	8	48	92%
Totals	**150**	**102**	**94**	**8**	**48**	**92%**

Strengths

BHI discontinued delegation of UM processes to the community mental health centers (CMHCs) in October 2013 and centralized the UM processes at BHI. The plan established criteria for approving the common higher levels of care and lower levels of care, adopted InterQual criteria, and implemented the Altruista UM system. As a result, the staff reported that the interrater reliability increased, and BHI enhanced its relationships with CMHC providers who were then more actively engaged in managing member treatment throughout the continuum of care. During the denials record review, HSAG noted that the denial letters to members routinely included suggestions for the member to receive alternative services. This inclusion was not required but was offered by the plan in consideration of the member's best interests.

Reports reflected that BHI was performing regular and active analyses of a variety of data sources to assess adequacy and availability of the provider network, and that it was researching additional measures or methods of establishing benchmarks to guide network development. BHI was using a consolidated review of data, member satisfaction surveys, and grievance information to monitor accessibility and adequacy of services. In addition, BHI demonstrated active engagement with the

CHMCs to increase the level of accountability for effective interventions to improve provider performance, as necessary.

Recommendations

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

Coverage and Authorization of Services

- BHI was required to remove the technical language and State or federal regulation citations from the main body of the member's NOA letter to ensure ease of understanding.
- BHI was required to revise its NOA policy and ensure that if BHI extends the authorization decision time frame, it is in the member's interest, rather than a convenience for the BHO, and BHI must ensure that it is able to justify the need for the extension.
- BHI was required to ensure that the member is notified in writing of any decision to deny a service authorization and that NOAs are sent within the required time frame unless the member requests an extension or the BHO sends the notice of extension.
- BHI was required to inform the member in the written notice of extension of the member's right to file a grievance if the member disagrees with the decision to extend the time frame, and to correct its policy to accurately describe that the member has the right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination.
- BHI was required to revise its policies and procedures that address emergency and poststabilization services to ensure that if the BHI representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation (e.g., after hours), the health plan must allow for contact between the treating provider and the health plan medical director or physician designee, and the health plan must pay for the poststabilization services until one of these circumstances occurs—a plan physician assumes responsibility for the member's care, the treating physician and health plan reach an agreement, or the member is discharged.

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: Based on results from monitoring and assessment of the delegated UM processes by the CMHCs, BHI discontinued delegation to the CMHCs and began performing these UM operations in-house. As a result, the staff reported that the interrater reliability increased. This demonstrated BHI's commitment to providing consistent services and the likelihood of improving members' health outcomes. Although BHI's policies and program descriptions incorporated many of the elements or language of the Medicaid contract requirements, procedures for operationalizing the policies were often written at a very high level and did not clearly outline the processes of implementation.

Timeliness: HSAG found several issues related to the timeliness domain. Some of the time frames for authorization decisions were inconsistently stated among BHI's policies, provider manual, and its UM program description. HSAG also found evidence that BHI was inappropriately using extensions when processing authorization decisions. Furthermore, two of the 15 denial records reviewed on-site included NOAs that were not sent within the required time frame. These issues negatively impacted BHI's performance in the timeliness domain.

Access: Policies and procedures articulated BHI's commitment to maintaining an adequate provider network, including analysis to determine the number, mix, and geographic distribution of providers to meet the anticipated mental health needs of BHI's Medicaid population. Policies also addressed BHI's commitment to contract with providers representing diverse languages and cultures, and stated that the provider network included therapists certified in sign language as well as providers who specialize in treating the physically or developmentally disabled.

Colorado Health Partnerships, LLC (CHP)

Findings

Table 5-6 presents the number of elements for each of the standards; the number of elements assigned a score of *Met, Partially Met, Not Met,* or *Not Applicable*; and the overall compliance score for the current year (FY 2013–2014).

Table 5-6—Summary of Scores for CHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	31	31	31	0	0	0	100%
Standard II—Access and Availability	15	15	15	0	0	0	100%
Totals	**46**	**46**	**46**	**0**	**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.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	150	99	99	0	51	100%
Totals	**150**	**99**	**99**	**0**	**51**	**100%**

Strengths

CHP delegated UM functions to ValueOptions (VO). VO's experience at the national and local BHO levels resulted in well-defined UM systems and processes, a well-trained and qualified UM staff, efficient operations, and extensive reporting and oversight of utilization outcomes and UM

performance. In addition, on-site interviews demonstrated that leadership staff members were continuously seeking opportunities for improvement in UM processes.

Due to CHP's long-standing presence as the BHO in the region, CHP has secured contracts with the majority of qualified providers in the service area. Therefore, CHP has engaged in several initiatives related to expanding the availability of mental health services to members through nontraditional means such as provision of home-based services, telemedicine, and primary care provider training programs for medication management of depression.

CHP maintained information on provider specialty areas (e.g., adoption, marital counseling, and anger management) as well as any unique cultural expertise. This information is communicated to members in the provider network directory and/or used by the staff to align members with providers to address areas of special need.

Recommendations

CHP scored 100 percent on each of the two 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 CHP's compliance monitoring results related to each of the three domains.

Quality: CHP demonstrated strong performance in the quality domain. Its QM program description and medical necessity policies thoroughly addressed the structure and goals of the program. Staff members described processes that demonstrated good coordination among claims management, UM, care management, quality management, and communications with providers concerning UM decisions.

Timeliness: All 15 of CHP's denial records reviewed by HSAG met the required time frames. CHP's provider handbook required providers to maintain 24-hour, seven-day-per-week coverage and communicated all appointment response time requirements. CHP also printed appointment standards in its member handbook. The Measurement of Access and Availability policy delineated the process to monitor provider compliance with access standards.

Access: CHP submitted numerous reports that demonstrated active staff engagement in evaluating the sufficiency of the provider network. Reports stated that the CHP network was adequate to meet the requirements for distribution of providers—geographic as well as provider type (e.g., mental health centers, independent practitioners, essential community providers, variety of licensed professionals)—and to address diverse member needs. CHP monitored access and availability reports and data reflecting member perceptions of access and availability, such as member surveys and grievances and appeals. CHP maintained information on provider specialty areas and cultural expertise and used the information to align members with providers qualified to address the member's area of special need.

Foothills Behavioral Health Partners, LLC (FBHP)

Findings

Table 5-8 presents the number of elements for each of the standards; the number of elements assigned a score of *Met, Partially Met, Not Met,* or *Not Applicable*; and the overall compliance score for the current year (FY 2013–2014).

Table 5-8—Summary of Scores for FBHP							
Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	31	31	31	0	0	0	100%
Standard II—Access and Availability	15	15	15	0	0	0	100%
Totals	**46**	**46**	**46**	**0**	**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.

Table 5-9—Summary of Scores for FBHP's Record Review						
Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	150	97	97	0	53	100%
Totals	**150**	**97**	**97**	**0**	**53**	**100%**

Strengths

FBHP delegated UM functions to ValueOptions. FBHP's NOAs were based on templates to ensure inclusion of all required information and were also customized to included member-specific information. NOAs included additional information when needed to increase clarity or refer the member to level of care guidelines, or to recommend a more appropriate level of care.

FBHP integrated provider access monitoring data into the quality improvement work plan with ongoing tracking and interventions. VO had a Web-based authorization system used by providers to receive authorizations immediately, which significantly decreased the amount of time for members to access needed services. Provider training programs were robust and were offered at least quarterly via in-person presentations and Webinars, and FBHP also maintained information on its Web site.

Recommendations

FBHP scored 100 percent on each of the two 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 UM program was comprehensive and included all of the required elements to ensure the appropriate utilization of services. Methods for ensuring the consistency of utilization review decisions included a robust training package for clinical care managers, periodic case audits, annual interrater reliability testing, and a daily rounds process. All 15 of the denial records reviewed by HSAG were compliant with all required criteria. Many of FHBP's NOAs included information beyond what was required to increase clarity or refer the member to where additional information could be found.

Timeliness: Eleven of the 15 denial records reviewed by HSAG were expedited requests. None of the cases included an extension of the decision time frame. FBHP made and communicated its decision to the member and provider within the required time frames. FBHP required its providers to maintain coverage 24 hours a day, seven days a week and communicated all appointment standards to both providers and members. FBHP had mechanisms in place to monitor providers and for compliance with appointment standard requirements.

Access: Numerous reports demonstrated that FBHP maintained a sufficient provider network of mental health centers, independent practitioners, essential community providers, and licensed independent practitioners. FBHP used single case agreements (SCAs) as necessary to provide out-of-network services or to meet a member's unique treatment or cultural needs. Policies and procedures outlined processes for second opinions and out-of-network services at no cost to the member.

Northeast Behavioral Health Partnership, LLC (NBHP)

Findings

Table 5-10 presents the number of elements for each of the two 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 2013–2014).

Table 5-10—Summary of Scores for NBHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard I—Coverage and Authorization of Services	31	31	31	0	0	0	100%
Standard II—Access and Availability	15	15	15	0	0	0	100%
Totals	**46**	**46**	**46**	**0**	**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.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	150	97	97	0	53	100%
Totals	**150**	**97**	**97**	**0**	**53**	100%

Strengths

NBHP delegated UM functions to ValueOptions. VO's experience at the national and local BHO levels resulted in well-defined UM systems and processes, a well-trained and qualified UM staff, efficient operations, and extensive reporting and oversight of both patient outcomes and UM staff performance. UM processes included real-time verbal exchange of clinical information and authorization decisions between requesting providers and clinical care managers. Clinical care managers also offered peer-to-peer consultation to every provider prior to finalizing any adverse authorization decision.

NBHP engaged in several initiatives related to expanding the availability of mental health services to members through nontraditional means, such as the Curbside Consult program, which allowed providers to remotely access child psychiatrists for consultations. NBHP mental health centers partnered with the National Alliance on Mental Illness to educate communities—including local firefighters and police—about how to recognize mental health issues. NBHP hired additional peer specialists to help address the needs of the severely mentally ill by providing members with advocates.

Recommendations

NBHP scored 100 percent on each of the two 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 NBHP's compliance monitoring results related to each of the three domains. QM

Quality: NBHP's quality management/UM program description and medical necessity policies adequately addressed the structure, goals, and staff responsibilities of the UM program. UM staff members at all levels were appropriately qualified and well-trained in UM procedures. The clinical staff participated in an annual interrater reliability audit. All of the denial records reviewed by HSAG were compliant with all required criteria.

Timeliness: All 15 of the denial records reviewed were compliant with the required time frames. The provider manual and member handbooks communicated all appointment response time requirements and NBHP monitored providers to ensure compliance with these standards.

Access: NBHP's policies outlined the access requirements for network providers and described mechanisms used to measure provider-to-member ratios, geographic distribution, distance between members and provider locations, provider language expertise, appointment availability standards,

and the number of SCAs. NBHP updated its Network Development Plan, as needed, to address any potential deficiencies in its network. Staff members stated that NBHP was monitoring utilization carefully in order to anticipate changing demands for services related to the Medicaid expansion populations.

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

Table 5-12 and Table 5-13 show the overall statewide average for each standard and record review, followed by conclusions drawn from the results of the compliance monitoring activity. Appendix E contains summary tables showing the detailed site review scores for the site review standards, by BHO, and the statewide average.

Table 5-12—Statewide Scores for Standards

Standards	FY 2013–2014 Statewide Average*
Standard I—Coverage and Authorization of Services	**95%**
Standard II—Access and Availability	**99%**
Overall Statewide Compliance Score	**97%**

* 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 2013–2014 Statewide Average*
Denials	**98%**
Overall Statewide Score for Record Reviews	**98%**

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

Quality: Colorado's BHOs demonstrated strong performance in the quality domain, with three of the five BHOs achieving full compliance in Standard I—Coverage and Authorization of Services. All five BHOs had comprehensive UM programs and each employed a variety of mechanisms to ensure consistent standards where applied when making authorization decisions. The majority of denial records reviewed demonstrated that qualified clinicians were making determinations based on criteria, and NOAs included required content. Two of the five BHOs were required to revise applicable policies and templates to accurately and clearly describe a member's right to file a grievance (not an appeal) if he or she disagrees with the decision to extend the authorization decision time frame.

Timeliness: Similar to the quality domain, BHOs also demonstrated strong performance statewide in the timeliness domain. Of the 47 denial records reviewed by HSAG, only two included an NOA that was sent outside of the required time frame. Furthermore, HSAG found ample evidence that all five of the BHOs notified both providers and members about the appointment standards and conducted monitoring to ensure compliance with those standards.

Access: Colorado BHO performance in the access domain was exceptional. All five of the BHOs demonstrated robust provider networks and comprehensive programs to ensure availability of culturally competent services. Each organization demonstrated willingness to provide out-of-network services to meet a member’s unique treatment or cultural needs and when services requested were not available in-network.

Validation of Performance Measures

The Department required the collection and reporting of 11 performance measures for the FY 2013–2014 validation process. Five were HEDIS-like measures and six were developed by the Department and the BHOs. Some of these measures have multiple indicators (e.g., *Hospital Average Length of Stay* has two indicators: *Non-State Hospitals* and *All Hospitals*). Counting all indicators, the results yielded a total of 37 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. All measures were validated and reported in the previous year, and comparisons with the previous year's results are listed.

