COLORADO

Department of Health Care Policy & Financing

2015–2016 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

October 2016

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary 1-1
Purpose of Report 1-1
Scope of EQR Activities—Physical Health 1-2
Scope of EQR Activities—Behavioral Health 1-2
Definitions 1-3
Overall Conclusions 1-4

2. External Quality Review (EQR) Activities 2-1
Physical Health 2-1
Behavioral Health 2-1

Physical Health Plans

3. Physical Health Findings, Strengths, and Recommendations With Conclusions Related to Healthcare Quality, Timeliness, and Access 3-1
Introduction 3-1
Compliance Monitoring Site Reviews 3-1
Validation of Performance Measures 3-10
Validation of Performance Improvement Projects (PIPs) 3-41
Consumer Assessment of Healthcare Providers and Systems (CAHPS) 3-47

4. Assessment of Health Plan Follow-Up on Prior Recommendations 4-1
Introduction 4-1

Behavioral Health Organizations

5. Behavioral Health Findings, Strengths, and Recommendations With Conclusions Related to Healthcare Quality, Timeliness, and Access 5-1
Introduction 5-1
Compliance Monitoring Site Reviews 5-1
Validation of Performance Measures 5-19
Validation of Performance Improvement Projects 5-45

6. Assessment of BHO Follow-Up on Prior Recommendations 6-1
Introduction 6-1

Appendix A. EQR Activities—Compliance Monitoring Site Reviews A-1
Introduction A-1
Objectives A-1
Technical Methods of Data Collection A-2
Description of Data Sources A-4
Data Aggregation, Analysis, and How Conclusions Were Drawn A-5

Appendix B. EQR Activities—Validation of Performance Measures B-1
Introduction B-1
Objectives B-1
Technical Methods of Data Collection—Physical Health B-1
Technical Methods of Data Collection—Behavioral Health B-2

Description of Data Obtained—Physical Health B-4
Description of Data Obtained—Behavioral Health B-4
Data Aggregation, Analysis, and How Conclusions Were Drawn—Physical Health............ B-5
Data Aggregation, Analysis, and How Conclusions Were Drawn—Behavioral Health B-5
Hybrid Measure Rates for HEDIS 2016 .... B-6

Appendix C. EQR Activities—Validation of Performance Improvement Projects C-1
Introduction C-1
Objectives C-1
Technical Methods of Data Collection............ C-1
Description of Data Obtained C-2
Data Aggregation, Analysis, and How Conclusions Were Drawn C-3

Appendix D. EQR Activities—Consumer Assessment of Healthcare Providers and Systems (CAHPS) (Physical Health Plans Only)............ D-1
Introduction D-1
Objectives D-1
Technical Methods of Data Collection............ D-1
Description of Data Obtained D-2
Data Aggregation, Analysis, and How Conclusions Were Drawn D-2

Appendix E. Summary Tables of EQR Activity Results—All Plans............ E-1
Introduction E-1
Results From the Compliance Monitoring Site Reviews E-1
Results From the Validation of Performance Measures E-3
Results From the Validation of Performance Improvement Projects............ E-11
Results From the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys... E-12

1. Executive Summary

Purpose of Report

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data from activities conducted in accordance with the Code of Federal Regulations (CFR), 42 CFR 438.358, were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' health plans. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding healthcare quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which the health plans addressed any previous recommendations. To meet this requirement, the State of Colorado Department of Health Care Policy & Financing (the Department) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare this report regarding the external quality review (EQR) activities performed for 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—Payment Reform Initiative for Medicaid Expansion (RMHP Prime), an MCO.[1-1]

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)

[1-1] In December 2014, RMHP discontinued one of its Medicaid lines of business. In September 2014, RMHP implemented a new Medicaid risk product that operates within the Accountable Care Collaborative program. During the transition, some members who had been enrolled in the discontinued product were enrolled into RMHP's Regional Care Collaborative Organization (RCCO) and others were enrolled into RMHP Prime. The RMHP Prime program serves a specialized population in a limited geographical region of RMHP's RCCO service area. Due to RMHP's Medicaid population change, because the results would represent different populations, trend analyses of RMHP Prime's data and comparisons or aggregations of DHMC and RMHP Prime data were not performed.

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 four standard areas 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®)[1-2] survey. Each health plan was responsible for conducting a survey of its members and forwarding the results to HSAG for inclusion in this report. For the health plans' findings, a substantial increase is noted when a measure's rate increased by 5 percentage points or more from the previous year. A substantial decrease is noted when a measure's rate decreased by 5 percentage points or more from the previous year.

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 four standard areas 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 the BHOs. The validation also determined the extent to which Medicaid-specific performance measures calculated by the BHOs followed specifications established by the Department.

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- **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."[1-3] 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 enrollees through its structural and operational characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement."[1-4]

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."[1-5] NCQA further discusses that the intent of this standard is to minimize any disruption in the provision of healthcare. 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. In the final 2016 rule, CMS recognizes the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR 438.206(a) and by requiring states, at 42 CFR 438.68(b), to develop both time and distance standards for network adequacy.

[1-3] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

[1-4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

[1-5] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.

Access

CMS defines "access" in the final 2016 rule at 42 CFR 438.320 as follows: "*Access,* as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services)."

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

Compliance Review Standards	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓		✓
Standard IV—Member Rights and Protections	✓		✓
Standard VIII—Credentialing and Recredentialing	✓		
Standard X—Quality Assessment and Performance Improvement	✓		✓
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	✓		
*Annual Dental Visit**	✓		
Prenatal and Postpartum Care	✓	✓	✓

Performance Measures	Quality	Timeliness	Access
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	✓	✓	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	✓		
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	✓		
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			✓
Antibiotic Utilization			✓
Frequency of Selected Procedures (Procedures per 1,000 MM)			✓
Performance Improvement Projects	**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	✓		

Performance Measures	Quality	Timeliness	Access
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Rating of All Health Care	✓		
Rating of Health Plan	✓		

*DHMC and RMHP Prime did not report this measure; therefore, this measure was not included in this report.

Table 1-2—Assignment of Activities to Performance Domains for BHOs

Compliance Review Standards	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓		✓
Standard IV—Member Rights and Protections	✓		✓
Standard VIII—Credentialing and Recredentialing	✓		
Standard X—Quality Assessment and Performance Improvement	✓		✓
Performance Measures	**Quality**	**Timeliness**	**Access**
Hospital Readmissions Within 180 Days (all facilities)	✓		
Mental Health Engagement		✓	✓
Overall Penetration Rates			✓
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)			✓
Penetration Rates by Age Group			✓
Penetration Rates by Medicaid Eligibility Category			✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	✓
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (non-state and all facilities)	✓		
Members With Physical Health Well-Care Visits	✓		✓
Inpatient Utilization (Rate/1,000 Members, All Ages)			✓
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition		✓	✓
Antidepressant Medication Management—Acute and Continuation Phases		✓	✓
Performance Improvement Projects	**Quality**	**Timeliness**	**Access**
Performance Improvement Projects	✓		

HSAG HEALTH SERVICES ADVISORY GROUP

Quality—Physical Health

Statewide performance for the physical health plans with regard to the quality domain was mixed. HSAG determined that performance in the quality domain, as determined by the standards reviewed, was strong. Both DHMC and RMHP Prime had processes that provided for each member to receive a thorough health assessment and that ensured that members and their families were actively involved in developing a comprehensive treatment plan. Both health plans demonstrated robust processes to educate members, staff, and providers about member rights and the expectation that those rights be taken into account when furnishing services. Both health plans had credentialing and recredentialing programs that were NCQA-compliant and both quality assessment and performance improvement (QAPI) programs addressed the majority of required components.

Related to the validation of performance measures, statewide performance in the quality domain was assessed based on Healthcare Effectiveness Data and Information Set (HEDIS®) rates for 51 measure indicators.[1-6] Four rates ranked at or above the national Medicaid 90th percentile, indicating positive performance. These were related to the rate of appropriate treatment for children with upper respiratory infections, percentage of adolescent females who unnecessarily received a cervical cancer screening, members with diabetes receiving medical attention for nephropathy, and avoidance of antibiotic treatment for members with acute bronchitis. Additionally, statistically significant improvements from 2015 to 2016 indicated strengths related to immunizations for children, counseling for nutrition and physical activity for children and adolescent members, rate of appropriate treatment for children with upper respiratory infections, chlamydia screening in women, medication management for members on antidepressants, diabetic members who received HbA1c testing, eye exams or medical attention for nephropathy, members who received systemic corticosteroids for acute exacerbations of chronic obstructive pulmonary disease (COPD), and those diagnosed with rheumatoid arthritis and who received a disease-modifying anti-rheumatic drug.

Conversely, rates for three of the 51 quality-related measures fell below the national Medicaid 10th percentile; and two of these measures demonstrated a statistically significantly decline, indicating opportunities for improvement related to well-child visits during the first 15 months of life. An additional nine of the 51 quality-related measures rates showed statistically significant declines in statewide rates. These included rates related to well-care visits for adolescent members, documentation of a weight assessment for children and adolescents, the percentage of appropriate testing for children with pharyngitis, the percentage of deliveries with timely prenatal care or postpartum care, the percentage of women 50 to 77 years of age who had a mammogram to screen for breast cancer, those whose BMI was documented during the measurement year, blood pressure control for members with hypertension, and those who had a recent HbA1c test performed wherein the HbA1c level was less than 8 percent.

Related to the validation of performance improvement projects activities, validation scores and validation status across the two PIPs demonstrated solid performance in the PIP design and

[1-6] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

implementation stages necessary to produce valid and reliable PIP results and strong quality improvement (QI) processes and activities needed to support desired improvement.

Related to the CAHPS survey, HSAG determined that, given RMHP Prime's population change, CAHPS results could not be aggregated or compared between the two plans or trended between measurement years. Examined individually however, for DHMC's adult population, DHMC experienced substantial increases in *Rating of Specialist Seen Most Often* (8.3 percentage points) and slight increases in *Getting Needed Care*, *Customer Service*, and *Rating of All Health Care*. For DHMC's child population, the measures related to the quality domain that demonstrated slight increases were *How Well Doctors Communicate*, *Customer Service*, and *Rating of Health Plan.* None of DHMC's measures rates for the adult or child population decreased substantially although some decreases were noted in measures related to the quality domain.

For RMHP Prime's CAHPS scores related to the quality domain, rates related to the quality domain for RMHP Prime's adult population that were above the 2015 NCQA adult Medicaid national averages were *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often.* Quality domain-related rates for the adult population that were lower than the 2015 NCQA adult Medicaid national averages were *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*. For the Child population quality-related rates higher than the Medicaid national averages were *How Well Doctors Communicate* and *Shared Decision Making.* Quality related rates lower than the 2015 NCQA general child Medicaid national averages were *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan.*

Quality—Behavioral Health

For the compliance monitoring activities for behavioral health, HSAG assigned all four standards reviewed in fiscal year (FY) 2015–2016 to the quality domain and found that, overall, statewide performance was strong. HSAG found that BHOs employed multiple mechanisms to ensure their members, staff, and providers were familiar with and took member rights into account when furnishing services. All of the BHOs had comprehensive NCQA-compliant credentialing and recredentialing programs; however, some struggled with meeting the 36-month recredentialing time frame. HSAG also found all BHOs had comprehensive QAPI programs that were fully compliant with state and federal regulations. The BHOs' performance was poorest on the coordination and continuity of care standard—due in large part to the difficulties associated with understanding the role of behavioral health providers in arranging for and coordinating benefits and services afforded under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. HSAG suggested that all BHOs continue working with the Department to more clearly define the role of behavioral health providers and the BHOs in the screening and provision of EPSDT services, and to develop and adopt practical and effective processes for ensuring the provision of EPSDT services as applicable to the behavioral health scope of services.

Related to performance measures, quality-related performance was assessed statewide based on rates for 11 measure indicators for the current measurement year (MY), MY 2014–2015. Of these 11 measures, 6 measure indicators were also reported for MY 2013–2014. Rates related to post-discharge hospital

readmissions varied with 2.94 percent reported as the lowest percentage of hospital readmissions and 15.47 percent reported as the highest percentage of hospital readmissions, where a higher rate indicates poorer performance and opportunities for improvement. Additionally, all of the indicator rates for the post-discharge hospital readmissions measure declined from the prior year, indicating better performance.

Timeliness—Physical Health

HSAG determined that the validation of performance improvement projects and none of the compliance standards reviewed during FY 2015–2016 related to the timeliness domain; however, validation of performance measures and the CAHPS survey each evaluated components related to the timeliness domain. Although performance in the timeliness domain was mixed, more strengths were observed.

Related to performance measures, of the 17 HEDIS measure rates that related to the timeliness domain, 7 rates that were related to immunizations for children ranked above the national Medicaid 75th percentile. All of the measures related to immunizations for children demonstrated statistically significant improvements from 2015 to 2016. Conversely, statewide weighted average measure indicator rates related to well-child visits during the first 15 months of life demonstrated opportunities for improvement, ranking below the national Medicaid 10th percentile. Additionally, statewide rates related to well-child visits during the first 15 months of life, well-care visits for adolescent members, and the percentage of deliveries with timely prenatal care or postpartum care statistically significantly declined from 2015 to 2016.

Related to the CAHPS activity for the adult and child Medicaid populations and related to timeliness, DHMC had no increase in rates and no substantial decreases in rates; however, for the adult population, *Getting Care Quickly*, the measure related to the timeliness domain, showed a slight decrease. For both the adult and child populations, DHMC's *Getting Care Quickly* rate was below the 2015 NCQA Medicaid national averages.

For RMHP Prime's performance in the timeliness domain, RMHP Prime's adult and child rates for *Getting Care Quickly* were above the 2015 NCQA Medicaid national averages.

Timeliness—Behavioral Health

HSAG determined that neither any validation of performance improvement projects nor any compliance standards reviewed during FY 2015–2016 related to the timeliness domain. Related to performance measures, timeliness-related performance was assessed statewide based on rates for nine measure indicators for the current MY. Of these nine measures, five measure indicators were also reported for MY 2013–2014. Rates related to mental health follow-up appointments varied, from as low as 47.87 percent to as high as 66.23 percent.

Access—Physical Health

HSAG determined that compliance monitoring and performance measures and one measure within the CAHPS survey assessed elements within the access domain. Although—as with the other domains—statewide performance was mixed, HSAG found many strengths related to statewide access. For the compliance monitoring activity, related to the access domain, both health plans exhibited multiple mechanisms to assist members—especially those with complex healthcare needs—with coordinating and accessing appropriate services. Both health plans had processes to allow members with special healthcare needs direct access to specialists and to afford those involved in an ongoing course of treatment to continue receiving services from ancillary or non-network providers. In the event that medically necessary services could not be provided in network, both health plans had processes to arrange for members to receive the unavailable services from out-of-network providers.

