COLORADO

Department of Health Care Policy & Financing

2014–2015 External Quality Review Technical Report

for

Colorado Medicaid

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

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HSAG HEALTH SERVICES ADVISORY GROUP

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Purpose of Report

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

Results are also presented and assessed for the following behavioral health organizations (BHOs):

- Access Behavioral Care—Denver (ABC-D)
- Access Behavioral Care—Northeast (ABC-NE)*
- Behavioral Healthcare, Inc. (BHI)
- Colorado Health Partnerships, LLC (CHP)
- Foothills Behavioral Health Partners, LLC (FBHP)

* Access Behavioral Care—Northeast's behavioral health contract with the Department went into effect July 1, 2014. Because it was only contracted with the Department for a portion of the year, it was not required to participate in all EQRO activities. HSAG noted instances where this occurs.

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
Standard V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		
Performance Measures	**Quality**	**Timeliness**	**Access**
Childhood Immunization Status	✓	✓	
Immunizations for Adolescents	✓	✓	
Well-Child Visits in the First 15 Months of Life	✓	✓	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓	✓	
Adolescent Well-Care Visits	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Appropriate Testing for Children with Pharyngitis	✓		
Appropriate Testing for Children with Upper Respiratory Infection	✓		
Prenatal and Postpartum Care	✓	✓	✓
Children's and Adolescents' Access to Primary Care Practitioners (PCPs)			✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Chlamydia Screening in Women	✓		
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		
Adult BMI Assessment	✓		
Antidepressant Medication Management	✓		
Follow-up Care for Children Prescribed ADHD Medication	✓	✓	

Table 1-1—Assignment of Activities to Performance Domains for Physical Health Plans			
Follow-Up After Hospitalization for Mental Illness	✓	✓	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	✓		
Controlling High Blood Pressure	✓		
Persistence of Beta-Blocker Treatment After a Heart Attack	✓		
Comprehensive Diabetes Care	✓		✓
Annual Monitoring for Patients on Persistent Medications	✓		
Use of Imaging Studies for Low Back Pain	✓		
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	✓		
Pharmacotherapy Management of COPD Exacerbation	✓		
Use of Appropriate Medications for People With Asthma	✓		
Medication Management 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			✓
Identification of Alcohol and Other Drug Services—Total			✓
Mental Health Utilization—Total			✓
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**
Standard V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		
Performance Measures	**Quality**	**Timeliness**	**Access**
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			✓
Behavioral Health Engagement			✓
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

Colorado's two managed care physical health plans performed well in the quality domain. With few exceptions, both plans had policies and procedures that outlined the benefits of each plan and the expectations and requirements to ensure quality services. Member handbooks were thorough, well written, and available in alternative formats and languages. The plans monitored their programs, providers, and staffs to ensure consistent quality services.

Statewide HEDIS performance on the 33 quality-related measures was mixed. While HSAG did not identify significant improvement in any of the measures, it did identify significant performance decline in at least one indicator in each of four measures: *Childhood Immunization Status*, *Well-Child Visits in the First 15 Months of Life*, and *Prenatal and Postpartum Care*. When compared to national benchmarks, statewide performance was diverse. Twelve measures had at least one rate ranked below the national 25th percentile and six ranked at or above the 90th percentile. Low percentile ranking was mostly found in measures under the Pediatric Care and Living with Illness categories. Low percentile ranking among the measures for immunizations and well-child visits under the Pediatric Care category could be related to a change to the State-required data collection

methodology from hybrid to administrative and may not represent true performance from all health plans.

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. While one of the PIPs earned a *Met* validation status, demonstrating application of methodologically sound design principles, the other PIP received a *Not Met* validation status, suggesting a need for improvement in the design stage to produce valid and reliable PIP results.

HSAG assigned all CAHPS measures to the quality domain. For the statewide adult Medicaid population, none of the measures increased or decreased substantially. The rates for four of the eight comparable measures increased slightly (*Getting Needed Care*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*) while the rates for three measures decreased slightly. The rate for one measure, *Getting Care Quickly*, remained the same as in the previous year.

For the statewide general child Medicaid population, one measure's rate increased substantially: *Rating of Personal Doctor* (6.3 percentage points). The rates for five of the eight comparable measures increased: *Getting Needed Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. As previously noted, the rates for the remaining three measures decreased; however, the decreases in the measures' rates were not substantial.

Quality—Behavioral Health

HSAG assigned all four of the standards reviewed to the quality domain and statewide performance was strong. All five BHOs scored 100 percent compliance with all requirements related to provider participation and program integrity as well as subcontracts and delegation. The BHOs also performed well in the member information standard, with an overall compliance score of 95 percent.

While the focus of a BHO's PIP may have been to improve performance related to healthcare quality, timeliness, or access, EQR activities were designed to evaluate the validity and quality of the plan's processes for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. All five PIPs validated by HSAG earned a *Met* validation status, demonstrating application of methodologically sound design principles necessary to produce valid and reliable PIP results.

The *Percent of Members with Serious Mental Illness (SMI) with a Focal Point of Behavioral Health Care*, *Hospital Recidivism*, and *Behavioral Health Engagement* were the quality measures reported for the current measurement year. This was the first year that the *Behavioral Health Engagement* measure was validated; therefore, comparison to the previous year's performance could not be performed. Statewide performance on the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure demonstrated a rate decline of 3.2 percentage points from the previous year. In addition, for *Hospital Recidivism*, three of four BHOs demonstrated a rate decrease for at least one indicator and statewide rates declined for all six indicators, suggesting room for improvement.

Timeliness—Physical Health

HSAG assigned the grievance system standard—the standard with the lowest statewide score—to the timeliness domain. Both plans struggled with requirements related to continuing services during an appeal and/or State fair hearing. Difficulty understanding this requirement was due in part to the rarity of such a request. Both DHMC and RMHP have structured their programs in a manner making it highly unlikely that either health plan would terminate, suspend, or reduce services it previously authorized.

Statewide HEDIS performance on the eight timeliness-related measures was mixed. Neither health plan had the required benefits to calculate the *Follow-Up After Hospitalization for Mental Illness (7- and 30-Day Follow-Up)* measure. None of the remaining measures had significant rate increases from the previous year. Two pediatric care measures and the *Prenatal and Postpartum Care* measure had at least one rate decline significantly from the previous year. When compared to national benchmarks, five measures—including four in the pediatric care category—had at least one rate ranked below the national 25th percentile. *Prenatal and Postpartum Care* and *Immunization for Adolescents* were the only two measures with performance above the national 50th percentile. Although low percentile ranking was noted in many timeliness-related measures under the pediatric care category, these results could be related to a change to the State-required data collection methodology from hybrid to administrative and may not represent true performance from all health plans.

One of the measures within the CAHPS survey addressed timeliness (*Getting Care Quickly*). The adult Medicaid statewide average remained the same between FY 2013–2014 and FY 2014–2015 while the rate for child Medicaid statewide average decreased slightly, by 3.9 percentage points.

Timeliness—Behavioral Health

Statewide BHO performance was lowest in the timeliness domain. All five of the BHOs struggled with the time frames associated with a request to continue benefits during and appeal and/or State fair hearing. Additionally, while the BHOs' policies, procedures, and member information was mostly accurate for the time frames related to acknowledgement and resolution of grievances and appeals, on-site record reviews demonstrated that the plans were not always meeting these time requirements. However, the majority of required actions that fell within the timeliness domain were related to policies and procedures for scenarios that rarely present. While performance in the timeliness domain was poorest, HSAG found ample evidence to suggest that Colorado BHOs provide timely decisions, services, and follow-up care to members.

Behavioral Health Engagement and *Follow-Up After Hospitalization for Mental Illness (7- and 30-Day Follow-Up)* were the two timeliness measures reported for the current measurement year. Rate comparison with last year's rate was not performed for the *Behavioral Health Engagement* measure. Contrary to the previous year's result, the statewide performance on the *Follow-Up After Hospitalization* measure demonstrated a rate increase for all four indicators ranging between 2.5 and 3.5 percentage points. All but one BHO showed a rate increase for all indicators in this measure.

Access—Physical Health

Most of the required actions this year related to the access domain. HSAG believes that ensuring members, providers, and the staff understand the benefits and services available is a key indicator to determine whether members will access those services. DHMC and RMHP did a good job presenting the required information to members, providers, and the staff, and in maintaining a network of qualified providers to deliver the services.

Statewide HEDIS performance in the access domain suggested opportunities for improvement for both health plans. Of the 10 access-related measures, only 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*). The first three measures reported significant decline in performance from the previous year in at least one indicator. When compared to national benchmarks, statewide performance was diverse. All rates from the *Prenatal and Postpartum Care* and most of the *Comprehensive Diabetes Care* rates ranked above the national 50th percentiles. However, the two main access-to-care measures ranked below the national 10th percentiles. The remaining six access-related measures (*Ambulatory Care, Inpatient Utilization, Identification of Alcohol and Other Drug Services, Mental Health Utilization, Antibiotic Utilization,* and *Frequency of Selected Procedures*) are utilization-based measures without any risk adjustment. The rates for these measures should be used for information only.

One of the measures within the CAHPS survey addressed access: *Getting Needed Care*. While the rates for both adult Medicaid and child Medicaid populations increased (3.3 percentage points for the adult population and 0.5 percentage points for the child population), these increases were not substantial.

Access—Behavioral Health

Statewide performance in the access domain was strong. All five BHOs demonstrated the availability of robust provider networks that served the needs of their members. The plans created and distributed member information written in easy-to-understand language that explained the benefits of the plan—including the availability of a grievance and appeal system—and how to access services.

Overall, statewide performance in the access domain showed mixed results. Of the 24 indicators in this domain, 15 demonstrated a rate decline while nine showed a rate increase. All nine improvements were observed in the Penetration Rates, with the *BC Women* indicator reporting a notable improvement. Three indicators (*BC Children, Buy-in: working Adults with Disabilities* and *Modified Adjusted Gross Income*) showed a notable decline.

Statewide performance of the utilization-based measures displayed rate declines for all indicators. The declines ranged between 2.7 percent and 18.2 percent. Although four utilization indicators showed notable declines, the actual differences in rates were minimal. Utilization-based indicators should be evaluated based on the characteristics of the BHOs' populations. Although conclusions cannot be drawn based on utilization results alone, when combined with other performance metrics the results can provide additional information that the BHOs can use to explore opportunities for rate improvements.

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–D 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 2014–2015 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards to review these performance areas. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. For each standard, HSAG conducted a desk review of documents sent by the health plans prior to the on-site portion of the review, conducted interviews with key health plan staff members on-site, and reviewed additional key documents on-site.

Each health plan's administrative records also were reviewed to evaluate implementation of managed care regulations related to Medicaid grievances and appeals. Using a random sampling technique, HSAG selected a sample of 10 plus an oversample of five from all applicable grievances and appeals filed between January 1, 2014, and December 31, 2014 (to the extent possible). HSAG used a standardized tool to review the records and document findings. Results of record reviews were considered in the scoring of applicable requirements in Standard VI—Grievance System. HSAG also calculated an overall record review score separately.

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—Assignment of Activities to Performance Domains

Standard	Quality	Timeliness	Access
Standard V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		

Denver Health Medicaid Choice (DHMC)

Findings

Table 3-2 and Table 3-3 present the number of elements for each standard 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 2014–2015).

Table 3-2—Summary of Scores for the Standards *for* DHMC

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	29	29	27	2	0	0	93%
Standard VI—Grievance System	26	26	17	9	0	0	65%
Standard VII—Provider Participation and Program Integrity	17	16	16	0	0	1	100%
Standard IX—Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**77**	**76**	**65**	**11**	**0**	**1**	**86%***

* 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)
Appeals	30	30	22	8	0	73%
Grievances	45	27	21	6	18	78%
Total	**75**	**57**	**43**	**14**	**18**	**75%**

Strengths

DHMC had policies and procedures that addressed member rights and described its processes for ensuring that members are informed of, and understand, their rights. The member handbook and other member materials comprehensively defined member benefits and included the information required at 42CFR438.10. The handbook described member rights, including grievance and appeals procedures, in an easy-to-understand format. The member handbook stated that member materials were available in alternative languages and formats and how to obtain them.

DHMC had a well-defined grievance system that included policies and procedures to address grievances, appeals, and member access to State fair hearings. Most policies and procedures were clear and included the required content and accurate time frames for standard reviews, expedited reviews, and extension processes. HSAG found ample evidence that providers and members were notified of member rights related to the grievance system.

DHMC's provider manual was comprehensive and its policies and procedures delineated contractual obligations as well as requirements for ongoing monitoring. Monitoring activities included HEDIS, performance improvement projects (PIPs), and CAHPS. In addition, the Denver Health and Hospitals Authority (DHHA) Integrity Office was contracted through a memorandum of understanding (MOU) to conduct medical record reviews. Credentialing policies and processes were thorough and the monitoring of provider quality and appropriateness was comprehensive and adequately reported. Physicians, employees, directors, vendors, and officers were queried monthly for suspension, exclusion, and debarment. Systems were in place to ensure compliance with provider nondiscrimination, sanctions and exclusions, and freedom to act on behalf of members. DHMC had policies for reporting adverse licensure or professional review actions and its compliance training was thorough and occurred at all levels.

Policies and procedures related to subcontracts and delegation included the required information. HSAG found evidence of a signed, executed agreement with each delegate that also included all required provisions. The agreements also outlined a process to provide oversight and monitoring of subcontractors and delegates while maintaining ultimate responsibility for all delegated tasks.

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:

Standard V—Member Information

- DHMC was required to revise member handbook information regarding the State-level grievance review to include the address where members could send the request for the second-level grievance review by the Department.
- DHMC was required to revise the member handbook to accurately state that Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services were available for members ages 20 and under and completely describe EPSDT and related services. DHMC also was required to submit the revised EPSDT section of the Medicaid member handbook to the EPSDT administrator at the Department for approval to ensure the accuracy of information provided to members.

Standard VI—Grievance System

- DHMC was required to revise its policy/procedure on drug utilization to depict that the termination, suspension, or reduction of a previously authorized service (in this case, a medication) was an action.
- DHMC was required to develop a mechanism to ensure that CHP+ appeal resolution letters were consistently sent to members within the required 10-working-day time frame and that the letters consistently include all required elements.
- DHMC was required to ensure that appeal decisions were reviewed by providers with the appropriate clinical expertise who had not been involved in a previous level of decision.
- DHMC was required to review applicable policies and member and provider materials to ensure it was clear that members needed only comply with timely filing requirements delineated in 42CFR438.420 if requesting the continuation of previously authorized services that the MCO was proposing to terminate, suspend, or reduce. Additionally, DHMC was required to review

policies for consistency across programs and periodically train grievance/appeal staff members specifically regarding federal regulations.

- DHMC was required to develop a mechanism to ensure that Medicaid grievance acknowledgement letters and appeal acknowledgement letters were consistently sent to members within the required two-working-day time frame.
- DHMC was required to develop a mechanism to ensure that Medicaid grievance disposition letters were consistently sent to members within the required 15-working-day time frame and that the letters included all of the required content.

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's policies and procedures described the processes to ensure that members, providers, and the staff understood member rights, services, and benefits available under the plan. DHMC's provider manual delineated the contractual obligations and its policies and procedures described the processes used to continually monitor its delivery of services and ensure consistent provision of quality services.

Timeliness: HSAG assigned the grievance system standard to the timeliness domain. DHMC's policies and procedures did not accurately describe the timely filing requirements when requesting the continuation of previously authorized services. Additionally, on-site grievance and appeal record reviews demonstrated that DMHC was not consistently meeting the required time frames.

Access: HSAG assigned member information, grievance system, and provider participation and program integrity standards to the access domain. While DHMC was required to implement corrective actions that could impact members' access to services, its overall performance in these three standards was very good. DHMC provided members with clear, easy-to-understand information about the benefits under the plan and how to access them.

Rocky Mountain Health Plans (RMHP)

Findings

Table 3-4 and Table 3-5 present the number of elements for each standard 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 2014–2015).

Table 3-4—Summary of Scores for the Standards *for* RMHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	25	25	20	5	0	0	80%
Standard VI—Grievance System	26	26	23	3	0	0	88%
Standard VII—Provider Participation and Program Integrity	15	15	14	1	0	0	93%
Standard IX—Subcontracts and Delegation	5	5	5	0	0	0	100%
Totals	**71**	**71**	**62**	**9**	**0**	**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 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)
Appeals	50	41	40	1	9	98%
Grievances	60	51	50	1	9	98%
Total	**110**	**92**	**90**	**2**	**18**	**98%**

Strengths

RMHP's Medicaid member handbook was written in easy-to-understand language and informed members that the handbook was available in alternative formats and languages. The handbook continually reinforced that RMHP's customer service department was available to assist in using and understanding plan benefits and offered examples of the kinds of questions members might ask. The handbook informed members about the importance of having a primary care provider (PCP) responsible for monitoring the member's overall health and encouraged members to work with their PCPs to identify when a specialist's services were needed, to choose a specialist in-network, and to help arrange for any necessary prior approvals. RMHP dedicated several pages of the member handbook to explaining EPSDT benefits and the services available through Colorado's Healthy Communities program. RMHP produced age-specific fliers and brochures that delineate the

importance of well-child visits, what parents and children could expect during well-child visits, and answers to common questions related to well-child visits and related immunizations.

RMHP had effective systems to process grievances and appeals and assist members with access to the State's fair hearing process. RMHP communicated the grievance system processes to members via the member handbook and to providers via the provider manual. RMHP also communicated that assistance was available to file grievances and appeals. The on-site record review demonstrated that, for records reviewed, RMHP sent grievance and appeal acknowledgement letters and resolution letters within the required time frames, and those letters included the required content.

RMHP had a robust credentialing and recredentialing program that included comprehensive policies and procedures effectively articulating how RMHP complied with National Committee for Quality Assurance (NCQA) standards and guidelines for credentialing and recredentialing. RMHP provided evidence that provider quality, appropriateness, and medical records standards were routinely monitored at both the aggregate and provider levels. RMHP routinely screened its providers and employees against regulatory databases, and policies and procedures regarding incentives met the requirements. Provider services contracts were thorough, included all regulatory requirements, and applied to all applicable lines of business. The corporate-wide compliance plan and related fraud and abuse policies and procedures were thorough, employee training was conducted annually, and policies related to compliance were described in the provider manual and the member handbook. Monitoring for fraud and abuse included system edits and internal auditing processes. Numerous committees and reporting structures existed for decision-making and oversight of the credentialing, quality improvement, and compliance programs.

RMHP delegated credentialing and recredentialing to 15 of its physician groups; specific utilization review activities to CareCore National, LLC (CCN); and pharmacy claims processing to MedImpact (RMHP's pharmacy benefit manager, or PBM). During the review period, RMHP terminated its contract with Express Scripts, the previous PBM, and provided evidence of having monitored and imposed corrective actions on Express Scripts prior to terminating the contract. RMHP also provided evidence that it conducted a comprehensive predelegation assessment prior to contracting with MedImpact. In addition, RMHP expanded its contract with CCN during 2014 and performed a predelegation review of CCN's capacity to provide the additional scope of work. RMHP provided evidence of ongoing monitoring (joint committee processes and regular review of delegates' reporting) and formal annual audits of each delegate. RMHP had a written delegation agreement with each delegate that included the required provisions.

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:

Standard V—Member Information

- RMHP was required to add a statement to its member handbook that told members how to access interpreter services. HSAG also suggested that RMHP notify its members that interpreter services were free.

- RMHP was required to revise information in its member handbook related to its utilization management program to clearly identify the department within RMHP that implemented the utilization management program; describe how RMHP determined medical necessity; remind members of their right to appeal decisions; and provide appropriate points of contact and telephone numbers for members desiring more information or having additional questions.
- RMHP was required to revise its discussion regarding emergency medical care to include the federal definition of "emergency medical condition."
- RMHP was required to revise its member handbook to include the statement that charges to members for poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor.
- RMHP was required to add a statement to its benefits booklet informing members that complaints regarding noncompliance with advance directives could be filed with the Colorado Department of Public Health and Environment.

Standard VI—Grievance System

- RMHP was required to review and revise all applicable policies and procedures to ensure accurate, complete, and consistent definitions of "action."
- RMHP was required to revise its grievance policy to accurately reflect the description of the second-level grievance review by the State. RMHP also was required to ensure that customer service and grievance staff members understood that providers must limit charges to members to Department-approved copays, and it was required to educate the provider and the customer service staff involved.
- RMHP was required to clarify its policy to state that members had 30 days from the notice of action to request a State fair hearing (unless the health plan provided 10-day advance notice of termination, suspension, or reduction of the previously authorized and disputed service and the member was requesting continuation of the disputed services—in which case the timely filing requirements in 42CFR438.420 applied).

Standard VII—Provider Participation and Program Integrity

- RMHP was required to revise its applicable policies and procedures to include the required advance directives provisions.

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: The quality domain issues that RMHP encountered related to ensuring that members received all of the required information regarding the benefits and services available to them. Additionally, RMHP needed to clarify information in its member handbook related to its utilization management program and how it determined medical necessity. Making sure members understood the benefits and services available would increase the likelihood that they achieved their desired health outcomes.

Timeliness: HSAG assigned the grievance system standard to the timeliness domain. While RMHP's score of 88 percent compliance indicated room for improvement, very few of the required actions were directly related to timeliness. On-site record review scores were very good and demonstrated that RMHP adhered to all time frames required for processing grievances and appeals.

Access: Most of RMHP's required corrective actions were related to missing, incomplete, or inaccurate information that could potentially impede its members' access to services. RMHP must ensure that it clearly conveys accurate information to its members, providers, and staff regarding services and benefits available under the plan and how to access those services and benefits.

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 V—Member Information	87%
Standard VI—Grievance System	77%
Standard VII—Provider Participation and Program Integrity	97%
Standard IX—Subcontracts and Delegation	100%
Total	**86%***

* 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*
Appeals	90%
Grievances	89%
Total	**89%**

* 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: Colorado's two managed care physical health plans performed well in the quality domain. With few exceptions, both plans had policies and procedures that outlined the benefits of the plan and the expectations and requirements for ensuring quality services. Member handbooks were thorough, well-written, and available in alternative formats and languages. The plans monitored their programs, providers, and staffs to ensure quality services.

Timeliness: HSAG assigned the grievance system standard to the timeliness domain, which is the standard with the lowest statewide score. Both plans struggled with requirements related to continuing services during an appeal and/or State fair hearing. Difficulty understanding this

requirement was due in part to the rarity of such a request. Both DHMC and RMHP had structured their programs in a manner making it highly unlikely that either would terminate, suspend, or reduce services it previously authorized.

Access: Most of the required actions this year related to the access domain. HSAG believes that ensuring members, providers, and the staff understand the benefits and services available is a key indicator for determining whether members will access those services. DHMC and RMHP did a good job presenting the required information to members, providers, and staffs, and maintaining a network of qualified providers to deliver the services.

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. All licensed organizations followed NCQA's methodology to conduct their HEDIS compliance audits. 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. Assessments were made based on statistical comparisons between the current year's rates and the prior year's rates, where available, as well as on comparisons against the national Medicaid benchmarks, where appropriate. As denoted by an asterisk in Table 3-8, a change was made on five measures in the Department-required data collection methodology (from hybrid to administrative). This change is likely to impact the health plan's overall performance on these measures. Although statistical comparisons and benchmark comparisons were made, these results may not represent the health plan's true performance and should be interpreted with caution. HSAG has noted these concerns where discussion of these results is made throughout the section.

Table 3-8—FY 2014–2015 Performance Measures Required for Validation

Measure	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Childhood Immunization Status	Administrative*	✓	✓	
Immunizations for Adolescents	Administrative*	✓	✓	
Well-Child Visits in the First 15 Months of Life	Administrative*	✓	✓	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Administrative*	✓	✓	
Adolescent Well-Care Visits	Administrative*	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Hybrid	✓		
Appropriate Testing for Children with Pharyngitis	Administrative	✓		
Appropriate Treatment for Children with Upper Respiratory Infection	Administrative	✓		
Prenatal and Postpartum Care	Hybrid	✓	✓	✓

Table 3-8—FY 2014–2015 Performance Measures Required for Validation				
Measure	**Data Collection Methodology Required by the Department**	**Quality**	**Timeliness**	**Access**
Children and Adolescents' Access to Primary Care Practitioners (PCPs)	Administrative			✓
Adults' Access to Preventive/Ambulatory Health Services	Administrative			✓
Chlamydia Screening in Women	Administrative	✓		
Breast Cancer Screening	Administrative	✓		
Cervical Cancer Screening	Hybrid	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	Administrative	✓		
Adult BMI Assessment	Hybrid	✓		
Antidepressant Medication Management	Administrative	✓		
Follow-up Care for Children Prescribed ADHD Medication	Administrative	✓	✓	
Follow-Up After Hospitalization for Mental Illness	Administrative	✓	✓	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Administrative	✓		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	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	✓		
Persistence of Beta-Blocker Treatment After a Heart Attack	Administrative	✓		
Comprehensive Diabetes Care	Hybrid	✓		✓
Annual Monitoring for Patients on Persistent Medications	Administrative	✓		
Use of Imaging Studies for Low Back Pain	Administrative	✓		
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	Administrative	✓		
Pharmacotherapy Management of COPD Exacerbation	Administrative	✓		
Use of Appropriate Medications for People With Asthma	Administrative	✓		

Table 3-8—FY 2014–2015 Performance Measures Required for Validation				
Measure	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Medication Management 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			✓
Identification of Alcohol and Other Drug Services	Administrative			✓
Mental Health Utilization	Administrative			✓
Antibiotic Utilization	Administrative			✓
Frequency of Selected Procedures (Procedures per 1,000 MM)	Administrative			✓

The Department required that 41 performance measures be validated in FY 2014–2015 based on HEDIS 2015 specifications. Seven measures were reported as new for this year. For measures that were validated in FY 2013–2014, HSAG also made comparisons between the previous year's and the current year's results.

Denver Health Medicaid Choice (DHMC)

Compliance with Information Systems (IS) Standards

DHMC was fully compliant with all but the following IS standards:

- IS 3.4 and 3.5 (substantial compliance for both): DHMC did not regularly collect credentialing data on its delegated Cofinity Network. No adverse impact on HEDIS reporting was identified.
- IS 5.1 and 5.2 (substantial compliance for both): The supplemental data source containing blood pressure data was not allowed. Other data sources had to be corrected. No other adverse impact on HEDIS was identified.
- IS 7.2 (noncompliance) and 7.3 (substantial compliance): Significant issues were experienced throughout the reporting cycle. *Inpatient Utilization (IPU)* and *Ambulatory Care (AMB)* measures were not reportable for the Medicaid product.