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 the BHO and the Department used 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, and access to, care provided by the BHOs, HSAG assigned each of the measures to one or more of the three performance domains shown 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 had no concerns or issues with the manner in which ABC received and processed eligibility data. Data files were downloaded daily from the Department's portal and were loaded into the transactional system. Files containing new consumer profiles, terminations, and changes for the month were downloaded. Eligibility files were received in an 834 file format. A reconciliation process for comparing the 834 eligibility file to the 820 capitation file was in place to ensure data accuracy.

HSAG identified no issues or concerns regarding policies/procedures for receiving, processing, and reporting claims and encounter data. Electronic claim files were submitted to a file transfer protocol (FTP) site and were subject to two automated quality check sweeps before electronic data interchange (EDI) claims were loaded into the PowerSTEPP transactional system. Paper claims were scanned via optical character recognition (OCR) software, batched, and converted into an 837 file format, and they were adjudicated by the contracted claims processing vendor, DST Systems. ABC had a good process in place for oversight of its claims processing vendor. A daily system check, quality meetings, weekly claims review reports, and monthly reconciliation processes were in place to ensure claims data accuracy. ABC also had excellent processes to monitor capitated providers' data submissions, including the use of a monthly volume report. Prior to submitting the encounters to the Department, all 837 files underwent an internal review process, including a code validity check to determine if these files were acceptable for submission.

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 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	96.1%	90.7%	*Report*
Improving Physical Healthcare Access	59.1%	86.4%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	6.2%	6.0%	*Report*
Adolescents 13 Through 17 Years of Age	14.8%	15.7%	*Report*
Adults 18 Through 64 Years of Age	19.1%	19.4%	*Report*
Adults 65 Years of Age or Older	6.7%	6.3%	*Report*
Penetration Rate by Service Category			
Inpatient Care	0.3%	0.3%	*Report*
Intensive Outpatient/Partial Hospitalization	0.05%	0.03%	*Report*
Ambulatory Care	10.2%	11.4%	*Report*
Overall Penetration Rates	11.5%	11.8%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	10.9%	10.5%	*Report*
AFDC/CWP Children	6.1%	6.2%	*Report*
AND/AB-SSI	33.7%	34.7%	*Report*
BC Children	6.2%	7.3%	*Report*
BC Women	13.4%	10.3%	*Report*
BCCP—Women Breast and Cervical Cancer	16.4%	15.7%	*Report*
Buy-in: Working Adults with Disabilities	—	35.7%	*Report*
Foster Care	43.2%	47.1%	*Report*
OAP-A	6.6%	6.2%	*Report*
OAP-B-SSI	24.2%	23.8%	*Report*
Modified Adjusted Gross Income	—	29.1%	*Report*
Buy-in: Children with Disabilities	—	15.4%	*Report*
Hospital Recidivism[1]			
Non-State Hospitals—7 Days	4.3%	1.9%	*Report*
30 Days	11.5%	7.3%	*Report*
90 Days	18.4%	13.3%	*Report*
All Hospitals—7 Days	4.3%	2.8%	*Report*
30 Days	11.4%	9.4%	*Report*
90 Days	18.9%	15.9%	*Report*

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

Performance Measures	Rate		FY 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
Hospital Average Length of Stay			
Non-State Hospitals	9.36	9.19	*Report*
All Hospitals	16.89	14.77	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	11.24	12.58	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	4.87	4.24	*Report*
All Hospitals	5.58	4.78	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	42.6%	39.7%	*Report*
30 Days	62.1%	59.4%	*Report*
All Hospitals—7 Days	42.5%	39.9%	*Report*
30 Days	62.2%	59.0%	*Report*

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

— Indicates the measure was not calculated.

Strengths

ABC had an outstanding readiness process in place for the October 2014 rollout of the ICD-10 implementation, including system analysis to ensure that ABC's system was capable of supporting ICD-10. ABC's performance measure reporting and process flow document is very detailed and serves as a valuable resource. ABC's performance measure team retained its core members for the past several years, adding to the reliability of existing processes.

ABC received a *Report* status for all audited performance measures. Increases in rates were observed for 19 indicators. Notable improvements (rate increase of more than 5 percentage points or a 10 percent change from prior year) were observed for *Improving Physical Health Access* (27.3 percentage-point increase), *90-day Hospital Recidivism* for non-state hospitals (5.1 percentage-point increase), *Emergency Room Utilization* (more than 10 percent decline in rate per 1,000 members), and *Inpatient Utilization* for non-state hospitals and all hospitals (more than 10 percent decline in rate per 1,000 members).

Recommendations

ABC should continue to work with the Department to address and resolve issues identified in the scope document, such as clarifying the type of mental health practitioners required. Decreases in rates were observed for 15 indicators, although only one (*Percent of Members with SMI with a Focal Point of Behavioral Health Care*) had a notable decline in performance of more than 5 percentage points. Additionally, although the decreases in rates for the *Follow-Up After Hospitalization for Mental Illness* were less than 5 percentage points, the decline was observed for both non-state and all hospitals for seven days and 30 days follow-up. ABC should investigate the reasons behind these declines.

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: The measures *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. ABC's performance on this domain was mixed, with the rate for *Percent of Members with SMI with a Focal Point of Behavioral Health Care* showing a decline for more than 5 percentage points and all indicators under the *Hospital Recidivism* measure showing an increase in rate. In particular, the *90 Days* indicator reported an improvement of 5.1 percentage points for non-state hospitals.

Timeliness: *Follow-Up After Hospitalization for Mental Illness* was the only timeliness measure reported this year. ABC's performance on this measure suggested opportunities for improvement. All indicators showed a rate decline from the previous year, although the decline was not significant, being about 3 percentage points.

Access: ABC's performance in the domain of access was mixed; opportunities for improvement existed for most of the measures. Although there were some rate changes in all of the indicators under *Penetration Rate*, the changes were no more than 5 percentage points. A decline in performance was noted in the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure (5.4 percentage points) and *Emergency Room Utilization* (12 percent). Improvement was observed for *Improving Physical Healthcare Access* (27.3 percentage points). For utilization-based access measures, *Inpatient Utilization* showed a decline of at least 10 percent for both non-state and all hospitals. Other utilization measures showed some slight changes in rates. It is important to assess utilization based on the characteristics of ABC's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the BHOs can use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Behavioral Healthcare, Inc.

Findings—System and Reporting Capabilities

BHI contracted with Colorado Access, an administrative service organization (ASO), to perform eligibility data processing. HSAG had no concerns with the manner in which BHI received and processed eligibility data. Daily change files and monthly full files were downloaded from the Department's portal and loaded into the transactional system. Eligibility files were received in an 834 file format and reconciled with the 820 capitation files monthly to ensure data accuracy.

HSAG identified no issues or concerns regarding policies/procedures for receiving, processing, and reporting claims and encounter data. Electronic claim files were submitted to an FTP site and were subject to two automated quality check sweeps prior to loading EDI claims into BHI's transactional system. Paper claims were scanned using OCR software, batched, and converted into an 837 file format and adjudicated by Colorado Access' contracted claims processing vendor, DST. A daily system check, quality meetings, weekly claims review reports, and monthly reconciliation processes

were in place to ensure claims data accuracy. BHI also had excellent processes to monitor encounters submitted by capitated providers via monthly volume reports. Prior to being submitted to the Department, all 837 files underwent an internal review process, including a code validity check to determine if these files were acceptable for submission.

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 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	92.8%	90.5%	*Report*
Improving Physical Healthcare Access	72.8%	87.1%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	6.4%	6.5%	*Report*
Adolescents 13 Through 17 Years of Age	16.7%	16.3%	*Report*
Adults 18 Through 64 Years of Age	18.3%	18.1%	*Report*
Adults 65 Years of Age or Older	4.6%	5.5%	*Report*
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.1%	*Report*
Intensive Outpatient/Partial Hospitalization	0.1%	0.08%	*Report*
Ambulatory Care	10.9%	11.2%	*Report*
Overall Penetration Rate	11.3%	11.4%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	12.9%	12.5%	*Report*
AFDC/CWP Children	7.0%	7.2%	*Report*
AND/AB-SSI	32.9%	32.5%	*Report*
BC Children	5.4%	6.8%	*Report*
BC Women	9.1%	7.9%	*Report*
BCCP—Women Breast and Cervical Cancer	12.1%	12.6%	*Report*
Buy-in: Working Adults with Disabilities	—	35.1%	*Report*
Foster Care	36.7%	34.5%	*Report*
OAP-A	4.6%	5.4%	*Report*
OAP-B-SSI	21.3%	23.2%	*Report*
Modified Adjusted Gross Income	—	35.6%	*Report*
Buy-in: Children with Disabilities	—	17.6%	*Report*

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

Performance Measures	Rate		FY 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	2.8%	3.0%	*Report*
30 Days	8.3%	7.9%	*Report*
90 Days	14.6%	12.4%	*Report*
All Hospitals—7 Days	3.0%	2.8%	*Report*
30 Days	8.8%	7.8%	*Report*
90 Days	15.1%	12.6%	*Report*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	7.13	7.76	*Report*
All Hospitals	15.54	12.90	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	9.95	9.94	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	2.87	2.81	*Report*
All Hospitals	3.83	3.39	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	57.8%	58.1%	*Report*
30 Days	70.8%	73.2%	*Report*
All Hospitals—7 Days	59.3%	61.2%	*Report*
30 Days	72.7%	75.2%	*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

BHI continued to have a very collaborative relationship with Colorado Access. As in prior years, BHI had the same cohesive team with a high degree of technical expertise responsible for performance measure calculation and reporting. BHI had an outstanding readiness process in place for the October 2014 rollout of the ICD-10 implementation, including system analysis to ensure that its system was capable of supporting ICD-10. BHI also had an excellent readiness process in place for the new claims transactional system QNXT implementation. BHI worked with the BHOs and the Department to revise the scope document.

BHI received a *Report* status for all audited performance measures. Increases in rates were observed for 24 indicators. Notable improvements were observed for *Improving Physical Health Access* (a 14.3 percentage-point increase) and *Inpatient Utilization* for all hospitals (more than 10 percent decline in rate per 1,000 members).

Recommendations

BHI should continue to work with the Department to address and resolve issues identified in the scope document, such as clarifying the type of mental health practitioners required. Although decreases in rates were observed for 10 indicators, none of these decreases suggested notable decline in performance. Nonetheless, HSAG observed opportunities for improvement on the *Hospital Average Length of Stay* indicator for non-state hospitals where the rate per 1,000 members increased by 8.9 percent while the same indicator for all hospitals declined (hence improved performance) by 17 percent. BHI should investigate the reason behind the diverse rate changes in the *Hospital Average Length of Stay* measure.

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: The measures *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. BHI's performance on this domain is mixed, with the rate for the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure showing a decline for more than 5 percentage points and all indicators under the *Hospital Recidivism* measure showing an increase, albeit less than 3 percentage points.

Timeliness: The *Follow-Up After Hospitalization for Mental Illness* measure was the only timeliness measure reported this year. BHI's rates showed an increase from the previous year, although by no more than 2.5 percentage points.

Access: BHI's performance in the access domain was mixed, with opportunities for improvement existing for most of the measures. Although there were some rate changes in all of the indicators under *Penetration Rate* and the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure, the changes were less than 5 percentage points. Improvement was observed for *Improving Physical Healthcare Access* (14.3 percentage points). For utilization-based access measures, *Hospital Average Length of Stay* showed rate changes in opposite directions between non-state hospitals (increased length of stay by 8.9 percent) and all hospitals (declined length of stay by 17 percent). *Inpatient Utilization* showed a notable decline in rate for all hospitals (11.4 percentage points). All other utilization measures reported some slight changes. It is important to assess utilization based on the characteristics of BHI's population. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, results provide additional information that BHOs 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 receiving and processing eligibility data. There were no major changes/updates to CHP's eligibility system since the previous reporting period. CHP's finance department retrieved a monthly proprietary flat file from the Department, which was loaded into the local system. In addition, daily eligibility update/change files were retrieved from the State's portal. CHP was using 834 file format and the prepaid health plans' (PHPs') interface file. Real-time eligibility was confirmed via the Department's portal.

HSAG had no concerns regarding CHP's process for receiving, processing, and reporting claims and encounter data. There were no major changes since the last reporting period. Encounter files were received on the 13th of each month in an 837 file format. CHP and the CMHCs carefully monitored encounter volumes and quality via report cards. Each CMHC received a report card with detailed information on the data CHP received from the CMHC. CHP researched and corrected encounter files for CMHCs with low volumes or high error rates prior to submitting the data to the Department. CHP also had an excellent process in place for quality control. CHP also performed an audit on all claims over $1,500.