Related to the performance measures, statewide performance in this domain was evaluated based on rates for 13 measures. One measure indicator rate for members with diabetes receiving medical attention for nephropathy ranked at or above the national Medicaid 90th percentile. Additionally, three measure indicators related to members with diabetes receiving HbA1c testing, receiving eye exams, and receiving medical attention for nephropathy demonstrated statistically significant improvements in 2016. In addition to the three measure indicators listed previously, an additional measure indicator related to adult members' access to preventive and ambulatory health services statistically significantly improved; however, the rate ranked below the national Medicaid 10th percentile. All four indicators related to children's and adolescents' access to primary care practitioners ranked below the national Medicaid 10th percentile, and three of these rates demonstrated a statistically significant decline from HEDIS 2015 to HEDIS 2016.

For both DHMC's adult and child Medicaid population the *Getting Needed Care* measure, related to the access domain, demonstrated slight increases. Although RMHP's rates for its Prime population was not trendable from the previous year, for both RMHP Prime's adult and child Medicaid population, the rates for *Getting Needed Care* were higher than the 2015 national averages.

Access—Behavioral Health

HSAG determined that only compliance monitoring and performance measures assessed elements within the access domain. For the compliance monitoring activity, HSAG found elements that addressed the access domain in three of the four standards reviewed: Coordination and Continuity of Care, Member Rights and Protections, and Quality Assessment and Performance Improvement. All five BHOs had policies that described the processes and persons responsible for coordinating care for all members and provided additional support services for members with complex needs. All BHOs allowed members direct access to behavioral health specialty providers and had processes to provide members access to out-of-network providers if and when covered services were not available in network. The BHOs' QAPI program included mechanisms to ensure that their networks were capable of providing members all necessary services.

Related to performance measures, access-related performance was evaluated statewide based on rates for 31 measure indicators for the current MY. Of these 31 measures, 22 measure indicators were also reported for MY 2013–2014. Penetration rates specifically related to members who received one mental health-related contact from the BHO varied, from as low as 1.98 percent of children within the Baby Care Program to as high as 35.50 percent of members who require aid for the needy disabled, may receive supplemental security income, or are disabled individuals up to 59 years of age. Additionally, penetration rates by age group varied, from as low as 7.46 percent of children 12 years of age and younger to as high as 19.14 percent of adults 18 through 64 years of age.

2. External Quality Review (EQR) Activities

Physical Health

HSAG conducted four EQR activities for the physical health plans: compliance monitoring site reviews, validation of performance measures required by the State, validation of PIPs required by the State, and summarizing of CAHPS results for two Medicaid physical health plans. HSAG conducted each activity in accordance with CMS protocols, Version 2.0, September 2012. Appendices A through 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 quality, timeliness, and access to services for both health plans and statewide, across the health plans.

Behavioral Health

HSAG conducted three EQR activities for the BHOs: compliance monitoring site reviews, validation of performance measures required by the State, and validation of PIPs required by the State for five BHOs. HSAG conducted each activity in accordance with the CMS protocols, Version 2.0, September 2012. Appendices A, B, and D, respectively, detail and describe how HSAG conducted each activity, addressing:

- 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 quality, timeliness, and access to services for each BHO and statewide, across the BHOs.

3. Physical Health Findings, Strengths, and Recommendations With Conclusions Related to Healthcare 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 2015–2016 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 III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. For each standard, HSAG conducted a desk review of documents sent by the health plan 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.

HSAG also reviewed the health plan's administrative credentialing and recredentialing records to evaluate implementation of federal healthcare regulations and compliance with NCQA requirements, effective July 2015. Using a random sampling technique, HSAG selected a sample of 10 plus an oversample of five records from all of the health plan's credentialing and recredentialing that occurred between January 1, 2013, and December 31, 2015. 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 VIII—Credentialing and Recredentialing. 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 Compliance Standards to Performance Domains

Standard	Quality	Timeliness	Access
III—Coordination and Continuity of Care	✓		✓
IV—Member Rights and Protections	✓		✓
VIII—Credentialing and Recredentialing	✓		
X—Quality Assessment and Performance Improvement	✓		✓

Denver Health Medicaid Choice

Findings

Table 3-2 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	13	13	12	1	0	0	92%
IV—Member Rights and Protections	5	5	5	0	0	0	100%
VIII—Credentialing and Recredentialing	48	48	47	1	0	0	98%
X—Quality Assessment and Performance Improvement	17	16	14	2	0	1	88%
Totals	**83**	**82**	**78**	**4**	**0**	**1**	**95%**

*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 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 3-3—Summary of Scores for the Record Reviews for DHMC

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	88	88	0	2	100%
Recredentialing	90	86	86	0	4	100%
Totals	**180**	**174**	**174**	**0**	**6**	**100%**

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

Strengths

DHMC had policies and procedures that addressed service accessibility, case management, and continuity of care. The health plan had a robust case management organizational structure that included several disease management and case management programs. The new-member welcome-call script included questions to ascertain whether the member was pregnant, had special healthcare needs, and whether or not the member was receiving services from an out-of-network provider. DHMC had policies and procedures that addressed EPSDT services and included the American Academy of Pediatrics Bright Futures periodicity schedule. The member handbook included information explaining EPSDT services. DHMC provided ample evidence of policies, procedures, and practices designed to ensure compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

DHMC also had policies and procedures requiring that employed and affiliated (contracted) providers take member rights into account when providing services. Through on-site interviews, DHMC staff members demonstrated that DHMC ensures that members receive information pertaining to member rights. DHMC trained staff in various departments to manage and forward grievances when issues arose or were identified during interactions with members.

Policies and procedures for the credentialing and privileging of providers were thorough and appropriate. The credentialing and recredentialing records reviewed by HSAG provided evidence that credentialing team leaders ensure that credentialing activities meet all NCQA requirements. During the on-site interview, staff described, from application to appointment, a credentialing process consistent with DHMC's written policies and HSAG's observations during on-site record reviews.

DHMC's QAPI program description addressed HEDIS, CAHPS, PIP topics, provider satisfaction surveys, member call center metrics, medical record reviews, mechanisms to detect over- and underutilization, case management programs for members with special healthcare needs, and clinical practice guidelines. The health plan's QAPI program description and related documentation (policies, procedures, brochures, articles, and committee meeting minutes) as well as the on-site in depth overview of the QI program demonstrated the health plan's commitment to improving quality of care provided to its members.

Recommendations

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

Standard III—Coordination and Continuity of Care

- DHMC was required to ensure that providers are instructed to refer members to the Department's Office of Clinical Services and/or Healthy Communities to obtain EPSDT-related wraparound services not covered under the managed care contract. DHMC was also required to revise the provider manual to include information about referring members for wraparound services and to reflect a 30-day scheduling time frame for EPSDT services consistent with DHMC's managed care contract and its own procedures.

Standard VIII—Credentialing and Recredentialing

- DHMC was required to ensure that staff members are aware of the threshold for provider site quality-related complaints which warrant site visits as well as the process, pursuant to the health plan's policy, for further follow up.

Standard X—Quality Assessment and Performance Improvement

- DHMC was required to develop a mechanism to ensure annual review of all clinical practice guidelines as required by the Medicaid managed care contract with the State.
- DHMC was also required to develop a mechanism to measure provider compliance with the EPSDT periodicity schedule and then develop interventions designed to ensure continued and/or improved compliance.

DHMC: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of DHMC's compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined performance across all four standards when evaluating the quality of care domain—defined as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes." DHMC had processes to conduct needs assessments and to ensure that members and their families participated in the development of individual treatment plans. DHMC care coordinators assisted members with complex needs in navigating the healthcare system and coordinated efforts and care among providers. DHMC informed members, providers, and staff about the rights afforded to members under State and federal laws and had processes to ensure that rights are taken into account when furnishing services. DHMC's NCQA-compliant credentialing and recredentialing processes ensured a comprehensive network of qualified providers. DHMC also demonstrated a robust QAPI program that provided for the ongoing evaluation of services and the impact of quality improvement initiatives developed as a result of data analysis.

Access: CMS defined "access" as "the timely use of services to achieve optimal outcomes." DHMC designed its care coordination program to assist members with complex needs with accessing necessary behavioral and physical health services. Its policies allowed members with special healthcare needs and members who are pregnant to continue receiving services from existing providers, regardless of the provider's network affiliation. DHMC's credentialing and recredentialing program ensured that DHMC's providers were qualified to address the needs of its member populations. When and if members required services not available in network, DHMC had a process to provide members with access to out-of-network providers, if needed. DHMC's health information system allowed it to monitor under- and overutilization and had mechanisms to ensure appropriate use of services.

Rocky Mountain Health Plans Prime

Table 3-4 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	12	12	12	0	0	0	100%
IV—Member Rights and Protections	5	5	4	1	0	0	80%
VIII—Credentialing and Recredentialing	48	46	46	0	0	2	100%
X—Quality Assessment and Performance Improvement	16	16	16	0	0	0	100%
Totals	**81**	**79**	**78**	**1**	**0**	**2**	**99%**

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

Table 3-5 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 3-5—Summary of Scores for the Record Reviews for RMHP Prime

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	83	83	0	7	100%
Recredentialing	90	90	90	0	0	100%
Totals	**180**	**173**	**173**	**0**	**7**	**100%**

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

Strengths

RMHP Prime had policies and procedures that addressed care coordination, assessments, care planning, and continuity of care. Its care coordination policy and procedure described a comprehensive, client- and family-centered, integrated, care coordination program that promoted service accessibility, attention to individual needs, continuity of care, and maintenance of health and independent living for its members. RMHP Prime's staff members presented case studies that demonstrated RMHP Prime's commitment to improving quality of care as well as demonstrating the level of coordination and integration provided for members whose needs may be difficult to address.

RMHP Prime's policies and procedures regarding member rights were comprehensive and well-written. During the on-site interview, staff members described the various mechanisms used to educate members, providers, and employees regarding member rights. In addition to the policies and procedures, RMHP Prime used newsletters, the provider manual, the member handbook, and its website to inform providers, members, and staff of the full list of member rights. RMHP Prime's Equal Opportunity policy required its staff, providers, and vendors to strictly adhere to all federal and State laws that pertain to member rights. RMHP Prime included its policy statement in its employee handbook, member handbook, and provider manual and attached the Equality Opportunity policy to all non-provider contracts.

RMHP Prime's written policies and procedures described a robust and comprehensive credentialing and recredentialing process consistent with NCQA standards. On-site review of both credentialing and recredentialing records demonstrated that provider applications included all NCQA-required content, that staff verified information using primary sources identified in the policies within the required time frames, and that RMHP Prime's credentialing committees reviewed files for providers who failed to meet the criteria delineated in RMHP Prime's policies. RMHP Prime had fully-executed delegation agreements with five organizations for the provision of credentialing activities. RMHP Prime provided documentation that demonstrated ongoing (quarterly) reporting and formal (annual audit) oversight of activities delegated to each organization as well as follow-up on identified opportunities for improvement.

RMHP Prime's Quality Improvement Program Description addressed HEDIS, CAHPS, PIP topics, provider satisfaction surveys, member call center metrics, medical record reviews, measures that detected over- and underutilization, programs for members with special healthcare needs, and clinical practice guidelines. RMHP Prime had mechanisms in place to ensure that all eligible Medicaid members under age 21 had access to the full range of medically necessary services under EPSDT, including periodic health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule.

Recommendations

Based on findings from the site review activities, RMHP Prime was required to submit a CAP that addressed the following required actions:

Standard IV—Member Rights and Protections

- RMHP Prime was required to revise its member rights policy and procedure to allow members to receive family planning services from any duly licensed provider, in or out of RMHP Prime's network.

RMHP Prime: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of RMHP Prime's compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined performance across all four standards when evaluating the quality of care domain—defined as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes." RMHP Prime employed a variety of policies and processes to assist its members with achieving desired health outcomes. RMHP Prime providers used comprehensive assessments as well as member and family input to design individual care plans. RMHP Prime educated members, providers, and staff about member rights and had processes to ensure that member rights are taken into account when furnishing services. RMHP Prime's credentialing and recredentialing program was NCQA-compliant and included mechanisms for ongoing monitoring of both individual and organizational providers. RMHP Prime's QAPI program provided for the continual assessment of the quality and appropriateness of its services, investigation of all alleged quality-of-care concerns, and required corrective actions to address identified deficiencies.

Access: CMS defined "access" as "the timely use of services to achieve optimal outcomes." RMHP Prime's processes ensured that each member was assigned to a primary care provider and allowed members with special healthcare needs direct access to specialists. Its care coordinators helped coordinate behavioral and physical health services and social services for members with complex health needs and assisted with transitions of care. RMHP Prime had mechanisms in place to ensure that all eligible Medicaid members had access to the full range of medically necessary EPSDT services, including periodic health screens. RMHP Prime regularly monitored under- and overutilization and had mechanisms to ensure appropriate use of services.

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

As part of its process, HSAG analyzed recommendations across plans to identify potential areas for statewide focus. Table 3-6 and Table 3-7 provide scores for the standards and record reviews by health plan as well as the statewide average for each standard area and record review.

Table 3-6—Statewide Summary of Scores for the Standards

Standards	DHMC	RMHP Prime	Statewide Average
III—Coordination and Continuity of Care	92%	100%	96%
IV—Member Rights and Protections	100%	80%	90%
VIII—Credentialing and Recredentialing	98%	100%	99%
X—Quality Assessment and Performance Improvement	88%	100%	94%
Overall Compliance Scores	**95%**	**99%**	**95%**

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

Table 3-7—Statewide Summary of Scores for the Record Reviews

Record Reviews	DHMC	RMHP Prime	Statewide Average
Credentialing	100%	100%	100%
Recredentialing	100%	100%	100%
Overall Record Review Scores	**100%**	**100%**	**100%**

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

HSAG identified no common recommendations for the health plans.

Statewide Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. Statewide performance in the quality and access domain, as determined by the standards reviewed, was strong. Both DHMC and RMHP Prime had processes that provided for each member to receive a thorough health assessment and that ensured that members and their families were actively involved in developing comprehensive treatment plans. Both health plans also exhibited multiple mechanisms to assist members—especially those with complex healthcare needs—with coordinating and accessing appropriate services. Both health plans demonstrated robust processes to educate members, staff, and providers about member rights and the expectation that those rights be

taken into account when furnishing services. Both health plans had credentialing and recredentialing programs that were NCQA-compliant, and both QAPI programs addressed most required components.

Both health plans had processes to allow members with special healthcare needs direct access to specialists and to afford those involved in an ongoing course of treatment to continue receiving services from ancillary or non-network providers. In the event that medically necessary services could not be provided in network, both health plans had processes to arrange for members to receive the unavailable services from out-of-network providers.