The auditor noted that DHMC had significant, continuing, and repetitive problems with data extraction and mapping into its calculation vendor's HEDIS reporting software. Due to a large conversion in the information technology department, DHMC did not assign information

technology resources to manage the HEDIS reporting project until February 2015. The lack of resources caused a major delay in achieving multiple HEDIS project milestones (completing the hybrid sampling process and auditor's review of the convenience sample). Subsequently, DHMC adjusted its reporting strategy by removing some measures from hybrid pursuit to rotation. Although DHMC was able to report almost a full measure set, the auditor recommended early and extensive testing of the extraction and mapping processes into the calculation vendor's software.

The auditor also noted that the supplemental data sources extracted from DHMC electronic medical record systems contained a large amount of extraneous information with inadequate and incorrect documentation. More specifically, the documented mapping for the blood pressure extract was incorrect. Consequently, the auditor did not approve this data source for reporting. The auditor recommended that the electronic medical record data extracts be more restricted (e.g., the body mass index [BMI] extract contain only records necessary for the BMI values). Another recommendation pertained to developing clear business requirements to verify the accuracy of the extraction and mapping.

Pediatric Care Performance Measures

Table 3-9 shows the DHMC HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 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 2015 Audit Results
	2014	2015		
Childhood Immunization Status				
Combination 2	78.35%	76.81%[2]	50th–74th	R
Combination 3	78.10%	75.85%[2]	50th–74th	R
Combination 4	77.62%	75.02%[2]	75th–89th	R
Combination 5	62.04%	64.98%[2]	75th–89th	R
Combination 6	63.50%	**57.96%**[2]	75th–89th	R
Combination 7	62.04%	64.41%[2]	75th–89th	R
Combination 8	63.26%	**57.64%**[2]	≥90th	R
Combination 9	53.53%	51.31%[2]	75th–89th	R
Combination 10	53.53%	51.05%[2]	≥90th	R
Immunizations for Adolescents—Combination 1	83.21%	80.27%[3]	50th–74th	R
Well-Child Visits in the First 15 Months of Life				
*Zero Visits***	2.68%	**5.19%**[4]	≥90th	R
Six or More Visits	63.50%	**2.36%**[4]	<10th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.04%	60.06%[4]	<10th	R
Adolescent Well-Care Visits	49.88%	**39.79%**[4]	10th–24th	R

Table 3-9—Review Results and Audit Designation for Pediatric Care Performance Measures *for* DHMC				
Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]	HEDIS 2015 Audit Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	91.73%	93.19%	≥90th	R
Counseling for Nutrition: Total	79.32%	77.86%	≥90th	R
Counseling for Physical Activity: Total	64.48%	62.04%	75th–89th	R
Appropriate Testing for Children with Pharyngitis	70.06%	72.78%	50th–74th	R
Appropriate Treatment for Children with Upper Respiratory Infection	—	98.03%	≥90th	R

Note: Measures shaded in blue with a black font indicate that the data collection methodology was hybrid for HEDIS 2014 and was administrative for HEDIS 2015. 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 the previous 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 2015 rate was below the national 10th percentile.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file for HEDIS 2015. DHMC reported HEDIS 2015 hybrid rates of 78.83 percent, 78.10 percent, 77.13 percent, 66.67 percent, 58.39 percent, 65.69 percent, 58.15 percent, 50.85 percent, and 50.61 percent for the *Childhood Immunization Status— Combination 2* through *Combination 10* indicators, respectively.

[3] Per the Department's required data collection methodology, the rate displayed reflects administrative data only and is not the final, reported hybrid rate in the plan-submitted file. DHMC reported the HEDIS 2015 hybrid rate of 86.13 percent for *Immunizations for Adolescents—Combination 1*.

[4] DHMC followed the Department's required administrative data collection methodology to report these measures. The rates displayed are the final rates in the plan-submitted file for HEDIS 2015.

Strengths

All DHMC performance measures within the pediatric care performance domain received an audit result of *Reportable (R)* for HEDIS 2015. Although none of the measures reported a significant increase in rate, three measures had at least one rate performing at or above the national HEDIS Medicaid 90th percentile. These measures were *Childhood Immunization Status*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent*, and *Appropriate Treatment for Children with Upper Respiratory Infection*.

Recommendations

Three measures (*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Well-Child Visits in the First 15 Months of Life;* and *Adolescent Well-Care Visits*) were below the national HEDIS Medicaid 25th percentile. These measures also showed a significant rate decrease from the prior year. However, this decrease could be related to a change in the Department-required data collection methodology from hybrid to administrative and may not reflect a true performance decline. Nonetheless, since all well-child visits rates were below the federal EPSDT mandate of 80 percent, HSAG recommends that DHMC focus its efforts on improving performance on the well-child visit measures.

Access to Care and Preventive Screening Performance Measures

Table 3-10 shows the DHMC HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 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 2015 Audit Results
	2014	2015		
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	89.29%	**84.67%**	50th–74th	R
Postpartum Care	57.42%	60.58%	25th–49th	R
Children's and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	92.24%	91.12%	<10th	R
Ages 25 Months to 6 Years	74.69%	**73.42%**	<10th	R
Ages 7 to 11 Years	80.82%	**79.27%**	<10th	R
Ages 12 to 19 Years	82.32%	**80.17%**	<10th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	71.00%	**69.07%**	<10th	R
Preventive Screening				
Chlamydia Screening in Women—Total	68.49%	68.60%	≥90th	R
Breast Cancer Screening	54.59%	53.09%	25th–49th	R
Cervical Cancer Screening	67.15%	63.02%	25th–49th	R
*Non-Recommended Cervical Cancer Screening in Adolescent Females***	—	0.21%	<10th	R
Adult BMI Assessment	90.51%	88.08%	75th–89th	R

Note: 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 the previous 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 measure, the HEDIS 2015 rate was at or above the national 90th percentile.
R is shown when the rate was reportable, according to NCQA standards.
[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

All access to care and preventive screening performance measures received an audit result of *Reportable (R)* for HEDIS 2015. Although none of the measures reported a significant increase in rate, two rates (*Chlamydia Screening in Women—Total* and *Non-Recommended Cervical Cancer Screening in Adolescent Females [an inverse measure]*) performed at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Two measures (*Children's and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services—Total*) were below the national HEDIS Medicaid 10th percentile. Although *Timeliness of Prenatal Care* declined significantly from the previous year, its performance was still above the national Medicaid 50th percentile. Therefore, HSAG recommends that DHMC focus its efforts on improving access to services for all its members.

Mental/Behavioral Health Performance Measures

Table 3-11 shows the DHMC HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 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 2015 Audit Results
	2014	2015		
Anti-depressant Medication Management				
Effective Acute Phase Treatment	41.58%	43.65%	10th–24th	R
Effective Continuation Phase Treatment	30.43%	29.62%	10th–24th	R
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	14.81%	**29.20%**	10th–24th	R
Continuation	NA	NA	—	NA
Follow-Up After Hospitalization for Mental Illness				
30-Day	—	NB	—	NB
7-Day	—	NB	—	NB
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.02%	59.73%	25th–49th	R
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	89.67%	87.66%	≥90th	R
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.97%	60.61%	10th–24th	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 previous year.

— is shown when no data were available or the measure was not reported in the previous 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. NB is shown when DHMC did not have the required benefit to calculate the measure.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Six of the 10 rates in this domain received an audit result of *Reportable (R)* for HEDIS 2015. One rate (*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication)* was at or above the national HEDIS Medicaid 90th percentile. Although the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* rate performed below the 25th percentile, the HEDIS 2015 rate was at least 10 percentage points significantly higher than the prior year.

Recommendations

With the exception of the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* measure, all measures with reportable rates in this domain performed below the national HEDIS Medicaid 50th percentile. Specifically, four rates (two under *Antidepressant Medication Management*, *Follow-up Care for Children Prescribed ADHD Medication—Initiation*, and *Diabetes Monitoring for People With Diabetes and Schizophrenia*) were below the 25th percentile. HSAG recommends DHMC develop strategies to target these measures.

Living With Illness Performance Measures

Table 3-12 shows the DHMC HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 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 2015 Audit Results
	2014	2015		
Controlling High Blood Pressure	66.42%	70.32%	≥90th	R
Persistence of Beta-Blocker Treatment After a Heart Attack	—	NA	—	NA
Comprehensive Diabetes Care				
HbA1c Testing	88.81%	85.64%	50th–74th	R
*HbA1c Poor Control (>9.0%)***	31.87%	**38.44%**	25th–49th	R
HbA1c Control (<8.0%)	58.39%	**50.85%**	50th–74th	R
Eye Exam	49.64%	47.93%	25th–49th	R
Medical Attention for Nephropathy	82.48%	79.32%	25th–49th	R
Blood Pressure Controlled <140/90 mm Hg	72.99%	69.10%	50th–74th	R
Annual Monitoring for Patients on Persistent Medications—Total	84.74%	85.56%	25th–49th	R
Use of Imaging Studies for Low Back Pain	81.12%	80.33%	75th–89th	R
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	—	53.41%	≥90th	R

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

Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]	HEDIS 2015 Audit Results
Pharmacotherapy Management of COPD Exacerbation				
Systemic corticosteroid	64.90%	**52.38%**	10th–24th	R
Bronchodilator	76.92%	**65.08%**	<10th	R
Use of Appropriate Medications for People With Asthma—Total	78.61%	79.12%	10th–24th	R
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	37.81%	<10th	R
Medication Compliance 75%—Total	—	14.32%	<10th	R
Asthma Medication Ratio—Total	53.60%	**29.98%**	<10th	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	30.26%	31.16%	50th–74th	R
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	81.48%	**64.63%**	25th–49th	R

Note: Rates shaded in red with a red font indicate a statistically significant decline in performance from the previous year.
— is shown when no data were available or the measure was not reported in the previous 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 denominator is less than 30 to report a valid rate.
** 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 2015 rate was between the national 50th and 75th percentiles.
1 Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

DMHC received an audit result of *Reportable (R)* for all but one HEDIS 2015 rates in this domain. Two measures (*Controlling High Blood Pressure* and *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis)* were at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Four measures (*Pharmacotherapy Management of COPD Exacerbation*, *Use of Appropriate Medications for People With Asthma—Total*, *Medication Management for People With Asthma*, and *Asthma Medication Ratio—Total*) were below the national HEDIS Medicaid 25th percentile. A significant rate decline occurred for two of these measures (*Pharmacotherapy Management of COPD Exacerbation* and *Asthma Medication Ratio—Total*) as well as for HbA1c control from *Comprehensive Diabetes Care* and *Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis*. Since majority of the poor performance appeared to be associated with management of respiratory conditions, HSAG recommends that DHMC focus its efforts on improving this area.

Use of Services Observations

Table 3-13 shows the DHMC HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 audit results for the use of services measures. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2014 and 2015 may not denote actual improvement or decline in performance. Percentile rankings are assigned to the HEDIS 2015 reported rates based on HEDIS 2014 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 2015 Audit Results
	2014	2015		
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	225.92	NR	—	NR
Emergency Department Visits	44.05	NR	—	NR
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 MM (Total Inpatient)	5.53	NR	—	NR
Days per 1,000 MM (Total Inpatient)	21.84	NR	—	NR
Average Length of Stay (Total Inpatient)	3.95	NR	—	NR
Discharges per 1,000 MM (Medicine)	4.27	NR	—	NR
Days per 1,000 MM (Medicine)	14.41	NR	—	NR
Average Length of Stay (Medicine)	3.37	NR	—	NR
Discharges per 1,000 MM (Surgery)	1.17	NR	—	NR
Days per 1,000 MM (Surgery)	7.21	NR	—	NR
Average Length of Stay (Surgery)	6.15	NR	—	NR
Discharges per 1,000 MM (Maternity)	0.15	NR	—	NR
Days per 1,000 MM (Maternity)	0.40	NR	—	NR
Average Length of Stay (Maternity)	2.61	NR	—	NR
Identification of Alcohol and Other Drug Services—Total				
Any Service	—	4.06%	50th–74th	R
Inpatient	—	1.09%	50th–74th	R
Intensive Outpatient/Partial Hospitalization	—	0.00%	10th–24th	R
Outpatient/ED	—	3.55%	50th–74th	R
Mental Health Utilization—Total				
Any Service	—	NB	—	NB
Inpatient	—	NB	—	NB
Intensive Outpatient/Partial Hospitalization	—	NB	—	NB

Table 3-13—Rates and Audit Results for Use of Services Measures *for* DHMC				
Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings	HEDIS 2015 Audit Results
Outpatient/ED	—	NB	—	NB
Antibiotic Utilization—All Ages				
Average Scrips for PMPY for Antibiotics	0.35	0.30	<10th	R
Average Days Supplied per Antibiotic Scrip	9.54	9.50	50th–74th	R
Average Scrips PMPY for Antibiotics of Concern	0.10	0.09	<10th	R
Percentage of Antibiotics of Concern of All Antibiotic Scrips	27.65%	28.02%	<10th	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	*	R
Bariatric weight loss surgery (20–44 Male)	0.00	0.00	10th–49th	R
Bariatric weight loss surgery (20–44 Female)	0.05	0.03	25th–49th	R
Bariatric weight loss surgery (45–64 Male)	0.00	0.00	10th–74th	R
Bariatric weight loss surgery (45–64 Female)	0.03	0.08	50th–74th	R
Tonsillectomy (0–9 Male & Female)	0.36	0.29	10th–24th	R
Tonsillectomy (10–19 Male & Female)	0.19	0.12	10th–24th	R
Hysterectomy, Abdominal (15–44 Female)	0.06	0.06	<10th	R
Hysterectomy, Abdominal (45–64 Female)	0.12	0.31	25th–49th	R
Hysterectomy, Vaginal (15–44 Female)	0.09	0.03	<10th	R
Hysterectomy, Vaginal (45–64 Female)	0.15	0.08	10th–24th	R
Cholecystectomy, Open (30–64 Male)	0.05	0.12	≥90th	R
Cholecystectomy, Open (15–44 Female)	0.05	0.02	≥75th	R
Cholecystectomy, Open (45–64 Female)	0.06	0.03	50th–74th	R
Cholecystectomy (laparoscopic) (30–64 Male)	0.20	0.10	<10th	R
Cholecystectomy (laparoscopic) (15–44 Female)	0.55	0.57	25th–49th	R
Cholecystectomy (laparoscopic) (45–64 Female)	0.36	0.57	25th–49th	R
Back Surgery (20–44 Male)	0.06	0.13	10th–24th	R
Back Surgery (20–44 Female)	0.04	0.06	10th–24th	R
Back Surgery (45–64 Male)	0.09	0.47	25th–49th	R
Back Surgery (45–64 Female)	0.15	0.34	25th–49th	R
Mastectomy (15–44 Female)	0.02	0.00	10th–24th	R
Mastectomy (45–64 Female)	0.03	0.05	10th–24th	R

Table 3-13—Rates and Audit Results for Use of Services Measures *for* DHMC				
Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings	HEDIS 2015 Audit Results
Lumpectomy (15–44 Female)	0.09	0.07	<10th	R
Lumpectomy (45–64 Female)	0.27	0.23	10th–24th	R

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

R is shown when the rate was reportable, according to NCQA standards. NR is shown for the *Ambulatory Care* and *Inpatient Utilization* measures as not reportable because the auditor determined the rates were materially biased. NB is shown when DHMC did not have the required benefit to calculate the measures.

* Percentile rank could not determine because the values for P10, P25, P50, P75, and P90 are zeros.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

According to DMHC's final audit report, the auditor noted that due to missing paid claims, the rates calculated for the *Ambulatory Care* and *Inpatient Utilization* measures were found to be materially biased. Consequently, these measures received an *NR* audit designation. Since DMHC did not offer mental health benefits to its members, the *Mental Health Utilization* measure received an *NB* audit designation. Rates increased for many procedures under the *Frequency of Selected Procedure* measure, but overall the rates remained very low (less than one procedure per 1,000 member months). 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: DHMC's performance on the 33 quality-related measures was mixed. The majority of the measures did not have any rate change from the previous year. One rate from the *Follow-up Care for Children Prescribed ADHD Medication* measure increased significantly. Eight measures had at least one rate decline significantly. When compared to national benchmarks, DHMC's performance was diverse. Ten measures had at least one rate ranked below the national 25th percentiles, and eight ranked at or above the 90th percentiles. Low percentile ranking was mostly found among measures under the living with illness category. Although a significant rate decline and a low percentile ranking were also noted in several measures under the pediatric care category, these results could be related to a change to the State-required data collection methodology from hybrid to administrative and may not represent DHMC's true performance.

Timeliness: DHMC's performance from the eight timeliness-related measures was mixed. One rate from the *Follow-up Care for Children Prescribed ADHD Medication* measure increased significantly. Three measures had at least one rate decline significantly. Declines were found in two pediatric care measures and *Prenatal and Postpartum Care.* When compared to national benchmarks, DHMC's performance was diverse. Although its performance on the immunization measures was above the national 50th percentiles, all the rates for the well-child visit measures ranked below the national 25th percentiles. In total, four measures had at least one rate ranked

below the national 25th percentiles. Although a significant rate decline and a low percentile ranking were also noted in several measures under the pediatric care category, these results could be related to a change to the State-required data collection methodology from hybrid to administrative and may not represent DHMC's true performance.

Access: DHMC's rates in this domain suggested mixed performance. Of the 10 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*). Three of these measures had a significant decline in performance from at least one of their indicators, of which two measures were found under the access to care category (*Children's and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services*). When compared to national benchmarks, DHMC's performance was diverse. The *Prenatal and Postpartum Care* and *Comprehensive Diabetes Care* measures had some rates ranked above the national 50th percentiles. However, there were two main access-to-care measures that ranked below the national 10th percentiles.

Although *Ambulatory Care, Inpatient Utilization, Identification of Alcohol and Other Drug Services, Mental Health Utilization, Antibiotic Utilization,* and *Frequency of Selected Procedures* were related to members' 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 (RMHP)

Compliance with Information Systems (IS) Standards

HSAG's review of RMHP's final audit report showed that 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 a negative impact on HEDIS reporting. The auditor had no recommendations for RMHP.

Pediatric Care Performance Measures

Table 3-14 shows the RMHP HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 audit results for each performance measure related to pediatric care. Since RMHP rotated six of the nine measures in this domain, statistical tests comparing HEDIS 2015 and HEDIS 2014 rates were not performed for these measures.

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

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2015 Audit Results
	2014	2015		
Childhood Immunization Status				
Combination 2	77.70%	36.01%[2]	<10th	R
Combination 3	73.95%	33.61%[2]	<10th	R

Table 3-14—Review Results and Audit Designation for Pediatric Care Performance Measures *for* RMHP				
Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]	HEDIS 2015 Audit Results
Combination 4	66.23%	31.08%[2]	<10th	R
Combination 5	60.71%	27.99%[2]	<10th	R
Combination 6	51.66%	25.32%[2]	<10th	R
Combination 7	57.17%	26.02%[2]	<10th	R
Combination 8	48.12%	23.91%[2]	10th–24th	R
Combination 9	43.93%	21.38%[2]	10th–24th	R
Combination 10	41.94%	20.25%[2]	10th–24th	R
Immunizations for Adolescents—Combination 1	59.65%	56.53%[2]	10th–24th	R
Well-Child Visits in the First 15 Months of Life				
*Zero Visits***	0.36%	1.44%[2]	25th–49th	R
Six or More Visits	80.73%	25.72%[2]	<10th	R
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.01%	64.36%[2]	10th–24th	R
Adolescent Well-Care Visits	45.58%	41.71%[2]	25th–49th	R
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment: Total	80.90%	81.42%	75th–89th	R
Counseling for Nutrition: Total	63.15%	64.16%	50th–74th	R
Counseling for Physical Activity: Total	62.47%	62.47%[3]	75th–89th	R
Appropriate Testing for Children with Pharyngitis	90.86%	90.06%	≥90th	R
Appropriate Treatment for Children with Upper Respiratory Infection	—	93.63%	75th–89th	R

Note: Measures shaded in blue with a black font indicate that the data collection methodology was hybrid for HEDIS 2014 and was administrative for HEDIS 2015.

— is shown when no data were available or the measure was not reported in the previous 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 statewide rate was between the 50th and 75th percentiles.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] RMHP rotated these measures for HEDIS 2015. Per the Department's required data collection methodology, the rates displayed reflect administrative data only and are not the final, reported hybrid rates in the plan-submitted file for HEDIS 2015. The final hybrid rates for these measures were essentially the HEDIS 2014 rates displayed in the 2014 HEDIS Rate column.

[3] RMHP rotated the Counseling for Physical Activity indicator for this measure only. Therefore, the HEDIS 2015 rate is the same as the HEDIS 2014 rate.

Strengths

RMHP received an audit result of *Reportable (R)* for all its HEDIS 2015 rates in this domain. One measure (*Appropriate Testing for Children with Pharyngitis)* was at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Since RMHP rotated six of the eight measures in this domain, HSAG did not perform statistical tests comparing HEDIS 2015 and HEDIS 2014 rates for them. When compared to national benchmarks, four measures (*Childhood Immunization Status, Immunization for Adolescents, Well-Child Visits in the First 15 Months of Life—Six or More Visits,* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life)* were rotated from HEDIS 2014 and were below the national HEDIS Medicaid 25th percentile. A low percentile ranking could be related to the change in the required data collection methodology from hybrid to administrative and may not represent RMHP's true performance. Nonetheless, since all well-child visits rates were below the federal EPSDT mandate of 80 percent, HSAG recommends that RMHP focus its efforts on improving this area.

Access to Care and Preventive Screening Performance Measures

Table 3-15 shows the RMHP HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 audit results for each performance measure related to access to care and preventive screening.

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

Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]	HEDIS 2015 Audit Results
Access to Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	95.64%	**91.31%**	75th–89th	R
Postpartum Care	73.83%	67.71%	50th–74th	R
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	97.85%	**91.77%**	<10th	R
Ages 25 Months to 6 Years	86.29%	**72.77%**	<10th	R
Ages 7 to 11 Years	89.55%	**85.74%**	10th–24th	R
Ages 12 to 19 Years	87.88%	**83.53%**	10th–24th	R
Adults' Access to Preventive/Ambulatory Health Services—Total	88.33%	**61.83%**	<10th	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 2015 Audit Results
	2014	2015		
Preventive Screening				
Chlamydia Screening in Women—Total	45.32%	**40.12%**	<10th	R
Breast Cancer Screening	51.96%	49.65%	10th–24th	R
Cervical Cancer Screening	70.25%	**48.47%**	10th–24th	R
*Non-Recommended Cervical Cancer Screening in Adolescent Females***	—	2.28%	10th–24th	R
Adult BMI Assessment	85.81%	87.80%	75th–89th	R

Note: 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 the previous 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 2015 rate was between the national 75th percentile and the 90th percentile.
1 Percentile rankings were assigned to the HEDIS 2014 reported rates based on HEDIS 2013 ratios and percentiles for Medicaid populations.

Strengths

RMHP received an audit result of *Reportable (R)* for all its HEDIS 2015 rates in this domain. Although no measure was at or above the national HEDIS Medicaid 90th percentile, three (*Timeliness of Prenatal Care*, *Non-Recommended Cervical Cancer Screening in Adolescent Females* [an inverse measure], and *Adult BMI Assessment*) performed at or above the 75th percentile.

Recommendations

Five measures (*Children's and Adolescents' Access to Primary Care Practitioners; Adults' Access to Preventive/Ambulatory Health Services—Total; Chlamydia Screening in Women—Total; Breast Cancer Screening*; and *Cervical Cancer Screening)* had at least one indicator below the national HEDIS Medicaid 25th percentile. Additionally, four of these measures experienced a significant rate decline. Poor performance was a decline of more than 10 percentage points. HSAG recommends that RMHP focus its efforts on improving member's access to services.

Mental/Behavioral Health Performance Measures

Table 3-16 shows the RMHP HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 audit results for the performance measures related to mental/behavioral health.

Table 3-16—Rates and Audit Results for Mental/Behavioral Health Performance Measures *for* RMHP				
Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2015 Audit Results
	2014	2015		
Antidepressant Medication Management				
Effective Acute Phase Treatment	NB*	57.69%	75th–89th	R
Effective Continuation Phase Treatment	NB*	40.06%	75th–89th	R
Follow-up Care for Children Prescribed ADHD Medication				
Initiation	31.67%	34.62%	25th–49th	R
Continuation	35.90%	32.31%	10th–24th	R
Follow-Up After Hospitalization for Mental Illness				
30-Day	—	NB	—	NB
7-Day	—	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 the previous 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 was too small (<30) to report a valid rate. NB is shown when RMHP did not have the required benefit to calculate the measures. NR is shown when RMHP chose not to report the measure.

NB* is shown in RMHP's HEDIS 2014 IDSS and its HEDIS 2015 IDSS, indicating that the health plan did not offer the benefit required by the measure. Because 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.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

RMHP showed good performance on the *Antidepressant Medication Management* measure. The HEDIS 2015 rates for both indicators ranked at or above the national HEDIS Medicaid 75th percentile.

Recommendations

Three measures in this domain received an NB audit designation, suggesting that RMHP did not offer the benefits required to calculate these measures. However, the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* measures do not

require behavioral health services. The audit designations approved by the plan's auditors should have been *NR* (plan chose not to report) rather than *NB* (no benefits offered). Additionally, RMHP chose not to report the *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* measure (an NR audit designation). For measures where an NB or NR designation was assigned, HSAG recommends that RMHP work with its auditors and the Department to resolve differences in understanding benefit assignment to services required for reporting these measures. Where measures were considered *Reportable* (an *R* audit designation), the *Follow-up Care for Children Prescribed ADHD Medication—Continuation* rate was below the national HEDIS Medicaid 25th percentile, suggesting opportunities for improvement.

Living With Illness Performance Measures

Table 3-17 shows the RMHP HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 audit results for performance measures related to Living with Illness.