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 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	85.9%	90.1%	*Report*
Improving Physical Healthcare Access	77.1%	92.1%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.3%	7.1%	*Report*
Adolescents 13 Through 17 Years of Age	18.7%	17.5%	*Report*
Adults 18 Through 64 Years of Age	19.9%	20.1%	*Report*
Adults 65 Years of Age or Older	6.9%	5.9%	*Report*
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	*Report*
Intensive Outpatient/Partial Hospitalization	0.00%	0.01%	*Report*
Ambulatory Care	12.7%	13.1%	*Report*
Overall Penetration Rate	13.4%	13.4%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	15.4%	15.1%	*Report*
AFDC/CWP Children	8.6%	8.3%	*Report*

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

Performance Measures	Rate		FY 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
AND/AB-SSI	28.9%	29.4%	*Report*
BC Children	6.1%	7.2%	*Report*
BC Women	14.4%	14.4%	*Report*
BCCP—Women Breast and Cervical Cancer	16.7%	14.8%	*Report*
Buy-in: Working Adults with Disabilities	—	26.0%	*Report*
Foster Care	31.6%	30.8%	*Report*
OAP-A	6.8%	5.8%	*Report*
OAP-B-SSI	20.0%	21.5%	*Report*
Modified Adjusted Gross Income	—	34.5%	*Report*
Buy-in: Children with Disabilities	—	13.0%	*Report*
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	2.4%	3.8%	*Report*
30 Days	7.9%	11.0%	*Report*
90 Days	14.9%	19.2%	*Report*
All Hospitals—7 Days	2.3%	3.3%	*Report*
30 Days	8.4%	10.0%	*Report*
90 Days	15.9%	17.7%	*Report*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	6.63	8.18	*Report*
All Hospitals	9.49	11.28	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	10.18	8.38	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.15	3.93	*Report*
All Hospitals	4.61	4.93	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	43.8%	44.5%	*Report*
30–Days	66.0%	64.3%	*Report*
All Hospitals—7 Days	48.5%	44.8%	*Report*
30–Days	70.0%	65.8%	*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

As in prior years, CHP had the same staff members responsible for performance measure calculation and reporting. CHP conducted regular meetings with staff members from information technology, quality, and finance departments to address any issues/concerns. The staff continues to be a cohesive team with a high degree of technical expertise.

CHP demonstrated an excellent monthly monitoring process of encounter submissions from its eight CMHCs via a report card format. The report card contained an executive summary with an overview of the CMHCs' overall performance as well as information on its timeliness of data submission, error counts, and error types. A monthly quality/clinical audit committee meeting was in place. CHP provided a quarterly reconciliation report to the CMHCs. Through this process, the CMHCs had the opportunity to reconcile encounter data before being submitted to the Department, which helped minimize errors and reduce the number of corrections.

CHP had an outstanding readiness process in place for the October 2014 rollout of the ICD-10 implementation. The readiness process included biweekly meetings, tools mapping, and verification that the available data fields were able to accommodate the required field size.

CHP received a *Report* status for all audited performance measures. Increases in rates were observed for 11 indicators. Notable improvements were observed for *Improving Physical Health Access* (a 15 percentage-point increase) and *Emergency Room Utilization* (more than 10 percent decline in rate per 1,000 members).

Recommendations

CHP should continue to work closely with the Department to evaluate the process of capturing the rendering providers and provider credentials. HSAG recommends that CHP continue to work with the Department to address and resolve issues identified in the scope document.

Decreases in rates were observed for 23 indicators, although only three indicators had a notable decline in performance. All three were related to inpatient service use: *Hospital Average Length of Stay* for both non-state hospitals and all hospitals showed an increase in the number of days by at least 15 percent. Additionally, *Inpatient Utilization* for both non-state hospitals had an increase in utilization rate per 1,000 members of close to 25 percent. CHP should investigate the reason behind the increase in use of inpatient services.

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: The measures *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* were the only quality measures reported this year. CHP's performance in this domain was mixed, with the rate for the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure showing an increase (4.2 percentage points) and all indicators under the *Hospital Recidivism* measure showing a decline in rate (ranging from 1 percentage point to 4.3 percentage points).

Timeliness: CHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) stayed relatively the same as the previous year's performance. One indicator (*Non-State Hospitals—7 Days*) reported an increase in rate of 0.7 percentage points but the other three showed a decline in rate ranging from 1.7 percentage points to 4.1 percentage points.

Access: CHP's performance in the access domain suggested opportunities for improvement, especially for *Penetration Rate*. Although there were some rate changes in all of the indicators under *Penetration Rate*, the changes were no more than 5 percentage points. Both the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure and the *Improving Physical Healthcare Access* measure reported an increase in rate, with the latter measure showing a notable improvement (15 percentage points). For utilization-based access measures, *Hospital Average Length of Stay* showed an increase of at least 15 percent in number of days for both non-state hospitals and all hospitals, with *Inpatient Utilization* showing a decline of at least 20 percent for non-state hospitals. On the other hand, *Emergency Room Utilization* showed a decline in utilization by 17.7 percent. It is important to assess utilization based on the characteristics of CHP'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 BHOs 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 receiving and processing eligibility data. There were no major changes/updates since the last reporting period. FBHP's national eligibility team retrieved monthly full eligibility flat files and daily change/update files from the Department's portal and loaded them into the local system. FBHP was using 834 file format and the prepaid health plans' interface file. Real-time eligibility was confirmed via the Department's portal.

HSAG identified no issues or concerns regarding FBHP's policies/procedures for receiving, processing, and reporting claims and encounter data. There were no major changes since the last reporting period. FBHP conducted a monthly data quality review to ensure encounter/claims record accuracy and completeness prior to data submission to the Department. The monthly data quality review allowed FBHP to identify encounter submission issues or data issues early. FBHP received all encounters electronically. Paper claims were scanned and converted into an electronic format via OCR. In addition, paper claims underwent an intense quality check for added quality control prior to processing.

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 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	91.1%	93.1%	*Report*
Improving Physical Healthcare Access	73.1%	87.2%	*Report*

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

Performance Measures	Rate		FY 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	12.9%	12.4%	*Report*
Adolescents 13 Through 17 Years of Age	26.3%	22.8%	*Report*
Adults 18 Through 64 Years of Age	24.4%	22.7%	*Report*
Adults 65 Years of Age or Older	7.3%	7.9%	*Report*
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	*Report*
Intensive Outpatient/Partial Hospitalization	0.02%	0.03%	*Report*
Ambulatory Care	15.0%	17.0%	*Report*
Overall Penetration Rate	18.2%	17.2%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	17.4%	15.4%	*Report*
AFDC/CWP Children	14.8%	13.7%	*Report*
AND/AB-SSI	35.8%	35.0%	*Report*
BC Children	8.6%	10.5%	*Report*
BC Women	15.7%	11.0%	*Report*
BCCP—Women Breast and Cervical Cancer	15.8%	17.0%	*Report*
Buy-in: Working Adults with Disabilities	—	62.6%	*Report*
Foster Care	38.8%	37.2%	*Report*
OAP-A	7.2%	7.8%	*Report*
OAP-B-SSI	26.8%	23.9%	*Report*
Modified Adjusted Gross Income	—	43.6%	*Report*
Buy-in: Children with Disabilities	—	3.0%	*Report*
Hospital Recidivism[1]			
Non-State Hospitals—7 Days	4.5%	2.8%	*Report*
30 Days	9.9%	9.5%	*Report*
90 Days	19.7%	14.4%	*Report*
All Hospitals—7 Days	4.0%	2.8%	*Report*
30 Days	10.8%	9.1%	*Report*
90 Days	19.5%	14.2%	*Report*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	7.00	7.28	*Report*
All Hospitals	19.05	20.03	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	9.68	9.59	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.11	4.13	*Report*
All Hospitals	5.28	5.97	*Report*

Table 5-18—Review Results and Audit Designation *for* FBHP			
Performance Measures	Rate		FY 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	54.0%	49.5%	*Report*
30 Days	71.1%	66.7%	*Report*
All Hospitals—7 Days	57.7%	49.2%	*Report*
30 Days	75.5%	67.8%	*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

As in prior years, FBHP had the same cohesive team, with a high degree of technical expertise, responsible for performance measure calculation and reporting.

FBHP had an excellent process to monitor ValueOptions, to whom it delegated claims processing and rate reporting. Monthly quality assurance committee meetings were in place, which gave both parties opportunities to address any issues or concerns. FBHP also demonstrated outstanding monitoring of its two CMHCs' monthly encounter submissions via a report card format. This tool was excellent in providing oversight of each CMHC's data submission timeliness, error types, and error counts. The report card contained an executive summary with an overview of the CMHC's overall performance. Each quarter, FBHP issued a reconciliation report to the CMHCs. This process allowed them to make necessary corrections prior to FBHP's encounter submission to the Department, helping to minimize errors and reduce the number of corrections.

FBHP had an excellent readiness process in place for the October 2014 rollout of the ICD-10 implementation. This included biweekly meetings, tool mapping, and verification that the available data fields were able to accommodate the required field size.

FBHP also reconciled the 837 file encounter data with the flat file format submitted to the Department. As a result of the close monitoring process, all data submitted to the Department were acceptable with very minimal and minor issues.

FBHP received a *Report* status for all audited performance measures. Increases in rates were observed for 16 indicators. Notable improvements were observed for *Improving Physical Healthcare Access* (a 14.2 percentage-point increase) and *90-day Hospital Recidivism* for both non-state and all hospitals (a 5.3 percentage-point increase each).

Recommendations

HSAG recommended that FBHP should continue to work closely with the Department to evaluate the process of capturing the rendering providers and provider credentials, as well as to address and resolve issues identified in the scope document.

Decreases in rates were observed for 18 indicators. A notable decline in performance was observed for *Inpatient Utilization* for both non-state and all hospitals (more than 10 percent increase in rate per 1,000 members) and 7-day and 30-day *Follow-Up After Hospitalization for Mental Illness* for state hospitals (8.5 percentage-point decline and 7.7 percentage-point decline, respectively). FBHP should investigate the reason behind these declines 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: The *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* measures were the only quality measures reported for this year. FBHP's performance on this domain demonstrated improvement from the previous year. All indicators under this domain showed an increase in rates, with notable improvement observed for the *90-day Hospital Recidivism* indicators for both non-state hospitals and all hospitals (5.3 percentage points).

Timeliness: FBHP's performance on the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) showed a decline from the previous year. All indicators under this measure showed a decline in rates of at least 4 percentage points, with state hospitals showing a decline of more than 5 percentage points.

Access: FBHP's performance in the domain of access was mixed, with opportunities for improvement present for most of the measures. Although there were some rate changes in all of the indicators under *Penetration Rate* and *Percent of Members with SMI with a Focal Point of Behavioral Health Care*, the changes were no more than 5 percentage points. Notable improvement was observed for *Improving Physical Healthcare Access* (14.2 percentage points). For utilization-based access measures, *Inpatient Utilization* showed a decline in performance of at least 10 percent for both non-state and all hospitals. Other utilization measures reported some slight changes. 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 receiving and processing eligibility data. There were no major changes/updates since the last reporting period. NBHP's national eligibility team retrieved the monthly full eligibility flat files and daily change/update files from the Department's portal and loaded this information into the local system. Eligibility files were received using multiple file formats (834 file, PHPs interface file, capitation report, and 820 file). Real-time eligibility was confirmed via the Department's portal.

HSAG identified no issues or concerns regarding NBHP's policies/procedures for receiving, processing, and reporting claims and encounter data. There were no major changes since the last reporting period. Electronic claims/encounters were received in an 837 file format and were subject to automated quality check sweeps prior to loading EDI claims into NBHP's claims system. Paper claims were scanned and the data were translated into an electronic format via OCR. In addition, prior to processing, paper claims underwent a more intense quality check for added quality control. The claims/encounters volume and quality were carefully monitored via data report cards, which included an executive summary, detailed reports on various error categories, data reconciliation, and file submission timeliness. Through these report cards, CMHCs could research any issues with low submission volumes or high error rates and continually improve submission quality.

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 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	81.3%	90.9%	*Report*
Improving Physical Healthcare Access	74.7%	91.0%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	6.9%	7.5%	*Report*
Adolescents 13 Through 17 Years of Age	20.2%	20.8%	*Report*
Adults 18 Through 64 Years of Age	19.5%	20.8%	*Report*
Adults 65 Years of Age or Older	5.9%	6.8%	*Report*
Penetration Rate by Service Category			
Inpatient Care	0.3%	0.3%	*Report*
Intensive Outpatient/Partial Hospitalization	0.00%	0.01%	*Report*
Ambulatory Care	12.2%	13.4%	*Report*
Overall Penetration Rate	12.7%	13.8%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	13.9%	15.2%	*Report*
AFDC/CWP Children	8.7%	9.5%	*Report*
AND/AB-SSI	32.3%	33.4%	*Report*
BC Children	4.7%	7.2%	*Report*
BC Women	10.3%	11.4%	*Report*
BCCP—Women Breast and Cervical Cancer	10.1%	7.1%	*Report*
Buy-in: Working Adults with Disabilities	—	32.3%	*Report*
Foster Care	35.1%	35.1%	*Report*
OAP-A	5.9%	6.8%	*Report*
OAP-B-SSI	22.8%	21.8%	*Report*
Modified Adjusted Gross Income	—	44.0%	*Report*
Buy-in: Children with Disabilities	—	12.5%	*Report*

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

Performance Measures	Rate		FY 2013–2014 Audit Designation
	FY 2012–2013	FY 2013–2014	
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	1.6%	2.3%	*Report*
30 Days	5.9%	4.2%	*Report*
90 Days	10.9%	7.4%	*Report*
All Hospitals—7 Days	1.8%	2.1%	*Report*
30 Days	5.9%	4.8%	*Report*
90 Days	11.7%	8.8%	*Report*
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	6.48	6.19	*Report*
All Hospitals	7.83	8.60	*Report*
Emergency Room Utilization (Rate/1000 Members, All Ages)	10.23	11.24	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	4.09	3.62	*Report*
All Hospitals	4.33	3.87	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	51.4%	50.8%	*Report*
30–Days	70.2%	69.6%	*Report*
All Hospitals—7 Days	51.9%	50.5%	*Report*
30 Days	71.0%	68.5%	*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

As in prior years, NBHP had the same staff members responsible for performance measure calculation and reporting. This staff continued to be a cohesive team with a high degree of technical expertise.