Validation of Performance Measures

The Department elected to use HEDIS methodology to satisfy the CMS validation of performance measure protocol requirements, which also included an assessment of information systems. DHMC and RMHP Prime 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 Prime, it did review the audit reports produced by the other licensed auditing organizations. All licensed auditing 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 validate performance measure activities.

The Department required that 35 performance measures with a total of 102 measure indicators be validated in FY 2015–2016 based on HEDIS 2016 specifications. Five measure indicators were new for this year (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*, *Annual Dental Visits*, and *Annual Monitoring for Patients on Persistent Medications—ACE/ARBs*, *Digoxin*, and *Diuretics*). DHMC and RMHP Prime did not report the *Annual Dental Visits* measure as dental benefits were not offered by either of the health plans; therefore, rates for this measure were not reported or included in this report. To make overall assessments about the quality and timeliness of, and access to, services 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.

Table 3-8—FY 2015–2016 Performance Measures Required for Validation

Performance Measures	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Childhood Immunization Status—Combinations 2–10	Administrative	✓	✓	
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)	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—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	Hybrid	✓		
Appropriate Testing for Children With Pharyngitis	Administrative	✓		

Performance Measures	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Appropriate Treatment for Children With Upper Respiratory Infection	Administrative	✓		
*Annual Dental Visit**	Administrative	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	Hybrid	✓	✓	✓
Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, 25 Months to 6 Years, 7 to 11 Years, and *12 to 19 Years*	Administrative			✓
Adults' Access to Preventive/Ambulatory Health Services—Total	Administrative			✓
Chlamydia Screening in Women—Total	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—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	Administrative	✓		
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	Administrative	✓	✓	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total	Administrative	✓		
Controlling High Blood Pressure	Hybrid	✓		
Persistence of Beta-Blocker Treatment After a Heart Attack	Administrative	✓		
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy, and *Blood Pressure Control (<140/90 mm Hg)*	Hybrid	✓		✓
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Digoxin, Diuretics, and *Total*	Administrative	✓		
Use of Imaging Studies for Low Back Pain	Administrative	✓		

Performance Measures	Data Collection Methodology Required by the Department	Quality	Timeliness	Access
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Administrative	✓		
Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and *Bronchodilator*	Administrative	✓		
Medication Management for People With Asthma—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	Administrative	✓		
Asthma Medication Ratio—Total	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 (Per 1,000 Member Months)—Outpatient Visits—Total and *Emergency Department Visits—Total*	Administrative			✓
Inpatient Utilization—General Hospital/Acute Care	Administrative			✓
Antibiotic Utilization	Administrative			✓
Frequency of Selected Procedures (Procedures per 1,000 Member Months)	Administrative			✓

* DHMC and RMHP Prime did not report this measure; therefore, this measure was not included in this report.

The health plans' performance measure results were evaluated 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. 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.

In the tables following, rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

Performance measure results for HEDIS 2016 were compared to HEDIS 2015 Quality Compass percentiles and are denoted in the measure results tables using the percentile rankings defined below in Table 3-9. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure indicator were compared to the 2015 NCQA Audit Means and Percentiles.

Table 3-9—Percentile Ranking Performance Levels

Percentile Ranking	Performance Level
<10th	Below the 10th Percentile
10th–24th	At or above the 10th percentile but below the 25th percentile
25th–49th	At or above the 25th percentile but below the 50th percentile
50th–74th	At or above the 50th percentile but below the 75th percentile
75th–89th	At or above the 75th percentile but below the 90th percentile
≥90th	At or above the 90th percentile

In the performance measure results tables below, HEDIS 2015 and HEDIS 2016 measure rates are presented for measures deemed "*Reportable*" as a result of performance measure validation, according to NCQA standards. A HEDIS 2015 or HEDIS 2016 measure result of "*Not Applicable (NA)*" indicates that the health plan or plans followed HEDIS specifications, but the denominator was too small (i.e., fewer than 30).

An em dash (—) indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report for this measure indicator. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Denver Health Medicaid Choice

Compliance with Information Systems (IS) Standards

According to the HEDIS Compliance Audit Report for the current reporting period, DHMC was compliant with all IS standards. The auditor noted that DHMC experienced challenges when completing tasks related to HEDIS measure results reporting due to understaffing for groups responsible for performing HEDIS-related tasks. Based on this observation, the auditor recommended that adding additional staff members and implementing automated processes and systems would help to complete HEDIS related tasks in a timely manner.

Pediatric Care Performance Measures

Table 3-10 shows the HEDIS 2015 and HEDIS 2016 Pediatric Care performance measure results for DHMC and the percentile rankings for the HEDIS 2016 rates.

Table 3-10—Pediatric Care Performance Measure Results for DHMC

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	76.81%	75.92%	50th–74th
Combination 3	75.85%	75.40%	50th–74th
Combination 4	75.02%	74.99%	75th–89th
Combination 5	64.98%	64.68%	75th–89th
Combination 6	57.96%	**52.87%^^**	75th–89th
Combination 7	64.41%	64.42%	75th–89th
Combination 8	57.64%	**52.67%^^**	75th–89th
Combination 9	51.31%	**47.02%^^**	75th–89th
Combination 10	51.05%	**46.87%^^**	75th–89th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	80.27%	**76.72%^^**	50th–74th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	5.19%	**7.69%^^**	<10th
Six or More Visits	2.36%	3.36%	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.06%	60.87%	10th–24th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	39.79%	**38.27%^^**	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	93.19%	**78.83%^^**	75th–89th
Counseling for Nutrition—Total	77.86%	77.37%	75th–89th
Counseling for Physical Activity—Total[1]	62.04%	63.26%	50th–74th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	72.78%	76.34%	50th–74th
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	98.03%	97.48%	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

Findings, Strengths, and Recommendations

Within the Pediatric Care measure domain, one of DHMC's measure rates, *Appropriate Treatment for Children With Upper Respiratory Infection*, ranked at or above the national Medicaid 90th percentile. Additionally, rates for *Childhood Immunization Status—Combinations 4–10* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Nutrition—Total* ranked above the 75th percentile. Although statistically significant declines were observed from HEDIS 2015 to 2016 for the *Childhood Immunization Status—Combinations 6, 8, 9,* and *10* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* measure indicator rates, performance was still positive in comparison to national Medicaid benchmarks.

Conversely, DHMC's HEDIS 2016 rates for *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits* fell below the national Medicaid 10th percentile and rates for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Adolescent Well-Care Visits* fell below the national Medicaid 25th percentile, indicating areas for improvement. Of note, benchmark comparisons should be interpreted with caution since rates for these measures presented in this report are based on administrative data only, whereas benchmarking rates were established using administrative and/or medical record review data. Additionally, hybrid measure rates derived using administrative data only likely underestimate health plan performance. Rates calculated using the hybrid methodology are located in Table B-1—DHMC's HEDIS 2016 Hybrid Measure Rates in Appendix B.

HSAG recommends that DHMC monitor its performance with regard to well-child visits for children and well-care visits for adolescents to determine if interventions are warranted. Additionally, HSAG recommends that DHMC identify improvement strategies that could be leveraged to improve all rates within the Pediatric Care measure domain.

Access to Care and Preventive Screening Performance Measures

Table 3-11 shows the HEDIS 2015 and HEDIS 2016 Access to Care and Preventive Screening performance measure results for DHMC and the percentile rankings for the HEDIS 2016 rates.

Table 3-11—Access to Care and Preventive Screening Performance Measure Results for DHMC

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	84.67%	81.75%	25th–49th
Postpartum Care	60.58%	54.74%	10th–24th
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	91.12%	89.33%	<10th
Ages 25 Months to 6 Years	73.42%	73.66%	<10th
Ages 7 to 11 Years	79.27%	78.22%	<10th
Ages 12 to 19 Years	80.17%	79.00%	<10th
Adults' Access to Preventive/Ambulatory Health Services			
Total	69.07%	**65.78%^^**	<10th
Preventive Screening			
Chlamydia Screening in Women			
Total	68.60%	69.33%	≥90th
Breast Cancer Screening			
Breast Cancer Screening	53.09%	**49.17%^^**	10th–24th
Cervical Cancer Screening			
Cervical Cancer Screening	63.02%	56.93%	25th–49th
Non-Recommended Cervical Cancer Screening in Adolescent Females[1],*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.21%	0.17%	≥90th
Adult BMI Assessment			
Adult BMI Assessment	88.08%	84.43%	50th–74th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

Findings, Strengths, and Recommendations

Within the Access to Care and Preventive Screening measure domain, two measure indicator rates ranked at or better than the national Medicaid 90th percentile: *Chlamydia Screening in Women—Total* and *Non-Recommended Cervical Cancer Screening in Adolescent Females*.

Conversely, DHMC's HEDIS 2016 measure rates for all the *Children and Adolescents' Access to Primary Care Practitioners* measure indicators and the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator fell below the national Medicaid 10th percentile indicating opportunities for improvement. Additionally, the *Adults' Access to Preventive/Ambulatory Health Services—Total* rate exhibited a statistically significant decline from HEDIS 2015 to HEDIS 2016.

HSAG recommends that DHMC monitor its rates for *Children and Adolescents' Access to Primary Care Practitioners, Adults' Access to Preventive/Ambulatory Health Services* to identify interventions for increasing members' access to care. HSAG recommends that DHMC identify improvement strategies that could be leveraged to improve all rates within the Access to Care and Preventive Screening measure domain.

Mental/Behavioral Health Performance Measures

Table 3-12 shows the DHMC HEDIS 2015 and HEDIS 2016 rates, the percentile rankings for HEDIS 2016 rates.

Table 3-12—Mental/Behavioral Health Performance Measure Results for DHMC

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	43.65%	46.35%	10th–24th
Effective Continuation Phase Treatment	29.62%	31.41%	25th–49th
Follow-up Care for Children Prescribed ADHD Medication			
Initiation Phase	29.20%	29.41%	10th–24th
Continuation and Maintenance Phase	—	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	4.55%	—

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

No DHMC HEDIS 2016 rates performed above the national Medicaid 50th percentile, suggesting overall opportunities for improvement related to measures in the Mental/Behavioral Health domain. Two measure indicator rates performed below the national Medicaid 25th percentile, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*. HSAG recommends that DHMC monitor appropriate management of antidepressant prescriptions and follow-up care for children prescribed ADHD medication to determine if interventions are warranted, focusing efforts on identifying improvement strategies that could be leveraged to improve all rates within this measure domain.

Living With Illness Performance Measures

Table 3-13 shows the HEDIS 2015 and HEDIS 2016 Living With Illness performance measure results for DHMC and the percentile rankings for the HEDIS 2016 rates.

Table 3-13—Living With Illness Performance Measure Results for DHMC

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Controlling High Blood Pressure			
Controlling High Blood Pressure	70.32%	63.99%	50th–74th
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	—	NA	—
Comprehensive Diabetes Care[1]			
Hemoglobin A1c (HbA1c) Testing	85.64%	89.78%	75th–89th
*HbA1c Poor Control (>9.0%)**	38.44%	36.74%	50th–74th
HbA1c Control (<8.0%)	50.85%	48.66%	50th–74th
Eye Exam (Retinal) Performed	47.93%	55.96%^	50th–74th
Medical Attention for Nephropathy	79.32%	89.29%^	≥90th
Blood Pressure Control (<140/90 mm Hg)	69.10%	73.72%	75th–89th
Annual Monitoring for Patients on Persistent Medications			
ACE Inhibitors or ARBs	85.12%	85.22%	25th–49th
Digoxin	—	NA	—
Diuretics	86.06%	85.05%	25th–49th
Total	85.56%	85.14%	25th–49th
Use of Imaging Studies for Low Back Pain[1]			
Use of Imaging Studies for Low Back Pain	80.33%	81.26%	75th–89th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis			
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	53.41%	45.54%	≥90th
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	52.38%	61.54%	25th–49th
Bronchodilator	65.08%	73.08%	10th–24th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Medication Management for People With Asthma			
Medication Compliance 50%—Total	37.81%	39.76%	<10th
Medication Compliance 75%—Total	14.32%	16.87%	<10th
Asthma Medication Ratio			
Total	29.98%	32.39%	<10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	31.16%	26.13%	25th–49th
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis			
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	64.63%	83.33%^	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Living With Illness measure domain, three of DHMC's HEDIS 2016 rates demonstrated statistically significant improvement from HEDIS 2015: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, Medical Attention for Nephropathy,* and *Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis;* however, caution should be used when evaluating *Comprehensive Diabetes Care* rates between HEDIS 2016 and prior years due to changes in the technical specifications for these indicators. Two of these rates, *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis,* along with *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* ranked at or above the national Medicaid 90th percentile.

Conversely, three of DHMC's HEDIS 2016 rates fell below the national Medicaid 10th percentile: *Medication Management for People With Asthma—Medication Compliance 50%—Total, Medication Compliance 75%—Total,* and *Asthma Medication Ratio—Total.*

HSAG recommends that DHMC monitor measure indicator rates related to asthma medication compliance and the ratio of asthma medications prescribed to members with asthma in an effort to identify interventions for increasing compliance with these measures.

Use of Services Observations

Table 3-14 shows the HEDIS 2015 and HEDIS 2016 Use of Services measure results for DHMC and the percentile rankings for the HEDIS 2016 rates. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2015 and 2016 are not indicative of performance improvement or decline. Percentile rankings are assigned to the HEDIS 2016 reported rates based on 2015 Quality Compass national Medicaid percentiles and are presented for information purposes only.