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

Performance Measures	HEDIS Rate		Percentile Rankings[1]	HEDIS 2015 Audit Results
	2014	2015		
Controlling High Blood Pressure	73.38%	68.44%	75th–89th	R
Persistence of Beta-Blocker Treatment After a Heart Attack	—	NA	—	NA
Comprehensive Diabetes Care				
HbA1c Testing	89.37%	89.37%[2]	75th–89th	R
*HbA1c Poor Control (>9.0%)***	26.41%	26.41%[2]	<10th	R
HbA1c Control (<8.0%)	65.61%	65.61%[2]	≥90th	R
Eye Exam	63.62%	63.62%[2]	75th–89th	R
Medical Attention for Nephropathy	75.58%	**82.61%**	50th–74th	R
Blood Pressure Controlled <140/90 mm Hg	76.74%	76.74%[2]	≥90th	R
Annual Monitoring for Patients on Persistent Medications—Total	83.22%	86.17%	50th–74th	R
Use of Imaging Studies for Low Back Pain	74.15%	**82.65%**	75th–89th	R
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	—	32.28%	75th–89th	R
Pharmacotherapy Management of COPD Exacerbation				
Systemic corticosteroid	32.53%	36.47%	<10th	R
Bronchodilator	48.19%	47.06%	<10th	R
Use of Appropriate Medications for People With Asthma—Total	85.94%	84.48%	25th–49th	R
Medication Management for People With Asthma				
Medication Compliance 50%—Total	—	50.20%	25th–49th	R
Medication Compliance 75%—Total	—	30.61%	50th–74th	R

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

Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]	HEDIS 2015 Audit Results
Asthma Medication Ratio—Total	62.35%	58.89%	10th–24th	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	29.59%	21.88%	10th–24th	R
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	52.54%	61.76%	10th–24th	R

Note: Rates shaded in green with a green font indicate a statistically significant improvement from the prior year.

— is shown when no data were available or the measure was not reported in the prior 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 was too small (<30) to report a valid rate.

** 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 2015 rate was at or above the national 90th percentile.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

[2] RMHP rotated this measure except the Medical Attention for Nephropathy indicator. The rates reported in the plan-submitted files are hybrid rates.

Strengths

RMHP received an audit result of *Reportable (R)* for all but one of its HEDIS 2015 rates in this domain. Three rates (*HbA1c Poor Control > 9.0%; HbA1c Control <8%;* and *Blood Pressure Controlled <140/90 mm Hg*, all under *Comprehensive Diabetes Care*) were at or above the national HEDIS Medicaid 90th percentile. Additionally, the *Medical Attention for Nephropathy* and *Use of Imaging Studies for Low Back Pain* rates increased significantly from the prior year.

Recommendations

Although no measure had a significant decline from HEDIS 2014, four measures (*Pharmacotherapy Management of COPD Exacerbation, Asthma Medication Ratio—Total, Use of Spirometry Testing in the Assessment and Diagnosis of COPD*. and *Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis)* were at or below the national HEDIS Medicaid 25th percentile. These measures presented opportunities for improvement for RMHP.

Use of Services Observations

Table 3-18 shows the RMHP HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and the HEDIS 2015 audit results for the measures related to use of services. Since the reported rates are not risk-adjusted, rate changes observed between HEDIS 2014 and 2015 may not denote actual improvement or a decline in performance. Percentile rankings are assigned to the HEDIS 2015 reported rates based on HEDIS 2014 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 2014	HEDIS Rate 2015	Percentile Rankings[1]	HEDIS 2015 Audit Results
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits	401.91	224.34	<10th	R
Emergency Department Visits	58.85	37.35	<10th	R
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 MM (Total Inpatient)	9.25	5.07	10th–24th	R
Days per 1,000 MM (Total Inpatient)	32.87	19.24	10th–24th	R
Average Length of Stay (Total Inpatient)	3.55	3.79	25th–49th	R
Discharges per 1,000 MM (Medicine)	4.08	2.37	10th–24th	R
Days per 1,000 MM (Medicine)	16.74	10.13	25th–49th	R
Average Length of Stay (Medicine)	4.10	4.28	75th–89th	R
Discharges per 1,000 MM (Surgery)	1.73	0.91	10th–24th	R
Days per 1,000 MM (Surgery)	8.86	5.42	25th–49th	R
Average Length of Stay (Surgery)	5.13	5.96	25th–49th	R
Discharges per 1,000 MM (Maternity)	6.14	2.56	10th–24th	R
Days per 1,000 MM (Maternity)	12.94	5.25	10th–24th	R
Average Length of Stay (Maternity)	2.11	2.05	<10th	R
Identification of Alcohol and Other Drug Services—Total				
Any Service	—	2.56%	25th–49th	R
Inpatient	—	0.62%	25th–49th	R
Intensive Outpatient/Partial Hospitalization	—	0.00%	10th–24th	R
Outpatient/ED	—	2.20%	25th–49th	R
Mental Health Utilization—Total				
Any Service	—	0.71%	<10th	R
Inpatient	—	0.10%	<10th	R
Intensive Outpatient/Partial Hospitalization	—	0.00%	10th–24th	R
Outpatient/ED	—	0.64%	<10th	R
Antibiotic Utilization—All Ages				
Average Scrips for PMPY for Antibiotics	1.01	0.54	<10th	R
Average Days Supplied per Antibiotic Scrip	9.71	9.59	75th–89th	R
Average Scrips PMPY for Antibiotics of Concern	0.36	0.21	<10th	R
*Percentage of Antibiotics of Concern of All Antibiotic Scrips***	35.93%	**38.50%**	10th–24th	R

Table 3-18—Rates and Audit Results for Use of Services Measures *for* RMHP				
Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]	HEDIS 2015 Audit Results
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	*	R
Bariatric weight loss surgery (20–44 Male)	0.07	0.02	50th–74th	R
Bariatric weight loss surgery (20–44 Female)	0.23	0.06	50th–74th	R
Bariatric weight loss surgery (45–64 Male)	0.00	0.00	10th–74th	R
Bariatric weight loss surgery (45–64 Female)	0.53	0.11	50th–74th	R
Tonsillectomy (0–9 Male & Female)	1.31	0.66	25th–49th	R
Tonsillectomy (10–19 Male & Female)	0.92	0.38	50th–74th	R
Hysterectomy, Abdominal (15–44 Female)	0.29	0.09	10th–24th	R
Hysterectomy, Abdominal (45–64 Female)	0.13	0.29	25th–49th	R
Hysterectomy, Vaginal (15–44 Female)	0.60	0.46	≥90th	R
Hysterectomy, Vaginal (45–64 Female)	0.20	0.29	75th–89th	R
Cholecystectomy, Open (30–64 Male)	0.05	0.00	10th–49th	R
Cholecystectomy, Open (15–44 Female)	0.00	0.00	10th–24th	R
Cholecystectomy, Open (45–64 Female)	0.07	0.00	10th–49th	R
Cholecystectomy (laparoscopic) (30–64 Male)	0.94	0.30	50th–74th	R
Cholecystectomy (laparoscopic) (15–44 Female)	1.36	0.77	50th–74th	R
Cholecystectomy (laparoscopic) (45–64 Female)	1.60	0.64	25th–49th	R
Back Surgery (20–44 Male)	0.63	0.24	25th–49th	R
Back Surgery (20–44 Female)	0.23	0.12	25th–49th	R
Back Surgery (45–64 Male)	0.95	0.36	10th–24th	R
Back Surgery (45–64 Female)	0.73	0.35	25th–49th	R
Mastectomy (15–44 Female)	0.04	0.02	50th–74th	R
Mastectomy (45–64 Female)	0.07	0.18	50th–74th	R
Lumpectomy (15–44 Female)	0.30	0.11	25th–49th	R
Lumpectomy (45–64 Female)	0.53	0.31	25th–49th	R

Note: Rates shaded in red with a red font indicate a statistically significant performance decline from the prior year.
— is shown when no data were available or the measure was not reported in the prior 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.
[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Compared to HEDIS 2014, RMHP reported a rate decrease in both indicators under the *Ambulatory Care* measure, all *Inpatient Utilization* indicators except *Average Length of Stay*, and many procedures under the *Frequency of Selected Procedures* measure. The significant rate increase noted in *Percentage of Antibiotics of Concern of All Antibiotic Scrips* (an inverse indicator) under *Antibiotic Utilization* may suggest a decline in performance. In general, 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 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: RMHP's performance from the 33 quality-related measures was mixed. RMHP elected to rotate six of these measures (all in the pediatric care category) for HEDIS 2015. The majority of the remaining measures did not have a rate change from the previous year. Two measures, both from the living with illness category, had at least one rate which increased significantly. Three measures had at least one rate which declined significantly. Declines were found in two preventive screening measures and *Prenatal and Postpartum Care*. When compared to national benchmarks, RMHP's performance was diverse. Twelve measures had at least one rate ranked below the national 25th percentiles, and two ranked at or above the 90th percentiles. Low percentile ranking was found in measures under pediatric care, preventive screening, and living with illness categories. Low percentile ranking among immunizations and well-child visit measures in the pediatric care category could be related to a change to the State-required data collection methodology from hybrid to administrative and may not represent RMHP's true performance.

Timeliness: RMHP's performance from the eight timeliness-related measures was mixed. RMHP elected to rotate six of these measures (all in the pediatric care category) for HEDIS 2015. Although the data collection methodology required by the Department for five of these measures changed from hybrid in FY 2013–2014 to administrative in FY 2014–2015, statistical comparisons were not made to these measures. None of the remaining measures had a significant rate increase from the previous year. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* rate declined significantly, although its percentile ranking was still above the national 75th percentile. When compared to national benchmarks, RMHP's performance suggested opportunities for improvement. Five measures, with four in the pediatric care category, had at least one rate ranked below the national 25th percentile. *Prenatal and Postpartum Care* was the only measure with performance above the national 50th percentile. Although a low percentile ranking was noted in many timeliness-related measures under the pediatric care category, these results could be related to a change in the state-required data collection methodology from hybrid to administrative and may not represent RMHP's true performance.

Access: RMHP's rates in this domain suggested mixed performance. Of the 10 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*). The first three measures reported significant decline in performance in at least one of their indicators, while significant improvement was noted in the *Nephropathy* rate for *Comprehensive Diabetes Care*. When compared to national benchmarks, RMHP's performance was diverse. All rates from the *Prenatal and Postpartum Care* and *Comprehensive Diabetes Care* measures ranked above the national 50th percentiles. Yet, there were two main access-to-care measures that ranked below the national 25th percentiles.

Although *Ambulatory Care*, *Inpatient Utilization*, *Identification of Alcohol and Other Drug Services*, *Mental Health Utilization*, *Antibiotic Utilization*, and *Frequency of Selected Procedures* were related to members' access to care, these are utilization-based measures without any risk adjustment. The rates for these measures 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 2014 and 2015 and the percentile rankings for each performance measure related to pediatric care. The statewide rate was calculated from the two health plans' rates, adjusted by their respective eligible populations. Since the statewide rates were computed by HSAG and did not undergo any HEDIS compliance audit, no audit designation result was presented.

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

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2014	2015	
Childhood Immunization Status			
Combination 2	78.13%	**64.06%**	10th–24th
Combination 3	76.70%	**62.65%**	10th–24th
Combination 4	73.77%	**61.29%**	25th–49th
Combination 5	61.59%	**53.43%**	25th–49th
Combination 6	59.50%	**47.76%**	50th–74th
Combination 7	60.40%	**52.42%**	25th–49th
Combination 8	58.15%	**47.10%**	50th–74th
Combination 9	50.29%	**41.96%**	50th–74th
Combination 10	49.61%	**41.43%**	50th–74th
Immunizations for Adolescents—Combination 1	76.13%	74.24%	50th–74th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits***	1.94%	3.96%	75th–89th
Six or More Visits	68.97%	**10.05%**	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.35%	61.36%	10th–24th
Adolescent Well-Care Visits	48.50%	**40.26%**	10th–24th

Table 3-19—Statewide Summary of Rates for Pediatric Care Performance Measures			
Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment—Total	87.94%	89.48%	≥90th
Counseling for Nutrition—Total	73.66%	73.54%	75th–89th
Counseling for Physical Activity—Total	63.78%	62.18%	75th–89th
Appropriate Testing for Children with Pharyngitis	85.51%	84.63%	≥90th
Appropriate Treatment for Children with Upper Respiratory Infection	—	95.64%	≥90th

Note: 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 hybrid for HEDIS 2014 and was administrative for HEDIS 2015.

— is shown when no data were available or the measure was not reported in the previous 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 realigned with this inverse indicator, the HEDIS 2015 statewide rate was between 10th percentile and 25th percentile.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Statewide performance was strongest in the following measures: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment: Total; Appropriate Testing for Children with Pharyngitis;* and *Appropriate Treatment for Children with Upper Respiratory Infection*. The statewide rates aggregated from the two health plans were at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Four of the five measures with a change in the data collection requirement from hybrid to administrative performed below the national HEDIS Medicaid 25th percentile. Of these four, two showed a significant rate decline from HEDIS 2014. Statewide performance on these measures may not reflect the health plans' true performance. HSAG recommends that the Department consider allowing the health plans to revert to using medical record data to report these measures, such that true performance could be assessed at the health plan and the statewide level.

Access to Care and Preventive Screening Performance Measures

Table 3-20 shows the statewide weighted averages for HEDIS 2014 and HEDIS 2015 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 2014	HEDIS Rate 2015	Percentile Rankings[1]
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	92.06%	**87.35%**	50th–74th
Postpartum Care	64.57%	63.46%	50th–74th
Children's and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	93.99%	**91.30%**	<10th
Ages 25 Months to 6 Years	78.52%	**73.21%**	<10th
Ages 7 to 11 Years	83.32%	**81.21%**	<10th
Ages 12 to 19 Years	84.07%	**81.21%**	<10th
Adults' Access to Preventive/Ambulatory Health Services—Total	76.83%	**65.72%**	<10th
Preventive Screening			
Chlamydia Screening in Women—Total	59.43%	57.49%	50th–74th
Breast Cancer Screening	53.73%	51.90%	25th–49th
Cervical Cancer Screening	68.28%	**56.13%**	25th–49th
*Non-Recommended Cervical Cancer Screening in Adolescent Females***	—	0.99%	<10th
Adult BMI Assessment	88.73%	87.97%	75th–89th

Note: 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 the previous 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 realigned with this inverse indicator, the HEDIS 2015 rate is above the national 90th percentile.
[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Although HSAG did not identify any measure with significant performance improvement the *Non-Recommended Cervical Cancer Screening in Adolescent Females* (an inverse measure with lower rate indicating better performance) was at or above the national HEDIS Medicaid 90th percentile.

Recommendations

Four measures had at least one rate showing a significant decline from HEDIS 2014. Performance decline in *Cervical Cancer Screening* was slightly more than 12 percentage points. In addition, the children's and adults' access measures ranked below the national HEDIS Medicaid 10th percentile. These results presented opportunities for improvement.

Mental/Behavioral Health Performance Measures

Table 3-21 shows the statewide weighted averages for HEDIS 2014 and HEDIS 2015 and the percentile rankings for the performance measures related to mental/behavioral health.

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

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2014	2015	
Antidepressant Medication Management			
Effective Acute Phase Treatment	41.58%	49.41%	25th–49th
Effective Continuation Phase Treatment	30.43%	33.90%	25th–49th
Follow-up Care for Children Prescribed ADHD Medication			
Initiation	23.68%	32.54%	10th–24th
Continuation	30.16%	30.49%	10th–24th
Follow-Up After Hospitalization for Mental Illness			
30-Day	—	NB	—
7-Day	—	NB	—
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.02%	59.73%	25th–49th
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	89.67%	87.66%	≥90th
Diabetes Monitoring for People With Diabetes and Schizophrenia	70.97%	60.61%	10th–24th
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	—

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

NB is shown when none of the health plans offered the required benefit to calculate the measure. NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Statewide performance in the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* measure was strong, with the rate at or above the national HEDIS Medicaid 90th percentile. Although not statistically significant, statewide rates increased more than 5 percentage points for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and the *Follow-up Care for Children Prescribed ADHD Medication—Initiation* measures.

Recommendations

Two measures (*Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Follow-up Care for Children Prescribed ADHD Medication*) had at least one rate below the national HEDIS Medicaid 25th percentile. This performance suggests statewide improvement initiatives. Additionally, both health plans indicated that they did not have the required benefits to calculate the *Follow-Up After Hospitalization for Mental Illness* measure. HSAG recommends that the Department work with the health plans to ensure required measures can be reported based on complete data accessible/available to the health plans.

Living with Illness Measures

Table 3-22 shows the statewide weighted averages for HEDIS 2014 and HEDIS 2015 and the percentile rankings for each performance measure related to living with illness.

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

Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2014	2015	
Controlling High Blood Pressure	68.56%	69.66%	75th–89th
Persistence of Beta-Blocker Treatment After a Heart Attack	—	77.42%	10th–24th
Comprehensive Diabetes Care			
HbA1c Testing	88.98%	86.76%	50th–74th
*HbA1c Poor Control (>9.0%)***	30.21%	34.86%	10th–24th
HbA1c Control (<8.0%)	60.60%	55.25%	75th–89th
Eye Exam	53.90%	52.61%	25th–49th
Medical Attention for Nephropathy	80.38%	80.45%	50th–74th
Blood Pressure Controlled <140/90 mm Hg	74.14%	71.38%	75th–89th
Annual Monitoring for Patients on Persistent Medications—Total	84.40%	85.72%	25th–49th
Use of Imaging Studies for Low Back Pain	78.49%	81.28%	75th–89th
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	—	38.99%	≥90th
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	55.67%	47.45%	<10th
Bronchodilator	68.73%	59.49%	<10th
Use of Appropriate Medications for People With Asthma—Total	80.79%	80.94%	10th–24th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	42.20%	<10th
Medication Compliance 75%—Total	—	20.09%	10th–24th
Asthma Medication Ratio—Total	56.22%	**39.93%**	<10th

Table 3-22—Statewide Summary of Rates for Living With Illness Performance Measures			
Performance Measures	HEDIS Rate		Percentile Rankings[1]
	2014	2015	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	30.03%	28.30%	25th-49th
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	69.29%	63.33%	10th-24th

Note: 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 the previous 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 realigned with this inverse indicator, the HEDIS 2015 statewide rate was between the 75th percentile and the 90th percentile.
[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Strengths

Statewide performance was strongest in the *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis* measure, whose rate was at or above the national Medicaid 90th percentile. Three more measures also had at least one rate ranking above the 75th percentiles: *Controlling High Blood Pressure, Comprehensive Diabetes Care,* and *Use of Imaging Studies for Low Back Pain*.

Recommendations

Six measures (*Persistence of Beta-Blocker Treatment After a Heart Attack, Pharmacotherapy Management of COPD Exacerbation, Use of Appropriate Medications for People With Asthma—Total, Medication Management for People With Asthma, Asthma Medication Ratio—Total,* and *Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis)* had at least one rate below the national HEDIS Medicaid 25th percentile. Additionally, the *Asthma Medication Ratio—Total* rate also declined significantly by at least 15 percentage points. Since many of these measures were related to asthma management, these findings may suggest an opportunity for a statewide initiative.

Use of Services Observations

Table 3-23 shows the statewide HEDIS 2014 and HEDIS 2015 rates, the percentile rankings for HEDIS 2015 rates, and HEDIS 2015 audit results for the measures related to use of services. Percentile rankings are assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations and are presented for information only.

Table 3-23—Statewide Summary of Rates for Use of Services Measures			
Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	280.29	224.34	<10th
Emergency Department Visits	48.62	37.35	<10th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 MM (Total Inpatient)	6.68	5.07	10th–24th
Days per 1,000 MM (Total Inpatient)	25.25	19.24	10th–24th
Average Length of Stay (Total Inpatient)	3.78	3.79	25th–49th
Discharges per 1,000 MM (Medicine)	4.21	2.37	10th–24th
Days per 1,000 MM (Medicine)	15.13	10.13	25th–49th
Average Length of Stay (Medicine)	3.59	4.28	75th–89th
Discharges per 1,000 MM (Surgery)	1.34	0.91	10th–24th
Days per 1,000 MM (Surgery)	7.72	5.42	25th–49th
Average Length of Stay (Surgery)	5.75	5.96	25th–49th
Discharges per 1,000 MM (Maternity)	2.02	2.56	10th–24th
Days per 1,000 MM (Maternity)	4.31	5.25	10th–24th
Average Length of Stay (Maternity)	2.13	2.05	<10th
Identification of Alcohol and Other Drug Services—Total			
Any Service	—	3.45%	50th–74th
Inpatient	—	0.90%	50th–74th
Intensive Outpatient/Partial Hospitalization	—	0.00%	10th–24th
Outpatient/ED	—	3.00%	50th–74th
Mental Health Utilization —Total			
Any Service	—	0.71%	<10th
Inpatient	—	0.10%	<10th
Intensive Outpatient/Partial Hospitalization	—	0.00%	10th–24th
Outpatient/ED	—	0.64%	<10th
Antibiotic Utilization—All Ages			
Average Scrips for PMPY for Antibiotics	0.55	0.40	<10th
Average Days Supplied per Antibiotic Scrip	9.63	9.55	75th–89th
Average Scrips PMPY for Antibiotics of Concern	0.18	0.13	<10th
*Percentage of Antibiotics of Concern of All Antibiotic Scrips***	32.24%	**33.78%**	<10th

Table 3-23—Statewide Summary of Rates for Use of Services Measures			
Performance Measures	HEDIS Rate 2014	HEDIS Rate 2015	Percentile Rankings[1]
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	*
Bariatric weight loss surgery (20–44 Male)	0.06	0.01	50th–74th
Bariatric weight loss surgery (20–44 Female)	0.15	0.05	25th–49th
Bariatric weight loss surgery (45–64 Male)	0.00	0.00	10th–74th
Bariatric weight loss surgery (45–64 Female)	0.11	0.10	50th–74th
Tonsillectomy (0–9 Male & Female)	0.94	0.41	10th–24th
Tonsillectomy (10–19 Male & Female)	0.72	0.21	25th–49th
Hysterectomy, Abdominal (15–44 Female)	0.23	0.08	10th–24th
Hysterectomy, Abdominal (45–64 Female)	0.44	0.30	25th–49th
Hysterectomy, Vaginal (15–44 Female)	0.60	0.23	75th–89th
Hysterectomy, Vaginal (45–64 Female)	0.17	0.19	50th–74th
Cholecystectomy, Open (30–64 Male)	0.15	0.06	75th–90th
Cholecystectomy, Open (15–44 Female)	0.01	0.01	25th–74th
Cholecystectomy, Open (45–64 Female)	0.00	0.01	10th–49th
Cholecystectomy (laparoscopic) (30–64 Male)	0.42	0.20	10th–24th
Cholecystectomy (laparoscopic) (15–44 Female)	1.11	0.66	25th–49th
Cholecystectomy (laparoscopic) (45–64 Female)	1.16	0.61	25th–49th
Back Surgery (20–44 Male)	0.37	0.19	25th–49th
Back Surgery (20–44 Female)	0.28	0.09	10th–24th
Back Surgery (45–64 Male)	0.50	0.41	25th–49th
Back Surgery (45–64 Female)	1.10	0.35	25th–49th
Mastectomy (15–44 Female)	0.05	0.01	25th–49th
Mastectomy (45–64 Female)	0.17	0.12	25th–49th
Lumpectomy (15–44 Female)	0.23	0.09	10th–24th
Lumpectomy (45–64 Female)	0.25	0.28	10th–24th

Note: 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 the previous year's technical report or HEDIS aggregate report.

*Percentile rank could not determine because the values for P10, P25, P50, P75, and P90 are zeros.

** 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).

[1] Percentile rankings were assigned to the HEDIS 2015 reported rates based on HEDIS 2014 ratios and percentiles for Medicaid populations.

Compared to HEDIS 2014, rates decline for *Ambulatory Care* and all *Inpatient Utilization* indicators except *Average Length of Stay*. Certain procedures under the *Frequency of Selected Procedures* measure also exhibited some rate fluctuations, with none of them having more than one procedure per 1,000 member months. A significant rate increase that was noted in *Percentage of Antibiotics of Concern of All Antibiotic Scrips* (an inverse indicator) under *Antibiotic Utilization* may suggest a decline in performance. In general, 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 others. The following is a summary assessment of statewide performance measures related to the domains of quality, timeliness, and access.

Quality: Statewide performance on the 33 quality-related measures was mixed. While HSAG did not identify significant improvement in any of the measures, it did identify significant performance decline in at least one indicator for *Childhood Immunization Status, Well-Child Visits in the First 15 Months of Life,* and *Prenatal and Postpartum Care*. When compared to national benchmarks, statewide performance was diverse. Twelve measures had at least one rate ranked below the national 25th percentile and six ranked at or above the 90th percentile. A low percentile ranking was found mostly in measures under categories for pediatric care and living with illness. Low percentile ranking among immunizations and well-child visit measures in the pediatric care category could be related to a change to the state-required data collection methodology from hybrid to administrative and may not represent true performance from all health plans.

Timeliness: Statewide performance on the eight timeliness-related measures was mixed. Neither health plan had the required benefits to calculate the *Follow-Up After Hospitalization for Mental Illness* measure. None of the remaining measures had a significant rate increase from the previous year. Two pediatric care measures and the *Prenatal and Postpartum Care* measure had at least one rate decline significantly from the previous year. When compared to national benchmarks, five measures—including four in the pediatric care category—had at least one rate ranked below the national 25th percentile. *Prenatal and Postpartum Care* and *Immunization for Adolescents* were the only measures with performance above the national 50th percentile. Although low percentile ranking was noted in many timeliness-related measures under the pediatric care category, these results could be related to a change to the State-required data collection methodology from hybrid to administrative and may not represent true performance from all health plans.

Access: Statewide performance in this domain suggested opportunities for improvement for all health plans. Of the 10 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*). The first three measures reported significant declines in performance in at least one of their indicators. When compared to national benchmarks, statewide performance was diverse. All rates from the *Prenatal and Postpartum Care* and most of the *Comprehensive Diabetes Care* rates ranked above the national 50th percentiles. However, the two main access-to-care measures ranked below the national 10th percentiles.

Although *Ambulatory Care*, *Inpatient Utilization*, *Identification of Alcohol and Other Drug Services*, *Mental Health Utilization*, *Antibiotic Utilization*, and *Frequency of Selected Procedures* were related to members' access to care, these are utilization-based measures without any risk adjustment. The rates for these measures should be used for information only.

Validation of Performance Improvement Projects (PIPs)

For FY 2014–2015, 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)	*Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*
Rocky Mountain Health Plans (RMHP)	*Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility*

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 (DHMC)

Findings

The DHMC *Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics* PIP focused on improving transitions of care for a population of overweight and obese pediatric members and their families. This was the first validation year for the PIP. DHMC reported the study design and completed Activities I through VI.

Table 3-25 provides a summary of DHMC's PIP validation results for the FY 2014–2015 validation cycle.

Table 3-25—FY 2014–15 Performance Improvement Project Validation Results *for* DHMC

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% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Data Analysis and Interpretation	Not Assessed		
	VIII.	Interventions and Improvement Strategies	Not Assessed		
Implementation Total			Not Assessed		
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

DHMC demonstrated strength throughout the study design of its PIP by receiving *Met* scores for all applicable evaluation elements in Activities I–VI. The health plan documented a methodologically sound study design. The PIP received a *Met* score for 100 percent of nine applicable evaluation elements.