NBHP had an excellent process to monitor ValueOptions, to whom it delegated claims processing and rate reporting. Monthly quality assurance committee meetings were in place, which gave both parties opportunities to address any issues or concerns. NBHP demonstrated outstanding monitoring of its three CMHCs' monthly encounter submissions by using a report card format. This tool was excellent in providing oversight of each CMHC's data submission timeliness, error types, and error counts. The report card contained an executive summary with an overview of the CMHC's overall performance. A reconciliation report was provided quarterly to the CMHCs. Through this process, the CMHCs had an opportunity to reconcile encounter data prior to submission to the Department, which helped minimize errors and reduce the number of corrections.

NBHP had an outstanding readiness process in place for the October 2014 rollout of the ICD-10 implementation. Biweekly meetings, tool mapping, and verification that the available data fields were able to accommodate the required field size were included in the readiness process.

NBHP also reconciled the encounter data between its 837 file format and the flat file format submitted to the Department. As a result of the close monitoring process, data submitted to the Department contained very few issues.

NBHP received a *Report* status for all audited performance measures. Increases in rates were observed for 22 indicators. Notable improvements were observed for *Percent of Members with SMI with a Focal Point of Behavioral Health Care* (9.6 percentage points), *Improving Physical Healthcare Access* (16.3 percentage points), and *Inpatient Utilization* for both non-state and all hospitals (more than 10 percent decline in rate per 1,000 members).

Recommendations

NBHP should continue to work with the Department 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.

Although decreases in rates were observed for 12 indicators, only two reported a rate change and an approximate notable decline in performance. The *Hospital Average Length of Stay* for all hospitals and *Emergency Room Utilization* showed a decline of nearly 10 percent. NBHP should investigate the reasons behind these declines.

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: The *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* measures were the only quality measures reported for this year. NBHP's performance in this domain demonstrated overall improvement. The rate for the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure showed a notable increase in rate (9.6 percentage points). There were rate changes in all indicators under *Hospital Recidivism*, but none showed a change from the previous year of more than 5 percentage points.

Timeliness: NBHP's performance in the only timeliness measure (*Follow-Up After Hospitalization for Mental Illness*) demonstrated declines over the previous measurement period. However, none of the decline was more than 2.5 percentage points.

Access: NBHP's performance in the access domain demonstrated overall improvement. Most of the rate changes in the indicators under *Penetration Rate* were increases from the previous year, although the increases were no more than 2.5 percentage points. Increases in rates were observed for *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and Improving Physical Healthcare Access (9.6 percentage points and 16.3 percentage points, respectively). For utilization-based access measures, *Inpatient Utilization* and *Hospital Average Length of Stay* showed a decline in rates for at least 10 percent for both non-state and all hospitals, whereas *Emergency Room Utilization* showed a rate increase of close to 10 percent. Other utilization measures showed some slight changes. It is important to assess utilization based on the characteristics of NHBP'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 BHOs 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 2013–2014 and the prior year.

Table 5-20—Statewide Weighted Average Rates for the Performance Measures			
Performance Measures	Rate		BHO FY 2013–2014 Rate Variations
	FY 2012–2013	FY 2013–2014	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	89.9%	90.8%	90.1%–93.1%
Improving Physical Healthcare Access	72.8%	89.3%	86.4%–92.1%
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.4%	7.4%	6.0–12.4%
Adolescents 13 Through 17 Years of age	18.7%	18.0%	15.7%–22.8%
Adults 18 Through 64 Years of age	19.9%	20.0%	18.1%–22.7%
Adults 65 Years of Age or Older	6.3%	6.3%	5.5%–7.9%
Penetration Rate by Service Category			
Inpatient Care	0.2%	0.2%	0.1%–0.3%
Intensive Outpatient/Partial Hospitalization	0.03%	0.03%	0.006%–0.08%
Ambulatory Care	12.0%	12.8%	11.2%–17.0%
Overall Penetration Rate	13.0%	13.1%	11.4%–17.2%
Penetration Rate by Medicaid Eligibility			
AFDC/CWP Adults	14.2%	13.9%	10.5%–15.4%
AFDC/CWP Children	8.4%	8.4%	6.2%–13.7%
AND/AB–SSI	31.8%	32.1%	29.4%–385.0%
BC Children	6.0%	7.5%	6.8%–10.5%
BC Women	12.5%	11.5%	7.9%–14.4%
BCCP—Women Breast and Cervical Cancer	15.0%	14.0%	7.1%–17.0%
Buy-in: Working Adults with Disabilities	—	36.6%	26.0%–62.6%
Foster Care	35.9%	35.2%	30.8%–47.1%
OAP-A	6.2%	6.2%	5.4%–7.8%
OAP-B-SSI	22.3%	22.6%	21.5%–23.9%
Modified Adjusted Gross Income	—	35.2%	29.1%–44.0%
Buy-in: Children with Disabilities	—	13.0%	3.0%–17.6%

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

Performance Measures	Rate		BHO FY 2013–2014 Rate Variations
	FY 2012–2013	FY 2013–2014	
***Hospital Recidivism*[1]**			
Non-State Hospitals—7 Days	3.0%	3.0%	1.9%–3.8%
30 Days	8.8%	8.7%	4.2%–11.0%
90 Days	15.6%	14.7%	7.4%–19.2%
All Hospitals—7 Days	3.0%	2.9%	2.1%–3.3%
30 Days	9.1%	8.8%	4.8%–10.0%
90 Days	16.3%	14.9%	8.8%–17.7%
Hospital Average Length of Stay (All Ages)			
Non-State Hospitals	7.39	7.93	6.19–9.19
All Hospitals	13.29	13.29	8.60–20.03
Emergency Room Utilization (Rate/1000 Members, All Ages)	10.25	9.97	8.38–12.58
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.49	3.69	2.81–4.24
All Hospitals	4.63	4.51	3.39–5.97
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	48.3%	47.3%	39.7%–58.1%
30 Days	67.1%	65.8%	59.4%–73.2%
All Hospitals—7 Days	50.9%	48.0%	39.9%–61.2%
30 Days	69.7%	66.8%	59.0%–75.2%

[1] For the *Hospital Recidivism* measure, an increase over the prior 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*. Although increases in rates were observed for 19 of the 37 indicators, notable improvement was observed for only one indicator (*Improving Physical Healthcare Access*, with an increase of 16.5 percentage points).

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. Some BHOs should also address specific issues with the Department,

such as required diagnoses for select measures or evaluating the process of capturing the rendering providers and provider credentials.

Although decreases in rates were observed for 15 indicators, none reflected notable declines from the previous year. HSAG continued to observe wide rate variations (more than 10 percentage points) by BHO in select eligibility categories for *Penetration Rate*, *90-day Hospital Recidivism* for non-state hospitals, and all four *Follow-Up After Hospitalization for Mental Illness* indicators. The Department should continue to identify performance measures with persistently low rates and initiate statewide performance improvement projects to reduce variations in performance among the BHOs.

Quality: The *Percent of Members with SMI with a Focal Point of Behavioral Health Care* and *Hospital Recidivism* measures were the only quality measures reported for this year. Statewide performance on both of these measures showed very slight change from the previous year (no more than a 1.5 percentage-point change). Wide rate variation (more than 5 percentage points) by BHO, as noted in *30-day* and *90-day Hospital Recidivism* for non-state and all hospitals, suggested room for continued improvement.

Timeliness: The *Follow-Up After Hospitalization for Mental Illness* measure was the only timeliness measure this year. Statewide performance on this measure showed some slight decline from the previous year's results. The decline in rate was no more than 3 percentage points. The variations in rates by BHO were above 10 percentage points for all indicators, suggesting room for continued improvement.

Access: Overall, statewide BHO performance in the access domain for the performance measures was very similar to the previous year's performance, with the exception of *Improving Physical Healthcare Access,* where a 16.5 percentage-point improvement was observed. Although all *Penetration Rate* indicators showed either similar performance or a decline in performance compared to the previous, none had a change in rate of more than 1.5 percentage points.

Statewide performance on the utilization-based measures was similar to last year, with change in rates of no more than 10 percent from the previous year's results. While HSAG cannot draw conclusions based on utilization results, if combined with other performance metrics, each BHO's results provide additional information that the BHOs can use to further assess barriers or patterns of utilization when evaluating improvement interventions. BHO rate variation were greatest in *Hospital Average Length of Stay* for all hospitals, where the range between the lowest and highest average length of stay was 11.4 days.

Validation of Performance Improvement Projects

For FY 2013–2014, HSAG validated one PIP for each of the five BHOs. Table 5-21 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)	*Care Coordination Between Behavioral Health and Primary Care*
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+*

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 second year for this PIP. ABC completed Activities I through IV and VI through IX, and reported results from the first remeasurement.

Table 5-22 provides a summary of ABC's combined PIP validation results for the FY 2013–2014 validation cycle.

Table 5-22—FY13–14 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)

Table 5-22—FY13–14 Performance Improvement Project Validation Results *for* ABC (n=1PIP)

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Implementation	VII.	Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total			100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			100% (4/4)	0% (0/4)	0% (0/4)
Percent Score of Applicable Evaluation Elements *Met*			**100% (25/25)**		

ABC demonstrated strong performance in conducting PIPs by receiving *Met* scores for all applicable evaluation elements for Activities I through IV and VI through IX. The plan documented a solid study design, which is essential to producing methodologically sound results. The interpretation of the PIP results was accurate and the study indicator demonstrated statistically significant improvement at Remeasurement 1. The ABC overall score for applicable evaluation elements that were met was 100 percent, wherein 25 of 25 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 2013–2014 validation cycle.

Table 5-23—FY13–14 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 Topic: Increasing Access to Mental Health Services for Youth				
Percentage of BHO members ages 5–17 with at least one mental health service contact in the measurement year.	10.19%	11.36	1.17↑	$p < 0.0001$

↑ Denotes an increase in the study indicator rate from the previous measurement period.

ABC documented a rate of 11.36 percent at the first remeasurement. The Remeasurement 1 result was a statistically significant ($p < 0.0001$) increase of 1.17 percentage points over the baseline percentage of eligible members having at least one mental health service contact in the measurement year. The statistically significant increase met the health plan's goal for the first remeasurement.

Strengths

ABC demonstrated strong performance in all stages of the PIP process by achieving *Met* scores for all applicable evaluation elements in Activities I through IV and VI through IX. The PIP's solid

study design laid the foundation for accurate data analysis and interpretation, and effective implementation of improvement strategies. ABC's strong performance on *Increasing Access to Mental Health Services for Youth* culminated in the PIP achieving statistically significant improvement, from baseline to Remeasurement 1, in the percentage of eligible members having at least one mental health service during the measurement year.

Interventions

For the current validation cycle, ABC documented that it would continue using standardized interventions in 2014, including the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program, designating specific care managers to coordinate care for children and adolescents, disseminating behavioral health resource information to primary care practices, distributing resource information to consumers, and partnering with public schools and crisis services to provide behavioral health resource and referral information to school staffs, students, and parents. ABC documented that it would evaluate interventions by tracking how many consumers called for behavioral health services as a result of receiving the flyer or seeing an article in the newsletter. Care managers will also track referral source information in 2014.

Recommendations

Based on the results of ABC's *Increasing Access to Mental Health Services for Youth* PIP validation for the FY 2013–2014 validation cycle, HSAG offers several recommendations. The health plan should ensure that each intervention is accompanied by an ongoing evaluation process to determine effectiveness throughout implementation. The evaluation process and results for each intervention should be thoroughly and clearly documented in the PIP summary form. Evaluation results should be used alongside recurring causal/barrier analyses to determine whether interventions should be continued, revised, or discontinued, in order to achieve outcomes improvement as efficiently as possible.

Behavioral Healthcare, Inc.

Findings

This was the third 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 IX and reported results from the first remeasurement.