Table 3-14—Use of Services Measure Results for DHMC

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits—Total	—	207.09	<10th
*Emergency Department Visits—Total**	—	43.97	75th–89th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	—	5.48	10th–24th
Days per 1,000 Member Months (Total Inpatient)	—	24.92	25th–49th
Average Length of Stay (Total Inpatient)	—	4.55	75th–89th
Discharges per 1,000 Member Months (Medicine)	—	3.06	50th–74th
Days per 1,000 Member Months (Medicine)	—	13.46	50th–74th
Average Length of Stay (Medicine)	—	4.41	75th–89th
Discharges per 1,000 Member Months (Surgery)	—	0.81	10th–24th
Days per 1,000 Member Months (Surgery)	—	7.12	25th–49th
Average Length of Stay (Surgery)	—	8.77	≥90th
Discharges per 1,000 Member Months (Maternity)	—	2.61	25th–49th
Days per 1,000 Member Months (Maternity)	—	7.03	25th–49th
Average Length of Stay (Maternity)	—	2.69	50th–74th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.30	0.34	≥90th
Average Days Supplied per Antibiotic Script	9.50	9.33	25th–49th
Average Scripts PMPY for Antibiotics of Concern	0.09	0.10	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	28.02%	28.12%	≥90th
Frequency of Selected Procedures (Procedures per 1,000 MM)[1]			
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)	0.00	0.00	<10th
Bariatric weight loss surgery (20–44 Female)	0.03	0.05	25th–49th
Bariatric weight loss surgery (45–64 Male)	0.00	0.02	75th–89th
Bariatric weight loss surgery (45–64 Female)	0.08	0.12	75th–89th
Tonsillectomy (0–9 Male & Female)	0.29	0.31	10th–24th
Tonsillectomy (10–19 Male & Female)	0.12	0.18	25th–49th
Hysterectomy, Abdominal (15–44 Female)	0.06	0.06	10th–24th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Hysterectomy, Abdominal (45–64 Female)	0.31	0.26	25th–49th
Hysterectomy, Vaginal (15–44 Female)	0.03	0.06	10th–24th
Hysterectomy, Vaginal (45–64 Female)	0.08	0.07	10th–24th
Cholecystectomy, Open (30–64 Male)	0.12	0.04	50th–74th
Cholecystectomy, Open (15–44 Female)	0.02	0.01	50th–74th
Cholecystectomy, Open (45–64 Female)	0.03	0.00	10th–24th
Cholecystectomy (Laparoscopic) (30–64 Male)	0.10	0.09	<10th
Cholecystectomy (Laparoscopic) (15–44 Female)	0.57	0.47	10th–24th
Cholecystectomy (Laparoscopic) (45–64 Female)	0.57	0.33	10th–24th
Back Surgery (20–44 Male)	0.13	0.10	10th–24th
Back Surgery (20–44 Female)	0.06	0.05	<10th
Back Surgery (45–64 Male)	0.47	0.62	50th–74th
Back Surgery (45–64 Female)	0.34	0.23	10th–24th
Mastectomy (15–44 Female)	0.00	0.00	10th–24th
Mastectomy (45–64 Female)	0.05	0.23	75th–89th
Lumpectomy (15–44 Female)	0.07	0.04	<10th
Lumpectomy (45–64 Female)	0.23	0.19	<10th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

** Percentile ranking could not be determined due to the fact that percentile values of <10th, 10th–24th, 25th–49th, 50th–74th, and ≥90th percentiles were zero.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Findings, Strengths, and Recommendations

Reported rates for DHMC's Use of Services measures did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, DHMC's utilization results provide additional information that DHMC may use to assess barriers or patterns of utilization when evaluating improvement interventions.

DHMC: Summary Assessment Related to Quality, Timeliness, and Access for Performance Measures

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

Quality

DHMC's quality-related performance was assessed based on rates for 52 measure indicators; three of these measure indicators were based on low denominators and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these three rates.

Of the remaining 49 measure rates, six rates ranked at or above the national Medicaid 90th percentile, indicating positive performance related to the percentage of appropriate treatment for children with upper respiratory infections, chlamydia screenings for women, percentage of adolescent females who unnecessarily received a cervical cancer screening, medical attention for diabetic members with nephropathy, avoidance of antibiotic treatment for members with acute bronchitis, and members diagnosed with rheumatoid arthritis and who received a disease-modifying anti-rheumatic drug. Additionally, statistically significant improvements from 2015 to 2016 indicated strengths related to members with diabetes receiving eye exams or medical attention for nephropathy and members diagnosed with rheumatoid arthritis and who received a disease-modifying anti-rheumatic drug.

Conversely, DHMC's HEDIS 2016 quality-related measure indicator rates demonstrated opportunities for improvement, ranking below the national Medicaid 10th percentile for measures related to well-child visits during the first 15 months of life, access to a primary care practitioner for children and adolescents, adult members' access to preventive and ambulatory health services, and those who had persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater. Additionally, rates related to immunizations for children and adolescents, well-care visits for adolescent members, documentation of a weight assessment for children and adolescent members, adult members' access to preventive and ambulatory health services, and the percentage of women 50 to 77 years of age who had a mammogram to screen for breast cancer demonstrated statistically significant decline from 2015 to 2016.

Timeliness

DHMC's timeliness-related performance was assessed based on rates for 18 measure indicators, one of which was based on a low denominator and not presented in this report. Significance testing and percentile ranking comparisons were not performed for this one rate.

Of the remaining 17 measure rates, seven rates ranked above the national Medicaid 75th percentile and were related to immunizations for children. None of these measures demonstrated statistically significant improvement from 2015 to 2016. Conversely, DHMC's HEDIS 2016 timeliness-related measure indicator rates demonstrated opportunities for improvement, ranking below the national Medicaid 10th percentile for measures related to well-child visits during the first 15 months of life. Additionally, rates related to immunizations for children and well-care visits during the first 15 months of life and for adolescent members demonstrated statistically significant decline from 2015 to 2016.

Access

DHMC's access-related performance was evaluated based on rates for 57 measure indicators; however, only 13 of these measures were related to health plan performance. These 13 measure rates were compared between HEDIS 2015 and HEDIS 2016, and rates were ranked according to comparisons to national Medicaid percentiles. One measure indicator rate for members with diabetes receiving medical attention for nephropathy ranked at or above the national Medicaid 90th percentile. Additionally, two measure indicators related to members with diabetes receiving eye exams or medical attention for nephropathy demonstrated statistically significant improvement in 2016. For the remaining 44 measures, which assessed utilization of services, rate changes observed from year to year may not necessarily indicate actual improvement or decline.

Rocky Mountain Health Plans Prime

Compliance With Information Systems (IS) Standards

According to the HEDIS Compliance Audit Report for the current reporting period, RMHP Prime was fully compliant with all IS standards relevant to the scope of the performance measure validation. The auditor identified no notable issues of negative impact on HEDIS measure results reporting and made no recommendations for RMHP Prime related to compliance with IS standards. Please note, HEDIS 2016 rates reported by RMHP Prime using the hybrid methodology were deemed invalid by the health plan due to issues with its vendor's medical record review process. Therefore, all rates for these measures, including values submitted for the administrative components of the measure rates, are denoted as "*Biased Rate (BR)*" in this report.

Pediatric Care Performance Measures

Table 3-15 shows the HEDIS 2016 Pediatric Care performance measure results for RMHP Prime and the percentile rankings for the HEDIS 2016 rates.

Table 3-15—Pediatric Care Performance Measure Results for RMHP Prime

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
***Childhood Immunization Status*[1]**		
Combination 2	BR	—
Combination 3	BR	—
Combination 4	BR	—
Combination 5	BR	—
Combination 6	BR	—
Combination 7	BR	—
Combination 8	BR	—
Combination 9	BR	—
Combination 10	BR	—

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
Immunizations for Adolescents[1]		
Combination 1 (Meningococcal, Tdap/Td)	BR	—
Well-Child Visits in the First 15 Months of Life[1]		
*Zero Visits**	NA	—
Six or More Visits	NA	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	BR	—
Adolescent Well-Care Visits[1]		
Adolescent Well-Care Visits	BR	—
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]		
BMI Percentile Documentation—Total	BR	—
Counseling for Nutrition—Total	BR	—
Counseling for Physical Activity—Total	BR	—
Appropriate Testing for Children With Pharyngitis[1]		
Appropriate Testing for Children With Pharyngitis	89.14%	≥90th
Appropriate Treatment for Children With Upper Respiratory Infection[1]		
Appropriate Treatment for Children With Upper Respiratory Infection	94.98%	75th–89th

[1] Indicates that the eligible population for the measure includes children. Due to changes in member eligibility for children in RMHP Prime, the rate may not be comparable to that of DHMC.

* For this indicator, a lower rate indicates better performance.

— Indicates that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

BR indicates that RMHP Prime's reported rate was invalid; therefore, the rate is not presented.

Findings, Strengths, and Recommendations

RMHP Prime had two reportable measures for the Pediatric Care measure domain, and both measure indicators ranked at or above the national Medicaid 75th percentile: *Appropriate Testing for Children With Pharyngitis* and *Appropriate Treatment for Children With Upper Respiratory Infection.*

Access to Care and Preventive Screening Performance Measures

Table 3-16 shows the HEDIS 2016 Access to Care and Preventive Screening performance measure results for RMHP Prime and the percentile rankings for the HEDIS 2016 rates.

Table 3-16—Access to Care and Preventive Screening Performance Measure Results for RMHP Prime

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
Access to Care		
***Prenatal and Postpartum Care*[1]**		
Timeliness of Prenatal Care	BR	—
Postpartum Care	BR	—
***Children and Adolescents' Access to Primary Care Practitioners*[1]**		
Ages 12 to 24 Months	NA	—
Ages 25 Months to 6 Years	84.93%	10th–24th
Ages 7 to 11 Years	91.67%	50th–74th
Ages 12 to 19 Years	89.60%	25th–49th
Adults' Access to Preventive/Ambulatory Health Services		
Total	71.69%	<10th
Preventive Screening		
***Chlamydia Screening in Women*[1]**		
Total	46.27%	10th–24th
Breast Cancer Screening		
Breast Cancer Screening	47.38%	10th–24th
Cervical Cancer Screening		
Cervical Cancer Screening	BR	—
***Non-Recommended Cervical Cancer Screening in Adolescent Females*[1,*]**		
Non-Recommended Cervical Cancer Screening in Adolescent Females	4.04%	25th–49th
Adult BMI Assessment		
Adult BMI Assessment	BR	—

[1] Indicates that the eligible population for the measure includes children. Due to changes in member eligibility for children in RMHP Prime, the rate may not be comparable to that of DHMC.

* For this indicator, a lower rate indicates better performance.

— Indicates that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

BR indicates that RMHP Prime's reported rate was invalid; therefore, the rate is not presented.

Findings, Strengths, and Recommendations

For the Access to Care and Preventive Screening measure domain, only one measure indicator ranked at or above the national Medicaid 50th percentile, *Children and Adolescents' Access to Primary Care Practitioners—Ages 7 to 11 Years*, suggesting overall opportunities for improvement related to measures in the Access to Care and Preventive Screening measure domain. Specifically, four of RMHP Prime's rates fell below the national Medicaid 25th percentile: *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years*, *Adults' Access to Preventive/Ambulatory Health Services—Total, Chlamydia Screening in Women—Total,* and *Breast Cancer Screening*. HSAG recommends that RMHP Prime monitor these rates and focus efforts on identifying improvement strategies that could be leveraged to improve all rates within this measure domain.

Mental/Behavioral Health Performance Measures

Table 3-17 shows the HEDIS 2016 Mental/Behavioral Health performance measure results for RMHP Prime and the percentile rankings for the HEDIS 2016 rates.

Table 3-17—Mental/Behavioral Health Performance Measure Results for RMHP Prime

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management		
Effective Acute Phase Treatment	69.92%	≥90th
Effective Continuation Phase Treatment	57.47%	≥90th
Follow-up Care for Children Prescribed ADHD Medication[1]		
Initiation Phase	35.19%	25th–49th
Continuation and Maintenance Phase	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents[1,*]		
Total	0.00%	—

[1] Indicates that the eligible population for the measure includes children. Due to changes in member eligibility for children in RMHP Prime, the rate may not be comparable to that of DHMC.

* For this indicator, a lower rate indicates better performance.

— Indicates that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

Findings, Strengths, and Recommendations

Within the Mental and Behavioral Health measure domain, both of RMHP Prime's *Antidepressant Medication Management* measure indicator rates ranked at or above the national Medicaid 90th percentile, indicating positive performance with regard to comparison to national benchmarks. RMHP Prime's rate fell below the national Medicaid 50th percentile for one measure indicator, *Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase;* therefore, RMHP Prime may consider monitoring this measure to identify interventions that may lead to increased follow-up care provided during the 30-day initiation phase to members prescribed ADHD prescriptions.

Living With Illness Performance Measures

Table 3-18 shows the HEDIS 2016 Living With Illness performance measure results for RMHP Prime and the percentile rankings for the HEDIS 2016 rates.

Table 3-18—Living With Illness Performance Measure Results for RMHP Prime

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
Controlling High Blood Pressure		
Controlling High Blood Pressure	BR	—
Persistence of Beta-Blocker Treatment After a Heart Attack		
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	—
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	BR	—
*HbA1c Poor Control (>9.0%)**	BR	—
HbA1c Control (<8.0%)	BR	—
Eye Exam (Retinal) Performed	BR	—
Medical Attention for Nephropathy	BR	—
Blood Pressure Control (<140/90 mm Hg)	BR	—
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	84.54%	10th–24th
Digoxin	NA	—
Diuretics	84.17%	10th–24th
Total	84.05%	10th–24th
Use of Imaging Studies for Low Back Pain		
Use of Imaging Studies for Low Back Pain	78.35%	75th–89th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	42.11%	≥90th
Pharmacotherapy Management of COPD Exacerbation		
Systemic Corticosteroid	53.99%	10th–24th
Bronchodilator	57.06%	<10th
Medication Management for People With Asthma		
Medication Compliance 50%—Total	65.91%	75th–89th
Medication Compliance 75%—Total	45.45%	≥90th
Asthma Medication Ratio		
Total	58.26%	25th–49th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	35.42%	50th–74th

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis		
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	65.00%	25th–49th

[1] Indicates that the eligible population for the measure includes children. Due to changes in member eligibility for children in RMHP Prime, the rate may not be comparable to that of DHMC.

* For this indicator, a lower rate indicates better performance.

— Indicates that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

NA indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate, resulting in a Not Applicable (NA) audit designation.

BR indicates that RMHP Prime's reported rate was invalid; therefore, the rate is not presented.

Findings, Strengths, and Recommendations

Within the Living With Illness measure domain, two of RMHP Prime's measure indicator rates ranked at or above the national Medicaid 90th percentile: *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* and *Medication Management for People With Asthma—Medication Compliance 75%—Total.*

However, RMHP Prime's HEDIS 2016 rates fell below the national Medicaid 25th percentile for five measure indicators: *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Diuretics,* and *Total, Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid,* and *Bronchodilator.* HSAG recommends that RMHP Prime monitor these measures and identify barriers to medication management among members on persistent medications or who have COPD.

Use of Services Observations

Table 3-19 shows the HEDIS 2016 Use of Services measure results for RMHP Prime and the percentile rankings for the HEDIS 2016 rates. Percentile rankings are assigned to the HEDIS 2016 reported rates based on 2015 Quality Compass national Medicaid percentiles and are presented for information purposes only.