Strengths

DHMC documented a solid study design, supported by key research principles, for its PIP. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the process. The study design submission of the PIP received a *Met* score for 100 percent of applicable evaluation elements in Activities I–VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for DHMC's PIP, in which the PIP received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG did not identify any opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. DHMC earned a *Met* validation status, demonstrating a strong application of PIP study design principles, which facilitated progression to the subsequent stages of PIP implementation and outcomes.

Rocky Mountain Health Plans (RMHP)

Findings

The RMHP *Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility* PIP focused on improving the transition of care by assisting members in accessing the healthcare system within 90 days of their prison release date. This was the first validation year for the PIP. RMHP reported the study design and completed Activities I through VI.

Table 3-26 provides a summary of RMHP's PIP validation results for the FY 2014–2015 validation cycle.

Table 3-26—FY 2014–15 Performance Improvement Project Validation Results *for* RMHP

Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Study Topic	100% (1/1)	0% (0/1)	0% (0/1)
	II.	Study Question	0% (0/1)	100% (1/1)	0% (0/1)
	III.	Study Population	0% (0/1)	100% (1/1)	0% (0/1)
	IV.	Study Indicator	0% (0/2)	100% (2/2)	0% (0/2)

Table 3-26—FY 2014–15 Performance Improvement Project Validation Results *for* RMHP					
Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
	V.	Sampling Techniques	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**50% (4/8)**	**50% (4/8)**	**0% (0/8)**
Implementation	VII.	Data Analysis and Interpretation	Not Assessed		
	VIII.	Interventions and Improvement Strategies	Not Assessed		
Implementation Total			Not Assessed		
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**50% (4/8)**		

The RMHP PIP received a *Met* score for four (50 percent) of eight applicable evaluation elements, demonstrating strength in Activities I and VI and meeting all of the evaluation requirements for these two activities. With *Partially Met* scores in Activities II, III, and IV, the PIP demonstrated a need for improvement in the study design. The validation results suggested that the PIP needed further development and revision in order to establish a methodologically sound foundation.

Strengths

RMHP selected an appropriate study topic for the PIP and documented a data collection process that aligned with the study topic.

Recommendations

Based on the FY 2014–2015 validation results for the RMHP *Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility* PIP, HSAG recommended that the health plan make revisions to the study question, study population criteria, and study indicator definition for the PIP in order to establish a solid methodological foundation for measuring and achieving improvement. For the PIP's study question, HSAG recommended adding language to define the length of time between prison release and Medicaid enrollment in order to establish a stable study population and maintain the focus of the PIP on the transition from prison to community services. For the study population, HSAG recommended revising the eligibility criteria to include all members released from prison throughout the calendar year of each measurement period. Expanding the study population to include members released throughout the year will prevent seasonal variation from impacting the measurement results and should still allow the health plan time for analysis and reporting. RMHP should revise the study indicator definition to align with the new study population criteria and should follow the calendar year measurement periods, beginning with 2014 as the baseline measurement period. Given the substantial revisions recommended for the study question, study population, and study indicator, HSAG also

recommended that RMHP update its data collection procedures to align with the updated study design.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. RMHP earned a *Not Met* validation status, demonstrating the need for further revision of the PIP study design in order to establish a methodological foundation that will allow for measurement and improvement achievement in subsequent PIP stages.

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

Table 3-27 shows the health plans' overall performance based on HSAG's validation of the FY 2014–2015 PIPs submitted for validation.

Table 3-27—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	*Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*	100%	100%	*Met*
RMHP	*Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility*	50%	25%	*Not Met*

The validation scores and validation status of the PIPs demonstrated mixed performance on developing the PIP study designs. Of the two PIPs reviewed by HSAG, one received a *Met* and the other a *Not Met* validation status. There was considerable variation in the percentage of critical evaluation elements receiving *Met* scores. One PIP received a *Met* score for 100 percent of the critical elements and the other PIP received a *Met* score for only 25 percent of critical elements.

While the focus of a health plan's PIP may have been to improve performance related to healthcare 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. While one PIP earned a *Met* validation status, demonstrating application of methodologically sound design principles, the other received a *Not Met* validation status, suggesting a need for improvement in the design stage in order to produce valid and reliable PIP results.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with healthcare. 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.

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 set and the Children with Chronic Conditions (CCC) measurement set 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 members who chose a response of "Usually" or "Always." For one composite (*Shared Decision Making*), the rates were based on members who chose a response of "Yes." For purposes of this report, results are reported for a CAHPS measure even when the minimum reporting threshold of 100 respondents has not been 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 are denoted as Not Comparable (NC). Appendix D contains additional details about the technical methods of data collection and analysis of survey data.[3-1, 3-2]

For all of the health plan findings, a substantial increase is noted when a measure's rate increased by more than 5 percentage points. A substantial decrease is noted when a measure's rate decreased by more than 5 percentage points.

[3-1] For purposes of this report, the FY 2014-2015 child Medicaid results presented for DHMC and RMHP are based on the CAHPS survey results for the general child population only. Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., CCC composites and items) are not presented in this report.

[3-2] Due to changes to the *Shared Decision Making* composite measure, comparisons of the current year's (FY 2014-2015) rates and the prior year's (FY 2013-2014) rates could not be performed.

Denver Health Medicaid Choice (DHMC)

Findings

Table 3-28 shows the adult Medicaid results achieved by DHMC for the current year (FY 2014–2015) and the prior year (FY 2013–2014).

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

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	70.3%	76.3%
Getting Care Quickly	74.3%	73.9%
How Well Doctors Communicate	90.0%	91.0%
Customer Service	83.5%	82.6%+
Shared Decision Making	NC	80.0%+
Rating of Personal Doctor	65.4%	73.0%
Rating of Specialist Seen Most Often	59.5%	58.9%
Rating of All Health Care	43.7%	47.0%
Rating of Health Plan	51.5%	58.1%

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.

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Table 3-29 shows the general child Medicaid results achieved by DHMC for the current year (FY 2014–2015) and the prior year (FY 2013–2014).[3-3]

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

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	73.5%	76.7%
Getting Care Quickly	85.5%	78.8%
How Well Doctors Communicate	94.3%	92.2%
Customer Service	86.1%	83.7%
Shared Decision Making	NC	80.0%+
Rating of Personal Doctor	75.4%	82.8%
Rating of Specialist Seen Most Often	73.8%+	78.9%+
Rating of All Health Care	66.7%	69.1%
Rating of Health Plan	70.1%	72.1%

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.

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

[3-3] The FY 2014-2015 child Medicaid results presented in Table 3-2 for DHMC are based on the results of the general child population only.

Recommendations

For the adult Medicaid population, DHMC had no substantial decrease in rates for any of the comparable measures; however, three measures, *Getting Care Quickly*, *Customer Service*, and *Rating of Specialist Seen Most Often*, showed a slight decrease. For the child Medicaid population, the rate for *Getting Care Quickly* decreased substantially. DHMC should continue to direct quality improvement activities toward these measures.

In order to improve members' perceptions on the *Getting Care Quickly* composite measure, DHMC's quality improvement activities should focus on evaluating no-show appointments, encouraging the use of electronic communication between providers and patients where appropriate, open-access scheduling, and assisting providers with monitoring patient flow. For the *Customer Service* composite measure, DHMC should continue to focus efforts on evaluating its call center hours and practices, customer service staff training programs, and establishing customer service performance measures. To improve in the area of *Rating of Specialist Seen Most Often*, DHMC should focus on working with providers to implement planned visit management systems, skills training for specialists, telemedicine, and developing care coordination teams.

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* (6.0 percentage points), *Rating of Personal Doctor* (7.6 percentage points), and *Rating of Health Plan* (6.6 percentage points). Two of the measures demonstrated slight increases: *How Well Doctors Communicate* and *Rating of All Health Care*. As noted, none of the measures' rates decreased substantially; however, the remaining three comparable measures showed rate decreases. Three of the measures for the adult Medicaid population had higher rates when compared to RHMP's rates in FY 2014-2015: *Rating of Personal Doctor*, *Rating of All Health Care*, and *Rating of Health Plan.*

For the general child Medicaid population, two of the eight comparable measures' rates increased substantially: *Rating of Personal Doctor* (7.4 percentage points) and *Rating of Specialist Seen Most Often* (5.1 percentage points). Three measures demonstrated slight increases: *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan.* The rate for one measure, *Getting Care Quickly*, decreased substantially (6.7 percentage points), and the rates for the remaining two measures also decreased. Four of the measures for the general child Medicaid population had higher rates when compared to RHMP's in FY 2014-2015: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan.*

Rocky Mountain Health Plans (RMHP)

Findings

Table 3-30 shows the adult Medicaid results achieved by RMHP for the current year (FY 2014–2015) and the prior year (FY 2013–2014).

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

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	84.9%	80.2%
Getting Care Quickly	83.2%	80.5%
How Well Doctors Communicate	89.4%	93.5%
Customer Service	84.3%+	84.7%+
Shared Decision Making	NC	80.4%
Rating of Personal Doctor	67.1%	60.1%
Rating of Specialist Seen Most Often	61.9%	59.5%
Rating of All Health Care	53.8%	45.7%
Rating of Health Plan	59.1%	56.0%

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, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Table 3-31 shows the general child Medicaid results achieved by RMHP for the current year (FY 2014–2015) and the prior year (FY 2013–2014).[3-4]

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

Measure	FY 2013–2014 Rate	FY 2014–2015 Rate
Getting Needed Care	92.6%	85.7%
Getting Care Quickly	91.8%	93.3%
How Well Doctors Communicate	94.5%	96.2%
Customer Service	87.7%+	84.8%
Shared Decision Making	NC	83.5%
Rating of Personal Doctor	71.3%	75.6%
Rating of Specialist Seen Most Often	69.2%+	69.7%+
Rating of All Health Care	60.2%	64.8%
Rating of Health Plan	68.5%	65.6%

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, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

[3-4] The FY 2014–2015 child Medicaid results presented in Table 3-4 for RMHP are based on the results of the general child population only.

Recommendations

For the adult Medicaid population, two of the eight comparable measures' rates decreased substantially: *Rating of Personal Doctor* and *Rating of All Health Care*. For the child Medicaid population, one of the measure's rates decreased substantially: *Getting Needed Care*. RMHP should continue to direct quality improvement activities toward these measures.

In order to improve members' satisfaction with *Rating of Personal Doctor*, RMHP should focus on assisting providers with monitoring appointment scheduling, additional methods for obtaining direct patient feedback, physician-patient communication, improving shared decision-making between patients and providers, and skills training for physicians. For *Rating of All Health Care*, RMHP's quality improvement activities should focus on identifying potential barriers for members receiving appropriate access to care, creating patient and family engagement advisory councils, patient- and family-centered care, and involving families in care coordination. To improve member's perceptions on the *Getting Needed Care* composite measure, RMHP's quality improvement activities should focus on identifying appropriate healthcare providers for members, providing interactive workshops, "max-packing," language concordance programs, and facilitating coordinated care.

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, the rates for two of the eight comparable measures increased: *How Well Doctors Communicate* and *Customer Service*. However, the increases were not substantial. Two of the measures' rates decreased substantially: *Rating of Personal Doctor* (7.0 percentage points) and *Rating of All Health Care* (8.1 percentage points). The remaining four comparable measures showed rate decreases. Six of the measures for the adult Medicaid population had higher rates when compared to DHMC's rates in FY 2014-2015: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, and *Rating of Specialist Seen Most Often*.

For the general child Medicaid population, the rates for five of the eight comparable measures increased: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care.* However, the increases were not substantial. The rate for one of the eight comparable measures decreased substantially: *Getting Needed Care* (6.9 percentage points). The remaining two comparable measures showed rate decreases. Five of the measures for the general child Medicaid population had higher rates when compared to DHMC's rates in FY 2014-2015: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*.

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

The adult Medicaid statewide averages presented in this section are derived from the combined adult Medicaid results for DHMC and RMHP. Therefore, the FY 2013–2014 CAHPS adult Medicaid statewide averages in this section will not match previous years' reports. Table 3-32 shows the adult Medicaid statewide averages for the current year (FY 2014–2015) and the prior year (FY 2013–2014).[3-5]

Table 3-32—Adult Medicaid Statewide Averages		
Measure	**FY 2013–2014 Rate**	**FY 2014–2015 Rate**
Getting Needed Care	75.0%	78.3%
Getting Care Quickly	77.2%	77.2%
How Well Doctors Communicate	89.8%	92.2%
Customer Service	83.7%	83.6%
Shared Decision Making	NC	80.2%
Rating of Personal Doctor	66.0%	66.6%
Rating of Specialist Seen Most Often	60.3%	59.2%
Rating of All Health Care	47.0%	46.4%
Rating of Health Plan	53.9%	57.1%

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.

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

The general child Medicaid statewide averages presented in this section are derived from the combined general child Medicaid results for DHMC and RMHP. Table 3-33 shows the child Medicaid statewide averages for the current year (FY 2014–2015) and the prior year (FY 2013–2014).[3-6,3-7]

Table 3-33—General Child Medicaid Statewide Averages		
Measure	**FY 2013–2014 Rate**	**FY 2014–2015 Rate**
Getting Needed Care	79.1%	79.6%
Getting Care Quickly	87.3%	83.4%
How Well Doctors Communicate	94.4%	93.5%
Customer Service	86.6%	84.0%

[3-5] The Colorado adult Medicaid statewide averages for the current year (FY 2014–2015) and the prior year (FY 2013–2014) represent weighted scores. The statewide averages were weighted based on each of the Colorado adult Medicaid plan's total eligible adult population for the corresponding year. In prior years, the Colorado adult Medicaid statewide averages were not weighted; therefore, the FY 2013-2014 rates presented in this section may not match the prior year's report.

[3-6] The Colorado general child Medicaid statewide averages for the current year (FY 2014–2015) and the prior year (FY 2013–2014) represent weighted scores. The statewide averages were weighted based on each of the Colorado child Medicaid plan's total eligible general child population for the corresponding year. In prior years, the Colorado child Medicaid statewide averages were not weighted; therefore, the FY 2013-2014 rates presented in this section for the Colorado general child Medicaid statewide average may not match the prior year's report.

[3-7] The child Medicaid statewide averages presented in Table 3-6 for the are based on the combined results of DHMC's and RMHP's general child population.

Table 3-33—General Child Medicaid Statewide Averages		
Measure	**FY 2013–2014 Rate**	**FY 2014–2015 Rate**
Shared Decision Making	NC	81.1%
Rating of Personal Doctor	74.2%	80.5%
Rating of Specialist Seen Most Often	72.4%	76.0%
Rating of All Health Care	64.8%	67.7%
Rating of Health Plan	69.6%	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.

Due to changes to the *Shared Decision Making* composite measure, the current year's rate is not comparable to the prior year's rate. This is denoted as Not Comparable (NC) in the table above.

Recommendations

The statewide adult Medicaid population did not demonstrate a substantial decrease in rates for any of the eight comparable measures; however, the rates for three measures showed a slight decrease: *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care*. The statewide child Medicaid population also did not demonstrate a substantial decrease in rates for any of the eight comparable measures; however, the rates for three measures showed a slight decrease: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

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, none of the measures increased or decreased substantially. The rates for four of the eight comparable measures increased slightly: *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. As previously noted, the rates for three measures decreased slightly. Furthermore, the rate for one measure, *Getting Care Quickly*, remained the same as the previous year.

For the statewide general child Medicaid population, one measure's rate increased substantially: *Rating of Personal Doctor* (6.3 percentage points). The rates for five of the eight comparable measures increased: *Getting Needed Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. As previously noted, the rates for the remaining three measures decreased; however, the decreases in the measures' rates were not substantial.

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 2013–2014. This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations or required actions from the FY 2013–2014 site EQR activities.

Denver Health Medicaid Choice (DHMC)

Compliance Monitoring Site Reviews

As a result of the 2013–2014 site review, DHMC was required to address the following:

- Ensure that notices of action are sent within the required time frames.
- Revise language in its member handbooks to clarify that DHMC uses a prudent layperson standard to determine payment for emergency services.
- Develop a mechanism to more fully explore wait list processes and develop a process to specifically track, by individual, the length of time members remain on the wait list.
- Work with the Department to remove barriers that create the need for the wait list and develop mechanisms to ensure that new adult Medicaid members are not wait-listed beyond the required access to care standards.
- Further define what is meant by "open panel" in the Strategic Access reports and more accurately describe the processes for access into the Denver Health and Hospitals Authority (DHHA) clinic system.
- Implement policies to provide out-of-network care when care within the network is not available, or consider options to expand the DHMC network through expansion of the DHHA provider network, or through contracts with non-DHHA providers.
- Develop an effective process to monitor scheduling wait times, identify barriers to complying with appointment guidelines delineated in the CHP+ managed care contract, and take appropriate action to ensure that appointment scheduling standards are met.
- Evaluate appointment capacity in the DHMC provider system and develop a mechanism to accommodate Medicaid and CHP+ populations equally.

DHMC initially submitted its CAP on June 6, 2014. HSAG reviewed several versions of the CAP, each time providing feedback regarding the sufficiency of the plan and/or requesting evidence of completion for which planned interventions had been approved by HSAG and the Department. While the planned interventions and related elements of corrective action have been approved for the required actions related to the following issues, at the time of the FY 2014–2015 site review,

DHMC had not yet provided documents to provide evidence that interventions were implemented. The required actions were:

- Timeliness of notice of action mailings.
- Revision to the DHMC member handbook to delete language that states DHMC was not responsible for payment if the emergency provider determined that the incident was not an emergency.
- Revision to the DHMC member handbook to delete language concerning refusal to cover emergency care based on DHMC's notification requirements.
- Ensuring that notices of action contained the required content and were written at approximately the sixth-grade level for ease of understanding.

In addition, at the time of the site review, DHMC had not yet submitted a CAP related to timely access to care that was sufficient. This dynamic affected several requirements within the Coverage and Authorization standard as well as the Access and Availability standard.

Validation of Performance Measures

Based on the FY 2013–2014 performance measure validation review, HSAG recommended that DHMC focus its improvement efforts on indicators that either demonstrated a significant rate decline or benchmarked below the national Medicaid HEDIS 10th or 25th percentiles. These indicators were:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits*
- *Adolescent Well-Care Visits (below federal mandate of 80 percent)*
- *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*
- *Antidepressant Medication Management*
- *Follow-up Care for Children Prescribed ADHD Medication (Initiation)*
- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*
- *Use of Appropriate Medications for People With Asthma—Total*

DHMC's HEDIS 2015 rates showed that only the *Follow-up Care for Children Prescribed ADHD Medication* measure had improvement (significant rate increase of at least 10 percentage points for the *Initiation* indicator). All others measures noted in the previous year's report for improvement opportunities either did not show a significant rate increase (e.g., *Antidepressant Medication Management* or *Use of Appropriate Medications for People With Asthma—Total)* or had a further rate decline (e.g., well-child visits measure, two access to care measures, and *Pharmacotherapy Management of COPD Exacerbation)*. Reasons for the decline or lack of improvement could be

related to a change in the data collection requirements for select measures from hybrid to administrative (for well-child visits measures) or an increase in membership due to the Medicaid expansion program. HSAG therefore could not ascertain if improvement efforts were implemented in these measures.

Validation of Performance Improvement Projects

Because this was DHMC's first submission of its *Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics* PIP, there were no prior requirements or recommendations.

Consumer Assessment of Healthcare Providers and Systems

DHMC's adult population was not surveyed in FY 2012–2013, so the FY 2013–2014 technical report compared results from FY 2011–2012 to FY 2013–2014. Between FY 2011–2012 and FY 2013–2014, DHMC experienced a substantial decrease in rates for two of its comparable adult measures (*Rating of all Health Care* and *Rating of Health Plan*). The FY 2014–2015 rate for the adult measure, *Rating of all Health Care*, increased by 3.3 percentage points and *Rating of Health Plan* increased by 6.6 percentage points. These increases may indicate that DHMC followed up on HSAG's recommendations.

DHMC also experienced a substantial decrease in rates between FY 2012–2013 and FY 2013–2014 for four of its comparable child measures (*Getting Needed Care, Shared Decision Making, Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*). Due to changes to the *Shared Decision Making* composite measure, the FY 2014–2015 rate was not comparable to the prior year's rate. DHMC experienced substantial rate increases of 7.4 percentage points and 5.1 percentage points for *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*, respectively, and a modest increase of 3.2 percentage points for the *Getting Needed Care* measure between FY 2013–2014 and FY 2014–2015. These increases may indicate that DHMC followed HSAG's recommendations.

Rocky Mountain Health Plans (RMHP)

Compliance Monitoring Site Reviews

As a result of the 2013–2014 Medicaid managed care site review, RMHP was required to implement five corrective actions related to Standard III—Coverage and Authorization of Services and two corrective actions related to Standard II—Access and Availability. For Coverage and Authorization of Services, RMHP was required to address issues that had resulted in inappropriate denials of claims payment, confusing and inaccurate notifications to members, and holding members responsible for payment without indicating what the member or provider could do so the service was covered. For Access and Availability, RMHP was required to have an effective mechanism to regularly monitor Medicaid provider scheduling standards. RMHP was also required to develop policies and procedures to address cultural characteristics broader than linguistics (e.g., providing programs and services that

incorporate the beliefs, attitudes, and practices of specific cultures) as well as for outreach to specific cultures to prevent and treat diseases prevalent in those groups.

RMHP submitted its proposed corrective action plan to HSAG and the Department in April 2014. HSAG and the Department worked with RMHP to ensure that planned interventions would fully address the required actions. HSAG reviewed documents on-site in June of 2014 and documents subsequently submitted in August 2014, when HSAG and the Department determined that RMHP had completed all required actions.

Validation of Performance Measures

Based on its FY 2013–2014 review, HSAG recommended that RMHP focus its improvement efforts on indicators that either demonstrated a significant rate decline or benchmarked below the national Medicaid HEDIS 10th or 25th percentiles. These indicators were:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Children's and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*
- *Chlamydia Screening in Women—Total*)
- *Comprehensive Diabetes Care* indicators [*HbA1c Poor Control (>9/0%), HbA1c Control (<8.0%),* and *Blood Pressure Controlled < 140/80 mm Hg*]
- *Pharmacotherapy Management of COPD Exacerbation*
- *Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis*

In addition to the measure-specific recommendation, the FY 2013–2014 review also noted that an *NB* (benefits not offered) designation was assigned to four of the seven measures in the IDSS (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, because 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's FY 2013–2014 review recommended that RMHP work with its auditors and the Department to ensure that the most accurate audit designations be assigned for these measures.

RMHP's HEDIS 2015 rates showed there was not much performance improvement in any of the measures noted in the previous year's report for improvement opportunities. Two measures (*Children's and Adolescents' Access to Primary Care Practitioners* and *Chlamydia Screening in Women—Total)* declined significantly from HEDIS 2014. Other measures did not show significant rate change. Although the *Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis* rate increased 9 percentage points, the increase was not statistically significant. Reasons for the decline or lack of improvement could be related to a change in the data collection requirements for select measures from hybrid to administrative (e.g., for well-child visits measures) or an increase in membership due to the Medicaid expansion program. HSAG therefore could not ascertain if improvement efforts were implemented in these measures. For measures with an

incorrect audit designation in HEDIS 2014, RMHP's audit review table continued to show the same audit designation (i.e., NB where measures indicated that the MCO should have the required benefits to calculate the measure). This suggested that a follow-up might not have been implemented.

Validation of Performance Improvement Projects

Because this was RMHP's first submission of its *Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility* PIP, there were no prior requirements or recommendations.

Consumer Assessment of Healthcare Providers and Systems

RMHP's adult population was not surveyed in FY 2012–2013, so the FY 2013–2014 technical report compared results from FY 2011–2012 to FY 2013–2014.

RMHP had no substantial decreases in rates for the adult Medicaid population between FY 2011–2012 and FY 2013–2014. The child Medicaid population, however, experienced a substantial decrease between FY 2012–2013 and FY 2013–2014 for two of its comparable measures (*Getting Needed Care* and *Shared Decision Making*). Due to changes to the *Shared Decision Making* composite measure, the FY 2014–2015 rate was not comparable to the prior year's rate. RMHP experienced a substantial rate decrease of 6.9 percentage points for *Getting Needed Care* between FY 2013–2014 and FY 2014–2015. HSAG was unable to determine if RMHP followed up on its recommendation.

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 2014–2015 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards to review these performance areas. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. For each standard, HSAG conducted a desk review of documents sent by the BHOs prior to the on-site portion of the review, conducted interviews with key BHO staff members on-site, and reviewed additional key documents on-site.

The BHOs' administrative records were also reviewed to evaluate implementation of managed care regulations related to Medicaid grievances and appeals. Using a random sampling technique, HSAG selected a sample of 10 plus an oversample of five from all applicable grievances and appeals filed between January 1, 2014, and December 31, 2014 (to the extent possible). HSAG used a standardized tool to review the records and document findings. Results of record reviews were considered in the scoring of applicable requirements in Standard VI—Grievance System. HSAG also calculated an overall record review score separately.

HSAG determined which standards contained requirements that related to the domains of quality, timeliness, or access, as shown in Table 5-1. Appendix A contains further details about the methodology used to conduct the EQR compliance monitoring site review activities.

Table 5-1—Assignment of Activities to Performance Domains

Standard	Quality	Timeliness	Access
Standard V—Member Information	✓		✓
Standard VI—Grievance System	✓	✓	✓
Standard VII—Provider Participation and Program Integrity	✓		✓
Standard IX—Subcontracts and Delegation	✓		

Access Behavioral Care—Denver (ABC-D)

Findings

Table 5-2 and Table 5-3 present the number of elements for each standard 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 2014–2015).

Table 5-2—Summary of Scores for the Standards *for* ABC-D

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	20	20	18	1	1	0	90%
Standard VI—Grievance System	26	26	23	2	1	0	88%
Standard VII—Provider Participation and Program Integrity	14	14	14	0	0	0	100%
Standard IX—Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals	**66**	**66**	**61**	**3**	**2**	**0**	**92%***

* 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-D's Record Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals	60	58	54	4	2	93%
Grievances	50	30	28	2	20	93%
Total	**110**	**88**	**82**	**6**	**22**	**93%**

Strengths

The member handbook and other vital member materials were written in easy-to-understand language, were translated into Spanish and were available in other languages on request, and were provided to members upon enrollment and at other times, as required. The ABC-D website, which allowed members to select translation into one of more than 50 languages, also provided online access to the member handbook, member rights, provider directories, and many other member information resources. Policies and procedures and supporting documentation confirmed that ABC-D notified members within the required time frames of provider termination, privacy policies, any significant changes in information, and the members' right to request information. The member handbook and other member materials included information about grievance and appeals procedures, including information on access to the Ombudsman for Medicaid Managed Care. With limited exceptions, the member handbook adequately defined the scope of benefits available to members, authorization procedures, access to emergency and post-stabilization services, and applicable advance directives information.