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—FY13–14 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% (9/9)	0% (0/9)	0% (0/9)
	VIII.	Interventions and Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total			100% (13/13)	0% (0/13)	0% (0/13)
Outcomes	IX.	Real Improvement	25% (1/4)	50% (2/4)	25% (1/4)
	X.	Sustained Improvement	*Not Assessed*		
Outcomes Total			25% (1/4)	50% (2/4)	25% (1/4)
Percent Score of Applicable Evaluation Elements *Met*			**91% (32/35)**		

BHI's *Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics* PIP received a *Met* score for 91 percent of all applicable evaluation elements. For the FY 2013–2014 validation cycle, the health plan progressed to reporting data from the first remeasurement and completed Activities I–IX. The PIP met 100 percent of the applicable evaluation requirements in the design and implementation stages but was scored down in the outcomes stage because not all of the study indicators demonstrated improvement during the first remeasurement. Overall, the PIP received a *Met* validation status, with 100 percent of critical evaluation elements and 91 percent of all applicable evaluation elements receiving a *Met* score.

Table 5-25 provides a summary of BHI's PIP-specific outcomes for the FY 2013–2014 validation cycle.

Table 5-25—FY13–14 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 Topic: *Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics*				
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%	9.97%	3.26↑	*p*=0.1875 *Not Statistically Significant*
Study Indicator 1b: Percentage of documented follow-up for abnormal lab results within 30 days from the date of lab documentation.	NA	100.00%	NA*	NA*

Table 5-25—FY13–14 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)
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%	7.72%	3.03↑	*p*=0.1342 *Not Statistically Significant*
Study Indicator 2b: Percentage of documented follow-up for abnormal lab results within 30 days from the date of the lab documentation.	57.14%	45.83%	11.31↓	*p*=0.6851 *Not Statistically Significant*

↑ Denotes an increase in the study indicator rate from the previous measurement period.
*No comparison could be made between baseline and Remeasurement 1 because a baseline rate was not calculated.

For the first remeasurement of the BHI *Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics* PIP, Study Indicators 1a and 2a demonstrated nonstatistically significant improvement over baseline. The percentage of eligible members with a documented plasma glucose lab result in the desired time frame increased by 3.26 percentage points and the percentage of eligible members with documented fasting lipid panel lab results increased by 3.03 percentage points at Remeasurement 1. In contrast, Study Indicator 2b demonstrated a decrease of 11.31 percentage points in the percentage of abnormal lipid panel results with documented timely follow-up at Remeasurement 1. Because a baseline rate could not be calculated for Study Indicator 1b, this indicator could not be assessed for improvement at the first remeasurement.

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.

Interventions

BHI determined that the prioritized barriers from baseline would remain the same for the first remeasurement, with the exception of the barrier regarding consumers losing the lab referral. BHI did not find this to be a crucial problem because the consumer can lose the lab referral and still complete the lab. BHI documented that in the first remeasurement, a large percentage of providers were still not ordering labs when consumers started a new atypical antipsychotic medication. In addition, the practice guideline did not include the documentation requirements. The BHO's chief medical officer plans to review the practice guidelines and discuss with providers what is being assessed and how improvement is defined. Going forward, the practice guidelines will be updated at least every two years, or as needed. Providers will continue to be informed of revisions to the practice guidelines.

BHI is also in the process of developing a new practice guideline program. A consumer information sheet about the practice guidelines will be created using consumer input and distributed to consumers

at various provider locations and on the provider's Web site. The consumer information sheet will also be discussed with the Member Advisory Board. In addition, BHI is refining its care management program. Care managers will be educated on the practice guidelines and help coordinate care for consumers between lab facilities and providers.

Recommendations

Based on the results of BHI's *Improving Metabolic Lab Documentation, Review, and Follow-Up for Clients Prescribed Atypical Antipsychotics* PIP validation for the FY 2013–2014 validation cycle, HSAG offers several recommendations. When selecting study indicators, the BHO should consider the potential population size for all indicators. Study indicators with a very small, or potentially zero, eligible population will make it difficult to assess improvement because it may result in rates that are not comparable across measurement periods. Also, if desired improvement in the study indicator is not achieved during a remeasurement period, the BHO should revisit the causal/barrier analysis process to consider potential barriers that were not addressed, as well as use intervention evaluation results to guide refinement of improvement strategies going forward.

Colorado Health Partnerships, LLC

Findings

This was the seventh 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 among physical and mental health providers. CHP completed Activities I through X and reported Remeasurement 5 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—FY13–14 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)

Table 5-26—FY13–14 Performance Improvement Project Validation Results *for* CHP (n=1 PIP)					
Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
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, with 45 of 49 elements receiving 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 demonstrate improvement in outcomes or sustained improvement during the current measurement period. CHP received a *Met* validation status. Overall, 92 percent of all applicable evaluation elements and 100 percent of critical evaluation elements received a *Met* score, yielding an overall *Met* validation status.

Table 5-27 provides a summary of CHP's PIP-specific outcomes for the FY 2013–2014 validation cycle.

	Table 5-27—FY13–14 Performance Improvement Project Specific Outcomes *for* CHP (n=1 PIP)								
PIP Study Indicator	Baseline	Remeasurement 1	Remeasurement 2	Remeasurement 3	Remeasurement 4	Remeasurement 5	Percentage Point Change	Statistical Significance (*p* value)	Sustained Improvement
	PIP Topic: ***Care Coordination Between Behavioral Health and Primary Care***								
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%	90.1%	5.1↑	$p<0.0001$ *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%	40.3%	9.1↓	$p=0.0152$ *Statistically Significant*	No

↑ Denotes an increase in the study indicator rate from the previous measurement period.
↓ Denotes a decrease in the study indicator rate from the previous measurement period.

CHP reported Remeasurement 5 results for the *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP. During the fifth remeasurement, CHP reported an increase in the Study Indicator 1 rate, from 85.0 percent to 90.1 percent. The rate increase was statistically significant with a *p* value less than 0.0001, and the plan met the Study Indicator 1 goal. The Study Indicator 2 rate decreased from 49.4 percent in Remeasurement 4 to 40.3 percent in Remeasurement

5. The rate decrease was statistically significant with a *p* value of 0.0152. During this measurement period, only Study Indicator 1 (penetration rate) demonstrated sustained improvement. Study Indicator 2 (documentation rate) did not achieve sustained improvement due to a statistically significant decline from Remeasurement 4 to Remeasurement 5.

Strengths

CHP demonstrated strength in Activities I through VIII by receiving *Met* scores for all applicable evaluation elements. The health 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.

Interventions

During the FY 2013–2014 validation cycle, CHP documented that annual compliance audit monitoring will be continued for all providers to ensure that the mental health agencies are addressing coordination of care satisfactorily. In July 2013, the health plan began conducting quarterly coordination of care chart audits and discussing the results. CHP anticipates that the barriers associated with coordination of care will be addressed as the health plan begins to implement the integration models associated with contract requirements and oversight monitoring of the new contract term.

Recommendations

Based on the results of CHP's *Coordination of Care Between Medicaid Physical and Behavioral Health Providers* PIP validation for the FY 2013–2014 validation cycle, HSAG offers several recommendations. The BHO should ensure that all data analysis results and interpretation are reported accurately and consistently throughout the PIP documentation. The BHO should also document regularly recurring causal/barrier analyses throughout the life of the PIP. The PIP documentation should include detailed information about the quality improvement processes and tools used for the causal/barrier analyses, as well as the data used. Additionally, identified barriers should be prioritized and the process for prioritizing should be documented. Finally, each intervention developed to address priority barriers should be evaluated for effectiveness and the PIP documentation should include a description of the ongoing evaluation process and results. Results of the causal/barrier analyses and intervention evaluations should be used to guide decisions about continuing, revising, or discontinuing interventions during the life of the PIP.

Foothills Behavioral Health Partners, LLC

Findings

The FBHP *Reducing Overall 90-Day Hospital Recidivism* PIP focused on reducing the percentage 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 second year FBHP submitted this PIP for validation. FBHP completed Activities I through IV and VI through IX and reported results from the first remeasurement.

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—FY13–14 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% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
		Implementation Total	100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement	100% (4/4)	0% (0/4)	0% (0/4)
	X.	Sustained Improvement	*Not Assessed*		
		Outcomes Total	100% (4/4)	0% (0/4)	0% (0/4)
Percent Score of Applicable Evaluation Elements Met			**100% (25/25)**		

FBHP's strong performance in Activities I through VI and VII and VIII indicates that the PIP was appropriately designed and implemented to measure outcomes and improvement. The solid study design and effective implementation of the PIP resulted in achievement of statistically significant improvement in the outcomes stage at the first remeasurement. The FBHP overall score for applicable evaluation elements *Met* was 100 percent, with 25 of 25 elements receiving a *Met* score. The PIP received a *Met* validation status.

Table 5-29 provides a summary of FBHP's PIP-specific outcomes for the FY 2013–2014 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 TOPIC: *Reducing Overall Hospital 90-Day Recidivism*				
The percentage of all hospital consumer discharges, for treatment of a covered mental health diagnosis, which do 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%	14.19	5.34↓^	*p*=0.0377 *Statistically Significant*

↓^ Denotes a decrease in the study indicator rate from the previous measurement period, which indicated an improvement in performance for this PIP.

For the first remeasurement, FBHP reported that 14.19 percent of consumers were readmitted to the hospital within 30 days of discharge. The Remeasurement 1 rate was a statistically significant decrease of 5.34 percentage points from the baseline rate. The study indicator for this PIP is inverse and the decrease in the rate represents an improvement in the outcomes.

Strengths

For the FY 2013–2014 validation cycle, the BHO progressed to reporting first remeasurement results and completed Activities I–IX. The BHO met the goal of achieving statistically significant improvement from baseline to the first remeasurement. FBHP demonstrated strength by receiving *Met* scores for all applicable evaluation elements.

Interventions

During the first remeasurement period, the BHO continued interventions, including same- or next-day provider appointments, implementation of discharge and follow-up guidelines, and hiring of additional staffing to provide transition care for consumers. The BHO revised interventions based on intervention evaluation. In addition, the BHO reported developing and revising procedures for tracking weekly telephone calls; outreach after no-shows; and self-care/crisis plans through electronic health record reporting, staff training on documentation, and use of spreadsheets. FBHP reported that it will collect data from centers quarterly and monitor progress.

Recommendations

Based on the results of FBHP's *Reducing Overall 90-Day Hospital Recidivism* PIP validation for the FY 2013–2014 validation cycle, HSAG offers several recommendations. The BHO should document regularly recurring causal/barrier analyses throughout the life of the PIP. The PIP documentation should include detailed information about the quality improvement team and the processes and tools used for the causal/barrier analyses, as well as data used. Additionally, identified barriers should be prioritized and the process for prioritizing should be documented. Finally, each intervention should be evaluated for effectiveness and the PIP documentation should

include a description of the ongoing evaluation process and results. Results of the causal/barrier analyses and intervention evaluations should be used to guide decisions about continuing, revising, or discontinuing interventions during the life of the PIP.

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 second year this PIP was submitted for validation, and NBHP completed Activities I through IV and VI through IX. 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 outcomes-focused validation methodology.

Table 5-30—FY13–14 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.	Data Analysis and Interpretation	100% (8/8)	0% (0/8)	0% (0/8)
	VIII.	Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
		Implementation Total	100% (11/11)	0% (0/11)	0% (0/11)
Outcomes	IX.	Real Improvement	75% (3/4)	0% (0/4)	25% (1/4)
	X.	Sustained Improvement	*Not Assessed*		
		Outcomes Total	75% (3/4)	0% (0/4)	25% (1/4)
Percent Score of Applicable Evaluation Elements Met			**96% (23/24)**		

For the FY 2013–2014 validation cycle, HSAG validated Activities I through IV and VI through IX for the first remeasurement period. The BHO received a *Met* score for 88 percent of critical evaluation elements and 96 percent for all applicable evaluation elements. The PIP received a *Not Met* validation status because of a lack of statistically significant improvement in the study indicator.

Table 5-31 provides a summary of NBHP's PIP specific outcomes for the FY 2013–2014 validation cycle.

Table 5-31—FY13–14 Performance Improvement Project Specific Outcomes *for* NBHP (n=1 PIP)

PIP Study Indicator	Baseline	Remeasurement 1	Percentage Point Change	Statistical Significance (*p* value)
PIP Topic: *Increasing Penetration for Medicaid Members Aged 65+*				
The percentage of individuals eligible for services who actually received one or more services during a specified time period.	5.93%	6.83%	0.90↑	$p = 0.0659$ *Not Statistically Significant*

↑ Denotes an increase in the study indicator rate from the previous measurement period.

In the first remeasurement for the *Increasing Penetration for Medicaid Members Aged 65+* PIP, 6.83 percent of eligible NBHP members aged 65 and older had at least one mental health service during the measurement year. The 0.90 percentage point increase in the rate from baseline to Remeasurement 1 was not statistically significant and, therefore, the goal for the first remeasurement was not met.

Strengths

For FY 2013–2014 PIP validation, the health plan progressed to reporting results from the first remeasurement and the PIP was validated through Activity IX (real improvement). NBHP demonstrated strength in the study design and implementation by receiving *Met* scores for all applicable evaluation elements in Activities I through VIII. The study design was sound and the intervention and improvement strategies were appropriately designed to improve outcomes.