Table 3-19—Use of Services Measure Results for RMHP Prime

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)[1]		
Outpatient Visits—Total	306.76	25th–49th
*Emergency Department Visits—Total**	71.40	25th–49th
Inpatient Utilization—General Hospital/Acute Care[1]		
Discharges per 1,000 Member Months (Total Inpatient)	9.35	75th–89th
Days per 1,000 Member Months (Total Inpatient)	32.70	50th–74th
Average Length of Stay (Total Inpatient)	3.50	25th–49th

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
Discharges per 1,000 Member Months (Medicine)	0.65	<10th
Days per 1,000 Member Months (Medicine)	2.53	<10th
Average Length of Stay (Medicine)	3.90	50th–74th
Discharges per 1,000 Member Months (Surgery)	6.37	≥90th
Days per 1,000 Member Months (Surgery)	25.02	≥90th
Average Length of Stay (Surgery)	3.93	<10th
Discharges per 1,000 Member Months (Maternity)	2.42	10th–24th
Days per 1,000 Member Months (Maternity)	5.34	10th–24th
Average Length of Stay (Maternity)	2.21	<10th
Antibiotic Utilization[1],*		
Average Scripts PMPY for Antibiotics	1.02	25th–49th
Average Days Supplied per Antibiotic Script	9.30	25th–49th
Average Scripts PMPY for Antibiotics of Concern	0.44	25th–49th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	43.15%	25th–49th
Frequency of Selected Procedures (Procedures per 1,000 MM)		
Bariatric weight loss surgery (0–19 Male)[1]	0.00	**
Bariatric weight loss surgery (0–19 Female)[1]	0.00	**
Bariatric weight loss surgery (20–44 Male)	0.05	≥90th
Bariatric weight loss surgery (20–44 Female)	0.11	75th–89th
Bariatric weight loss surgery (45–64 Male)	0.06	≥90th
Bariatric weight loss surgery (45–64 Female)	0.16	75th–89th
Tonsillectomy (0–9 Male & Female)[1]	0.84	75th–89th
Tonsillectomy (10–19 Male & Female)[1]	0.33	50th–74th
Hysterectomy, Abdominal (15–44 Female)[1]	0.15	50th–74th
Hysterectomy, Abdominal (45–64 Female)	0.26	25th–49th
Hysterectomy, Vaginal (15–44 Female)[1]	0.49	≥90th
Hysterectomy, Vaginal (45–64 Female)	0.47	≥90th
Cholecystectomy, Open (30–64 Male)	0.00	10th–24th
Cholecystectomy, Open (15–44 Female)[1]	0.00	25th–49th
Cholecystectomy, Open (45–64 Female)	0.03	50th–74th
Cholecystectomy (Laparoscopic) (30–64 Male)	0.35	50th–74th
Cholecystectomy (Laparoscopic) (15–44 Female)[1]	0.99	75th–89th
Cholecystectomy (Laparoscopic) (45–64 Female)	0.91	75th–89th
Back Surgery (20–44 Male)	0.35	50th–74th
Back Surgery (20–44 Female)	0.24	75th–89th
Back Surgery (45–64 Male)	0.92	75th–89th
Back Surgery (45–64 Female)	0.58	50th–74th
Mastectomy (15–44 Female)[1]	0.04	75th–89th
Mastectomy (45–64 Female)	0.21	75th–89th

Performance Measures	HEDIS 2016 Rate	Percentile Ranking
Lumpectomy (15–44 Female)[1]	0.21	≥90th
Lumpectomy (45–64 Female)	0.36	25th–49th

[1] Indicates that the eligible population for the measure includes children. Due to changes in member eligibility for children in RMHP Prime, the rate may not be comparable to that of DHMC.

* For this indicator, a lower rate indicates better performance.

** Percentile ranking could not be determined due to the fact that percentile values of <10th, 10th–24th, 25th–49th, 50th–74th, and ≥90th percentiles were zero.

Findings, Strengths, and Recommendations

Reported rates for RMHP Prime's Use of Services measures did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, RMHP Prime's utilization results provide additional information that RMHP Prime may use to assess barriers or patterns of utilization when evaluating improvement interventions.

RMHP Prime: Summary Assessment Related to Quality, Timeliness, and Access for Performance Measures

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

Quality

RMHP Prime's quality-related performance was assessed based on rates for 52 measure indicators. Five of these measure indicators were based on low denominators and were not presented in this report. Significance testing and percentile ranking comparisons were not performed for these five rates. Additionally, 26 of RMHP Prime's reported rates were deemed invalid and, therefore, were not presented in this report. These were identified with a "BR."

Of the remaining 21 measure rates, five rates ranked at or above the national Medicaid 90th percentile, indicating positive performance related to the percentage of appropriate testing for children with pharyngitis, management of medication for members prescribed antidepressant medication, avoidance of antibiotic treatment for members with acute bronchitis, and medication management for members who have persistent asthma.

Conversely, RMHP Prime's HEDIS 2016 quality-related measure indicator rates demonstrated opportunities for improvement, ranking below the national Medicaid 25th percentile for measures related to chlamydia screening, breast cancer screening, medication management for members on persistent medications, and pharmacotherapy for members with COPD.

Timeliness

RMHP Prime's timeliness-related performance was assessed based on rates for 18 measure indicators, three of which were based on low denominators and are not presented in this report. Significance testing and percentile ranking comparisons were not performed for these three rates. Additionally, 14 of RMHP Prime's reported rates were deemed invalid and therefore are not presented in this report. These were identified with a "BR."

The remaining measure in this domain, related to appropriate follow-up for children on ADHD medication during the initiation phase, was ranked below the national Medicaid 50th percentile.

Access

RMHP Prime's access-related performance was evaluated based on rates for 57 measure indicators. One of these measure indicators was based on a low denominator and was not presented in this report. Additionally, eight of RMHP Prime's reported rates were deemed invalid and therefore are not presented in this report. These were identified with a "BR." Of the remaining 48 measures, only four of these measures were related to health plan performance.

Of the four measures related to health plan performance; all were related to children and adolescents' access to primary care practitioners, with one measure ranking at or above the national Medicaid 50th percentile but below the national Medical 75th percentile ranking. One measure, related to adults' access to preventive or ambulatory care, ranked below the national Medicaid 10th percentile. For the remaining 44 measures, which assessed utilization of services, comparisons to the national Medicaid percentiles do not necessarily indicate high or low performance.

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

The statewide rates were calculated from the two health plans' rates and weighted based on their respective eligible populations.

Table 3-20 shows the statewide weighted averages for HEDIS 2015 and HEDIS 2016 along with the percentile ranking for each Pediatric Care performance measure.

Table 3-20—Statewide Summary of Rates for Pediatric Care Performance Measures

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	64.06%	75.92%^	50th–74th
Combination 3	62.65%	75.40%^	50th–74th
Combination 4	61.29%	74.99%^	75th–89th
Combination 5	53.43%	64.68%^	75th–89th
Combination 6	47.76%	52.87%^	75th–89th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Combination 7	52.42%	64.42%^	75th–89th
Combination 8	47.10%	52.67%^	75th–89th
Combination 9	41.96%	47.02%^	75th–89th
Combination 10	41.43%	46.87%^	75th–89th
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	74.24%	76.72%	50th–74th
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	3.96%	**7.69%^^**	<10th
Six or More Visits	10.05%	**3.36%^^**	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	61.36%	60.87%	10th–24th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	40.26%	**38.27%^^**	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	89.48%	**78.83%^^**	75th–89th
Counseling for Nutrition—Total	73.54%	77.37%^	75th–89th
Counseling for Physical Activity—Total[1]	62.18%	63.26%^	50th–74th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	84.63%	**81.12%^^**	75th–89th
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	95.64%	96.85%^	≥90th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

Findings, Strengths, and Recommendations

Within the Pediatric Care measure domain, 10 statewide weighted average rates for HEDIS 2016 ranked above the national Medicaid 75th percentile but below the 90th percentile, and one measure rate, *Appropriate Treatment for Children With Upper Respiratory Infection,* exceeded the national Medicaid 90th percentile. Specifically, the statewide weighted averages demonstrated positive performance as compared to national benchmarks in areas pertaining to immunizations for children, weight assessment and counseling for nutrition for children and adolescents, testing for children with pharyngitis, and treatment for children with upper respiratory infections.

Conversely, HEDIS 2016 statewide weighted rates for *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits* fell below the national Medicaid 10th percentile and demonstrated statistically significant declines from HEDIS 2015.

Of note, benchmark comparisons should be interpreted with caution as statewide rates presented in this domain, with the exception of *Weight Assessment and Counseling for Nutrition and Physical Activities*, are based on administrative data only, whereas benchmarking rates were established using administrative and/or medical record review data. Additionally, hybrid measure rates derived using administrative data only likely underestimate health plan performance.

Access to Care and Preventive Screening Performance Measures

Table 3-21 shows the statewide weighted averages for HEDIS 2015 and HEDIS 2016 along with the percentile ranking for each Access to Care and Preventive Screening performance measure.

Table 3-21—Statewide Summary of Rates for Access to Care and Preventive Screening Performance Measures

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	87.35%	**81.75%^^**	25th–49th
Postpartum Care	63.46%	**54.74%^^**	10th–24th
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	91.30%	**89.30%^^**	<10th
Ages 25 Months to 6 Years	73.21%	73.74%	<10th
Ages 7 to 11 Years	81.21%	**78.33%^^**	<10th
Ages 12 to 19 Years	81.21%	**79.12%^^**	<10th
Adults' Access to Preventive/Ambulatory Health Services			
Total	65.72%	68.91%^	<10th
Preventive Screening			
Chlamydia Screening in Women			
Total	57.49%	60.91%^	50th–74th
Breast Cancer Screening			
Breast Cancer Screening	51.90%	**48.70%^^**	10th–24th
Cervical Cancer Screening			
Cervical Cancer Screening	56.13%	56.93%	25th–49th
Non-Recommended Cervical Cancer Screening in Adolescent Females[1,*]			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.99%	0.66%	≥90th
Adult BMI Assessment			
Adult BMI Assessment	87.97%	**84.43%^^**	50th–74th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

Findings, Strengths, and Recommendations

For the Access to Care and Preventive Screening measure domain, the statewide weighted average rate for *Non-Recommended Cervical Cancer Screening in Adolescent Females* ranked at or above the national Medicaid 90th percentile.

Conversely, statewide weighted averages for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years*, and *Ages 12 to 19 Month*s and *Adults' Access to Preventive/Ambulatory Health Services—Total* fell below the national Medicaid 10th percentile, suggesting opportunities for improvement related to members' access to care.

HSAG recommends that the health plans monitor rates related to access to a primary care practitioner for children and adolescents to identify provider, member, and systems interventions that could be implemented to improve measure rates in this area.

Mental/Behavioral Health Performance Measures

Table 3-22 shows the statewide weighted averages for HEDIS 2015 and HEDIS 2016 along with the percentile ranking for each Mental/Behavioral Health performance measure.

Table 3-22—Statewide Summary of Rates for Mental/Behavioral Health Performance Measures

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	49.41%	56.96%^	75th–89th
Effective Continuation Phase Treatment	33.90%	43.14%^	75th–89th
Follow-up Care for Children Prescribed ADHD Medication			
Initiation Phase	32.54%	31.97%	10th–24th
Continuation and Maintenance Phase	30.49%	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	2.70%	—

* For this indicator, a lower rate indicates better performance.

— Indicates that the measure was not presented in last year's technical report. Therefore, a HEDIS 2015 measure rate is not presented in this year's report. This symbol may also indicate that a percentile ranking was not determined because either the HEDIS 2016 measure rate was not reportable or the measure did not have an applicable benchmark.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

NA indicates that the health plan or plans followed the specifications but the denominator was too small (<30) to report a valid rate.

Findings, Strengths, and Recommendations

Based on the rates reported for the statewide weighted averages for the Mental/Behavioral Health measure domain, rates for *Antidepressant Medication Management—Effective Acute Phase Treatment*

and *Effective Continuation Phase Treatment* ranked at or above the national Medicaid 75th percentile and demonstrated statistically significant improvement from HEDIS 2015 to HEDIS 2016.

Conversely, HEDIS 2016 performance measure rates for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* fell below the national Medicaid 25th percentile. HSAG recommends that Medicaid health plans monitor the follow-up care for children prescribed ADHD medication to determine if interventions are warranted.

Living With Illness Performance Measures

Table 3-23 shows the statewide HEDIS 2015 and HEDIS 2016 Living With Illness performance measure results and the percentile rankings for the HEDIS 2016 rates.

Table 3-23—Statewide Summary of Rates for Living With Illness Performance Measures

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Controlling High Blood Pressure			
Controlling High Blood Pressure	69.66%	63.99%^^	50th–74th
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	77.42%	75.00%	10th–24th
Comprehensive Diabetes Care[1]			
Hemoglobin A1c (HbA1c) Testing	86.76%	89.78%^	75th–89th
*HbA1c Poor Control (>9.0%)**	34.86%	36.74%	50th–74th
HbA1c Control (<8.0%)	55.25%	48.66%^^	50th–74th
Eye Exam (Retinal) Performed	52.61%	55.96%^	50th–74th
Medical Attention for Nephropathy	80.45%	89.29%^	≥90th
Blood Pressure Control (<140/90 mm Hg)	71.38%	73.72%	75th–89th
Annual Monitoring for Patients on Persistent Medications			
ACE Inhibitors or ARBs	85.59%	84.92%	25th–49th
Digoxin	NA	58.06%	50th–74th
Diuretics	86.08%	84.65%	10th–24th
Total	85.72%	84.65%	25th–49th
Use of Imaging Studies for Low Back Pain[1]			
Use of Imaging Studies for Low Back Pain	81.28%	79.96%	75th–89th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis			
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	38.99%	43.16%	≥90th
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	47.45%	58.22%^	10th–24th
Bronchodilator	59.49%	66.04%	10th–24th
Medication Management for People With Asthma			
Medication Compliance 50%—Total	42.20%	43.20%	10th–24th
Medication Compliance 75%—Total	20.09%	20.63%	10th–24th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Asthma Medication Ratio			
Total	39.93%	36.00%	<10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	28.30%	27.94%	25th–49th
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis			
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	63.33%	73.37%^	50th–74th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.

Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05.

Findings, Strengths, and Recommendations

Within the Living With Illness measure domain, statewide weighted average rates for *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* ranked at or above the national Medicaid 90th percentile, indicating positive performance for HEDIS 2016 in these areas.

Conversely, seven statewide weighted average rates fell below the national Medicaid 25th percentile, indicating the need for improved rates for *Persistence of Beta-Blocker Treatment After a Heart Attack, Annual Monitoring for Patients on Persistent Medications—Diuretics, Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator, Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total,* and *Asthma Medication Ratio—Total.*

Use of Services Observations

Table 3-24 shows the statewide weighted averages for HEDIS 2015 and HEDIS 2016 along with the percentile ranking for each Use of Services performance measure. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2015 and HEDIS 2016 may not denote actual improvement or decline in performance.