ABC-D's appeal processes were managed by the staff of Colorado Access, (ABC-D's corporate entity) and tracked through the central Altruista information system. Appeals and grievance processes were thoroughly defined in policies and procedures, described in the member handbooks and other member communications, and included in an appeals information attachment sent with notices of action and appeal resolution letters. Time frames for filing and resolving grievances and appeals were accurately defined and grievance and appeals record reviews demonstrated 100 percent compliance with all required time frames. State fair hearing processes also were thoroughly addressed in policies and member communications. Appeals and grievance decisions were made by persons uninvolved in any previous decision-making and by persons with appropriate clinical expertise, as applicable. Staff members stated that Colorado Access contracted with an external medical review vendor to make appeals decisions when an appropriate specialist was not available internally. Expedited review procedures and how members may request continuation of benefits were also adequately described in policies and member communications. Appeals resolution letters included a description of the appeals review results and the date of resolution, substantiated through record review scores of 100 percent on this element.

Policies and procedures documented thorough processes for credentialing and recredentialing providers in compliance with NCQA and URAC standards. Policies also specified methods for pre-credentialing and monthly monitoring for provider sanctions against applicable federal and State databases, monitoring of grievances and other quality of care actions against providers, annual on-site audit of medical record standards for a rotating sample of high-volume providers, and quarterly secret shopper surveys to monitor access to care standards. All findings were reported to senior management committees and were considered in the recredentialing process as appropriate. Provider corrective action plans were developed to address identified deficiencies. The Colorado Access Professional Provider Agreement (applicable to all lines of business) included all required elements. Numerous corporate policies and procedures, the Corporate Compliance Plan, and the Medicaid Compliance Plan documented robust and well-established procedures to guard against fraud, waste, and abuse and to maintain all corporate compliance standards. Advance directives policies and communications to providers and members documented that ABC-D had addressed all applicable advance directives requirements outlined in federal regulations.

All policies, procedures, and processes related to the requirements for subcontracts and delegation were corporately driven and applied to all Colorado Access lines of business. Policies and written agreements with delegates documented that ABC-D retains ultimate responsibility for delegated functions. Pre-delegation assessment of a prospective delegate's capabilities included an extensive desk review and an on-site audit of policies, procedures, and adequacy of staff members to perform the delegated activities. Colorado Access performed a comprehensive annual audit of the delegates as well as ongoing monitoring through periodic reports submitted by the delegate. Any deficiencies identified in pre-delegation or ongoing audits required a corrective action plan, with a re-auditing every three months until action plans were completed. Delegation agreements described the delegated responsibilities in detail, periodic reporting responsibilities of the delegate, an annual audit by Colorado Access with action plans to remedy any deficiencies, and the ability of Colorado Access to revoke delegated functions or the entire delegation agreement based on inadequate performance.

Recommendations

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

Standard V—Member Information

- ABC-D was required to determine, in a timely manner, the appropriate language to inform members of the Child Mental Health Treatment Act (CMHTA) and update member materials to include this information.
- ABC-D was required to develop mechanisms to ensure that providers and subcontractors understood their responsibility to provide members with the required information. ABC-D also was required to develop a mechanism to periodically monitor whether providers had made the required information available and accessible to members.

Standard VI—Grievance System

- ABC-D was required to ensure that resolution letters included an adequate explanation of the results of the grievance process so the member could understand that the grievance was actually resolved.
- ABC-D was required to revise policies and procedures and related member communications, including the member handbooks, to accurately describe:
  - That a member may request a State fair hearing for any action (including suspension, termination, or reduction of services) within 30 calendar days from the date of the notice of action, unless the member requested continuation of previously authorized services during the appeal or State fair hearing process.
  - When requesting continuation of previously authorized services pending the outcome of a State fair hearing, the member had 10 calendar days or until the intended effective date of the action to request a State fair hearing.
- ABC-D was required to provide grievance and appeal information, as specified in the requirement, to providers and subcontractors at the time they entered into a contract.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: HSAG assigned all four standards to the quality domain. ABC-D's overall score of 92 percent compliance indicates that ABC-D has implemented policies, procedures, and processes to ensure that members, providers, and the staff understand the parameters of the plan and that services provided are compliant with federal and State requirements.

Timeliness: ABC-D's performance in the timeliness domain was good. The only required action related to timeliness was regarding the request to continue previously authorized services during the appeal or State fair hearing process. On-site review of grievance and appeal records indicated that ABC-D is meeting all of the required time frames for processing requests.

Access: Part of ensuring adequate access and availability of services is making sure that members, providers, and the staff understand what services are available and how to access them. Colorado Access improved access to its services by streamlining its policies and processes across all lines of business. Furthermore, ABC-D's member information provides an easy to understand explanation of benefits and instructions on how to access them. While HSAG identified a few areas that required additional effort and clarity, overall, ABC-D performed very well in the access domain.

Access Behavioral Care—Northeast (ABC-NE)

Findings

Table 5-4 and Table 5-5 present the number of elements for each standard 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 2014–2015).

Table 5-4—Summary of Scores for the Standards *for* ABC-NE

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	20	20	18	1	1	0	90%
Standard VI—Grievance System	26	26	23	2	1	0	88%
Standard VII—Provider Participation and Program Integrity	14	14	14	0	0	0	100%
Standard IX—Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals	**66**	**66**	**61**	**3**	**2**	**0**	**92%***

* 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 ABC-NE's Record Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals	12	12	12	0	0	100%
Grievances	50	34	32	2	16	94%
Total	**62**	**46**	**44**	**2**	**16**	**96%**

Strengths

The member handbook and other vital member materials were written in easy-to-understand language, were translated into Spanish and were available in other languages on request, and were provided to members upon enrollment and at other times, as required. The ABC-NE website, which allowed members to select translation into one of more than 50 languages, also provided online access to the member handbook, member rights, provider directories, and many other member

information resources. Policies and procedures and supporting documentation confirmed that ABC-NE notified members within the required time frames of provider termination, privacy policies, any significant changes in information, and the members' right to request information. The member handbook and other member materials included information about grievance and appeals procedures, including information on access to the Ombudsman for Medicaid Managed Care. With limited exceptions, the member handbook adequately defined the scope of benefits available to members, authorization procedures, access to emergency and post-stabilization services, and applicable advance directives information.

ABC-NE's appeal processes were managed by the staff of Colorado Access, the corporate entity, and tracked through the central Altruista information system. Appeals and grievance processes were thoroughly defined in policies and procedures, described in the member handbooks and other member communications, and included in an appeals information attachment sent with notices of action and appeal resolution letters. Time frames for filing and resolving grievances and appeals were accurately defined and grievance and appeals record reviews demonstrated 100 percent compliance with all required time frames. State fair hearing processes also were thoroughly addressed in policies and member communications. Appeals and grievance decisions were made by persons uninvolved in any previous decision-making and by persons with appropriate clinical expertise, as applicable. Staff members stated that Colorado Access contracted with an external medical review vendor to make appeal decisions when an appropriate specialist was not available internally. Expedited review procedures and how members could request continuation of benefits were also adequately described in policies and member communications. Appeal resolution letters included a description of the appeal review results and the date of resolution, substantiated through record review scores of 100 percent on this element.

Policies and procedures documented thorough processes for credentialing and recredentialing providers in compliance with NCQA and URAC standards. Policies also specified methods for pre-credentialing and monthly monitoring for provider sanctions against applicable federal and State databases, monitoring of grievances and other quality of care actions against providers, an annual on-site audit of medical record standards for a rotating sample of high-volume providers, and quarterly secret shopper surveys to monitor access to care standards. All findings were reported to senior management committees and were considered in the recredentialing process as appropriate. Provider corrective action plans were developed to address identified deficiencies. The Colorado Access Professional Provider Agreement (applicable to all lines of business) included all required elements. Numerous corporate policies and procedures, the Corporate Compliance Plan, and the Medicaid Compliance Plan documented robust and well-established procedures to guard against fraud, waste, and abuse, and to maintain all corporate compliance standards. Advance directives policies and communications to providers and members documented that ABC-NE had addressed all applicable advance directives requirements outlined in federal regulations.

All policies, procedures, and processes related to the requirements for subcontracts and delegation were corporately driven and applied to all Colorado Access lines of business. Policies and written agreements with delegates documented that ABC-NE retained ultimate responsibility for delegated functions. Pre-delegation assessment of a prospective delegate's capabilities included an extensive desk review and an on-site audit of policies, procedures, and adequacy of the staff to perform the delegated activities. Colorado Access performed a comprehensive annual audit of the delegates as well as ongoing monitoring through periodic reports submitted by the delegate. Any deficiencies

identified in pre-delegation or ongoing audits required a corrective action plan, with re-auditing every three months until action plans were completed. Delegation agreements described the delegated responsibilities in detail, the periodic reporting responsibilities of the delegate, the annual audit by Colorado Access with action plans to remedy any deficiencies, and the ability of Colorado Access to revoke delegated functions or the entire delegation agreement based on inadequate performance.

Recommendations

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

Standard V—Member Information

- ABC-NE was required to determine, in a timely manner, the appropriate language to inform members of the CMHTA and update member materials to include this information.
- ABC-NE was required to develop mechanisms to ensure that providers and subcontractors understood their responsibility to provide members with the required information. ABC-NE also was required to develop a mechanism to periodically monitor whether providers had made the required information available and accessible to members.

Standard VI—Grievance System

- ABC-NE was required to ensure that resolution letters included an adequate explanation of the results of the grievance process so that the member could understand that the grievance was actually resolved.
- ABC-NE was required to revise policies and procedures and related member communications, including the member handbooks, to accurately describe:
  - That a member may request a State fair hearing for any action (including suspension, termination, or reduction of services) within 30 calendar days from the date of the notice of action, unless the member was requesting continuation of previously authorized services during the appeal or State fair hearing process.
  - When requesting continuation of previously authorized services pending the outcome of a State fair hearing, the member had 10 calendar days or until the intended effective date of the action to request a State fair hearing.
- ABC-NE was required to provide grievance and appeals information, as specified in the requirement, to providers and subcontractors at the time they entered into a contract.

Summary Assessment Related to Quality, Timeliness, and Access

The following is a summary assessment of ABC-NE's compliance monitoring results related to each of the three domains. As mentioned earlier, the findings for ABC-NE were essentially the same as those for ABC-D.

Quality: HSAG assigned all four standards to the quality domain. While this was ABC-NE's first year in business, it benefited greatly from the experience and expertise of its parent (Colorado Access) and sister (ABC-D) organizations. As with ABC-D, ABC-NE's overall score of 92 percent

compliance indicated that it had implemented policies, procedures, and processes to ensure members, providers, and the staff understood the parameters of the plan and that services provided were compliant with federal and State requirements.

Timeliness: ABC-NE's performance in the timeliness domain was good. The only required action related to timeliness was regarding the request to continue previously authorized services during the appeals or State fair hearing process. On-site review of grievance and appeals records indicated that ABC-NE was meeting all of the required time frames for processing requests.

Access: Part of ensuring adequate access and availability of services is making sure that members, providers, and the staff understand what services are available and how to access them. Colorado Access improved access to its services by streamlining its policies and processes across all lines of business. Furthermore, ABC-NE's member information provides an easy-to-understand explanation of benefits and instructions on how to access them. While HSAG identified a few areas that required additional effort and clarity, overall, ABC-NE performed very well in the access domain.

Behavioral Healthcare, Inc. (BHI)

Findings

Table 5-6 and Table 5-7 present the number of elements for each standard 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 2014–2015).

Table 5-6—Summary of Scores for the Standards *for* BHI

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	20	20	19	1	0	0	95%
Standard VI—Grievance System	26	26	19	7	0	0	73%
Standard VII—Provider Participation and Program Integrity	14	14	12	2	0	0	86%
Standard IX—Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals	**66**	**66**	**56**	**10**	**0**	**0**	**85%***

* 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 BHI's Record Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals	60	57	42	15	3	74%
Grievances	50	30	30	0	20	100%
Total	**110**	**87**	**72**	**15**	**23**	**83%**

Strengths

BHI's member handbook provided well-organized information to assist members in understanding the behavioral health managed care program and how to obtain services through BHI, and it included all other member handbook requirements. The member handbook was available in English and Spanish, and BHI had mechanisms in place to provide the handbook in alternative formats as well. BHI distributed postcard-size quick reference cards at community health fairs, school-based clinics, and the diabetes fair. BHI designed different cards to provide information to potential members and to help providers within the medical community and school-based health centers understand BHI and its services. Members and providers were informed about member rights via the member handbook and the provider manual, respectively, as well as member and provider newsletters.

BHI had a well-defined process for responding to Medicaid member grievances and appeals. This included assisting members with access to the State fair hearing process. BHI's member handbook informed members that they could file grievances and appeals orally or in writing, and HSAG found evidence that BHI accepted grievances and appeals both orally and in writing. BHI maintained a grievance and appeals database and individual records, and it reported grievances and appeals to the Department quarterly, as required. The on-site record review provided evidence that BHI staff members maintained communication throughout the process. Grievance resolution letters were easy to understand and addressed the members' concerns.

All providers contracted with BHI were subject to its credentialing and recredentialing policies and procedures. BHI had delegated its individual provider credentialing activities to Colorado Access through its Administrative Service Organization Agreement. The credentialing policies and procedures were reviewed annually to ensure compliance with NCQA standards. BHI's policies and processes for conducting ongoing provider monitoring were well-defined and the BHO instituted corrective action plans for all providers scoring less than 90 percent on their provider chart audit. BHI's policy for monitoring provider sanctions included the application of corrective action plans for adverse events such as violations of BHI's policies and regulations, and for failure to achieve satisfactory utilization and quality standards. This policy outlined Colorado Access' and BHI's respective responsibilities to monitor and report BHI's provider exclusions and sanctions. The provider contracts delineated the responsibilities and performance standards between BHI and its providers. The contracts also required that members not be held liable for covered services.

In addition to individual provider credentialing, BHI had delegated enrollment processing, claims processing, and care management to Colorado Access. The delegation agreement included the key performance metrics and the related reporting requirements. In addition to the quarterly review of Colorado Access' contract performance summary, BHI conducted an annual audit. BHI demonstrated appropriate remediation and oversight strategies when Colorado Access had previous difficulties in meeting the performance expectations related to claims processing.

Recommendations

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

Standard V—Member Information

- BHI was required to send the privacy practices to members annually. BHI could consider including the content within one of the member newsletters or as an enclosure in the annual member letter.

Standard VI—Grievance System

- BHI was required to revise the appeals section of its member handbook to accurately state that members could file an appeal when BHI failed to meet grievance and appeals resolution time frames.
- BHI was required to revise applicable policies and procedures to clarify the difference in concurrent review processes and requirements related to the request for acute inpatient care and to continuing long term services for which a 10-day advance notice had been given.
- BHI was required to ensure that, for all standard appeals, it sent written acknowledgement to the member and/or provider/DCR within the two working day time frame.
- BHI was required to ensure that all standard member appeals were processed within the 10 working day time frame as required by Colorado regulation at *10 CCR 2505-10, Section 8. 209.*
- BHI was required to revise the appeal resolution template letters to accurately depict the time frames and requirements related to the continuation of services during a State fair hearing.
- BHI was required to ensure that appeal resolution letters included the required content and were sent within the required time frames. BHI also was required to ensure that members were always copied on any member appeal communication and that letters were written at the sixth grade reading level, to the extent possible.
- BHI was required to ensure that documentation existed to demonstrate that individuals who made appeals decisions had not been involved in any previous level of review and had the appropriate clinical expertise to treat the member's condition.
- BHI was required to clarify the definition of an "expedited appeal." Urgent care is not subject to prior authorization and therefore should not be denied during a utilization review. BHI also was required to clarify that the only circumstances under which a member might have to pay for the services if the appeals or State fair hearing decision was adverse to the member involved those services that were specifically continued in accordance with 42CFR438.420. Other final denials (e.g., claims denials related to provider procedural issues) might not result in members being held responsible for payment of services.
- BHI was required to revise its provider manual to ensure comprehensive and accurate information about the grievance system specified in 42CFR438.10(g)(1).

Standard VII—Provider Participation and Program Integrity

- BHI was required to enhance its provider audit/oversight processes to ensure that all providers' performance was monitored for compliance with contractual requirements, as indicated in 42CFR438.230(b)(3). As a reference, the provider contractual requirements included, but were not limited to, access to care standards, timely and accurate claims filing, submission of reports, and compliance with BHI's corporate compliance plan. BHI was also required to explore

additional metrics and processes to examine provider performance individually and in aggregate by leveraging existing data sources.

- BHI was required to develop more definitive policies and procedures to identify potential fraud, waste, and abuse, with specific tools to identify and report suspected incidences of upcoding, unbundling of services, and identifying services that were never rendered or billed at an inflated rate. Additionally, BHI was told it should enhance the scope of its corporate compliance training curriculum to include more examples and tools to identify services that could be incorrectly upcoded, unbundled, never rendered, or billed at an inflated rate to ensure that its employees and contractors could optimally follow the policies and procedures for guarding against fraud, waste, and abuse.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: BHI's overall compliance score across all four standards was 85 percent, which indicates the need for improvement. HSAG identified several areas where BHI provided incomplete or inaccurate information, either in the member handbook, provider directory, or in its policies and procedures. These deficiencies were most frequently noted in the grievance system standard. However, on-site interviews with BHI staff members demonstrated that BHI already had identified many of the deficiencies and had begun addressing them.

Timeliness: HSAG assigned the grievance standard to the timeliness domain. BHI struggled with communicating correct and consistent time frames to its members, providers, and staff. However, on-site review of 10 appeals records and 10 grievance records demonstrated that BHI mailed acknowledgment letters within the required time frame 88 percent of the time and resolved all appeals and grievances within the required time frames 100 percent of the time.

Access: BHI performed best in the access domain. Its member handbook included all of the required elements in an easy-to-understand language and format. BHI also communicated the benefits and services available under the plan to its providers as well as the expectation that providers assist members with understanding the benefits and how to access them. BHI also demonstrated its commitment to educating not only its members but the community at large about the behavioral health services available and where members and nonmembers could go for help.

Colorado Health Partnerships, LLC (CHP)

Findings

Table 5-8 and Table 5-9 present the number of elements for each standard 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 2014–2015).

Table 5-8—Summary of Scores for the Standards *for* CHP							
Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	20	20	20	0	0	0	100%
Standard VI—Grievance System	26	26	20	6	0	0	77%
Standard VII—Provider Participation and Program Integrity	14	14	14	0	0	0	100%
Standard IX—Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals	**66**	**66**	**60**	**6**	**0**	**0**	**91%***

* 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 CHP's Record Review						
Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals	50	31	26	5	19	84%
Grievances	60	60	52	8	0	87%
Total	**110**	**91**	**78**	**13**	**19**	**86%**

Strengths

Member materials, including the member handbook, were written in easy-to-understand language. CHP developed a "simple word thesaurus" as a tool to assist with converting complex health plan jargon into sixth grade reading level language for member materials and communications. The handbook was well-organized and indexed to allow members to readily search for specific topics. CHP translated numerous written materials into Spanish and were available for dissemination. CHP mailed all member materials within required time frames, including enrollment materials, the annual letter and privacy notice, and notice of significant change in benefits or other vital information. CHP clearly communicated to providers the responsibility to distribute specific information to members at provider facilities. CHP supported providers in this process through member advocates who assisted members in understanding their rights and by distributing vital member materials at the partner community mental health centers (CMHCs). The member handbook and/or website included information on covered services, the Colorado Preferred Drug List (PDL), the CMHTA, community resources, grievance and appeal procedures, member rights, trainings, the ombudsman, EPSDT services, wrap-around services, advance directives, emergency services, and provider network directories. The provider directory included all required information, and staff members stated that only providers accepting new patients were included in the directory.

CHP had a well-defined, comprehensive system to process member grievances and appeals. Policies and procedures included definitions of a grievance and an appeal, procedures and time frames for processing grievances and appeals, and thorough member communications regarding the resolution

of grievances and appeals. Grievances were investigated, resolved, and documented in the grievance database by CHP's Office of Member and Family Affairs (OMFA) and member advocates at the partner CMHCs (delegates for processing grievances). CHP's partner owner, ValueOptions (VO), processed all appeals in its clinical department, with coordination by the OMFA. Appeals were tracked and files maintained in the VO Service Connect appeals database. With the exception of some confusion regarding timely filing requirements related to continuation of previously authorized services, all grievance and appeals procedures were accurately defined in multiple documents. OMFA staff members were actively involved in assisting members with grievances, appeals, and State fair hearings—and efficiently achieving resolution. The CHP OMFA staff demonstrated in-depth knowledge of the grievance and appeal processes and conscientious commitment to successful program outcomes.

CHP described a thorough NCQA-compliant provider selection and credentialing process that combined the resources of the national VO credentialing organization and a local credentialing committee. CHP delegated provider monitoring and audit activities to VO. CHP/VO had extensive policies and procedures and implemented numerous ongoing monitoring and audit activities to evaluate provider performance and hold providers accountable for compliance with contract requirements. CHP demonstrated that it takes corrective action based on monitoring results, when needed. Provider contracts specifically outlined provider responsibilities to comply with policies and procedures, the provider manual, and State and federal requirements—and included provisions for revocation or sanctions based on performance. Both CHP and VO maintained a written compliance plan; code of conduct; fraud, waste, and abuse policies; and compliance oversight committees. CHP delegated many of the compliance oversight activities to VO; however, CHP had a local compliance officer and a compliance oversight group that coordinated activities between CHP and VO.

CHP delegated numerous operational functions to its partner owner, VO. The operational agreement with VO is the ownership agreement between VO and CHP, and it describes VO responsibilities as a partner in the LLC, including sanctions. The Member Participation Agreement outlined CHP's agreement with the eight participating CMHCs to provide covered services and perform specific functions such as staff credentialing and grievance functions. While the ownership/partnership and delegate agreements reflect complex legal and regulatory interrelationships, staff members stated that the functional relationships are long-standing, effective, and well-understood. VO submitted ongoing reports to CHP's Class B board related to delegated activities and to a comprehensive annual delegation audit conducted by an independent auditor engaged by CHP. The audit tool demonstrated a detailed assessment of documents and/or on-site review pertaining to the delegation contract requirements. Results of the audit were reported to the board and corrective action plans for performance deficiencies were implemented. CHP's staff also performed annual audits of CMHC requirements through medical record and process reviews, which were reported to the board with any identified corrective action plans.

Recommendations

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

Standard VI—Grievance System

- CHP was required to ensure that all grievances were resolved with a grievance resolution letter sent to the member within 15 working days of receipt of the grievance.
- CHP was required to ensure that the grievance was fully addressed in the description of the results of the resolution process.
- CHP was required to correct the provider manual to ensure that members could appeal an action to reduce, suspend, or terminate previously approved services within 30 calendar days of the notice of action, unless the member was requesting continuation of benefits during the appeal.
- CHP was required to ensure that members/designated client representatives (DCRs) were notified in writing of the outcome of a standard appeal within 10 working days of receipt of the appeal. CHP also was required to ensure that the member (as well as the DCR), as a defined party to the appeal (10 CCR 2505—10, Section 8.209.4.I), was informed in writing of the appeal resolution.
- CHP was required to revise the grievance and appeal brochure to be consistent with CHP policies and procedures concerning the time frame for resolving expedited appeals.
- CHP was required to correct member and provider materials to clarify that members could request a State fair hearing for reduction, suspension, or termination of previously authorized services within 30 calendar days of the notice of action, *unless* the member was requesting continuation of previously authorized benefits pending the State fair hearing decision.
- CHP was required to clarify the policy and the member and provider materials to ensure that the member could request continuation of previously authorized services pending the outcome of an appeal or State fair hearing by filing on or before the later of 10 days after mailing the notice of action, or by the intended effective date of the action.

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 scored 100 percent compliance with three of the four standards reviewed. Its member information was thorough, well-organized, and written in easy-to-understand language and format. CHP clearly communicated the benefits and services available to its members and providers under the plan. Member advocates located at the partner community mental health centers assisted providers with distribution of vital member materials while assisting members with understanding their rights and benefits. Both documents submitted and on-site interviews demonstrated that CHP had an active and in-depth commitment to maintaining integrity in both the provider network and the administrative organization.

Timeliness: All of CHP's required actions were associated with the time frames for grievances, appeals, and State fair hearings. HSAG identified a minor discrepancy between the grievance and appeal brochure and CHP's policies and procedures, and some inaccurate information regarding the time frames involved with requesting continuation of benefits during an appeal or State fair hearing. Also, CHP did not mail resolution letters on time for two of the 10 grievance records reviewed and two of the 10 appeal records reviewed.

Access: CHP's performance in the access domain was good. It employed multiple mechanisms to ensure members understood the benefits and services available under the plan and how to access them. CHP also maintained a robust network of qualified providers and contractors to ensure it thoroughly addressed the needs of its membership.

Foothills Behavioral Health Partners, LLC (FBHP)

Findings

Table 5-10 and Table 5-11 present the number of elements for each standard 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 2014–2015).

Table 5-10—Summary of Scores for the Standards *for* FBHP

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Standard V—Member Information	20	20	20	0	0	0	100%
Standard VI—Grievance System	26	26	20	6	0	0	77%
Standard VII—Provider Participation and Program Integrity	14	14	14	0	0	0	100%
Standard IX—Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals	**66**	**66**	**60**	**6**	**0**	**0**	**91%***

* 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 FBHP's Record Review

Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals	48	48	44	4	0	92%
Grievances	50	36	36	0	14	100%
Total	**98**	**84**	**80**	**4**	**14**	**95%**

Strengths

FBHP's member materials, including the member handbook, were written in easy-to-understand language. The handbook was well-organized and indexed to allow members to readily search for specific topics. FBHP translated numerous written materials into Spanish and made them available for dissemination. FBHP clearly communicated to providers the responsibility to distribute specific information to members at provider facilities. The FBHP website was easy to navigate and included much of the essential member information, with visible links to specific topics. The member handbook and/or website included information on covered services, the Medicaid preferred drug

list, the CMHTA, community resources and national and local behavioral agencies and organizations, grievance and appeals procedures, member rights, trainings and newsletter information for members, the ombudsman, advance directives, emergency services, and other vital information. FBHP included in the member handbook a commendable description of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and a variety of Colorado waiver programs and how to access them. Other member communications included the annual member letter and privacy policy, and notices to members regarding any substantial change in services or provider termination.