Interventions

NBHP planned PowerPoint training for providers to increase knowledge of consumer support and treatment needs; however, when it was determined that several trainings were already in place, this intervention was not implemented in 2013. NBHP documented additional interventions that were implemented to address the barriers of provider stereotypes and providers unwilling to provide services to older adults. The interventions were completed by the mental health centers and they included monthly consultations with nursing home social services; weekly staff meetings with peer counselors; monthly adult protection meetings with service providers; quarterly bioethics meetings; and provider trainings on geriatric issues that included dementia, depression in later life, and challenging geriatric behaviors.

NBHP evaluated its mailing intervention by analyzing how many recipients who received the informational packet from January to July 2013 obtained mental health services. Eight of 221 recipients, or 3.6 percent, obtained mental health services. The BHO determined the mailing intervention should continue.

Recommendations

Based on the results of NBHP's *Increasing Penetration for Medicaid Members Aged 65+* PIP validation for the FY 2013–2014 validation cycle, HSAG offers several recommendations. NBHP should thoroughly document all PIP measurement results in the PIP data table, including full date ranges (month, day, and year) of each measurement period. The BHO should continue to strive toward statistically significant improvement during PIP remeasurement periods. If statistically significant improvement is not achieved for all study indicators, the BHO should revisit the causal/barrier analysis results, as well as the results of intervention evaluations, in order to guide decisions about refining improvement strategies to achieve the desired 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 2013–2014 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*	91%	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+*	96%	88%	*Not Met*

Four of the five BHO PIPs reviewed received a *Met* validation status, suggesting a thorough application of the PIPs' design. The NBHP *Increasing Penetration for Medicaid Member Aged 65+* PIP received a *Met* score on 96 percent of all applicable evaluation elements; however, because the PIP was scored using the outcomes-focused PIP validation methodology and it did not achieve statistically significant improvement over the baseline measurement, one critical evaluation element in Activity IX (*Real Improvement*) was scored *Not Met* and therefore, the PIP received a *Not Met* validation status.

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% (1/1)	75%* (3/4)	100% (2/2)	100% (1/1)	100% (1/1)
Number of rates that improved	100% (1/1)	67% (2/3)	50% (1/2)	100%^ (1/1)	100% (1/1)
Number of rates that declined	0% (0/1)	33% (1/3)	50% (1/2)	0%^ (0/1)	0% (0/1)
Number of rates that showed statistically significant improvement over the previous measurement period	100% (1/1)	0% (0/3)	50% (1/2)	100% (1/1)	0% (0/1)
Number of rates that showed statistically significant improvement over baseline	100% (1/1)	0% (0/3)	50% (1/2)	100% (1/1)	0% (0/1)

*There was no baseline rate for one study indicator due to a denominator of zero; therefore, one study indicator did not have comparable baseline and Remeasurement 1 rates.

^The BHO used an inverse study indicator so a lower rate was better.

All five of the BHOs reported remeasurement findings for the current PIP validation cycle. At the first remeasurement, ABC reported statistically significant improvement in the study indicator rate for the *Increasing Access to Mental Health Services for Youth* PIP. At the first remeasurement for the *Improving Metabolic Lab Documentation, Review, and Follow-up for Clients Prescribed Atypical Antipsychotics* PIP, BHI reported nonstatistically significant improvement in two of four study indicators and a decline in one study indicator; the fourth study indicator did not have a comparable baseline rate so improvement could not be assessed. At the fifth remeasurement for the *Care Coordination Between Behavioral Health and Primary Care* PIP, CHP reported a statistically significant increase and sustained improvement in Study Indicator 1 and a statistically significant decrease in Study Indicator 2. For the first remeasurement in the *Reducing Overall Hospital 90 Day Recidivism* PIP, FBHP reported a statistically significant decrease in the PIP's inverse study indicator, indicating a statistically significant improvement. At the first remeasurement of the *Increasing Penetration for Medicaid Member Aged 65+* PIP, NBHP reported a nonstatistically significant improvement in the study indicator rate at the first remeasurement.

While the focus of a BHO's PIP may have been to improve performance related to health care quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the health plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Four of the five PIPs earned a *Met* validation status. A *Met* validation status demonstrates that each BHO 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 2012–2013. 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 (ABC)

Compliance Monitoring Site Reviews

While Colorado Access/ABC had numerous and appropriate methods to prevent discrimination during credentialing and recredentialing processes, no monitoring method was in place to ensure nondiscriminatory credentialing practices, as required by NCQA. ABC was required to develop monitoring processes to ensure nondiscriminatory credentialing practices. ABC submitted its corrective action plan (CAP), as well as documents demonstrating that the CAP had been implemented, to HSAG and the Department in May 2013. After careful review, HSAG and the Department determined that ABC had successfully completed the required action.

Performance Measures

During the FY 2012–2013 audit, HSAG observed four of the six *Hospital Recidivism* indicators showed increased rates, indicating decreased performance, although none increased by more than 1 percentage point. A decrease in all six rates was identified for FY 2013–2014 (indicating improvement), one of which showed an improvement of more than 5 percentage points. These findings suggest ABC might have conducted quality initiatives designed to improve performance for *Hospital Recidivism*.

Performance Improvement Projects

For the FY 2012–2013 validation cycle, ABC submitted one PIP for validation—the *Increasing Access to Mental Health Services for Youth* PIP. The BHO reported baseline data and the PIP was validated on Activities I–VII, receiving a *Met* score for 100 percent of the applicable evaluation elements and an overall *Met* validation status. HSAG did not identify any deficiencies or make recommendations.

Behavioral Healthcare, Inc. (BHI)

Compliance Monitoring Site Reviews

As a result of the FY 2012–2013 compliance monitoring site review, BHI was required to:

- Develop a mechanism to monitor the credentialing/recredentialing program at least annually to ensure nondiscrimination in credentialing and recredentialing processes. This mechanism must be described in BHI's policies and procedures.
- Develop a mechanism to ensure that organizational providers are reassessed every three years.
- Incorporate review of future Mental Health Statistics Improvement Program (MHSIP) Consumer, Youth Services Survey for youths (YSS), and Youth Services Survey for Families (YSS-F) satisfaction survey results into the 2013 Quality Improvement Work Plan, and to provide evidence of review and action, as needed, by the appropriate quality improvement oversight committees.

BHI submitted its CAP to HSAG and the Department in April 2013. After careful review, HSAG and the Department determined that, if implemented as written, BHI would achieve full compliance in the related requirements. In July 2013, BHI began sending HSAG and the Department documents that demonstrated it had completed its required corrective actions. By August 2013, HSAG and the Department determined that BHI had successfully completed all required actions.

Performance Measures

During FY 2012–2013 audit, HSAG observed opportunities for improvement on almost all of the *Penetration Rate* indicators for BHI; none of the measures demonstrated more than a 2.8 percentage-point of improvement over the previous measurement period. The FY 2013–2014 rates for all the *Penetration Rate* indicators remained stable; none of the rates showed changes for more than 1 percentage point. This could be due to program expansion in several aid categories (e.g., working adults with disabilities, individuals with modified adjusted gross income, and children with disabilities).

Performance Improvement Projects

BHI submitted its PIP, *Improving Metabolic Lab Documentation, Review, and Follow-up for Clients Prescribed Atypical Antipsychotics*, reporting baseline results for the FY 2012–2013 validation cycle. The PIP was validated on Activities I through VIII and received a *Met* validation score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG did not identify any deficiencies or make recommendations.

Colorado Health Partnerships, LLC (CHP)

Compliance Monitoring Site Reviews

The delegation agreement between ValueOptions and CHP did not include a provision that CHP retains the right to approve, suspend, and terminate individual practitioners and/or providers. This provision was present in the delegation agreement submitted for the 2010 external quality review organization (EQRO) site visit, but it had been removed from the most recently signed agreement. CHP was required to 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/or providers.

CHP submitted its CAP to HSAG and the Department in February 2013. HSAG and the Department reviewed the plan and determined that, if implemented as written, CHP would achieve full compliance with the requirement. CHP submitted documents in April 2013 that demonstrated it had successfully completed the required action.

Performance Measures

During the FY 2012–2013 audit, HSAG noted the *Non-State Hospitals—7 Days* indicator under *Follow-Up After Hospitalization for Mental Illness* reported a 2.2 percentage-point decrease from the prior year. The FY 2013–2014 rate for this indicator reported a 0.7 percentage-point increase from the previous year. This small increase in rate does not provide sufficient evidence for HSAG to determine if quality strategies were implemented to improve the rate. All other indicators within this measure reported a decline in rate, though none exceeded 5 percentage points. The rate changes observed could be random.

Performance Improvement Projects

In FY 2012–2013, CHP submitted its *Care Coordination Between Behavioral Health and Primary Care* PIP for validation, reporting results from the fourth remeasurement. The PIP received a *Met* score for 45 (92 percent) of 49 applicable evaluation elements in Activities I through X and an overall *Met* validation status. The PIP received a *Partially Met* score for four evaluation elements in the outcomes stage. In Activity IX, three evaluation elements were scored *Partially Met* because one of the two study indicators did not demonstrate improvement and, therefore, the interventions did not appear to result in improvement of this study indicator. Because only one of the two study indicators sustained statistically significant improvement over baseline at the fourth remeasurement, the evaluation element in Activity X was also scored *Partially Met*. In FY 2013–2014, CHP progressed to reporting results from the fifth remeasurement, with similar outcomes. The PIP again received a *Partially Met* score for four evaluation elements in Activities IX and X because one study indicator continued to demonstrate sustained improvement and the other failed to demonstrate improvement.

Foothills Behavioral Health Partners, LLC (FBHP)

Compliance Monitoring Site Reviews

FBHP earned an overall compliance score of 100 percent for the four standards (Coordination and Continuity of Care, Member Rights and Protections, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement) reviewed by HSAG during FY 2012–2013. FBHP had no required actions as a result of the site review.

Performance Measures

During the FY 2012–2013 audit, FBHP's performance suggested room for improvement on *Penetration Rate* and *Hospital Recidivism* measures. The FY 2013–2014 rates for *Penetration Rate* showed diverse changes from the prior year, although none was more than 5 percentage points. FBHP's *Hospital Recidivism* showed an increase in rates across all indicators, with the 90-day rates for both non-state and all hospitals demonstrating an improvement of at least 5 percentage points. These findings suggested the FBHP might have initiated improvement strategies to reduce hospital recidivism during the year.

Performance Improvement Projects

In FY 2012–2013, FBHP reported baseline results for its *Reducing Overall 90-Day Hospital Recidivism* PIP. The PIP was validated through Activity VIII and received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG did not identify any deficiencies or make any recommendations.

Northeast Behavioral Health Partnership, LLC (NBHP)

Compliance Monitoring Site Reviews

The delegation agreement between ValueOptions and NBHP 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 EQRO site visit, but was absent from the most recently signed agreement. NBHP was required to 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.

NBHP submitted its CAP to HSAG and the Department in March 2013. HSAG and the Department reviewed the plan and determined that, if implemented as written, NBHP would achieve full compliance with the requirement. NBHP submitted documents in April 2013 that demonstrated it had successfully completed the required action.

Performance Measures

During the FY 2012–2013 audit, NBHP's performance suggested widespread opportunities for improvement because of declines among all six *Hospital Recidivism* indicators. Additionally, each of the four indicators in the *Follow-Up After Hospitalization for Mental Illness* category reported a decreased rate since the previous measurement period, and the rate for one indicator declined more than 5 percentage points. The FY 2013–2014 rates for four of the six *Hospital Recidivism* indicators showed an increase from the previous year; two other indicators reported a decline in rate but the change was less than 1 percentage point. For the *Follow-Up After Hospitalization for Mental Illness* measure, all indicators still demonstrated a decline in rates from the previous year, although none of the declines exceeded 2.5 percentage points.

Performance Improvement Projects

NBHP reported baseline results for its *Increasing Penetration for Medicaid Members Aged 65+* PIP in FY 2012–2013. The PIP was validated through Activity VIII and received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG did not identify any deficiencies or make any recommendations.

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 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

In developing the data collection tools and in reviewing documentation related to the standards, HSAG used the behavioral health organizations' (BHOs') contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* 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 BHOs, HSAG performed the five compliance monitoring activities described in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. These activities were establishing compliance thresholds, performing preliminary review, conducting site visits, compiling and analyzing 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 reviewing the physical health plans' and BHOs' documents prior to the on-site portion of the review.

On-site review activities included a review of additional documents, policies, and committee minutes to determine compliance with federal health care regulations and implementation of the organizations' policies. As part of Standard I—Coverage and Authorization of Services, HSAG conducted an on-site review of 15 administrative records to evaluate implementation of managed care regulations related to service and claims denials and notices of action. HSAG incorporated the results of the record reviews into the findings for the standard.

Also during the on-site portion of the review, HSAG conducted an opening conference to review the agenda and objectives of the site review and to allow the physical health plans and 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 recommendations and opportunities for improvement.

Table A-1 describes the tasks performed for each activity in the CMS final protocol for monitoring compliance during FY 2013–2014.

Table A-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, and on-site agendas, and to set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.