Table 3-24—Statewide Summary of Rates for Use of Services Measures

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits—Total	224.34	239.20	<10th
*Emergency Department Visits—Total**	37.35	52.81	50th–74th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	5.07	6.73	25th–49th
Days per 1,000 Member Months (Total Inpatient)	19.24	27.43	25th–49th
Average Length of Stay (Total Inpatient)	3.79	4.08	50th–74th
Discharges per 1,000 Member Months (Medicine)	2.37	2.28	10th–24th
Days per 1,000 Member Months (Medicine)	10.13	9.94	25th–49th
Average Length of Stay (Medicine)	4.28	4.36	75th–89th
Discharges per 1,000 Member Months (Surgery)	0.91	2.60	≥90th
Days per 1,000 Member Months (Surgery)	5.42	12.89	75th–89th
Average Length of Stay (Surgery)	5.96	4.95	10th–24th
Discharges per 1,000 Member Months (Maternity)	2.56	2.53	10th–24th
Days per 1,000 Member Months (Maternity)	5.25	6.31	10th–24th
Average Length of Stay (Maternity)	2.05	2.49	25th–49th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.40	0.56	≥90th
Average Days Supplied per Antibiotic Script	9.55	9.31	25th–49th
Average Scripts PMPY for Antibiotics of Concern	0.13	0.21	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.78%	36.89%	75th–89th
Frequency of Selected Procedures (Procedures per 1,000 MM)[1]			
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)	0.01	0.03	75th–89th
Bariatric weight loss surgery (20–44 Female)	0.05	0.08	50th–74th
Bariatric weight loss surgery (45–64 Male)	0.00	0.04	75th–89th
Bariatric weight loss surgery (45–64 Female)	0.10	0.14	75th–89th
Tonsillectomy (0–9 Male & Female)	0.41	0.32	10th–24th
Tonsillectomy (10–19 Male & Female)	0.21	0.19	25th–49th
Hysterectomy, Abdominal (15–44 Female)	0.08	0.10	10th–24th
Hysterectomy, Abdominal (45–64 Female)	0.30	0.26	25th–49th

Performance Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	Percentile Ranking
Hysterectomy, Vaginal (15–44 Female)	0.23	0.26	75th–89th
Hysterectomy, Vaginal (45–64 Female)	0.19	0.31	75th–89th
Cholecystectomy, Open (30–64 Male)	0.06	0.02	25th–49th
Cholecystectomy, Open (15–44 Female)	0.01	0.00	25th–49th
Cholecystectomy, Open (45–64 Female)	0.01	0.02	25th–49th
Cholecystectomy (Laparoscopic) (30–64 Male)	0.20	0.24	25th–49th
Cholecystectomy (Laparoscopic) (15–44 Female)	0.66	0.71	50th–74th
Cholecystectomy (Laparoscopic) (45–64 Female)	0.61	0.67	50th–74th
Back Surgery (20–44 Male)	0.19	0.26	50th–74th
Back Surgery (20–44 Female)	0.09	0.15	25th–49th
Back Surgery (45–64 Male)	0.41	0.79	75th–89th
Back Surgery (45–64 Female)	0.35	0.44	25th–49th
Mastectomy (15–44 Female)	0.01	0.02	25th–49th
Mastectomy (45–64 Female)	0.12	0.22	75th–89th
Lumpectomy (15–44 Female)	0.09	0.12	25th–49th
Lumpectomy (45–64 Female)	0.28	0.29	10th–24th

[1] Due to changes in the technical specifications for this measure, exercise caution when trending rates between 2016 and prior years.

* For this indicator, a lower rate indicates better performance.

** Percentile ranking could not be determined due to the fact that percentile values of <10th, 10th–24th, 25th–49th, 50th–74th, and ≥90th percentiles were zero.

Findings, Strengths, and Recommendations

Statewide Medicaid average rates for Use of Services measures did not take into account the characteristics of the population; therefore, HSAG could not draw conclusions on performance based on the reported utilization results. Nonetheless, combined with other performance metrics, utilization results provide additional information that the Department may use to assess barriers or patterns of utilization when evaluating improvement interventions.

Statewide Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

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

Quality

Statewide performance in this domain was assessed based on rates for 52 measure indicators. One of these measure indicators was based on a low denominator and was not presented in this report. Significance testing and percentile ranking comparisons were not performed for this one rate.

Of the remaining 51 measure rates, four rates ranked at or above the national Medicaid 90th percentile, indicating positive performance related to the rate of appropriate treatment for children with upper respiratory infections, percentage of adolescent females who unnecessarily received a cervical cancer screening, members with diabetes receiving medical attention for nephropathy, and avoidance of antibiotic treatment for members with acute bronchitis. Additionally, statistically significant improvements from 2015 to 2016 indicated strengths related to immunizations for children; counseling for nutrition and physical activity for children and adolescent member; appropriate treatment for children with upper respiratory infections; chlamydia screening in women; medication management for members on antidepressants; diabetic members who received HbA1c testing, eye exams, or medical attention for nephropathy; members who received systemic corticosteroids for acute exacerbations of COPD; and those diagnosed with rheumatoid arthritis and who received a disease-modifying anti-rheumatic drug.

Conversely, rates for three of the 51 quality-related measures fell below the national Medicaid 10th percentile and two of these measures demonstrated a statistically significantly decline, indicating opportunities for improvement related to well-child visits during the first 15 months of life. An additional nine of the 51 quality-related measures rates showed statistically significant decline in quality provided statewide. These included rates related to well-care visits for adolescent members, documentation of a weight assessment for children and adolescents, the percentage of appropriate testing for children with pharyngitis, the percentage of deliveries with timely prenatal care or postpartum care, the percentage of women 50 to 77 years of age who had a mammogram to screen for breast cancer, those whose BMI was documented during the measurement year, blood pressure control for members with hypertension, and those who had a recent HbA1c test performed wherein the HbA1c level was less than 8 percent.

Timeliness

Statewide performance in this domain was assessed based on rates for 18 measure indicators, one of which was based on a low denominator and was not presented in this report. Significance testing and percentile ranking comparisons were not performed for this one rate.

Of the remaining 17 measure rates, seven rates ranked above the national Medicaid 75th percentile and were related to immunizations for children. All measures related to immunizations for children

demonstrated statistically significant improvements from 2015 to 2016. Conversely, the statewide weighted average timeliness-related measure indicator rates demonstrated opportunities for improvement, ranking below the national Medicaid 10th percentile for measures related to well-child visits during the first 15 months of life. Additionally, rates related to well-child visits during the first 15 months of life, well-care visits for adolescent members, and the percentage of deliveries with timely prenatal care or postpartum care demonstrated statistically significant decline from 2015 to 2016.

Access

Statewide performance in this domain was evaluated based on rates for 57 measure indicators, however, only 13 of these measures were related to health plan performance. These 13 measure rates were compared between HEDIS 2015 and HEDIS 2016, and rates were ranked according to comparisons to national Medicaid percentiles. One measure indicator rate, for members with diabetes receiving medical attention for nephropathy, ranked at or above the 90th national Medicaid percentile. Additionally, three measure indicators related to members with diabetes receiving hemoglobin A1c testing, eye exams, and medical attention for nephropathy demonstrated statistically significant improvement in 2016. In addition to the three measure indicators listed preceding, an additional measure indicator related to adult members' access to preventive and ambulatory health services demonstrated statistically significant improvement; however, the rate ranked below the national Medicaid 10th percentile. All four indicators related to children and adolescents' access to primary care practitioners ranked below the national Medicaid 10th percentile, and three of these rates demonstrated a statistically significant decline from HEDIS 2015 to HEDIS 2016. For the remaining 44 measures, which assessed utilization of services, rate changes observed from year to year may not necessarily indicate actual improvement or decline.

Validation of Performance Improvement Projects (PIPs)

For FY 2015–2016, HSAG validated one PIP each for DHMC and RMHP Prime. Table 3-25 lists the PIP topics identified by each plan.

Table 3-25—FY2015–2016 PIP Topics Selected by MCOs

Health Plan	PIP Topic
DHMC	*Improving Follow-Up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*
RMHP Prime	*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

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 second validation year for this PIP. DHMC reported baseline study indicator results and completed Activities I through VIII of the PIP Summary Form.

Table 3-26 provides a summary of DHMC's PIP validation results for the FY 2015–2016 validation cycle.

Table 3-26—Performance Improvement Project Validation Results for DHMC

Study Stage	Activity	Percentage 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)**

Study Stage	Activity	Percentage of Applicable Elements		
		Met	Partially Met	Not Met
Implementation	VII. Data Analysis and Interpretation	67% (2/3)	0% (0/3)	33% (1/3)
	VIII. Interventions and Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
	Implementation Total	**80% (4/5)**	**0% (0/5)**	**20% (1/5)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	Outcomes Total	***Not Assessed***	***Not Assessed***	***Not Assessed***
	Percent Score of Applicable Evaluation Elements Met	**93% (13/14)**	**0% (0/14)**	**7% (1/14)**

Overall, 93 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, HSAG validated only the Design and Implementation stages (Activities I through VIII).

Table 3-27 provides a summary of DHMC's PIP outcomes for the FY 2015–2016 validation cycle.

Table 3-27—Performance Improvement Project Outcomes for DHMC
PIP Topic: *Improving Follow-Up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*

Study Indicator	Baseline Period (07/01/2014–06/30/2015)	Remeasurement 1 (07/01/2015–06/30/2016)	Remeasurement 2 (07/01/2016–06/30/2017)	Sustained Improvement
1. The percentage of patients with referrals to the Healthy Lifestyle Clinic for overweight or obesity, with a completed visit and whose referring provider and PCP (if PCP is not the referring provider) receives a specialty report within 7 days of the patient visit.	100%			
2. The percentage of patients with referrals to the Children's Hospital Lifestyle Medicine Clinic for overweight or obesity, with a completed visit and whose referring provider and PCP (if PCP is not the referring provider) receives a specialty report within 30 days of the patient visit.	91%			

DHMC's baseline rates were 100 percent and 91 percent respectively, which demonstrates that little to no opportunity for improvement exists. The MCO will be proposing a new PIP topic for the next validation year.

Strengths

DHMC designed a scientifically sound project supported by the use of 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. Although DHMC will not be continuing this PIP topic, the MCO reported and interpreted its available baseline data accurately. The MCO also conducted a causal/barrier analysis using appropriate quality improvement tools and prioritized its identified barriers.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the MCO's overall success in improving PIP rates.

Although the MCO will be proposing a new topic for next year, for this PIP, DHMC completed a process map and failure modes and effects analysis and identified the following barriers:

- Members do not show up for appointments.
- Lack of effective follow-up activities by the provider.
- Appointment request list protocols are not being followed by the provider when entering the reason for the referral.
- Lack of synchronization between EPIC and Denver Health referral information systems.

At the time of submission, DHMC had not implemented any interventions.

Recommendations

DHMC's PIP documentation demonstrated that the baseline rates were 100 percent for Study Indicator 1 and 91 percent for Study Indicator 2. These rates do not support the need for improvement in the selected PIP topic. During a technical assistance call with DHMC and the Department, it was decided that the MCO will conduct further analysis and determine a new PIP topic. As DHMC initiates a new PIP topic, it should seek technical assistance from HSAG to ensure a sound study design.

DHMC: Summary Assessment Related to Quality, Timeliness, and Access Related to PIPs

While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation 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 and the use of appropriate QI activities to support improvement of PIP outcomes.

Rocky Mountain Health Plans Prime

Findings

The RMHP Prime *Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility* PIP focused on improving the transition of care by assisting members who have been paroled with accessing a primary care provider within 90 days of enrollment into RMHP Prime. This was the second validation year for the PIP. RMHP Prime reported baseline study indicator results and completed Activities I through VIII of the PIP Summary Form.

Table 3-28 provides a summary of RMHP Prime's PIP validation results for the FY 2015–2016 validation cycle.

Table 3-28—Performance Improvement Project Validation Results for RMHP Prime

Study Stage	Activity	Percentage 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% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total		**100% (6/6)**	**0% (0/6)**	**0% (0/6)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percent Score of Applicable Evaluation Elements Met		**100% (14/14)**	**0% (0/14)**	**0% (0/14)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, HSAG validated the Design and Implementation stages (Activities I through VIII).

Table 3-29 provides a summary of RMHP Prime's PIP outcomes for the FY 2015–2016 validation cycle.

Table 3-29—Performance Improvement Project Outcomes for RMHP Prime
PIP Topic: *Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*

Study Indicator	Baseline Period (07/01/2014–06/30/2015)	Remeasurement 1 (07/01/2015–06/30/2016)	Remeasurement 2 (07/01/2016–06/30/2017)	Sustained Improvement
The percentage of members paroled to Mesa County, DOC Adult Parole-Grand Junction Office, and enrolled into RMHP Prime during the measurement year and had a visit with a primary care provider within 90 days of enrollment into Prime.	20.3%			

The baseline rate for members who have been paroled and had a visit with a primary care provider within 90 days of enrollment into RMHP Prime was 20.3 percent. This rate is 14.7 percentage points below the first remeasurement goal of 35 percent.

Strengths

RMHP Prime designed a scientifically sound project supported by the use of 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. RMHP Prime reported and interpreted its baseline data accurately. The plan completed its initial causal/barrier analysis using the appropriate quality improvement tools. RMHP Prime developed a methodologically sound project and has set the foundation from which to move forward.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the MCO's overall success in improving PIP rates.

For the *Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility* PIP, RMHP Prime identified two primary barriers to address:

- Lack of a parolee's ability to identify a primary care medical provider (PCMP) with which to schedule a visit.
- Lack of education and awareness of the importance of regularly visiting a PCMP to manage chronic health conditions or to maintain health.

The MCO indicated that the two barriers identified were equal in their priority ranking; therefore, as RMHP Prime implements interventions, it will target both of these barriers. To address these barriers, RMHP Prime implemented the following interventions:

- Assigned a care coordinator to each parolee to assess for health needs and help coordinate primary care, schedule the initial appointment, and ensure that the parolee attends the appointment.
- Provided education to each parolee, through the care coordinator, on the importance of having a medical home and regularly seeking care to manage chronic conditions.

Recommendations

As the PIP progresses, HSAG recommends that RMHP Prime do the following:

- Simplify how it states the study question.
- Evaluate and document annually whether or not factors threaten validity of the data reported and comparability of the data.
- Use and describe quality improvement tools such as a causal/barrier analysis, a key driver diagram, process mapping, or failure modes and effects analysis at least annually to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.
- Describe methods used to prioritize newly identified barriers.
- Develop active, innovative interventions that can directly impact the study indicator outcomes.
- Use techniques based on quality improvement science such as the Plan-Do-Study-Act (PDSA) model as part of the improvement strategies. Interventions may be tested on a small scale, evaluated, and then expanded to full implementation, if deemed successful.
- Develop a process or plan to evaluate the effectiveness of each implemented intervention.

RMHP Prime: Summary Assessment Related to Quality, Timeliness, and Access for PIPs

While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation 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 Prime earned a *Met* validation status, demonstrating a strong application of PIP study design principles and the use of appropriate QI activities to support improvement of PIP outcomes.

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

Table 3-30 shows the health plans' overall performance based on HSAG's validation of the FY 2015–2016 PIPs submitted for validation.