FBHP's policy and procedures, as well as various member and provider communications, clearly substantiated that FBHP had a well-defined, robust process for processing member grievances and appeals that included definitions of a grievance and an appeal, procedures and time frames for processing grievances and appeals, and thorough member communications regarding the resolution of grievances and appeals. Grievances were investigated and resolved through the FBHP Office of Member and Family Affairs (OMFA) staff and the delegated partner CMHCs. All appeal procedures were executed through FBHP's partner owner, VO. The FBHP and VO OMFA staffs were actively involved in assisting members with grievances, appeals, and State fair hearings, and with efficiently achieving resolution. FBHP informed members and providers of all applicable grievance and appeal procedures in the member handbook and provider manual, respectively. Appeal and grievance resolution letters included applicable dates, reviewer credentials, thorough descriptions of disposition, and alternatives for next steps. During the on-site interview, FBHP staff members demonstrated that they were very knowledgeable and conscientious with the appropriate processing of grievances and appeals.

FBHP had a complex structure to meet the requirements of the Provider Participation and Program Integrity standard. Many of the requirements, including provider credentialing, were delegated to VO, a partner owner as well as a management services organization (MSO) subcontractor. However, FBHP's corporate compliance officer assumed responsibility for the compliance program, and the chief quality officer and her staff assumed responsibility for monitoring quality, appropriateness, member access, most reporting requirements, medical record requirements, and contract compliance. FBHP's staff presented flowcharts that detailed the VO credentialing process for both facilities and practitioners. FBHP's staff also provided evidence of a very comprehensive system for monitoring provider and subcontractor performance; demonstrated that corrective actions were taken, well-documented, and tracked; and provided a VO corrective action plan for review. FBHP established a thorough process to protect against fraud and abuse. The corporate compliance program was comprehensive and addressed leadership and structure, standards and procedures, training and education, communication, auditing and monitoring, and enforcement of standards.

FBHP had a written delegation agreement with each subcontractor that incorporated all of the required elements. FBHP initiated the delegation agreement with one of its delegates within the prior year and provided evidence of a pre-delegation evaluation, an action plan to improve performance in several areas, and a mechanism for tracking progress and completion of the action plan. FBHP implemented a comprehensive system to monitor subcontractor performance on an ongoing basis. To ensure impartiality, FBHP also contracted with an independent auditor to conduct a full audit of the delegates' performance every three years.

Recommendations

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

Standard VI—Grievance System

- FBHP was required to ensure that members could appeal an action to reduce, suspend, or terminate previously approved services within 30 calendar days of the notice of action, unless the member was requesting continuation of benefits during the appeal.
- FBHP was required to ensure that all appeals were acknowledged in writing within two working days of receiving the appeal.
- FBHP was required to ensure that standard appeals were resolved within 10 working days (plus 14 calendar days, if extended) of the initial receipt of the appeal (verbal or written).
- FBHP was required to ensure that the appeal resolution letter for all appeals not resolved wholly in favor of the member informed the member of the right to continue previously approved benefits during a State fair hearing and that the member could be held liable for the cost of these benefits if the hearing decision upheld the contractor's action.
- FBHP was required to correct member and provider materials to clarify that members could request a State fair hearing for reduction, suspension, or termination of previously authorized services within 30 calendar days of the notice of action, unless the member was requesting continuation of benefits pending the State fair hearing decision.
- FBHP was required to clarify the provider manual and any related communications to ensure that the member could request continuation of benefits pending the outcome of an appeal or State fair hearing by filing on or before the later of 10 days after mailing of the notice of action or the intended effective date of the action.

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 scored 100 percent compliance with three of the four standards reviewed. Its member information was thorough, well-organized, and written in easy-to-understand language and format. FBHP included in the member handbook a commendable description of EPSDT services and a variety of Colorado waiver programs and how to access them. FBHP provided documented multiple methods it employed to monitor providers' and subcontractors' performance and required corrective actions, when necessary.

Timeliness: All of FBHP's required actions were associated with the time frames for grievances, appeals, and State fair hearings. Aside from some inaccurate information regarding the time frames involved with requesting the continuation of benefits during an appeal or State fair hearing, HSAG found FBHP's policies and procedures related to grievances, appeals, and State fair hearings thorough and accurate. On-site review of eight appeal records demonstrated that FBHP failed to meet the required time frame for mailing an acknowledgment letter in two cases and failed to mail

the resolution notice in one case. FBHP met the required time frames 100 percent of the time for all 10 grievance records reviewed.

Access: FBHP's performance in the access domain was good. It employed multiple mechanisms to ensure members understood the benefits and services available under the plan and how to access them. FBHP also maintained a robust network of qualified providers and contractors to ensure it thoroughly addressed the needs of its membership.

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 2014–2015 Statewide Average*
Standard V—Member Information	**95%**
Standard VI—Grievance System	**81%**
Standard VII—Provider Participation and Program Integrity	**97%**
Standard IX—Subcontracts and Delegation	**100%**
Overall Statewide Compliance Score	**90%**

* Statewide average rates 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*
Appeals	**94%**
Grievances	**88%**
Overall Statewide Score for Record Reviews	**82%**

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

Quality: HSAG assigned all four of the standards reviewed to the quality domain and statewide performance was strong. All five BHOs scored 100 percent compliance with all requirements related to provider participation and program integrity as well as subcontracts and delegation. The BHOs also performed well in the member information standard, with an overall compliance score of 95 percent.

Timeliness: Statewide BHO performance was lowest in the timeliness domain. All five of the BHOs struggled with the time frames associated with a request for continuation of benefits during and appeal and/or State fair hearing. Additionally, while the BHOs' policies, procedures, and

member information were mostly accurate for the time frames related to acknowledgement and resolution of grievances and appeals, on-site record reviews demonstrated that the plans were not consistently meeting these time frame requirements. However, the majority of required actions that fell within the timeliness domain were related to policies and procedures for scenarios that rarely occurred. While performance in the timeliness domain was poorest, HSAG found ample evidence to suggest that Colorado BHOs provide timely authorization, grievance, and appeal decisions, services, and follow-up care to members.

Access: Statewide performance in the access domain was strong. All five BHOs demonstrated the availability of robust provider networks that served the needs of their members. The plans created and distributed member information written in easy-to-understand language that explained the benefits of the plan—including the availability of a grievance and appeal system—and how to access services.

Validation of Performance Measures

The Department required the collection and reporting of 11 performance measures for the FY 2014–2015 validation process (Table 5-14). Five were HEDIS-like measures and six were developed by the Department and the BHOs. Out of the 11 measures, seven measures have multiple indicators, yielding a total of 36 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. This scope document contained detailed information related to data collection and rate calculation for each measure under the scope of the audit, as well as reporting requirements.

HSAG conducted the validation activities on the following BHOs:

- Access Behavioral Care—Denver (ABC-D)
- Behavioral Healthcare, Inc. (BHI)
- Colorado Health Partnerships, LLC (CHP)
- Foothills Behavioral Health Partners, LLC (FBHP)

The Department's contract with Access Behavioral Care—Northeast (ABC-NE) went into effect July 1, 2014. Because ABC-NE was not providing services during the period under review, it was not required to participate in the validation of performance measures activities.

HSAG performed the validation as outlined in the Center 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 several sources: the Information System Capabilities Assessment Tool (ISCAT) completed by the BHOs and the Department; site reviews; source code (programming language) review; and rate reviews.

The ISCAT contained detailed information of all systems being used by the BHOs and the Department for performance measure reporting activities. This information 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 and interviews with staff members to further clarify the processes and procedures required for accurate performance measure reporting. The source code review compared each measure's specification outlined in the scope document against the programming language used to calculate performance measure rates. Rate reviews included comparing the current year's rates against the prior year's rates and assessing the reasonability of the denominator and numerator of each measure.

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, as shown in Table 5-1, using findings from the validation of performance measure.

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 Medicaid Eligibility Category			✓
Overall Penetration Rates			✓
Behavioral Health Engagement	✓	✓	
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—Denver (ABC-D)

Findings—System and Reporting Capabilities

HSAG had no concerns with the way ABC-D received and processed eligibility data. Colorado Access, the BHO's administrative service organization (ASO), obtained enrollment information from the Department's portal on behalf of ABC-D. The BHO received a monthly full enrollment file and daily eligibility change files. Data were loaded into a data scrubber, where the system applied business rules, to ensure that only accurate enrollment information was being loaded into the BHO's transactional system. The eligibility information was reconciled with the monthly full file. In case of any discrepancy, a real-time eligibility check was available via the Department's portal.

HSAG identified no issues or concerns with the way ABC-D received, processed, and reported claims and encounter data. In November 2013, ABC-D changed its claims processing system from PowerSTEPP to QNXT operated by TriZetto. Adequate oversight was in place and was well-

documented for the system change. The community mental health centers (CMHCs) uploaded electronic files in an 837 file format to the Colorado Access web portal. The files were then copied to a file share between Colorado Access and TriZetto and went through a validation process prior to being loaded into QNXT. Daily error reports were generated for added quality assurance. In addition, monthly quality review meetings were in place to ensure claims data accuracy.

Paper claims were scanned using optical character recognition (OCR) and uploaded daily to TriZetto via secure file transfer protocol (FTP) site, where the image was converted to an 837 file format and loaded into QNXT. ABC-D had adequate oversight of its claims processing vendor. In addition to TriZetto's claims audit, ABC-D performed a review on the processed claims, including 100 percent audits on professional claims exceeding the threshold of $5,000 and on facility claims exceeding the threshold of $20,000.

Prior to submitting 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. Nonetheless, ABC-D reported discrepancies between the flat files submitted to the Department's rate team and the 837 encounter files in the State's Medicaid Management Information System (MMIS). ABC-D should investigate the reasons behind these discrepancies.

Findings—Performance Measure Results

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

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

Performance Measures	Rate		FY 2014–2015 Audit Designation
	FY 2013–2014	FY 2014–2015	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	90.7%	85.8%	*Report*
Improving Physical Healthcare Access	86.4%	88.6%	*Report*
Emergency Room Utilization (Rate/1,000 Members, All Ages)	12.58	14.55	*Report*
Overall Penetration Rate	11.8%	14.3%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	6.0%	6.7%	*Report*
Adolescents 13 Through 17 Years of Age	15.7%	16.3%	*Report*
Adults 18 Through 64 Years of Age	19.4%	21.6%	*Report*
Adults 65 Years of Age or Older	6.3%	8.5%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	10.5%	13.2%	*Report*
AFDC/CWP Children	6.2%	7.7%	*Report*
AND/AB-SSI	34.7%	39.3%	*Report*
BC Children	7.3%	2.5%	*Report*
BC Women	10.3%	14.1%	*Report*
BCCP—Women Breast and Cervical Cancer	15.7%	7.4%	*Report*
Buy-in: Working Adults with Disabilities	35.7%	33.0%	*Report*

Table 5-15—Review Results and Audit Designation *for* ABC–D			
Performance Measures	Rate		FY 2014–2015 Audit Designation
	FY 2013–2014	FY 2014–2015	
Foster Care	47.1%	40.4%	*Report*
OAP-A	6.2%	8.5%	*Report*
OAP-B-SSI	23.8%	27.8%	*Report*
Modified Adjusted Gross Income	29.1%	22.2%	*Report*
Buy-in: Children with Disabilities	15.4%	14.2%	*Report*
Behavioral Health Engagement			
Mental Health Engagement	—	34.6%	*Report*
Substance Use Disorder	—	29.5%	*Report*
Hospital Recidivism[1]			
Non-State Hospitals—7 Days	1.9%	2.9%	*Report*
30 Days	7.3%	11.9%	*Report*
90 Days	13.3%	18.4%	*Report*
All Hospitals—7 Days	2.8%	2.9%	*Report*
30 Days	9.4%	11.7%	*Report*
90 Days	15.9%	18.5%	*Report*
Hospital Average Length of Stay			
Non-State Hospitals	9.19	8.80	*Report*
All Hospitals	14.77	16.63	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	4.24	4.78	*Report*
All Hospitals	4.78	5.24	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	39.7%	46.2%	*Report*
30 Days	59.4%	70.4%	*Report*
All Hospitals—7 Days	39.9%	46.4%	*Report*
30 Days	59.0%	70.1%	*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

Staff members responsible for performance measure calculation and reporting have been consistent for many years and possess a high degree of technical expertise. In 2014, ABC-D experienced major system change along with an increase in membership. However, the BHO was able to maintain its performance level throughout the year. For the current measurement year, ABC-D received a *Report* status for all the audited performance measures and it experienced improved rates for 17 indicators. Notable improvements (rate increase of more than 5 percentage points or a 10 percent increase from the prior year) were observed for all four *Follow-Up After Hospitalization for Mental Illness* indicators (between 6.45 and 11.13 percentage points).

Recommendations

HSAG recommended that ABC-D continue to work closely with the Department to resolve the discrepancies identified between the flat files and the 837 files in the State's MMIS. Additionally, ABC-D experienced declined performance for 17 indicators. Performance for all six *Hospital Recidivism* indicators declined (this is an inverse measure and higher rates indicate poorer performance). Specifically, the *90-day Hospital Readmission* for the non-state hospitals indicator increased for more than 5 percentage points (hence a decline in performance). Rates for three indicators of the *Penetration Rate by Medicaid Eligibility Category* measure (*BCCP—Women Breast and Cervical Cancer*, *Foster Care* and *Modified Adjusted Gross Income*) declined more than 5 percentage points. As for utilization measures, *Emergency Room Utilization*, *Inpatient Utilization—Non-State Hospitals*, and *Hospital Average Length of Stay—All Hospitals* also reported an increase for more than 15 percent. ABC should investigate the reasons behind these declines in performances and increased utilization. Specifically, ABC should explore options for better inpatient discharge planning in an effort to improve the hospital recidivism indicators rates.

Summary Assessment Related to Quality, Timeliness, and Access

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

Quality: ABC-D's performance in the quality domain suggested areas for improvement. HSAG assigned the *Percent of Members with SMI with a Focal Point of Behavioral Health Care*, *Behavioral Health Engagement* and *Hospital Recidivism* measures to the quality domain. This was the first year that the *Behavioral Health Engagement* measure was validated, so comparison to the previous year's rates could not be performed. ABC-D's performance was lowest when compared to the other three BHOs. Additionally, ABC-D's performance on the *Percent of Members with SMI with a Focal Point* of *Behavioral Health Care* and *Hospital Recidivism—Non-State Hospitals (90 Days Readmission)* measure suggested a decline in performance.

Timeliness: ABC-D showed improvement in its performance in the timeliness domain. *Behavioral Health Engagement* and *Follow-Up After Hospitalization for Mental Illness* were the two timeliness measures reported and validated for this year. Although comparison with the previous year's rate was not performed for the *Behavioral Health Engagement* measure, ABC-D's *Follow-Up After Hospitalization for Mental Illness* measure increased by more than 5 percentage points for all four indicators.

Access: ABC-D's performance in the access domain demonstrated mixed results. Eleven indicators of the *Penetration Rate by Medicaid Eligibility Category* measure displayed a rate increase and six displayed a rate decline. Three of the rates (*BCCP-Women Breast and Cervical Cancer*, *Foster Care*, and *Modified Adjusted Gross Income*) declined more than 5 percentage points. All utilization-based access measures declined from the prior year; the biggest opportunity for improvement was in *Emergency Room Utilization* (a decline of 15.70 percent). Since high or low values of these utilization-based access measures do not reflect better or worse performance, it is important to assess utilization-based indicators with the clinical characteristics of ABC-D's population as well as with other performance metrics.

Behavioral Healthcare, Inc. (BHI)

Findings—System and Reporting Capabilities

HSAG had no concerns with the way BHI received and processed eligibility data. As in prior years, the BHO contracted with Colorado Access to perform eligibility data processing. Eligibility files were received in an 834 file format and reconciled monthly with the 820 capitation files to ensure data accuracy. Colorado Access, on behalf of BHI, downloaded daily change files and monthly full files from the Department's portal. Data were loaded into a data scrubber, where the system applied business rules to ensure only accurate enrollment information was loaded into the transactional system. The eligibility information was reconciled with the monthly full file. In case of any discrepancy, a real-time eligibility check was available via the Department's portal.

HSAG identified no issues or concerns regarding policies/procedures for receiving, processing, and reporting claims and encounter data. In November 2013, BHI changed its claims processing system from PowerSTEPP to QNXT, operated by TriZetto. Adequate oversight was in place and was well-documented for the system change. The CMHCs uploaded electronic files in an 837 file format to the Colorado Access web portal. The files were then copied to a file share between Colorado Access and TriZetto and were validated prior to being loaded into QNXT. Daily error reports were generated for added quality assurance. In addition, monthly quality review meetings were in place to ensure claims data accuracy.

Paper claims were scanned using OCR software, batched, converted into an 837 file format, and loaded into QXNT. Colorado Access maintained adequate oversight of its claims processing vendor. In addition to TriZetto's claims audit, Colorado Access performed a review on the processed claims, including 100 percent audits on professional claims exceeding the threshold of $5,000 and on facility claims exceeding the threshold of $20,000.

Prior to submitting 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. Nonetheless, BHI noted that there were discrepancies between the flat files sent to the Department's rates team and the 837 encounter files loaded to the State's MMIS.

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 2014–2015 Audit Designation
	FY 2013–2014	FY 2014–2015	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	90.5%	84.8%	*Report*
Improving Physical Healthcare Access	87.1%	87.3%	*Report*
Emergency Room Utilization (Rate/1,000 Members, All Ages)	9.94	12.46	*Report*
Overall Penetration Rate	11.4%	12.0%	*Report*

Table 5-16—Review Results and Audit Designation *for* BHI			
Performance Measures	Rate		FY 2014–2015 Audit Designation
	FY 2013–2014	FY 2014–2015	
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	6.5%	6.5%	*Report*
Adolescents 13 Through 17 Years of Age	16.3%	16.0%	*Report*
Adults 18 Through 64 Years of Age	18.1%	17.6%	*Report*
Adults 65 Years of Age or Older	5.5%	6.1%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	12.5%	12.6%	*Report*
AFDC/CWP Children	7.2%	7.7%	*Report*
AND/AB-SSI	32.5%	32.8%	*Report*
BC Children	6.8%	2.2%	*Report*
BC Women	7.9%	12.5%	*Report*
BCCP—Women Breast and Cervical Cancer	12.6%	10.5%	*Report*
Buy-in: Working Adults with Disabilities	35.1%	27.8%	*Report*
Foster Care	34.5%	34.5%	*Report*
OAP-A	5.4%	6.0%	*Report*
OAP-B-SSI	23.2%	23.8%	*Report*
Modified Adjusted Gross Income	35.6%	18.7%	*Report*
Buy-in: Children with Disabilities	17.6%	14.2%	*Report*
Behavioral Health Engagement			
Mental Health Engagement	—	36.0%	*Report*
Substance Use Disorder	—	42.7%	*Report*
Hospital Recidivism[1]			
Non-State Hospitals—7 Days	3.0%	3.2%	*Report*
30 Days	7.9%	7.7%	*Report*
90 Days	12.4%	13.0%	*Report*
All Hospitals—7 Days	2.8%	3.5%	*Report*
30 Days	7.8%	8.1%	*Report*
90 Days	12.6%	13.5%	*Report*
Hospital Average Length of Stay			
Non-State Hospitals	7.76	7.11	*Report*
All Hospitals	12.90	13.17	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	2.81	3.29	*Report*
All Hospitals	3.39	3.84	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	58.1%	52.4%	*Report*
30 Days	73.2%	70.6%	*Report*
All Hospitals—7 Days	61.2%	54.6%	*Report*
30 Days	75.2%	71.3%	*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

BHI continued to have a collaborative relationship with Colorado Access. As in prior years, the BHO had the same team (with a high degree of technical expertise), which was responsible for performance measure calculation and reporting. BHI received a *Report* status for all of its audited performance measures. Increases in rates were observed for 13 indicators; however, for the current measurement year none of the increase was more than 5 percentage points.

Recommendations

BHI should continue to work closely with the Department to resolve discrepancies with the flat files not matching the 837 files in the State's MMIS. For the current measurement year, HSAG observed rate decrease for 21 indicators, of which eight had notable decline. These included two *Penetration Rate* measures (*Buy-in: Working Adults with Disabilities* and *Modified Adjusted Gross Income*), *Percent of Members with SMI with a Focal Point of Behavioral Health Care*, *Emergency Room Utilization*, and two out of four *Follow-Up After Hospitalization for Mental Illness* indicators. Although both *Inpatient Utilization* indicators demonstrated a rate decline of 17 and 13 percent, respectively, the actual difference in discharges per 1,000 members was less than one. BHI should investigate the reason behind these rate declines.

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: HSAG assigned the *Percent of Members with SMI with a Focal Point of Behavioral Health Care*, *Behavioral Health Engagement*, and the *Hospital Recidivism* measures to the quality domain. Since this was the first year that the *Behavioral Health Engagement* measure was validated, comparison to the previous year's rate could not be performed. BHI's performance was the second lowest when compared to the other three BHOs. *The Percent of Members with SMI with a Focal Point of Behavioral Health Care* indicator showed a notable decline of 5.72 percentage points. In addition, five out of six *Hospital Recidivism* indicators showed a slight decline (less than 1 percentage point).

Timeliness: *Behavioral Health Engagement* and *Follow-Up After Hospitalization for Mental Illness* were the two timeliness measures reported and validated for the current measurement year. Since this was the first year that the *Behavioral Health Engagement* measure was validated, comparison to the previous year's rate could not be performed. BHI's rates for all *Follow-Up After Hospitalization for Mental Illness* indicators showed a decline from the previous year, with two rates (non-state 7 days and all hospitals 7 days) having a notable decline of more than 5 percentage points.

Access: BHI's performance in the access domain showed mixed results. Ten rates under the *Penetration Rate* measure demonstrated an increase while seven demonstrated a decline with two (*Buy-in: Working Adults with Disabilities* and *Modified Adjusted Gross Income*) having a notable decline of more than 5 percentage points. For utilization-based access measures, the *Hospital Average Length of Stay—Non-State Hospitals* indicator declined by 8 percent, and the *All Hospitals* indicator showed an increased length of stay by 2 percent. The most notable change was seen in the *Emergency Room Utilization* measure, where the rate declined by more than 25 percent from last year. Since high or low values of

these utilization-based access measures do not reflect better or worse performance, it is important to assess utilization-based indicators on the characteristics of BHI's population as well as with other performance metrics.

Colorado Health Partnerships, LLC (CHP)

Findings—System and Reporting Capabilities

HSAG had no concerns with the way CHP received and processed enrollment data. There were no major changes or updates since the previous measurement year. CHP had an eligibility team dedicated to obtaining and processing eligibility data. Enrollment information was obtained from the State via FTP site using 834 file formats. Monthly full file and daily change/update file were retrieved, and a validation was performed to ensure data accuracy prior to loading enrollment information into the eligibility system. Enrollment data were distributed to the appropriate CMHCs via secure e-mail. A real-time eligibility check was available via the Department's portal.

HSAG had no concerns with the way CHP received, processed, and reported claims and encounter data. There were no major system changes for the current reporting year. Claims were submitted in either paper or electronic format. The CMHCs submitted the encounter files on the 10th of each month, using the 837 file format via electronic data transfer. CHP used a data report card to track the status and the quality of the encounter data received from the CMHCs. This step ensured that only quality data were being submitted to the Department. Paper claims were scanned using OCR and the data were translated to an electronic format. CHP had an outstanding quality control in place. Nightly, 3 percent of the claims were held for prepayment audit. In addition, CHP performed 100 percent audits on claims exceeding the threshold of $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 2014–2015 Audit Designation
	FY 2013–2014	FY 2014–2015	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	90.1%	88.3%	*Report*
Improving Physical Healthcare Access	92.1%	91.3%	*Report*
Emergency Room Utilization (Rate/1,000 Members, All Ages)	8.38	8.83	*Report*
Overall Penetration Rate	13.4%	13.9%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.1%	6.7%	*Report*
Adolescents 13 Through 17 Years of Age	17.5%	16.6%	*Report*
Adults 18 Through 64 Years of Age	20.1%	20.1%	*Report*
Adults 65 Years of Age or Older	5.9%	6.1%	*Report*

Table 5-17—Review Results and Audit Designation *for* CHP			
Performance Measures	Rate		FY 2014–2015 Audit Designation
	FY 2013–2014	FY 2014–2015	
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	15.1%	14.9%	*Report*
AFDC/CWP Children	8.3%	8.2%	*Report*
AND/AB-SSI	29.4%	30.2%	*Report*
BC Children	7.2%	2.0%	*Report*
BC Women	14.4%	21.4%	*Report*
BCCP—Women Breast and Cervical Cancer	14.8%	17.7%	*Report*
Buy-in: Working Adults with Disabilities	26.0%	22.8%	*Report*
Foster Care	30.8%	30.2%	*Report*
OAP-A	5.8%	6.0%	*Report*
OAP-B-SSI	21.5%	19.1%	*Report*
Modified Adjusted Gross Income	34.5%	22.3%	*Report*
Buy-in: Children with Disabilities	13.0%	9.9%	*Report*
Behavioral Health Engagement			
Mental Health Engagement	—	37.4%	*Report*
Substance Use Disorder	—	61.8%	*Report*
Hospital Recidivism[1]			
Non-State Hospitals—7 Days	3.8%	3.2%	*Report*
30 Days	11.0%	10.0%	*Report*
90 Days	19.2%	16.6%	*Report*
All Hospitals—7 Days	3.3%	3.3%	*Report*
30 Days	10.0%	10.4%	*Report*
90 Days	17.7%	17.1%	*Report*
Hospital Average Length of Stay			
Non-State Hospitals	8.18	8.47	*Report*
All Hospitals	11.28	12.74	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.93	4.88	*Report*
All Hospitals	4.93	5.66	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	44.5%	50.6%	*Report*
30 Days	64.3%	68.7%	*Report*
All Hospitals—7 Days	44.8%	50.0%	*Report*
30 Days	65.8%	68.9%	*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

As in prior years, CHP has had the same team members responsible for data collection, performance measure calculation, and reporting. These staff members have many years of experience and a high degree of technical expertise. Monthly quality meetings were in place with representatives from the finance department, information technology team, clinical team, and representatives from CHP's health centers. These meetings gave all parties an opportunity to address any issues or concerns. CHP had excellent communication with the Department to resolve any outstanding issues, which resulted in fewer file rejections for the current measurement year.