Table A-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Behavioral Health Quality Improvement Committee (BQuIC) meetings and Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan/BHO in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the two standards and on-site activities. Thirty days prior to the review, the health plan/BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and the on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's/BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans and BHOs also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. HSAG used a random sampling technique to select records for review during the site visit. ◆ 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 3:	**Conduct Site Visit**
	◆ During the on-site portion of the review, HSAG met with the health plan's/BHO's key staff members to obtain a complete picture of the health plan's/BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's/BHO's performance. ◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to health plan/BHO service and claims denials and notices of action. ◆ Also while on-site, HSAG collected and reviewed additional documents, as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with health plan/BHO staff members and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2013–2014 Site Review Report template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.

Table A-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ HSAG submitted the site review report to the health plan/BHO and the Department for review and comment. ◆ HSAG incorporated the health plan's/BHO's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the health plan/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
- Management/monitoring reports
- Quarterly reports
- Provider manual and directory
- Consumer handbook and informational materials
- Staff training materials and documentation of attendance
- 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.

The health plans' administrative records were also reviewed to evaluate implementation of managed care regulations related to service and claims denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 15 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable health plan service and claims denials that occurred between January 1, 2013, and December 31, 2013 (to the extent possible). For the record review, the health plan received a score of *C* (Compliant), *NC* (Not Compliant), or *NA* (Not Applicable) for each of

the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

All *Not Met* or *Partially Met* findings resulted in a required action that HSAG documented in the corrective action plan template approved by the Department. The template was included in the final report to the health plan and the Department, and was used by the plan to submit its intended corrective actions to HSAG and the Department for review. Corrective actions were monitored by HSAG and the Department until successfully completed.

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 HEDIS auditors. 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 2014 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 2014 (CY 2013) data may also have been interviewed and asked to provide documentation of their work.

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 that NCQA and the auditor considered necessary to obtain a reasonable basis for rendering an opinion. Although HSAG did not audit the health plans, it 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' performance.

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 for FY 2013–2014 as part of the validation of performance measures:

- **Final Audit Reports**. The final audit reports, produced by the health plans' licensed organizations, provided information on the health plans' compliance to information system standards and audit findings for each measure required to be reported.
- **Measure Certification Report**. The vendor's measure certification report was reviewed to confirm that all of the required measures for reporting had a "pass" status.
- **Rate Files from Previous Years and Current Year**. Final rates provided by health plans either in IDSS format or a special rate reporting template 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.

Description of Data Obtained—Behavioral Health

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data for FY 2013-2014 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 results from the Department calculated on behalf of each of the BHOs. HSAG also received performance measure results calculated by 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.

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

At the end of the HEDIS audit season, 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 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. 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 two PIPs for the physical health plans. Table C-1 lists the BHOs and their PIP study titles. Table C-2 lists the physical health plans and their PIP study titles.

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

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 physical health plan 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:

- 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

[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.

* 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 C-3—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
PIP Summary Form (completed by each health plan)	FY 2013–2014

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

Introduction

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

Objectives

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

Technical Methods of Data Collection

For the adult and child Primary Care Physician Program (PCPP) populations, the technical method of data collection was through the administration of a modified version of the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set and survey questions from the Adult Clinician and Group CAHPS surveys with Patient-Centered Medical Home™ (PCMH™) items ("Adult CAHPS PCMH Survey") for the adult population, and the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item and survey questions from the Child Clinician and Group CAHPS surveys with PCMH™ items ("Child CAHPS PCMH Survey") for the child population.[D-1, D-2]

For DHMC and RMHP, 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 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 48 items for the CAHPS 5.0 Child Medicaid Health Plan Survey without the Children with Chronic Conditions [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 to select members and distribute surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the

[D-1] Patient-Centered Medical Home™ (PCMH™) is a trademark of the National Committee for Quality Assurance (NCQA).
[D-2] It is important to note that for the adult and child PCPP CAHPS survey administration, the Department elected to modify the CAHPS 5.0 Medicaid Health Plan Surveys and remove the Rating of Health Plan global rating question and Customer Service composite measure survey questions; therefore, CAHPS survey results for the adult and child PCPP populations are limited to the three global ratings (Rating of All Heath Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Shared Decision Making).

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.[D-3] The global ratings reflected patients' overall satisfaction with their personal doctors, specialists, health plans, 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. As a result of the transition to the CAHPS 5.0 Adult and Child Medicaid Health Plan Surveys and changes to the Shared Decision Making composite measure, national data are not available for this composite measure and comparisons could not be performed.

[D-3] As previously noted, as a result of the modifications to the adult and child PCPP CAHPS survey instruments, survey results are limited to the three global ratings and four composite measures.

Description of Data Obtained

Table D-1 and Table D-2 present the question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for the 2014 global ratings and 2014 composite scores, respectively, for the adult population. DHMC and RMHP provided HSAG with the data in the two tables. Morpace and the Center for the Study of Services (CSS) administered the CAHPS 5.0H Adult 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 2013 NCQA national averages are highlighted in yellow.

Table D-1—Question Summary Rates for Global Ratings

Measure of Member Satisfaction	Adult Medicaid 2014		
	DHMC	RMHP	PCPP
Rating of Personal Doctor	65.4%	67.1%	61.0%
Rating of Specialist Seen Most Often	59.5%	61.9%	59.3%
Rating of All Health Care	43.7%	53.8%	49.7%
Rating of Health Plan	51.5%	59.1%	NA

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 2013 NCQA CAHPS national average.

NA indicates CAHPS survey results are not available for the CAHPS measure.

Table D-2—Question Summary Rates for Composite Scores

Measure of Member Satisfaction	Adult Medicaid 2014		
	DHMC	RMHP	PCPP
Getting Needed Care	70.3%	84.9%	80.2%
Getting Care Quickly	74.3%	83.2%	80.0%
How Well Doctors Communicate	90.0%	89.4%	88.9%
Customer Service	83.5%	84.3%+	NA
Shared Decision Making	52.2%	50.1%	54.2%

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 measure, comparisons to national data could not be performed for 2014.

Indicates a rate is at or above the 2013 NCQA CAHPS national average.

NA indicates CAHPS survey results are not available for the CAHPS measure.

Table D-3 and Table D-4 present the question summary rates and global proportions (i.e., the percentage of respondents offering a positive response) for the 2014 global ratings and 2014 composite scores, respectively, for the child population. DHMC and RMHP provided HSAG with the data presented in the following tables. Morpace and 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 2013 NCQA national averages are highlighted in yellow.

Table D-3—Question Summary Rates for Global Ratings

Measure of Member Satisfaction	Child Medicaid 2014		
	DHMC	RMHP	PCPP
Rating of Personal Doctor	75.4%	71.3%	72.8%
Rating of Specialist Seen Most Often	73.8%+	69.2%+	67.7%+
Rating of All Health Care	66.7%	60.2%	65.7%
Rating of Health Plan	70.1%	68.5%	NA

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.

Due to changes to the *Shared Decision Making* composite measure, comparisons to national data could not be performed for 2014.

Indicates a rate is at or above the 2013 NCQA CAHPS national average.

NA indicates CAHPS survey results are not available for the CAHPS measure.

Table D-4—Global Proportions for Composite Scores

Measure of Member Satisfaction	Child Medicaid 2014		
	DHMC	RMHP	PCPP
Getting Needed Care	73.5%	92.6%	86.6%
Getting Care Quickly	85.5%	91.8%	92.4%
How Well Doctors Communicate	94.3%	94.5%	92.1%
Customer Service	86.1%	87.7%+	NA
Shared Decision Making	55.8%+	52.1%+	56.8%+

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.

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

NA indicates CAHPS survey results are not available for the CAHPS measure.

Data Aggregation, Analysis, and How Conclusions Were Drawn

Overall perceptions of the quality of medical care and services received can be assessed from both criterion and normative frames of reference. A normative frame of reference was used to compare the responses within each health plan.

The BBA, at 42 CFR 438.204(d) and (g) and 438.320, provides a framework for using findings from EQR activities to evaluate quality, timeliness, and access. HSAG recognized the interdependence of quality, timeliness, and access and has assigned each of the CAHPS survey measures to one or more of the three domains. Using this framework, Table D-5 shows HSAG's assignment of the CAHPS measures to these performance domains.

Table D-5—Assignment of CAHPS Measures to Performance Domains

CAHPS Measures	Quality	Timeliness	Access
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Shared Decision Making	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

Appendix E. Summary Tables of EQR Activity Results—All Plans

Introduction

This appendix presents tables with detailed findings for all physical and behavioral health plans for each EQR activity performed in FY 2013–2014.

Results from the Compliance Monitoring Site Reviews

Table E-1 and Table E-2 show the compliance summary scores and record review scores for each physical health plan, as well as the statewide average. Statewide average scores were calculated by dividing the total number of elements that were met across both plans by the total number of applicable elements across both plans.

Table E-1—Standard Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Standard I—Coverage and Authorization of Services (2014)	91%	85%	88%
Standard II—Access and Availability (2014)	80%	90%	85%
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 black text were reviewed in 2014.
Standards presented in green text were reviewed in 2013.
Standards presented in blue text were reviewed in 2012.
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Table E-2—Record Review Scores for the Physical Health Plans

Description of Standard	DHMC	RMHP	Statewide Average
Denials (2014)	98%	86%	92%
Credentialing (2013)	100%	100%	100%
Recredentialing (2013)	100%	100%	100%
Appeals (2012)	93%	92%	93%

Table E-3 and Table E-4 show the summary compliance monitoring scores and record review scores for each BHO, as well as the statewide average. Statewide average scores were calculated by dividing the total number of elements that were met across all five plans by the total number of applicable elements across all five plans.

Table E-3—Standard Scores for the BHOs						
Description of Component	ABC	BHI	CHP	FBHP	NBHP	Statewide Average
Standard I—Coverage and Authorization of Services (2014)	97%	81%	100%	100%	100%	95%
Standard II—Access and Availability (2014)	93%	100%	100%	100%	100%	99%
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 black text were reviewed in 2014.
Standards presented in green text were reviewed in 2013.
Standards presented in blue text were reviewed in 2012.

Table E-4—Record Review Scores for the BHOs						
Description of Component	ABC	BHI	CHP	FBHP	NBHP	Statewide Average
Denials (2014)	100%	92%	100%	100%	100%	98%
Credentialing (2013)	100%	100%	100%	100%	100%	100%
Recredentialing (2013)	100%	100%	98%	98%	97%	99%
Appeals (2012)	100%	81%	100%	100%	100%	97%

Results from the Validation of Performance Measures

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

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

Performance Measures	DHMC	RMHP	Statewide Average
Childhood Immunization Status—Combination 2	78.35%	77.70%	78.13%
Childhood Immunization Status—Combination 3	78.10%	73.95%	76.70%
Childhood Immunization Status—Combination 4	77.62%	66.23%	73.77%
Childhood Immunization Status—Combination 5	62.04%	60.71%	61.59%
Childhood Immunization Status—Combination 6	63.50%	51.66%	59.50%
Childhood Immunization Status—Combination 7	62.04%	57.17%	60.40%
Childhood Immunization Status—Combination 8	63.26%	48.12%	58.15%
Childhood Immunization Status—Combination 9	53.53%	43.93%	50.29%
Childhood Immunization Status—Combination 10	53.53%	41.94%	49.61%
Immunizations for Adolescents—Combination 1	83.21%	59.65%	76.13%
Well-Child Visits in the First 15 Months of Life—Zero Visits	2.68%	0.36%	1.94%
Well-Child Visits in the First 15 Months of Life—6+ Visits	63.50%	80.73%	68.97%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.04%	66.01%	63.35%
Adolescent Well-Care Visits	49.88%	45.58%	48.50%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment: Total	91.73%	80.90%	87.94%
Counseling for Nutrition: Total	79.32%	63.15%	73.66%
Counseling for Physical Activity: Total	64.48%	62.47%	63.78%
Appropriate Testing for Children with Pharyngitis	70.06%	90.86%	85.51%

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

Table E-6—Access to Care and Preventive Screening Performance Measures for Physical Health Plans and Statewide Average

Performance Measures	DHMC	RMHP	Statewide Average
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	89.29%	95.64%	92.06%
Postpartum Care	57.42%	73.83%	64.57%
Children's and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	92.24%	97.85%	93.99%
Ages 25 Months to 6 Years	74.69%	86.29%	78.52%
Ages 7 to 11 Years	80.82%	89.55%	83.32%
Ages 12 to 19 Years	82.32%	87.88%	84.07%
Adults' Access to Preventive/Ambulatory Health Services—Total	71.00%	88.33%	76.83%
Preventive Screening			
Chlamydia Screening in Women—Total	68.49%	45.32%	59.43%
Breast Cancer Screening	54.59%	51.96%	53.73%
Cervical Cancer Screening	67.15%	70.25%	68.28%
Adult BMI Assessment	90.51%	85.81%	88.73%

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

Table E-7—Mental/Behavioral Health Performance Measures for Physical Health Plans and Statewide Average

Performance Measures	DHMC	RMHP	Statewide Average
Anti-depressant Medication Management			
Effective Acute Phase Treatment	41.58%	NB	41.58%
Effective Continuation Phase Treatment	30.43%	NB	30.43%
Follow-up Care for Children Prescribed ADHD Medication			
Initiation	14.81%	31.67%	23.68%
Continuation	NA	35.90%	30.16%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			
Initiation	45.39%	NB	45.39%
Engagement	3.50%	NB	3.50%

Table E-7—Mental/Behavioral Health Performance Measures for Physical Health Plans and Statewide Average			
Performance Measures	**DHMC**	**RMHP**	**Statewide Average**
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.02%	NB	64.02%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	89.67%	NB	89.67%
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.97%	NR	70.97%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NR	NA

NB is shown in RMHP's HEDIS 2014 IDSS, indicating that the health plan did not offer the benefit.
NR is shown because RMHP was not required to report the measure.
NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.