Table 3-30—Summary of Each MCO's PIP Validation Scores and 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*	93%	100%	*Met*
RMHP Prime	*Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*	100%	100%	*Met*

The validation scores and validation status across the two PIPs demonstrated solid performance in the PIP design and implementation stages, meeting 100 percent of all critical elements. Consequently, each PIP received a *Met* validation status.

The two PIPs validated by HSAG each earned a *Met* validation status, demonstrating a sound application of design principles necessary to produce valid and reliable PIP results and strong QI processes and activities needed to support desired improvement.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS surveys ask members and patients to report on and evaluate their experiences with healthcare. These surveys cover topics important to members such as communication skills of providers and accessibility of services. The CAHPS survey is recognized nationally as an industry standard for both commercial and public payers. The CAHPS sampling and data collection procedures promote both the standardized administration of survey instruments and the comparability of resulting health plan data.

The technical method of data collection was through the administration of the *CAHPS 5.0H Adult Medicaid Health Plan Survey* for the adult population, and the *CAHPS 5.0H Child Medicaid Health Plan Survey* for the child population for both RMHP Prime and DHMC.

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 (+).

For DHMC's findings, a substantial increase is noted when a measure's rate increases by 5 percentage points or more from the previous year. A substantial decrease is noted when a measure's rate decreases by 5 percentage points or more from the previous year. Due to changes in the population for RMHP Prime, the rates for RMHP Prime are not trendable.

Denver Health Medicaid Choice

Findings

Table 3-31 shows the adult Medicaid results achieved by DHMC for FY 2015–2016 and the prior year (FY 2014–2015).

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

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Getting Needed Care	76.3%	78.1%
Getting Care Quickly	73.9%	69.7%
How Well Doctors Communicate	91.0%	89.5%
Customer Service	82.6%+	84.5%
Shared Decision Making	80.0%+	79.3%
Rating of Personal Doctor	73.0%	71.5%
Rating of Specialist Seen Most Often	58.9%	67.2%
Rating of All Health Care	47.0%	50.2%
Rating of Health Plan	58.1%	56.0%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). When fewer than 100 respondents for a CAHPS measure are noted, caution should be exercised in interpreting results.

Table 3-32 shows the child Medicaid results achieved by DHMC for FY 2015–2016 and the prior year (FY 2014–2015).

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

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Getting Needed Care	76.7%	80.6%
Getting Care Quickly	78.8%	85.8%
How Well Doctors Communicate	92.2%	93.6%
Customer Service	83.7%	88.2%
Shared Decision Making	80.0%+	75.8%+

Measure	FY 2014–2015 Rate	FY 2015–2016 Rate
Rating of Personal Doctor	82.8%	80.7%
Rating of Specialist Seen Most Often	78.9%+	75.0%+
Rating of All Health Care	69.1%	66.9%
Rating of Health Plan	72.1%	73.3%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). When fewer than 100 respondents for a CAHPS measure are noted, caution should be exercised in interpreting results.

Recommendations

For the adult and child Medicaid populations, DHMC had no substantial decrease in rates. However, for the adult population, five measures—*Getting Care Quickly*, *How Well Doctors Communicate, Shared Decision Making, Rating of Personal Doctor*, and *Rating of Health Plan*—showed a slight decrease. For the child Medicaid population, four measures—*Shared Decision Making, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Rating of All Health Care*—showed a slight decrease. 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. To improve satisfaction on the *How Well Doctors Communicate* composite measure, DHMC should focus on communication tools, improving health literacy, and language barriers. For the *Shared Decision Making* composite measure, DHMC should encourage increased member participation in personal healthcare, provide patient decision aids to members, and develop training materials for physicians designed to encourage physicians to listen to and respect members' goals and preferences and use member preferences to guide members' treatments. For the *Rating of Health Plan* global rating, DHMC should focus on alternatives to one-on-one visits, health plan operations, enhancing online patient portals, promoting QI initiatives, and coordination of health services. For the *Rating of Personal Doctor* global rating, DHMC should continue to focus efforts on monitoring appointment scheduling, obtaining direct patient feedback, enhancing physician-patient communication, improving shared decision making, and training care managers about the principles of patient/family centered care. To improve in the area of *Rating of Specialist Seen Most Often*, DHMC should continue to focus on skills training for specialists, telemedicine, and enhancing the care coordination teams. For the *Rating of All Health Care* global rating, DHMC should explore activities that target member perception of access to care, patient and family engagement advisory councils, patient- and family-centered care, and involving families in care coordination.

DHMC: Summary Assessment Related to Quality, Timeliness, and Access for CAHPS

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

For DHMC's adult Medicaid population, one measure rate increased substantially, *Rating of Specialist Seen Most Often* (8.3 percentage points). Three of the measures demonstrated slight increases: *Getting*

Needed Care, *Customer Service*, and *Rating of All Health Care*. As noted, no measures' rates decreased substantially; however, the remaining five measures did show rate decreases.

For the DHMC's child Medicaid population, one measure rate increased substantially, *Getting Care Quickly* (7.0 percentage points). Four measures demonstrated slight increases: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Health Plan.* As noted, no measures' rates decreased substantially; however, the rates for the remaining four measures did decrease.

DHMC's 2016 rates for the adult Medicaid population were lower than the 2015 NCQA adult Medicaid national averages for six measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, and *Rating of Health Plan*. Of these, one measure was at least 5 percentage points lower than the 2015 national average, *Getting Care Quickly*. Three measures were higher than the 2015 national averages: *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. Of these, the *Rating of Personal Doctor* measure rate was at least 5 percentage points greater than the 2015 national averages.

DHMC's 2016 rates for the child Medicaid population were lower than the 2015 NCQA child Medicaid national averages for three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Shared Decision Making*. For DHMC's child Medicaid population, six measures were higher than the 2015 national averages: *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of All Health Care*, and *Rating of Health Plan*. Of these, the *Rating of Personal Doctor* measure rate was at least 5 percentage points greater than the 2015 national average.

Rocky Mountain Health Plans Prime

Table 3-33 shows the adult Medicaid results achieved by RMHP Prime for FY 2015–2016. Due to changes in RMHP Prime's population, results are not comparable to the FY 2014–2015 rates.

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

Measure	FY 2015–2016 Rate
Getting Needed Care	84.9%
Getting Care Quickly	81.9%
How Well Doctors Communicate	94.4%
Customer Service	82.2%+
Shared Decision Making	77.0%+
Rating of Personal Doctor	67.8%
Rating of Specialist Seen Most Often	66.7%+
Rating of All Health Care	48.8%
Rating of Health Plan	55.0%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). When fewer than 100 respondents for a CAHPS measure are noted, caution should be exercised in interpreting results.

Table 3-34 shows the child Medicaid results achieved by RMHP Prime for FY 2015–2016. Due to changes in RMHP Prime's population, results are not comparable to the FY 2014–2015 rates.

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

Measure	FY 2015–2016 Rate
Getting Needed Care	84.9%+
Getting Care Quickly	90.8%+
How Well Doctors Communicate	93.7%+
Customer Service	87.4%+
Shared Decision Making	94.6%+
Rating of Personal Doctor	72.5%+
Rating of Specialist Seen Most Often	65.1%+
Rating of All Health Care	55.7%+
Rating of Health Plan	61.9%+

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). When fewer than 100 respondents for a CAHPS measure are noted, caution should be exercised in interpreting results.

Recommendations

RMHP Prime should continue to evaluate the satisfaction of members in its health plan. Once comparable trend data are available, RMHP Prime should evaluate for areas requiring improvement.

RMHP Prime: Summary Assessment Related to Quality, Timeliness, and Access for CAHPS

All measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access and *Getting Care Quickly* addressed timeliness. Given that the population for RMHP Prime changed from previous years, results are not trendable. These results represent a baseline and should be evaluated for trends in upcoming years.

RMHP Prime's 2016 rates for the adult Medicaid population were lower than the 2015 NCQA adult Medicaid national averages for four measures: *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*. Five measures had rates above the 2015 NCQA adult Medicaid national averages: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often.* However, the rates for all measures were neither higher nor lower by 5 or more percentage points than the 2015 NCQA adult Medicaid national averages.

RMHP Prime's 2016 rates for the child Medicaid population were lower than the 2015 NCQA general child Medicaid national averages for five measures: *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan.* Of these, three measures were at least 5 percentage points lower than the 2015 national average: *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan.* Four measures were

higher than the 2015 national averages: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. Of these, the *Shared Decision Making* measure rate was at least 5 percentage points greater than the 2015 national average. RMHP Prime's 2016 rates for the child Medicaid population were calculated based on fewer than 100 respondents for each measure; therefore, caution should be used when interpreting results. Comparing to the 2015 NCQA child Medicaid national averages would not provide accurate representation of the health plan's performances.

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

In December 2014, RMHP discontinued its existing Medicaid product in which children and adults were enrolled. Some Medicaid members were transitioned to the ACC program (i.e., RCCO Region 1) whereas others were enrolled into RMHP Prime. RMHP Prime implemented a new Medicaid risk managed care program in September 2014; adults and children within a small geographic area were enrolled into this Medicaid product. Children who qualified on the basis of disability were the only children enrolled in this program. In general, low income children were not eligible for the new Medicaid risk product. As RMHP Prime's 2016 results are not comparable to prior years' CAHPS results due to RMHP's Medicaid population change, a trend analysis was not performed for RMHP Prime. In addition, for the same reason of different populations, RMHP Prime's and DHMC's results were not compared or combined to create an aggregate.

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 2014–2015. This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations or required actions from the previous year.

Denver Health Medicaid Choice

Compliance Monitoring Site Review

As a result of the FY 2014–2015 site review, DHMC was required to address 11 *Partially Met* scores—two related to Member Information and nine related to the Grievance System. DHMC submitted its CAP in April. After HSAG and the Department reviewed and approved the plan, DHMC began submitting documents to demonstrate completion of the approved interventions. As of December 2015, DHMC had two outstanding required actions, both related to member information regarding EPSDT services. DHMC worked with the Department to address the remaining issues, and in May 2016 HSAG found that DHMC had completed all required actions.

In addition to addressing required actions for the FY 2014–2015 site review, DHMC was required to address outstanding corrective actions resulting from the FY 2013–2014 site review. These required actions were related to timeliness and content of notices of action, member information related to emergency services, and timely access to care. HSAG and the Department continued to work with DHMC and in February 2016 determined that DHMC had completed all FY 2013–2014 required actions.

Validation of Performance Measures

During the FY 2014–2015 review, HSAG recommended that DHMC focus efforts on improving performance on the well-child visits measures and access to services for all members. Further, based on analyses of DHMC's HEDIS 2015 measure rates compared to the previous year's rates and national Medicaid benchmarks, HSAG recommended that DHMC develop strategies to improve antidepressant medication management, follow-up care for children on ADHD medications, diabetic testing for members with diabetes and schizophrenia, HbA1c control for members with diabetes, and management of respiratory conditions.

As a result, DHMC reported that it worked to provide greater appointment availability and increased its capacity for members to schedule appointments. It also expanded the physical space available in various clinics, offices, and community service locations; and increased clinical staff for well-child and primary care services. These efforts were mainly related to well-child and access-to-care measures. For HEDIS 2016, several of DHMC's rates related to well-child visits and access to care (i.e., *Well-Child Visits in*

the First 15 Months of Life—Zero Visits and *Six or More Visits*, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, and *Adolescent Well-Care Visits)* fell below the 25th percentile; and rates for *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Adolescent Well-Care Visits* demonstrated statistically significant declines from HEDIS 2015. Additionally, rates for the *Prenatal and Postpartum Care* measure indicators fell below the 50th percentile, rates for *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services* fell below the 10th percentile, and the rate for *Adults' Access to Preventive/Ambulatory Health Services* declined statistically significantly from HEDIS 2015.

At the time that this report was written, DHMC had not provided information regarding quality initiatives developed as a result of HSAG's FY 2014–2015 recommendations related to improving rates for antidepressant medication management, follow-up care for children on ADHD medications, diabetic testing for members with diabetes and schizophrenia, HbA1c control for members with diabetes, and management of respiratory conditions. HEDIS 2016 rates related to *Antidepressant Medication Management*, *Follow-Up Care for Children Prescribed ADHD Medication*, and management of respiratory conditions *(Pharmacotherapy Management of COPD Exacerbation, Medication Management for People With Asthma, Asthma Medication Ratio*) all showed slight increases but still remain below the 50th percentile (with the asthma measures falling below the 10th Percentile). Regarding HbA1c control for diabetic members, the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* rate improved and ranked above the 75th percentile. The percentage of diabetic members with poorly controlled HbA1c (< 9.0%) declined slightly; however, the percentage of members with adequately controlled HbA1c (< 8.0%) also declined. Both of these rates, however, were above the national Medicaid 50th percentile.

Of note, comparisons of the health plans' rates to benchmarks should be interpreted with caution due to the facts that the health plan's rates were reported to NCQA using the hybrid methodology and DHMC's rates are presented here administratively. HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014–2015 was the first year for DHMC's *Improving Follow-Up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics* PIP. Validated for Activities I through VI, the PIP received a *Met* score for 100 percent of the applicable evaluation elements and an overall *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Consumer Assessment of Healthcare Providers and Systems

Between FY 2014–2015 and FY 2015–2016, DHMC experienced no substantial decrease in rates for any adult measures. The FY 2015–2016 rate for the adult measure, *Rating of Specialist Seen Most Often,* increased by 8.3 percentage points. Three adult measures demonstrated slight increases: *Getting Needed Care*, *Customer Service*, and *Rating of All Health Care*. These increases may indicate that DHMC followed up on HSAG's recommendations

DHMC experienced no substantial decrease in rates between FY 2014–2015 and FY 2015–2016 for any child measures. Between FY 2014–2015 and FY 2015–2016 DHMC experienced a substantial rate increase of 7.0 percentage points for *Getting Care Quickly* and modest increases of 3.9 and 4.5 percentage points for the *Getting Needed Care* and *Customer Service* measures, respectively. These increases may indicate that DHMC followed HSAG's recommendations.

DHMC implemented various efforts to identify key aspects to improve health plans' customer service, including regular monitoring of recorded calls to identify areas for improvement and asking members follow-up questions to ensure that needed help or information had been provided. Additionally, DHMC took the initiative to provide greater appointment availability through the following efforts: expanded capacity by opening new facilities; added providers to existing centers; and improved processes within NurseLine, which provides care by phone to members. DHMC also worked with providers to expand hours of operations, including Saturday availability for appointments.

Rocky Mountain Health Plans Prime

Compliance Monitoring Site Review

As a result of the 2014–2015 RMHP Prime site review, RMHP Prime was required to implement five corrective actions related to Member Information, three corrective actions related to the Grievance System, and one corrective action related to Provider Participation and Program Integrity. RMHP Prime submitted its proposed corrective action plan to HSAG and the Department in July 2015. HSAG and the Department worked with RMHP Prime to ensure that planned interventions would fully address the required actions. HSAG reviewed documents in October 2015 and again in January 2016, when HSAG and the Department determined that RMHP Prime had completed all required actions.