Encounter data monitoring via report card format proved an excellent process to monitor each of the eight mental health centers. This report card provided an overview of each mental health center's overall performance (executive summary), timeliness of data submission, and error counts with error types. Each health center received this report monthly for review and to provide an opportunity to reconcile encounter data prior to final submission to the Department.

For the current measurement year, CHP received a *Report* status for all audited performance measures. HSAG observed rate increase for 14 indicators. Notable improvements (rate increase of more than 5 percentage points or a 10 percent change from prior year) were observed for two of the *Follow-Up After Hospitalization for Mental Illness* indicators (6.11 percentage points for *Non-State Hospital 7-day Follow-Up* and 5.20 percentage points for *All Hospitals 7-Day Follow-Up*), and one of the *Penetration Rate* indicators (6.96 percentage points for *BC Women*).

Recommendations

CHP noted that there were discrepancies between the flat files sent to the Department's rates team and the 837 encounter files loaded to the State's MMIS. CHP should continue to work closely with the Department to resolve these discrepancies. For the current measurement year, HSAG observed a rate decline for 20 indicators and a notable decline for five indicators. Although the *Inpatient Utilization* indicators and the *Hospital Average Length of Stay—All Hospitals* indicator showed a notable rate decline (more than 10 percent), the actual difference in discharges per 1,000 members/days was less than one. CHP should investigate the reason behind these declines in order to improve rates for the next measurement year.

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 *Percent of Members with SMI with a Focal Point* of *Behavioral Health Care*, *Behavioral Health Engagement*, and the *Hospital Recidivism* indicators were the quality measures reported for the current measurement year. Since this was the first year that the *Behavioral Health Engagement* measure was validated, comparison to the previous year's rates could not be performed. Nonetheless, CHP's performance was the second highest when compared to the other three BHOs. The *Percent of Members with SMI with a Focal Point of Behavioral Health Care* indicator showed a slight decline in rates when compared to the prior year. In regard to the *Hospital Recidivism*, four out of its six indicators demonstrated a rate increase and two showed a slight decline in rates.

Timeliness: *Behavioral Health Engagement* and *Follow-Up After Hospitalization for Mental Illness* were the two timeliness measures reported for the current measurement year. Rate comparison with the prior year's rate was not performed for the *Behavioral Health Engagement* measure. All four *Follow-Up After Hospitalization for Mental Illness* indicators demonstrated a rate increase for the current year, with the two *7-Day Follow-Up* indicators showing notable increases.

Access: CHP's performance in the access domain demonstrated mixed results. Out of the 24 indicators in this domain, 18 showed a rate decline and five demonstrated a rate increase for the current measurement year. Under the *Penetration Rates*, one indicator (*BC Women*) had a notable increase of 6.96 percentage points and two had a notable decline of more than 5 percentage points (*BC Children* and *Modified Adjusted Gross Income*). All three utilization-based access measures (*Hospital Average Length of Stay*, *Emergency Room Utilization*, and *Inpatient Utilization*) demonstrated rate increases. Since high or low values of these utilization-based access measures do not reflect better or worse performance, it is important to assess utilization-based indicators with the clinical characteristics of CHP's population as well as with other performance metrics.

Foothills Behavioral Health Partners, LLC (FBHP)

Findings—System and Reporting Capabilities

HSAG identified no concerns with FBHP's process for receiving and processing enrollment data. There were no major systems or process changes since the prior measurement year. FBHP's eligibility team obtained enrollment information from the State via FTP site using 834 file formats. Monthly full eligibility file and daily change/update file were retrieved, and validation was performed to ensure data accuracy prior to loading enrollment information into the eligibility system. Eligibility data were distributed to the appropriate CMHCs via secure e-mail. A real-time eligibility check was available via the Department's portal.

HSAG identified no issues or concerns with the way FBHP received, processed, and reported claims and encounter data. There were no major system changes for the current reporting year. Claims were submitted via either paper or electronic format. CMHCs submitted encounter files on the 10th of each month, using the 837 file format via electronic data transfer. The BHO used a data report card to track the status and quality of the encounter data received from the CMHCs. Paper claims were scanned using OCR, the data were translated to an electronic format, and quality checks were performed for added quality control prior to claims adjudication. Nightly, 3 percent of the claims were held for prepayment audit. In addition, FBHP performed 100 percent audits on claims exceeding the threshold of $1,500.

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 2014–2015 Audit Designation
	FY 2013–2014	FY 2014–2015	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	93.1%	93.3%	*Report*
Improving Physical Healthcare Access	87.2%	86.1%	*Report*
Emergency Room Utilization (Rate/1,000 Members, All Ages)	9.59	8.81	*Report*
Overall Penetration Rate	17.2%	16.8%	*Report*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	12.4%	11.5%	*Report*
Adolescents 13 Through 17 Years of Age	22.8%	20.8%	*Report*
Adults 18 Through 64 Years of Age	22.7%	21.3%	*Report*
Adults 65 Years of Age or Older	7.9%	7.2%	*Report*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	15.4%	14.9%	*Report*
AFDC/CWP Children	13.7%	12.8%	*Report*
AND/AB-SSI	35.0%	33.9%	*Report*
BC Children	10.5%	2.6%	*Report*
BC Women	11.0%	13.9%	*Report*
BCCP—Women Breast and Cervical Cancer	17.0%	7.3%	*Report*
Buy-in: Working Adults with Disabilities	62.6%	44.8%	*Report*
Foster Care	37.2%	33.9%	*Report*
OAP-A	7.8%	7.1%	*Report*
OAP-B-SSI	23.9%	25.0%	*Report*
Modified Adjusted Gross Income	43.6%	23.6%	*Report*
Buy-in: Children with Disabilities	3.0%	20.7%	*Report*
Behavioral Health Engagement			
Mental Health Engagement	—	41.6%	*Report*
Substance Use Disorder	—	68.6%	*Report*
Hospital Recidivism[1]			
Non-State Hospitals—7 Days	2.8%	2.8%	*Report*
30 Days	9.5%	6.7%	*Report*
90 Days	14.4%	13.3%	*Report*
All Hospitals—7 Days	2.8%	2.7%	*Report*
30 Days	9.1%	7.0%	*Report*
90 Days	14.2%	13.1%	*Report*
Hospital Average Length of Stay			
Non-State Hospitals	7.28	7.74	*Report*
All Hospitals	20.03	16.94	*Report*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	4.13	4.51	*Report*

Table 5-18—Review Results and Audit Designation *for* FBHP			
Performance Measures	Rate		FY 2014–2015 Audit Designation
	FY 2013–2014	FY 2014–2015	
All Hospitals	5.97	5.75	*Report*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	49.5%	50.8%	*Report*
30 Days	66.7%	68.3%	*Report*
All Hospitals—7 Days	49.2%	52.0%	*Report*
30 Days	67.8%	68.7%	*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

As in prior years, FBHP had the same staff members responsible for data collection, performance measure calculation, and reporting. The staff members all had a high degree of technical expertise. Monthly quality assurance committee meetings were in place with representatives from the finance department, information technology team, clinical team, and the FBHP's CMHCs. These meetings allowed all parties the opportunity to address any issues or concerns. FBHP demonstrated excellent communication with the Department in resolving any outstanding issues, which resulted in fewer file rejections.

CMHCs' encounter submissions were monitored via a report card. This report card provided an overview of the CMHCs' overall performance (executive summary), timeliness of data submission, and error counts with error types. The report card was provided to the CMHCs monthly for their review and afforded an opportunity to reconcile encounter data prior to final submission to the Department. In addition, FBHP demonstrated its robust quality check by adding an additional step to review the CMHCs' encounters prior to data submission to generate its report card.

FBHP received a *Report* status for all the audited performance measures. HSAG observed rate increases for 16 indicators. Notable improvements (a rate increase of more than 5 percentage points or a 10 percent change from the prior year) were observed for two indicators: *Penetration Rate by Medicaid Eligibility Category—Buy-in Children with Disabilities* and *Hospital Average Length of Stay—All Hospitals*.

Recommendations

FBHP noted that there were discrepancies between the flat files sent to the Department's rates team and the 837 encounter files loaded to the State's MMIS. FBHP should continue to work closely with the Department to resolve these discrepancies. For the current measurement year, HSAG observed a rate decline for 18 indicators. A notable decline was observed for four indicators under the *Penetration Rate by Medicaid Eligibility Category* measure (*BC Children, BCCP-Women Breast and Cervical Cancer, Buy-in: Working Adults with Disabilities*, and *Modified Adjusted Gross Income*). FBHP should investigate the reason behind these declines in order to improve rates for the following measurement year.

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*, *Behavioral Health Engagement,* and the *Hospital Recidivism* indicators were the quality measures reported for the current measurement year. Since this was the first year that the *Behavioral Health Engagement* measure was validated, comparison could not be performed. Nonetheless, FBHP's performance was the highest when compared to the other three BHOs. The *Percent of Members with SMI with a Focal Point of Behavioral Health Care* indicator showed a slight rate increase for the current year. In regard to the *Hospital Recidivism,* five rates increased but none by more than 5 percentage points. Only the *Non-State Hospitals 7-Day* indicator demonstrated a slight decline.

Timeliness: *Behavioral Health Engagement* and *Follow-Up After Hospitalization for Mental Illness* were the two timeliness measures reported for the current measurement year. Since this was the first year that the *Behavioral Health Engagement* measure was validated, a comparison could not be performed. All four *Follow-Up After Hospitalization for Mental Illness* rates increased from the previous year but none by more than 5 percentage points.

Access: For the current measurement year, FBHP's performance in the access domain demonstrated mixed results. Of the 24 indicators in this domain, 17 showed a decline in rates and seven demonstrated a rate increase. Under the *Penetration Rates*, one indicator (*Buy-in Children*) had a notable increase of 17.74 percentage points, while four had a notable decline of more than 5 percentage points. For the utilization-based access measures, *Hospital Average Length of Stay* and *Inpatient Utilization* showed a slight increase in utilization for the non-state hospitals but a decline for all hospitals. The *Emergency Room Utilization* also showed a rate decline. Among these measures, a notable increase was noted only for *Hospital Average Length of Stay—All Hospitals*. Since high or low values of these utilization-based access measures do not reflect better or worse performance, it is important to assess utilization-based indicators with the clinical characteristics of FBHP's population as well as with other performance metrics.

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

Table 5-19 provides a summary of the statewide weighted averages for the performance measure rates for FY 2014–2015 and the prior year.

Table 5-19—Statewide Weighted Average Rates for the Performance Measures

Performance Measures	Rate		FY 2014–2015 Rate Variations
	FY 2013–2014	FY 2014–2015	
Percent of Members with SMI with a Focal Point of Behavioral Health Care	90.8%	87.6%	*84.8%–93.3%*
Improving Physical Healthcare Access	89.3%	89.0%	*86.1%–91.3%*
Emergency Room Utilization (Rate/1,000 Members, All Ages)	9.97	10.92	*8.81–14.55*
Overall Penetration Rate	13.1%	13.9%	*12.0%–16.8%*
Penetration Rate by Age Category			
Children 12 Years of Age and Younger	7.4%	7.2%	*6.5%–11.5%*
Adolescents 13 Through 17 Years of Age	18.0%	16.9%	*16.0%–20.8%*
Adults 18 Through 64 Years of Age	20.0%	19.9%	*17.6%–21.6%*
Adults 65 Years of Age or Older	6.3%	6.8%	*6.1%–8.5%*
Penetration Rate by Medicaid Eligibility Category			
AFDC/CWP Adults	13.9%	14.0%	*12.6%–14.9%*
AFDC/CWP Children	8.4%	8.6%	*7.7%–12.8%*
AND/AB-SSI	32.1%	33.1%	*30.2%–39.3%*
BC Children	7.5%	2.2%	*2.0%–2.6%*
BC Women	11.5%	16.7%	*12.5%–21.4%*
BCCP—Women Breast and Cervical Cancer	14.0%	12.5%	*7.3%–17.6%*
Buy-in: Working Adults with Disabilities	36.6%	30.8%	*22.8%–44.8%*
Foster Care	35.2%	33.5%	*30.2%–40.4%*
OAP-A	6.2%	6.8%	*6.0%–8.4%*
OAP-B-SSI	22.6%	22.9%	*19.1%–27.8%*
Modified Adjusted Gross Income	35.2%	21.6%	*18.7%–23.5%*
Buy-in: Children with Disabilities	13.0%	14.1%	*9.9%–20.7%*
Behavioral Health Engagement			
Mental Health Engagement	—	37.1%	*34.5%–41.6%*
Substance Use Disorder	—	46.0%	*29.5%–68.6%*
Hospital Recidivism[1]			
Non-State Hospitals—7 Days	3.0%	3.1%	*2.8%–3.2%*
30 Days	8.7%	9.5%	*6.7%–11.9%*
90 Days	14.7%	15.7%	*13.0%–18.3%*
All Hospitals—7 Days	2.9%	3.2%	*2.7%–3.5%*
30 Days	8.8%	9.6%	*7.0%–11.7%*
90 Days	14.9%	16.0%	*13.1%–18.5%*

Table 5-19—Statewide Weighted Average Rates for the Performance Measures			
Performance Measures	Rate		FY 2014–2015 Rate Variations
	FY 2013–2014	FY 2014–2015	
Hospital Average Length of Stay			
Non-State Hospitals	7.93	8.15	*7.11–8.80*
All Hospitals	13.29	14.24	*12.74–16.94*
Inpatient Utilization (Rate/1000 Members, All Ages)			
Non-State Hospitals	3.69	4.36	*3.29–4.88*
All Hospitals	4.51	5.08	*3.84–5.75*
Follow-Up After Hospitalization for Mental Illness			
Non-State Hospitals—7 Days	47.3%	50.1%	*46.2%–52.4%*
30 Days	65.8%	69.3%	*68.3%–70.6%*
All Hospitals—7 Days	48.0%	50.5%	*46.4%–54.5%*
30 Days	66.8%	69.5%	*68.7%–71.3%*

[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

All four BHOs had the same cohesive team responsible for data collection, performance measure calculation, and reporting. Staff members at each BHO have many years of experience and a high degree of technical expertise. Each BHO received a *Report* status for all of their validated performance measures. HSAG observed rate increases for 13 of the 36 indicators; however, notable improvement was observed for only one indicator (*BC Women*) in the *Penetration Rate by Medicaid Eligibility* measure, with an increase of 5.3 percentage points.

Statewide Recommendations

All four BHOs noted discrepancies between the flat files submitted to the Department and the 837 files submitted to the State's MMIS. As such, HSAG recommended that all four BHOs continue to work closely with the Department to resolve these discrepancies.

For the current measurement year, HSAG observed rate decreases for 21 indicators, with seven reflecting notable declines from the previous year. Three notable declines were in the *Penetration Rate by Medicaid Eligibility* measure (*BC Children, Buy-in: Working Adults with Disabilities,* and *Modified Adjusted Gross Income*). Since all four BHOs demonstrated a decline in rates for these three indicators, the Department should continue its effort to identify the reason behind these declines and initiate performance improvement projects to improve the BHOs' rates for the upcoming measurement year. Although four utilization-based indicators (*Hospital Average Length of Stay—All Hospital, Emergency Room Utilization,* and the two *Inpatient Utilization* indicators) demonstrated a rate decline, the actual difference in rates was minimal.

Summary Assessment Related to Quality, Timeliness, and Access

Quality: The *Percent of Members with SMI with a Focal Point of Behavioral Health Care*, *Hospital Recidivism,* and *Behavioral Health Engagement* were the quality measures reported for the current measurement year. This was the first year that the *Behavioral Health Engagement* measure was validated; therefore, comparison to the prior year's performance could not be performed. Statewide performance on the *Percent of Members with SMI with a Focal Point of Behavioral Health Care* measure demonstrated a rate decline of 3.2 percentage points from the previous year. In addition, for *Hospital Recidivism*, three of four BHOs demonstrated a rate decrease for at least one indicator and statewide rates declined for all six indicators. This suggested room for improvement.

Timeliness: *Behavioral Health Engagement* and *Follow-Up After Hospitalization for Mental Illness* were the two timeliness measures reported for the current measurement year. A rate comparison with the previous year's rate was not performed for the *Behavioral Health Engagement* measure. Contrary to the prior year's result, the statewide performance on the *Follow-Up After Hospitalization* measure demonstrated a rate increase for all four indicators ranging between 2.5 and 3.5 percentage points. All but one BHO showed a rate increase for all indicators in this measure.

Access: Overall, statewide performance in the access domain showed mixed results. Of the 24 indicators in this domain, 15 demonstrated a rate decline while nine showed a rate increase. All nine improvements were observed under *Penetration Rates,* with the *BC Women* indicator reporting a notable improvement. Three indicators (*BC Children, Buy-in: Working Adults with Disabilities,* and *Modified Adjusted Gross Income*) showed a notable decline.

Statewide performance of the utilization-based measures displayed rate declines for all indicators. The declines ranged between 2.7 percent and 18.2 percent. Although four utilization indicators showed notable declines, the actual differences in rates were minimal. Utilization-based indicators should be evaluated based on the characteristics of the BHOs' population. Although conclusions cannot be drawn based on utilization results alone, when combined with other performance metrics, the results can provide additional information that can be used by the BHOs to further explore the possibilities for rate improvements.

Validation of Performance Improvement Projects

For FY 2014–2015, HSAG validated one PIP for each of the five BHOs. Table 5-20 lists the PIP topics identified by each BHO.

Table 5-20—FY14–15 PIP Topics Selected by BHOs	
BHO	**PIP Topic**
Access Behavioral Care–Denver	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*
Access Behavioral Care–Northeast	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*
Behavioral Healthcare, Inc.	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*
Colorado Health Partnerships, LLC	*Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release*
Foothills Behavioral Health Partners, LLC	*Improving Transition from Jail to Community Based Behavioral Health Treatment*

Appendix C, 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–Denver (ABC-D)

Findings

The ABC–D *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP focused on improving the percentage of adolescent members who complete a follow-up visit with a behavioral health provider within 30 days of screening positive for depression with a medical provider. This was the first validation year for the PIP. ABC–D reported the study design for the PIP and completed Activities I through IV and Activity VI.

Table 5-21 provides a summary of ABC–D's combined PIP validation results for the FY 2014–2015 validation cycle.

Table 5-21—FY14–15 Performance Improvement Project Validation Results *for* ABC–D					
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% (3/3)	0% (0/3)	0% (0/3)
		Design Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Table 5-21—FY14–15 Performance Improvement Project Validation Results *for* ABC–D					
Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Implementation	VII.	Data Analysis and Interpretation	Not Assessed		
	VIII.	Interventions and Improvement Strategies	Not Assessed		
		Implementation Total	Not Assessed		
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
		Outcomes Total	Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

ABC–D demonstrated strength throughout the study design of its PIP by receiving *Met* scores for all applicable evaluation elements in Activities I–VI. The health plan documented a methodologically sound study design. The ABC–D PIP received a *Met* score for 100 percent of nine applicable evaluation elements.

Strengths

ABC–D documented a solid study design, supported by key research principles, for the *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission received a *Met* score for 100 percent of applicable evaluation elements in Activities I–VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for the ABC–D *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP, in which the PIP received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG did not identify any opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a 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. ABC–D earned a *Met* validation status, demonstrating a strong application of PIP study design principles and facilitating progression to the subsequent stages of PIP implementation and outcomes.

Access Behavioral Care–Northeast (ABC-NE)

Findings

The ABC–NE *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP focused on improving the percentage of adolescent members who completed a follow-up visit with a behavioral health provider within 30 days of screening positive for depression with a medical provider. This was the first validation year for the PIP. ABC–NE reported the study design for the PIP and completed Activities I through VI.

Table 5-22 provides a summary of ABC–NE's combined PIP validation results for the FY 2014–2015 validation cycle.

Table 5-22—FY14–15 Performance Improvement Project Validation Results *for* ABC–NE

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% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Data Analysis and Interpretation	Not Assessed		
	VIII.	Interventions and Improvement Strategies	Not Assessed		
Implementation Total			Not Assessed		
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

ABC–NE demonstrated strength throughout the study design of its PIP by receiving *Met* scores for all applicable evaluation elements in Activities I–VI. The health plan documented a methodologically sound study design. The PIP received a *Met* score for 100 percent of nine applicable evaluation elements.

Strengths

ABC–NE's documented solid study design for the *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP was supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission of the PIP received a *Met* score

for 100 percent of applicable evaluation elements in Activities I–VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for ABC–NE's PIP, for which it received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG did not identify any opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a 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. ABC–NE earned a *Met* validation status, demonstrating a strong application of PIP study design principles and facilitating progression to the subsequent stages of PIP implementation and outcomes.

Behavioral Healthcare, Inc. (BHI)

Findings

The BHI *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP focused on improving the percentage of adolescent members who completed a follow-up visit with a behavioral health provider within 30 days of screening positive for depression with a medical provider. This was the first validation year for the PIP. BHI reported the study design and completed Activities I through VI.

Table 5-23 shows BHI scores based on HSAG's evaluation. HSAG reviewed and evaluated each activity according to its validation methodology.

Table 5-23—FY14–15 Performance Improvement Project Validation Results *for* BHI

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% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Data Analysis and Interpretation	Not Assessed		
	VIII.	Interventions and Improvement Strategies	Not Assessed		
Implementation Total			Not Assessed		

Table 5-23—FY14–15 Performance Improvement Project Validation Results *for* BHI					
Study Stage	Activity		Percent of Applicable Elements		
			Met	Partially Met	Not Met
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

BHI demonstrated strength throughout the study design by receiving *Met* scores for all applicable evaluation elements in Activities I–VI. The health plan documented a methodologically sound study design. The BHI PIP received a *Met* score for 100 percent of nine applicable evaluation elements.

Strengths

BHI documented a solid study design, supported by key research principles, for the *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP. The technical design was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission received a *Met* score for 100 percent of applicable evaluation elements in Activities I–VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for BHI's PIP, for which it received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG did not identify any opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a 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. BHI earned a *Met* validation status, demonstrating a strong application of PIP study design principles and facilitating progression to the subsequent stages of PIP implementation and outcomes.

Colorado Health Partnerships, LLC (CHP)

Findings

The CHP *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release* PIP focused on improving the percentage of members released from jail with an identified behavioral health issue and who attended a behavioral health appointment within 30 days of release. This was the first validation year for the PIP. CHP reported the study design and completed Activities I through VI.

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

Table 5-24—FY14–15 Performance Improvement Project Validation Results *for* CHP

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% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Data Analysis and Interpretation	Not Assessed		
	VIII.	Interventions and Improvement Strategies	Not Assessed		
Implementation Total			Not Assessed		
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

CHP demonstrated strength throughout the study design by receiving *Met* scores for all applicable evaluation elements in Activities I–VI. The health plan documented a methodologically sound study design. The CHP PIP received a *Met* score for 100 percent of nine applicable evaluation elements.

Strengths

CHP documented a solid study design, supported by key research principles, for the *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release* PIP. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission received a *Met* score for 100 percent of applicable evaluation elements in Activities I–VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for CHP's PIP, for which it received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG did not identify any opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a 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. CHP earned a *Met* validation status, demonstrating a strong application of PIP study design principles and facilitating progression to the subsequent stages of PIP implementation and outcomes.

Foothills Behavioral Health Partners, LLC (FBHP)

Findings

The FBHP *Improving Transition from Jail to Community Based Behavioral Health Treatment* PIP focused on improving the percentage of members released from jail with an identified behavioral health issue and who attended a behavioral health appointment within seven days of release. This was the first validation year for the PIP. FBHP reported the study design and completed Activities I through VI.

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

Table 5-25—FY14–15 Performance Improvement Project Validation Results *for* FBHP

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% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Data Analysis and Interpretation	Not Assessed		
	VIII.	Interventions and Improvement Strategies	Not Assessed		
Implementation Total			Not Assessed		
Outcomes	IX.	Real Improvement	Not Assessed		
	X.	Sustained Improvement	Not Assessed		
Outcomes Total			Not Assessed		
Percent Score of Applicable Evaluation Elements Met			**100% (9/9)**		

FBHP demonstrated strength throughout the study design of its PIP by receiving *Met* scores for all applicable evaluation elements in Activities I–VI. The health plan documented a methodologically sound study design. The FBHP PIP received a *Met* score for 100 percent of nine applicable evaluation elements.

Strengths

FBHP documented a solid study design, supported by key research principles, for its PIP. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study design submission received a *Met* score for 100 percent of applicable evaluation elements in Activities I–VI and an overall *Met* validation status.

Recommendations

Based on the FY 2014–2015 validation results for FBHP's PIP, for which it received a *Met* score for 100 percent of applicable evaluation elements for the study design submission, HSAG did not identify any opportunities for improvement.

Summary Assessment Related to Quality, Timeliness, and Access

While the focus of a 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. FBHP earned a *Met* validation status, demonstrating a strong application of PIP study design principles and facilitating progression to the subsequent stages of PIP implementation and outcomes.

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

Table 5-26 shows the health plans' overall performance based on HSAG's validation of the FY 2014–2015 PIPs that were submitted for validation.

Table 5-26—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-D	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	100%	100%	*Met*
ABC-NE	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	100%	100%	*Met*
BHI	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	100%	100%	*Met*
CHP	*Improving Transition from Jail to Community Based Behavioral Health Treatment*	100%	100%	*Met*
FBHP	*Improving Transition from Jail to Community Based Behavioral Health Treatment*	100%	100%	*Met*

The validation scores and validation status of the PIPs demonstrated solid PIP study designs that will support the progression to the subsequent stages of PIP implementation and outcomes. All five of the BHO PIPs reviewed received a *Met* validation status. Additionally, all of the PIPs received a *Met* score for 100 percent of all applicable evaluation elements.

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. All five PIPs validated by HSAG earned a *Met* validation status, demonstrating application of methodologically sound design principles necessary to produce valid and reliable PIP results.

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 2013–2014. 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–Denver (ABC–D)

Compliance Monitoring Site Reviews

As a result of the FY 2013–2014 site review, ABC-D was required to revise its applicable policies and templates to accurately describe a member's right to file a grievance (versus an appeal) if he or she disagrees with the decision to extend the time frame for making the authorization determination. ABC-D also needed to require that for Medicaid members, its providers maintain hours of operation that are no less than the hours of operation for commercial members.

HSAG and the Department reviewed ABC-D's corrective action plan and determined that, if implemented as written, ABC-D would achieve compliance with all required actions. In June 2014, ABC-D submitted its revised Utilization Review Determination Procedure and its notice of extension template letter as well as proposed revisions to its provider manual that specified a provider's hours of operation for Medicaid members must not be less than those offered to commercial members. After HSAG and the Department approved the revised language, ABC-D sent evidence that it had distributed the revised procedure to its utilization management staff along with copies of provider bulletins that notified providers of changes in the provider manual regarding the required hours of operation. HSAG and the Department reviewed all submitted information and determined that ABC-D successfully completed the required actions.