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

Table E-8—Living With Illness Performance Measures for Physical Health Plans and Statewide Average			
Performance Measures	**DHMC**	**RMHP**	**Statewide Average**
Controlling High Blood Pressure	66.42%	73.38%[2]	68.56%
Comprehensive Diabetes Care			
HbA1c Testing	88.81%	89.37%	88.98%
HbA1c Poor Control (>9.0%)	31.87%	26.41%	30.21%
HbA1c Control (<8.0%)	58.39%	65.61%	60.60%
Eye Exam	49.64%	63.62%	53.90%
LDL-C Screening	76.64%	72.09%	75.26%
LDL-C Level <100 mg/dL	55.23%	43.19%	51.56%
Medical Attention for Nephropathy	82.48%	75.58%	80.38%
Blood Pressure Controlled <140/80 mm Hg	56.20%	55.15%	55.88%
Blood Pressure Controlled <140/90 mm Hg	72.99%	76.74%	74.14%
Annual Monitoring for Patients on Persistent Medications—Total	84.74%	83.22%	84.40%
Use of Imaging Studies for Low Back Pain	81.12%	74.15%	78.49%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	64.90%	32.53%	55.67%
Bronchodilator	76.92%	48.19%	68.73%
Use of Appropriate Medications for People With	78.61%	85.94%	80.79%

Table E-8—Living With Illness Performance Measures for Physical Health Plans and Statewide Average

Performance Measures	DHMC	RMHP	Statewide Average
Asthma—Total			
Asthma Medication Ratio—Total	53.60%	62.35%	56.22%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	30.26%	29.59%	30.03%
Disease Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	81.48%	52.54%	69.29%

Table E-9 presents Use of Services performance scores for each physical health plan and the statewide average.

Table E-9—Use of Services Performance Measures for Physical Health Plans and Statewide Average

Ambulatory Care (per 1,000 member months)			
Outpatient Visits	225.92	401.91	280.29
Emergency Department Visits	44.05	58.85	48.62
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 MM (total inpatient)	5.53	9.25	6.68
Days per 1,000 MM (total inpatient)	21.84	32.87	25.25
Average Length of Stay (total inpatient)	3.95	3.55	3.78
Discharges per 1,000 MM (medicine)	4.27	4.08	4.21
Days per 1,000 MM (medicine)	14.41	16.74	15.13
Average Length of Stay (medicine)	3.37	4.10	3.59
Discharges per 1,000 MM (surgery)	1.17	1.73	1.34
Days per 1,000 MM (surgery)	7.21	8.86	7.72
Average Length of Stay (surgery)	6.15	5.13	5.75
Discharges per 1,000 MM (maternity)	0.15	6.14	2.02
Days per 1,000 MM (maternity)	0.40	12.94	4.31
Average Length of Stay (maternity)	2.61	2.11	2.13
Antibiotic Utilization			
Average Scrips for PMPY for Antibiotics (all ages)	0.35	1.01	0.55
Averages Days Supplied per Antibiotic Scrip (all ages)	9.54	9.71	9.63
Average Scrips PMPY for Antibiotics of Concern (all ages)	0.10	0.36	0.18
Percentage of Antibiotics of Concern of all Antibiotic Scrips (all ages)	27.65%	35.93%	32.24%

Table E-9—Use of Services Performance Measures for Physical Health Plans and Statewide Average			
Frequency of Selected Procedures (procedures per 1,000 MM)			
Bariatric weight loss surgery (0–19 male)	0.00	0.00	0.00
Bariatric weight loss surgery (0–19 female)	0.00	0.00	0.00
Bariatric weight loss surgery (20–44 male)	0.00	0.07	0.02
Bariatric weight loss surgery (20–44 female)	0.05	0.23	0.12
Bariatric weight loss surgery (45–64 male)	0.00	0.00	0.00
Bariatric weight loss surgery (45–64 female)	0.03	0.53	0.19
Tonsillectomy (0–9 male & female)	0.36	1.31	0.65
Tonsillectomy (10–19 male & female)	0.19	0.92	0.40
Hysterectomy, Abdominal (15–44 female)	0.06	0.29	0.14
Hysterectomy, Abdominal (45–64 female)	0.12	0.13	0.13
Hysterectomy, Vaginal (15–44 female)	0.09	0.60	0.27
Hysterectomy, Vaginal (45–64 female)	0.15	0.20	0.17
Cholecystectomy, Open (30–64 male)	0.05	0.05	0.05
Cholecystectomy, Open (15–44 female)	0.05	0.00	0.03
Cholecystectomy, Open (45–64 female)	0.06	0.07	0.06
Cholecystectomy (laparoscopic) (30–64 male)	0.20	0.94	0.39
Cholecystectomy (laparoscopic) (15–44 female)	0.55	1.36	0.83
Cholecystectomy (laparoscopic) (45–64 female)	0.36	1.60	0.75
Back Surgery (20–44 male)	0.06	0.63	0.22
Back Surgery (20–44 female)	0.04	0.23	0.11
Back Surgery (45–64 male)	0.09	0.95	0.29
Back Surgery (45–64 female)	0.15	0.73	0.33
Mastectomy (15–44 female)	0.02	0.04	0.03
Mastectomy (45–64 female)	0.03	0.07	0.04
Lumpectomy (15–44 female)	0.09	0.30	0.16
Lumpectomy (45–64 female)	0.27	0.53	0.35

Table E-10 includes FY 2013–2014 performance measure results for each BHO as well as the statewide average.

Table E-10—Performance Measure Results for BHOs						
Performance Measures	**ABC**	**BHI**	**CHP**	**FBHP**	**NBHP**	**Statewide Average**
Percentage of Members with SMI with a Focal Point of Behavioral Health Care	90.7%	90.5%	90.1%	93.1%	90.9%	90.8%
Improving Physical Healthcare Access	86.4%	87.1%	92.1%	87.2%	91.0%	89.3%
Penetration Rate by Age Category						
Children 12 Years of Age and Younger	6.0%	6.5%	7.1%	12.4%	7.5%	7.4%
Adolescents 13 Through 17 Years of Age	15.7%	16.3%	17.5%	22.8%	20.8%	18.0%
Adults 18 Through 64 Years of Age	19.4%	18.1%	20.1%	22.7%	20.8%	20.0%
Adults 65 Years of Age or Older	6.3%	5.5%	5.9%	7.9%	6.8%	6.3%
Penetration Rate by Service Category						
Inpatient Care	0.3%	0.1%	0.2%	0.2%	0.3%	0.2%
Intensive Outpatient/Partial Hospitalization	0.03%	0.08%	0.01%	0.03%	0.01%	0.03%
Ambulatory Care	11.4%	11.2%	13.1%	17.0%	13.4%	12.8%
Overall Penetration Rate	11.8%	11.4%	13.4%	17.2%	13.8%	13.1%
Penetration Rate by Medicaid Eligibility Category						
AFDC/CWP Adults	10.5%	12.5%	15.1%	15.4%	15.2%	13.9%
AFDC/CWP Children	6.2%	7.2%	8.3%	13.7%	9.5%	8.4%
AND/AB-SSI	34.7%	32.5%	29.4%	35.0%	33.4%	32.1%
BC Children	7.3%	6.8%	7.2%	10.5%	7.2%	7.5%
BC Women	10.3%	7.9%	14.4%	11.0%	11.4%	11.5%
BCCP—Women Breast and Cervical Cancer	15.7%	12.6%	14.8%	17.0%	7.1%	14.0%
Buy-in: Working Adults with Disabilities	35.7%	35.1%	26.0%	62.6%	32.3%	36.6%
Foster Care	47.1%	34.5%	30.8%	37.2%	35.1%	35.2%
OAP-A	6.2%	5.4%	5.8%	7.8%	6.8%	6.2%
OAP-B-SSI	23.8%	23.2%	21.5%	23.9%	21.8%	22.6%
Modified Adjusted Gross Income	29.1%	35.6%	34.5%	43.6%	44.0%	35.2%
Buy-in: Children with Disabilities	15.4%	17.6%	13.0%	3.0%	12.5%	13.0%
Hospital Recidivism						
Non-State Hospitals—7 Days	1.9%	3.0%	3.8%	2.8%	2.3%	3.0%
30 Days	7.3%	7.9%	11.0%	9.5%	4.2%	8.7%
90 Days	13.3%	12.4%	19.2%	14.4%	7.4%	14.7%
All Hospitals—7 Days	2.8%	2.8%	3.3%	2.8%	2.1%	2.9%
30 Days	9.4%	7.8%	10.0%	9.1%	4.8%	8.8%
90 Days	15.9%	12.6%	17.7%	14.2%	8.8%	14.9%

Table E-10—Performance Measure Results for BHOs						
Performance Measures	**ABC**	**BHI**	**CHP**	**FBHP**	**NBHP**	**Statewide Average**
Hospital Average Length of Stay						
Non-State Hospitals	9.19	7.76	8.18	7.28	6.19	7.93
All Hospitals	14.77	12.90	11.28	20.03	8.60	13.29
Emergency Room Utilization (rate/1000 members, all ages)	12.58	9.94	8.38	9.59	11.24	9.97
Inpatient Utilization (Rate/1000 Members, All Ages)						
Non-State Hospitals	4.24	2.81	3.93	4.13	3.62	3.69
All Hospitals	4.78	3.39	4.93	5.97	3.87	4.51
Follow-Up After Hospitalization for Mental Illness						
Non-State Hospitals—7 Days	39.7%	58.1%	44.5%	49.5%	50.8%	47.3%
30 Days	59.4%	73.2%	64.3%	66.7%	69.6%	65.8%
All Hospitals—7 Days	39.9%	61.2%	44.8%	49.2%	50.5%	48.0%
30 Days	59.0%	75.2%	65.8%	67.8%	68.5%	66.8%

Results from the Validation of Performance Improvement Projects

Table E-11 lists the PIP study conducted by each physical health plan and the corresponding summary scores.

Table E-11—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*	85%	100%	*Met*
RMHP	*Adult BMI Assessment*	97%	100%	*Met*

Table E-12 lists the PIP study conducted by each BHO and the corresponding summary scores.

Table E-12—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*	91%	100%	*Met*

Table E-12—Summary of Each BHO's PIP Validation Scores and Validation Status				
BHO	**PIP Study**	**% of All Elements *Met***	**% of Critical Elements *Met***	**Validation Status**
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+*	96%	88%	*Not Met*

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

Table E-13 shows each physical health plan's summary rates and global proportions for the adult CAHPS survey. For FY 2013–2014, the survey administered to the adult PCPP population was different than the survey administered to the DHMC and RMHP populations; therefore, rates between these populations are not comparable and a statewide average is not available.

Table E-13—Adult Medicaid Question Summary Rates and Global Proportions			
Measure	**DHMC**	**RMHP**	**PCPP**
Getting Needed Care	70.3%	84.9%	80.2%
Getting Care Quickly	74.3%	83.2%	80.0%
How Well Doctors Communicate	90.0%	89.4%	88.9%
Customer Service	83.5%	84.3%+	NA
Shared Decision Making	52.2%	50.1%	54.2%
Rating of Personal Doctor	65.4%	67.1%	61.0%
Rating of Specialist Seen Most Often	59.5%	61.9%	59.3%
Rating of All Health Care	43.7%	53.8%	49.7%
Rating of Health Plan	51.5%	59.1%	NA

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.

NA indicates CAHPS survey results are not available for the CAHPS measure.

Table E-14 shows each physical health plan's summary rates and global proportions for the child CAHPS survey. For FY 2013–2014, the survey administered to the child PCPP population was different than the survey administered to the DHMC and RMHP populations; therefore, rates between these populations are not comparable and a statewide average is not available.

Table E-14—Child Medicaid Question Summary Rates and Global Proportions

Measure	DHMC	RMHP	PCPP
Getting Needed Care	73.5%	92.6%	86.6%
Getting Care Quickly	85.5%	91.8%	92.4%
How Well Doctors Communicate	94.3%	94.5%	92.1%
Customer Service	86.1%	87.7%+	NA
Shared Decision Making	55.8%+	52.1%+	56.8%+
Rating of Personal Doctor	75.4%	71.3%	72.8%
Rating of Specialist Seen Most Often	73.8%+	69.2%+	67.7%+
Rating of All Health Care	66.7%	60.2%	65.7%
Rating of Health Plan	70.1%	68.5%	NA

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.

NA indicates CAHPS survey results are not available for the specific CAHPS measure.