Performance Measures

During the FY 2013–2014 audit, rates decreased for all four *Follow-Up After Hospitalization for Mental Illness* indicators. For the FY 2014–2015 audit, ABC-D demonstrated an increase of more than 5 percentage points for all four indicators. These increases suggested that the BHO might have taken steps to improve these rates.

Performance Improvement Projects

Because this was ABC-D's first submission of its *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP, there were no prior requirements or recommendations.

Access Behavioral Care–Northeast (ABC–NE)

This was the first year for ABC-NE, so it did not have any prior recommendations. This section of the report is not applicable for ABC-NE.

Behavioral Healthcare, Inc. (BHI)

Compliance Monitoring Site Reviews

As a result of the FY 2013–2014 site review, BHI was required to address one *Not Met* and five *Partially Met* findings for Standard I—Coverage and Authorization of Services. These required actions were related to the content of notices of action and policies as well as the time frames associated with notices of action.

BHI submitted its corrective action plan to HSAG and the Department in May 2014 and began submitting documents to demonstrate implementation of the planned interventions in June. HSAG and the Department requested minor revisions to BHI's documents before determining in October 2014 that BHI had completed all required actions.

Performance Measures

During the FY 2013–2014 audit, HSAG noted opportunities for improvement on the *Hospital Average Length of Stay—Non-State Hospitals* indicators since its rate increase of 8.9 percent suggested a decline in performance. The FY 2014–2015 rates declined by 8.4 percent (hence improved performance). This result suggested that BHI might have taken steps to enhance performance.

Performance Improvement Projects

Because this was BHI's first submission of its *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP, there were no prior requirements or recommendations.

Colorado Health Partnerships, LLC (CHP)

Compliance Monitoring Site Reviews

For the two standards reviewed by HSAG (Access and Availability and Coordination of Care), CHP earned an overall compliance score of 100 percent. CHP had no required actions as a result of the FY 2013–2014 site review.

Performance Measures

CHP's FY 2013–2014 performance suggested opportunities for improvement on the *Hospital Average Length of Stay* and the *Inpatient Utilization* measures. CHP's FY 2014–2015 rates still showed a decline in performance. Nonetheless, the magnitude of these declines was very minor. HSAG could not ascertain whether CHP followed up with the prior year's recommendation.

Performance Improvement Projects

Because this was CHP's first submission of its *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release* PIP, there were no prior requirements or recommendations.

Foothills Behavioral Health Partners, LLC (FBHP)

Compliance Monitoring Site Reviews

For the two standards reviewed by HSAG (Access and Availability and Coordination of Care), FBHP earned an overall compliance score of 100 percent. FBHP had no required actions as a result of the FY 2013–2014 site review.

Performance Measures

During the FY 2013–2014 audit, HSAG noted opportunities for improvement on the *Inpatient Utilization* and the *Follow-Up After Hospitalization for Mental Illness* measures. The FY 2014–2015 rates showed a slight improvement on the *Follow-Up After Hospitalization for Mental Illness* measure, although the increase was less than 5 percentage points. This finding suggested that FBHP might have taken actions to improve its rates for this measure.

Performance Improvement Projects

Because this was FBHP's first submission of its *Improving Transition from Jail to Community Based Behavioral Health Treatment* PIP, there were no prior requirements or 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 2014–2015 site review process, the Department requested a review of four areas of performance. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. HSAG developed a strategy and monitoring tools to review compliance with federal managed care regulations and managed care contract requirements related to each standard.

In developing the data collection tools and in reviewing documentation related to the standards, HSAG used the behavioral health organizations' (BHOs') and physical health managed care plans' 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 VI—Grievance System, HSAG conducted an on-site review of 10 appeals records and 10 grievance records, to the extent possible, to evaluate implementation of federal healthcare regulations and managed care contract requirements as specified in 42CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. HSAG incorporated the results into the findings for the standard. HSAG also separately calculated a grievance record review score, an appeals record review score, and an overall record review score.

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 2014–2015.

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 plans' 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/BHO also submitted a list of all Medicaid grievances and appeals that occurred between January 1, 2014, and December 31, 2014. 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 2014–2015 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.

A sample of the health plan's/BHO's administrative records related to Medicaid grievances and appeals was also reviewed to evaluate implementation of federal healthcare regulations and Medicaid managed care contract requirements, as specified in 42CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all Medicaid grievances and appeals that occurred between January 1, 2014, and December 31, 2014, to the extent available at the time of the site review request.

HSAG reviewed a sample of 10 grievance records and 10 appeals records, to the extent possible. For the record review, the health plan received a score of *Met*, *Not Met*, or *Not Applicable* for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievance record review score, an appeals record review score, and 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 processes/activities constitute the standard practice for HEDIS audits regardless of the auditing firm. These processes/activities follow NCQA's HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5.

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.
- Detailed review of the health plan's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.

- On-site meetings at the health plan's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.
  - 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 health plan's MRR contractor's determinations for the same records.
- Requests for corrective actions and modifications to the health plan'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 2015 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) completed by the health plan and/or its contractor.

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. All licensed organizations followed NCQA's methodology to conduct their HEDIS compliance audits.

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 a review of the ISCAT and supporting documentation, 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.
  - A review of processes used to collect, store, validate, and report the performance measure data. This session, 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 2014–2015 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.

Description of Data Obtained—Behavioral Health

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data for FY 2014-2015 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—Denver (ABC-D)	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*
Access Behavioral Care—Northeast (ABC-NE)	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*
Behavioral Healthcare, Inc. (BHI)	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*
Colorado Health Partnerships, LLC (CHP)	*Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release*
Foothills Behavioral Health Partners, LLC (FBHP)	*Improving Transition from Jail to Community Based Behavioral Health Treatment*

Table C-2—Summary of Each MCO's PIP	
Health Plan	**PIP Study**
Denver Health Medicaid Choice (DHMC)	*Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*
Rocky Mountain Health Plans (RMHP)	*Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility*

Technical Methods of Data Collection

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-1] Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, 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. Use a Representative and Generalizable Study Population
- Activity IV. Select the Study Indicator(s)
- Activity V. Use Sound Sampling Techniques
- Activity VI. Reliably Collect Data
- Activity VII.* Implement Intervention and Improvement Strategies
- Activity VIII.* Analyze Data and Interpret Study Results
- Activity IX. Assess for Real Improvement
- Activity X. Assess for Sustained Improvement

* To ensure that health plans analyzed and interpreted data prior to identifying and implementing interventions, HSAG reversed the order of Activities VII and VIII in the PIP Summary Form for new PIPs that were implemented during FY 2012. Thus, for all PIPs developed during and after FY 2012, health plans are required to provide an analysis and interpretation of data in Activity VII followed by a description of planned interventions and improvement strategies in Activity VIII.

[D-1] 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.

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. 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 2014–2015

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.

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 PIP reviewers validated each PIP upon original submission; resubmitted PIPs were validated a second time. 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

The technical method of data collection was through the CAHPS 5.0 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set for the adult population, and through the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item and the Children with Chronic Condition (CCC) measurement set for the child population. The surveys include a set of standardized items (58 items for the CAHPS 5.0 Adult Medicaid Health Plan Survey and 83 items for the CAHPS 5.0 Child Medicaid Health Plan Survey with CCC measurement set) that assess patient perspectives on care. To support the reliability and validity of the findings, standardized sampling and data collection procedures were followed 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 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-1] 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

[D-1] For purposes of this report, the CAHPS 5.0H Child Medicaid Health Plan Survey results presented for DHMC and RMHP are based on the results of the general child population only (i.e., CAHPS survey results do not include the sample of children selected as part of the CCC oversample). Thus, results for the five CCC composite measures and individual items are not reported.

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 two categories: (1) "Never," "Sometimes," "Usually," and "Always;" or (2) "No" and "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

It is important to note that with the release of the 2015 CAHPS 5.0 Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure; therefore, comparisons to NCQA national average data could not be performed for this measure for 2015.

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 2015 global ratings and 2015 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 5.0 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 2014 NCQA national averages are highlighted in yellow.

Table D-1—Question Summary Rates for Global Ratings

Measure of Member Satisfaction	Adult Medicaid 2015	
	DHMC	RMHP
Rating of Personal Doctor	73.0%	60.1%
Rating of Specialist Seen Most Often	58.9%	59.5%
Rating of All Health Care	47.0%	45.7%
Rating of Health Plan	58.1%	56.0%

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

Indicates a rate is at or above the 2014 NCQA CAHPS national average.

Table D-2—Question Summary Rates for Composite Scores

Measure of Member Satisfaction	Adult Medicaid 2015	
	DHMC	RMHP
Getting Needed Care	76.3%	80.2%
Getting Care Quickly	73.9%	80.5%
How Well Doctors Communicate	91.0%	93.5%
Customer Service	82.6%+	84.7%+
Shared Decision Making	80.0%+	80.4%

A global proportion is the percentage of respondents offering a positive response ("Usually/Always" or "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 2015.

Indicates a rate is at or above the 2014 NCQA CAHPS national average.

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 2015 global ratings and 2015 composite scores, respectively, for the general child population.[D-2] DHMC and RMHP provided HSAG with the data presented in the following tables. Morpace and CSS administered the CAHPS 5.0 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 2014 NCQA national averages are highlighted in yellow.

Table D-3—Question Summary Rates for Global Ratings

Measure of Member Satisfaction	Child Medicaid 2015	
	DHMC	RMHP
Rating of Personal Doctor	82.8%	75.6%
Rating of Specialist Seen Most Often	78.9%+	69.7%+
Rating of All Health Care	69.1%	64.8%
Rating of Health Plan	72.1%	65.6%

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 2014 NCQA CAHPS national average.

Table D-4—Global Proportions for Composite Scores

Measure of Member Satisfaction	Child Medicaid 2015	
	DHMC	RMHP
Getting Needed Care	76.7%	85.7%
Getting Care Quickly	78.8%	93.3%
How Well Doctors Communicate	92.2%	96.2%
Customer Service	83.7%	84.8%
Shared Decision Making	80.0%+	83.5%

A global proportion is the percentage of respondents offering a positive response ("Usually/Always" or "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 2015.

Indicates a rate is at or above the 2014 NCQA CAHPS national average.

[D-2] As previously noted, the Child Medicaid CAHPS survey results presented in Table D-3 and D-4 for DHMC and RMHP are based on the results of the general child population.

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 2014–2015.

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 (2015)	93%	80%	87%
Standard VI—Grievance System (2015)	65%	88%	77%
Standard VII—Provider Participation and Program Integrity (2015)	100%	93%	97%
Standard VIII—Credentialing and Recredentialing (2013)	94%	100%	97%
Standard IX—Subcontracts and Delegation (2015)	100%	100%	100%
Standard X—Quality Assessment and Performance Improvement (2013)	85%	77%	81%

Standards in black were reviewed in FY 2014–2015.
Standards presented in green text were reviewed in FY 2013–2014.
Standards presented in blue text were reviewed in FY 2012–2013.

Table E-2—Record Review Scores for the Physical Health Plans

Description of Record Reviews	DHMC	RMHP	Statewide Average
Appeals (2015)	73%	98%	90%
Credentialing (2013)	100%	100%	100%
Denials (2014)	98%	86%	92%
Grievances (2015)	78%	98%	89%
Recredentialing (2013)	100%	100%	100%

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-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Standard I—Coverage and Authorization of Services (2014)	97%	—	81%	100%	100%	95%
Standard II—Access and Availability (2014)	93%	—	100%	100%	100%	99%
Standard III—Coordination and Continuity of Care (2013)	100%	—	100%	100%	100%	100%
Standard IV—Member Rights and Protections (2013)	100%	—	100%	100%	100%	100%
Standard V—Member Information (2015)	90%	90%	95%	100%	100%	95%
Standard VI—Grievance System (2015)	88%	88%	73%	77%	77%	81%
Standard VII—Provider Participation and Program Integrity (2015)	100%	100%	86%	100%	100%	100%
Standard VIII—Credentialing and Recredentialing (2013)	98%	—	96%	98%	100%	98%
Standard IX—Subcontracts and Delegation (2015)	100%	100%	100%	100%	100%	100%
Standard X—Quality Assessment and Performance Improvement (2013)	100%	—	94%	100%	100%	99%

Standards in black were reviewed in FY 2014–2015.
Standards presented in green text were reviewed in FY 2013–2014.
Standards presented in blue text were reviewed in FY 2012–2013.

Table E-4—Record Review Scores for the BHOs

Description of Component	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Appeals (2015)	93%	100%	74%	84%	92%	94%
Credentialing (2013)	100%	—	100%	100%	100%	100%
Denials (2014)	100%	—	92%	100%	100%	98%
Grievances (2015)	93%	94%	100%	87%	100%	88%
Recredentialing (2013)	100%	—	100%	98%	98%	99%

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	76.81%	36.01%	64.06%
Childhood Immunization Status—Combination 3	75.85%	33.61%	62.65%
Childhood Immunization Status—Combination 4	75.02%	31.08%	61.29%
Childhood Immunization Status—Combination 5	64.98%	27.99%	53.43%
Childhood Immunization Status—Combination 6	57.96%	25.32%	47.76%
Childhood Immunization Status—Combination 7	64.41%	26.02%	52.42%
Childhood Immunization Status—Combination 8	57.64%	23.91%	47.10%
Childhood Immunization Status—Combination 9	51.31%	21.38%	41.96%
Childhood Immunization Status—Combination 10	51.05%	20.25%	41.43%
Immunizations for Adolescents—Combination 1	80.27%	56.53%	74.24%
Well-Child Visits in the First 15 Months of Life—Zero Visits	5.19%	1.44%	3.96%
Well-Child Visits in the First 15 Months of Life—6+ Visits	2.36%	25.72%	10.05%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.06%	64.36%	61.36%
Adolescent Well-Care Visits	39.79%	41.71%	40.26%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment: Total	93.19%	81.42%	89.48%
Counseling for Nutrition: Total	77.86%	64.16%	73.54%
Counseling for Physical Activity: Total	62.04%	62.47%	62.18%
Appropriate Testing for Children with Pharyngitis	72.78%	90.06%	84.63%
Appropriate Treatment for Children with Upper Respiratory Infection	98.03%	93.63%	95.64%

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	84.67%	91.31%	87.35%
Postpartum Care	60.58%	67.71%	63.46%
Children's and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	91.12%	91.77%	91.30%
Ages 25 Months to 6 Years	73.42%	72.77%	73.21%
Ages 7 to 11 Years	79.27%	85.74%	81.21%
Ages 12 to 19 Years	80.17%	83.53%	81.21%
Adults' Access to Preventive/Ambulatory Health Services—Total	69.07%	61.83%	65.72%
Preventive Screening			
Chlamydia Screening in Women—Total	68.60%	40.12%	57.49%
Breast Cancer Screening	53.09%	49.65%	51.90%
Cervical Cancer Screening	63.02%	48.47%	56.13%
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.21%	2.28%	0.99%
Adult BMI Assessment	88.08%	87.80%	87.97%

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	43.65%	57.69%	49.41%
Effective Continuation Phase Treatment	29.62%	40.06%	33.90%
Follow-up Care for Children Prescribed ADHD Medication			
Initiation	29.20%	34.62%	32.54%
Continuation	NA	32.31%	30.49%

Table E-7—Mental/Behavioral Health Performance Measures for Physical Health Plans and Statewide Average			
Performance Measures	**DHMC**	**RMHP**	**Statewide Average**
Follow-Up After Hospitalization for Mental Illness			
30-Day	NB	NB	—
7-Day	NB	NB	—
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	59.73%	NB*	59.73%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	87.66%	NB*	87.66%
Diabetes Monitoring for People With Diabetes and Schizophrenia	60.61%	NR	60.61%
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	70.32%	68.44%	69.66%
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	77.42%
Comprehensive Diabetes Care			
HbA1c Testing	85.64%	89.37%	86.76%
HbA1c Poor Control (>9.0%)	38.44%	26.41%	34.86%
HbA1c Control (<8.0%)	50.85%	65.61%	55.25%
Eye Exam	47.93%	63.62%	52.61%
Medical Attention for Nephropathy	79.32%	82.61%	80.45%
Blood Pressure Controlled <140/90 mm Hg	69.10%	76.74%	71.38%
Annual Monitoring for Patients on Persistent Medications—Total	85.56%	86.17%	85.72%
Use of Imaging Studies for Low Back Pain	80.33%	82.65%	81.28%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	53.41%	32.28%	38.99%

Table E-8—Living With Illness Performance Measures for Physical Health Plans and Statewide Average			
Performance Measures	**DHMC**	**RMHP**	**Statewide Average**
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	52.38%	36.47%	47.45%
Bronchodilator	65.08%	47.06%	59.49%
Use of Appropriate Medications for People With Asthma—Total	79.12%	84.48%	80.94%
Medication Management for People with Asthma			
Medication Compliance 50%—Total	37.81%	50.20%	42.20%
Medication Compliance 75%—Total	14.32%	31.61%	20.09%
Asthma Medication Ratio—Total	29.98%	58.89%	39.93%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	31.16%	21.88%	28.30%
Disease Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	64.63%	61.76%	63.33%

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			
Performance Measures	**DHMC**	**RMHP**	**Statewide Average**
Ambulatory Care (per 1,000 member months)			
Outpatient Visits	NR	224.34	224.34
Emergency Department Visits	NR	37.35	37.35
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 MM (total inpatient)	NR	5.07	5.07
Days per 1,000 MM (total inpatient)	NR	19.24	19.24
Average Length of Stay (total inpatient)	NR	3.79	3.79
Discharges per 1,000 MM (medicine)	NR	2.37	2.37
Days per 1,000 MM (medicine)	NR	10.13	10.13
Average Length of Stay (medicine)	NR	4.28	4.28
Discharges per 1,000 MM (surgery)	NR	0.91	0.91
Days per 1,000 MM (surgery)	NR	5.42	5.42
Average Length of Stay (surgery)	NR	5.96	5.96
Discharges per 1,000 MM (maternity)	NR	2.56	2.56
Days per 1,000 MM (maternity)	NR	5.25	5.25

Table E-9—Use of Services Performance Measures for Physical Health Plans and Statewide Average			
Performance Measures	**DHMC**	**RMHP**	**Statewide Average**
Average Length of Stay (maternity)	NR	2.05	2.05
Identification of Alcohol and Other Drug Services—Total			
Any Service	4.06%	2.56%	3.45%
Inpatient	1.09%	0.62%	0.90%
Intensive Outpatient/Partial Hospitalization	0.00%	0.00%	0.00%
Outpatient/ED	3.55%	2.20%	3.00%
Mental Health Utilization—Total			
Any Service	NB	0.71%	0.71%
Inpatient	NB	0.10%	0.10%
Intensive Outpatient/Partial Hospitalization	NB	0.00%	0.00%
Outpatient/ED	NB	0.64%	0.64%
Antibiotic Utilization—All Ages			
Average Scrips for PMPY for Antibiotics	0.30	0.54	0.40
Averages Days Supplied per Antibiotic Scrip	9.50	9.59	9.55
Average Scrips PMPY for Antibiotics of Concern	0.09	0.21	0.13
Percentage of Antibiotics of Concern of all Antibiotic Scrips	28.02%	38.50%	33.78%
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	0.02	0.01
Bariatric weight loss surgery (20–44 female)	0.03	0.06	0.05
Bariatric weight loss surgery (45–64 male)	0.00	0.00	0.00
Bariatric weight loss surgery (45–64 female)	0.08	0.11	0.10
Tonsillectomy (0–9 male & female)	0.29	0.66	0.41
Tonsillectomy (10–19 male & female)	0.12	0.38	0.21
Hysterectomy, Abdominal (15–44 female)	0.06	0.09	0.08
Hysterectomy, Abdominal (45–64 female)	0.31	0.29	0.30
Hysterectomy, Vaginal (15–44 female)	0.03	0.46	0.23
Hysterectomy, Vaginal (45–64 female)	0.08	0.29	0.19
Cholecystectomy, Open (30–64 male)	0.12	0.00	0.06
Cholecystectomy, Open (15–44 female)	0.02	0.00	0.01
Cholecystectomy, Open (45–64 female)	0.03	0.00	0.01

Table E-9—Use of Services Performance Measures for Physical Health Plans and Statewide Average			
Performance Measures	DHMC	RMHP	Statewide Average
Cholecystectomy (laparoscopic) (30–64 male)	0.10	0.30	0.20
Cholecystectomy (laparoscopic) (15–44 female)	0.57	0.77	0.66
Cholecystectomy (laparoscopic) (45–64 female)	0.57	0.64	0.61
Back Surgery (20–44 male)	0.13	0.24	0.19
Back Surgery (20–44 female)	0.06	0.12	0.09
Back Surgery (45–64 male)	0.47	0.36	0.41
Back Surgery (45–64 female)	0.34	0.35	0.35
Mastectomy (15–44 female)	0.00	0.02	0.01
Mastectomy (45–64 female)	0.05	0.18	0.12
Lumpectomy (15–44 female)	0.07	0.11	0.09
Lumpectomy (45–64 female)	0.23	0.31	0.28

Table E-10 includes FY 2014–2015 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	Statewide Average
Percentage of Members with SMI with a Focal Point of Behavioral Health Care	85.8%	84.8%	88.3%	93.3%	87.6%
Improving Physical Healthcare Access	88.6%	87.3%	91.3%	86.1%	89.0%
Emergency Room Utilization (rate/1,000 members, all ages)	14.55	12.46	8.83	8.81	10.92
Overall Penetration Rate	14.3%	12.0%	13.9%	16.8%	13.9%
Penetration Rate by Age Category					
Children 12 Years of Age and Younger	6.7%	6.5%	6.7%	11.5%	7.2%
Adolescents 13 Through 17 Years of Age	16.3%	16.0%	16.6%	20.8%	16.9%
Adults 18 Through 64 Years of Age	21.6%	17.6%	20.1%	21.3%	19.9%
Adults 65 Years of Age or Older	8.5%	6.1%	6.1%	7.2%	6.8%
Penetration Rate by Medicaid Eligibility Category					
AFDC/CWP Adults	13.2%	12.6%	14.9%	14.9%	14.0%
AFDC/CWP Children	7.7%	7.7%	8.2%	12.8%	8.6%
AND/AB-SSI	39.3%	32.8%	30.2%	33.9%	33.1%
BC Children	2.5%	2.2%	2.0%	2.6%	2.2%
BC Women	14.1%	12.5%	21.4%	13.9%	16.7%
BCCP—Women Breast and Cervical Cancer	7.4%	10.5%	17.7%	7.3%	12.5%
Buy-in: Working Adults with Disabilities	33.0%	27.8%	22.8%	44.8%	30.8%
Foster Care	40.4%	34.5%	30.2%	33.9%	33.5%

Table E-10—Performance Measure Results for BHOs					
Performance Measures	**ABC**	**BHI**	**CHP**	**FBHP**	**Statewide Average**
OAP-A	8.5%	6.0%	6.0%	7.1%	6.8%
OAP-B-SSI	27.8%	23.8%	19.1%	25.0%	22.9%
Modified Adjusted Gross Income	22.2%	18.7%	22.3%	23.6%	21.6%
Buy-in: Children with Disabilities	14.2%	14.2%	9.9%	20.7%	14.1%
Behavioral Health Engagement					
Mental Health Engagement	34.6%	36.0%	37.4%	41.6%	37.1%
Substance Use Disorder	29.5%	42.7%	61.8%	68.6%	46.0%
Hospital Recidivism					
Non-State Hospitals—7 Days	2.9%	3.2%	3.2%	2.8%	3.1%
30 Days	11.9%	7.7%	10.0%	6.7%	9.5%
90 Days	18.4%	13.0%	16.6%	13.3%	15.7%
All Hospitals—7 Days	2.9%	3.5%	3.3%	2.7%	3.2%
30 Days	11.7%	8.1%	10.4%	7.0%	9.6%
90 Days	18.5%	13.5%	17.1%	13.1%	16.0%
Hospital Average Length of Stay					
Non-State Hospitals	8.80	7.11	8.47	7.74	8.15
All Hospitals	16.63	13.17	12.74	16.94	14.24
Inpatient Utilization (Rate/1,000 Members, All Ages)					
Non-State Hospitals	4.78	3.29	4.88	4.51	4.36
All Hospitals	5.24	3.84	5.66	5.75	5.08
Follow-Up After Hospitalization for Mental Illness					
Non-State Hospitals—7 Days	46.2%	52.4%	50.6%	50.8%	50.1%
30 Days	70.4%	70.6%	68.7%	68.3%	69.3%
All Hospitals—7 Days	46.4%	54.6%	50.0%	52.0%	50.5%
30 Days	70.1%	71.3%	68.9%	68.7%	69.5%

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	*Improving Follow-up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*	100%	100%	*Met*
RMHP	*Improving Transitions of Care for Individuals Recently Discharged from a Corrections Facility*	50%	25%	*Not 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-D	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	100%	100%	*Met*
ABC-NE	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	100%	100%	*Met*
BHI	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	100%	100%	*Met*
CHP	*Improving Transition from Jail to Community Based Behavioral Health Treatment*	100%	100%	*Met*
FBHP	*Improving Transition from Jail to Community Based Behavioral Health Treatment*	100%	100%	*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 2014–2015, 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	Statewide Average
Getting Needed Care	76.3%	80.2%	78.3%
Getting Care Quickly	73.9%	80.5%	77.2%
How Well Doctors Communicate	91.0%	93.5%	92.2%
Customer Service	82.6%+	84.7%+	83.6%
Shared Decision Making	80.0%+	80.4%	80.2%
Rating of Personal Doctor	73.0%	60.1%	66.6%
Rating of Specialist Seen Most Often	58.9%	59.5%	59.2%
Rating of All Health Care	47.0%	45.7%	46.4%
Rating of Health Plan	58.1%	56.0%	57.1%

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.

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

Table E-14 shows each physical health plan's summary rates and global proportions for the child CAHPS survey. For FY 2014–2015, 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	Statewide Average
Getting Needed Care	76.7%	85.7%	79.6%
Getting Care Quickly	78.8%	93.3%	83.4%
How Well Doctors Communicate	92.2%	96.2%	93.5%
Customer Service	83.7%	84.8%	84.0%
Shared Decision Making	80.0%+	83.5%	81.1%
Rating of Personal Doctor	82.8%	75.6%	80.5%
Rating of Specialist Seen Most Often	78.9%+	69.7%+	76.0%
Rating of All Health Care	69.1%	64.8%	67.7%
Rating of Health Plan	72.1%	65.6%	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.

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