Validation of Performance Measures

During the FY 2014–2015 review, HSAG recommended that RMHP Prime concentrate on improving rates related to well-child visits, focus efforts on increasing members' access to services and follow-up care for children on ADHD medications, and improve care for members with COPD and rheumatoid arthritis.

As a result, RMHP Prime reported that it initiated reporting enhancements in an effort to improve reporting for medication management measures. RMHP Prime was also actively involved with assisting members to access primary care services and providing more education to members regarding preventive health care, diabetes care, and hypertension management. For HEDIS 2016, the rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* and *Ages 12 to 19 Years*, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase,* and *Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis* fell below the 50th percentile; the rate for *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* fell below the 25th percentile; and the rates for *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* fell below the 10th percentile.

Several of RMHP Prime's rates related to well-child visits (i.e., *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*), access to care (i.e., *Prenatal and Postpartum Care, Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months)* and *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* were not reportable (i.e., the health plan followed the specifications but the denominator was too small [<30] to report a valid rate, resulting in a Not Applicable [NA] audit designation; or RMHP Prime's reported rate was invalid, and the rate is therefore not presented).

Additional time may be needed to see the effects of efforts and interventions implemented by the health plan to improve care; therefore, HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014–2015 was the first year for RMHP Prime's *Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility* PIP. The PIP received an overall validation score of 50 percent and a *Not Met* validation status. HSAG required that RMHP Prime revise its study question, study population, and study indicator prior to baseline data collection. The FY 2015–2016 PIP validation process indicated that RMHP Prime had addressed all of HSAG's recommendations. The PIP received a *Met* score for 100 percent of the applicable evaluation elements and an overall *Met* validation status.

Consumer Assessment of Healthcare Providers and Systems

In December 2014, RMHP discontinued their existing Medicaid product. Due to changes in RMHP's population, adult and child Medicaid results were not comparable between FY 2014–2015 and FY 2015–2016 for any measures. HSAG was unable to determine if RMHP followed up on its recommendations from FY 2014–2015. However, RMHP did provide information about initiatives taken over the past year to improve access to primary care, which include increasing Customer Service and Care Management staff members' active involvement in assisting members to access primary care services.

5. Behavioral Health Findings, Strengths, and Recommendations With Conclusions Related to Healthcare Quality, Timeliness, and Access

Introduction

This section of the report includes a summary assessment of each behavioral health organization's (BHO's) strengths and opportunities for improvement derived from the results of the EQR activities. Also included are HSAG's recommendations for improving the BHOs' performance. In addition, this section includes a summary assessment related to the quality and timeliness of, and access to, services furnished by each BHO and a summary of overall statewide performance related to the quality and timeliness of, and access to, services.

Compliance Monitoring Site Reviews

For the FY 2015–2016 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 III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. For each standard, HSAG conducted a desk review of documents sent by the BHO 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.

HSAG also reviewed the BHO's administrative credentialing and recredentialing records to evaluate implementation of federal healthcare regulations and compliance with NCQA requirements, effective July 2015. Using a random sampling technique, HSAG selected a sample of 10 plus an oversample of five records from all of the BHO's credentialing and recredentialing that occurred between January 1, 2013, and December 31, 2015. 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 VIII—Credentialing and Recredentialing. 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 Compliance Standards to Performance Domains

Standard	Quality	Timeliness	Access
III—Coordination and Continuity of Care	✓		✓
IV—Member Rights and Protections	✓		✓
VIII—Credentialing and Recredentialing	✓		✓
X—Quality Assessment and Performance Improvement	✓		

Access Behavioral Care—Denver

Findings

Table 5-2 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	10	10	7	3	0	0	70%
IV—Member Rights and Protections	6	6	5	0	1	0	83%
VIII—Credentialing and Recredentialing	46	45	42	3	0	1	93%
X—Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**75**	**68**	**6**	**1**	**1**	**91%**

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

Table 5-3 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 5-3—Summary of Scores for the Record Reviews for ABC-D

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	80	80	0	10	100%
Recredentialing	90	70	70	0	20	100%
Totals	**180**	**150**	**150**	**0**	**30**	**100%**

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

Strengths

Colorado Access is the parent organization of ABC-D. Many of the policies and procedures ABC-D submitted are applicable to all Colorado Access lines of business. HSAG refers to these documents as "Colorado Access" policies rather than ABC-D policies.

Colorado Access/ABC-D had policies, procedures, and resources in place to address coordination and continuity of care for members. ABC-D behavioral health providers were responsible for coordinating care with the member's primary care provider (PCP). The community mental health centers' (CMHCs') care management staff assisted with coordinating services. ABC-D designated care management staff to assist with assessment and coordination of needed services for members with complex behavioral, physical, and social needs. Care coordination activities included coordination with community providers and external agencies. ABC-D ensured members an ongoing source of behavioral healthcare by offering an openly accessible network of providers (i.e., no referrals or authorizations required), informing members how to access the network, and offering assistance in connecting members with behavioral health medical homes. The ABC-D provider manual charged providers with the responsibility of contacting the member's PCP to obtain results of EPSDT screenings, documenting results in the member assessment, and referring members to a PCP when EPSDT screening is needed but has not yet been performed.

Colorado Access' policies and procedures articulated commitment to ensuring the rights of its members. Customer service staff members participated in member rights training within the review period, and Colorado Access provided all staff members with laminated lists of member rights for posting at their desks. ABC-D offered all new providers training that included a review of member rights and how to report suspected and alleged rights violations. ABC-D also included member rights and instructions on how to report alleged rights violations in the provider manual, accessible through the website along with the webinar training. Additionally, ABC-D distributed member rights posters for display in all service locations. ABC-D included information about member rights in newsletters, annual mailings, on the ABC-D website, and in its member handbook.

Colorado Access' credentialing and recredentialing policies were well-written, comprehensive, and compliant with NCQA standards and guidelines. During on-site interviews, credentialing staff members

displayed extensive knowledge of NCQA requirements and Colorado Access policies. Colorado Access' credentialing and recredentialing delegation agreements described the activities, responsibilities, reporting requirements, and remedies available to Colorado Access should the delegate fall short of its obligations. HSAG reviewed annual credentialing audit findings for each delegated entity and found evidence that Colorado Access required corrective actions when necessary and followed up as appropriate.

Colorado Access' QAPI program encompassed monitoring of access and availability, utilization management, member satisfaction, clinical outcomes/performance measures, and PIPs as well as evaluation of internal operational performance, practice guidelines, and care management. Colorado Access reported all activities to the Quality Improvement Committee (QIC) (accountable to the Board of Directors) through a well-designed and comprehensive annual report, which presented an overview and summary data from all quality activities performed throughout the year.

Recommendations

Based on findings from the site review activities, ABC-D was required to submit a corrective action plan that addressed the following:

Standard III—Coordination and Continuity of Care

- ABC-D was required to enhance the scope of monitoring providers to ensure that each member receives an intake assessment and has a comprehensive service plan that addresses the elements outlined in the requirement.
- ABC-D was required to enhance its procedures and provider communications to more specifically address requirements for providing referral assistance for treatment and services not covered by the BHO but found to be needed as a result of conditions discovered during EPSDT screening and diagnosis.

Standard IV—Member Rights and Protections

- ABC-D was required to revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.

Standard VIII—Credentialing and Recredentialing

- ABC-D was required to develop and employ a process to ensure that organizations with which it contracts are recredentialed at least every three years.
- ABC-D was required to ensure that unaccredited organizations with which it contracts credential practitioners in a manner consistent with Colorado Access' policies, procedures, and standards.
- ABC-D was required to specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified in Colorado Access' credentialing and recredentialing policies. ABC-D was required to ensure that CMS and

State quality reviews used are no more than three years old at the time of the credentialing decision. Colorado Access was also required to ensure completion of any required corrective actions identified by the CMS or State reviews and to document the completion of those corrective actions.

ABC-D: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of ABC-D's compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined ABC-D's performance across all four standards when evaluating the quality of care domain—defined as the degree to which an MCO or PIHP increases the likelihood of desired health outcomes—and found ABC-D's performance to be strong. Its care coordinators worked with members and with physical health providers, waiver service providers, and public health agencies to ensure the provision of comprehensive medically necessary services. ABC-D repeatedly reminded its staff, providers, and members about the rights and protections afforded members and ABC-D's commitment to uphold those rights and protections. ABC-D's NCQA-compliant credentialing and recredentialing program ensured its members access to a robust network of quality providers. ABC-D's QAPI program was robust and addressed all required components.

Access: CMS defines access as the timely use of services to achieve optimal outcomes. ABC-D allowed members direct access to specialists and had processes for providing members with access to out-of-network providers when medically necessary services were not available in network. While ABC-D had processes to assist members with accessing EPSDT services not covered by ABC-D, HSAG suggested areas for improvement. Overall, ABC-D's performance in the access domain was very good.

Access Behavioral Care—Northeast

Findings

Colorado Access is also the parent organization of ABC-NE. Because its policies and procedures are applicable across all Colorado Access lines of business, the findings for ABC-NE are identical to those for ABC-D.

Table 5-4 presents the number of elements for each standard; 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 2015–2016).

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	10	10	7	3	0	0	70%
IV—Member Rights and Protections	6	6	5	0	1	0	83%
VIII—Credentialing and Recredentialing	46	45	42	3	0	1	93%
X—Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**75**	**68**	**6**	**1**	**1**	**91%**

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

Table 5-5 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year (FY 2015–2016).

Table 5-5—Summary of Scores for the Record Reviews for ABC-NE

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	81	81	0	9	100%
Recredentialing	90	70	70	0	20	100%
Totals	**180**	**151**	**151**	**0**	**29**	**100%**

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

Strengths

Colorado Access/ABC-NE had policies, procedures, and resources in place to address coordination and continuity of care for members. ABC-NE behavioral health providers were responsible for coordinating a member's care with the member's PCP. The CMHCs' care management staff assisted with coordinating services. ABC-NE designated care management staff to assist with assessment and coordination of needed services for members with complex behavioral, physical, and social needs. Care coordination activities included coordination with community providers and external agencies. ABC-NE ensured members an ongoing source of behavioral healthcare by offering an openly accessible network of providers (i.e., no referrals or authorizations required), informing members how to access the network, and offering assistance in connecting members with behavioral health medical homes. The ABC-NE provider manual charged providers with the responsibility of contacting the member's PCP to obtain results of EPSDT screenings, documenting results in the member assessment, and referring members to a PCP when EPSDT screening is needed but has not yet been performed.

Colorado Access' policies and procedures articulated its commitment to ensuring the rights of its members. Customer service staff members participated in member rights training within the review period, and Colorado Access provided all staff members with laminated lists of member rights for posting at their desks. ABC-NE offered all new providers an introductory webinar training that included a review of member rights and how to report suspected and alleged rights violations. ABC-NE also included member rights and instructions on how to report alleged rights violations in the provider manual, accessible through the website along with the webinar training. Additionally, ABC-NE published and distributed member rights posters for display in all service locations. ABC-NE included information about member rights in newsletters, annual mailings, on the website, and in its member handbook.

Colorado Access' credentialing and recredentialing policies were well-written, comprehensive, and compliant with NCQA standards and guidelines. During on-site interviews, credentialing staff members displayed extensive knowledge of NCQA requirements and Colorado Access policies and appeared confident discussing the processes and procedures used. Colorado Access' credentialing and recredentialing delegation agreements described the activities, responsibilities, reporting requirements, and remedies available to Colorado Access should the delegate fall short of its obligations. HSAG reviewed annual audit findings for each delegated entity and found evidence that Colorado Access required corrective actions when necessary and followed up as appropriate.

Colorado Access' QAPI program description stated that quality monitoring encompasses access and availability; utilization management; member satisfaction; clinical outcomes/performance measures; PIPs; and evaluation of internal operational performance, practice guidelines, and care management. Colorado Access reported all activities to the QIC (accountable to the Board of Directors) through a well-designed and comprehensive annual report, which presented an overview and summary data from all quality activities performed throughout the year.

Recommendations

Based on findings from the site review activities, ABC-NE was required to submit a corrective action plan that addressed the following:

Standard III—Coordination and Continuity of Care

- ABC-NE was required to enhance the scope of monitoring providers to ensure that members receive an intake assessment and that they have a comprehensive service plan that addresses the elements outlined in the requirement.
- ABC-NE was required to enhance its procedures and provider communications to more specifically address requirements for providing referral assistance for treatment and services not covered by the BHO but found to be needed as a result of conditions discovered during EPSDT screening and diagnosis.

Standard IV—Member Rights and Protections

- ABC-NE was required to revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.

Standard VIII—Credentialing and Recredentialing

- ABC-NE was required to develop and employ a process to ensure that organizations with which it contracts are recredentialed at least every three years.
- ABC-NE was required to ensure that unaccredited organizations with which it contracts credential practitioners in a manner consistent with Colorado Access' own policies, procedures, and standards.
- Colorado Access was required to specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified in Colorado Access' policy. Colorado Access was required to ensure that CMS and State quality reviews used are no more than three years old at the time of the credentialing decision; and if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access was required to document that the organization completed those corrective actions.

ABC-NE: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of ABC-NE's compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined ABC-NE's performance across all four standards when evaluating the quality of care domain—defined as the degree to which an MCO or PIHP increases the likelihood of desired health outcomes. As with ABC-D, HSAG found ABC-NE's performance as related to the quality domain to be strong. Its care coordinators worked with members and with physical health providers, waiver service providers, and public health agencies to ensure the provision of comprehensive medically necessary services. ABC-NE repeatedly reminded its staff, providers, and members about the rights and protections afforded members and ABC-NE's commitment to uphold those rights and protections. ABC-NE's NCQA-compliant credentialing and recredentialing program ensured its members access to a robust network of quality providers. ABC-NE's QAPI program was robust and addressed all required components.

Access: CMS defines "access" as "the timely use of services to achieve optimal outcomes." ABC-NE allowed members direct access to specialists and had processes for providing members with access to out-of-network providers when medically necessary services were not available in-network. Additionally, while ABC-NE had processes to assist members with accessing EPSDT services not covered by ABC-NE, HSAG suggested areas for improvement. Overall, ABC-NE's performance in the access domain was very good.

Behavioral Healthcare, Inc.

Findings

Table 5-6 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	10	10	9	1	0	0	90%
IV—Member Rights and Protections	6	6	6	0	0	0	100%
VIII—Credentialing and Recredentialing	46	46	44	2	0	0	96%
X—Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**76**	**73**	**3**	**0**	**0**	**96%**

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

Table 5-7 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year (FY 2015–2016).

Table 5-7—Summary of Scores for the Record Reviews for BHI

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	81	81	0	9	100%
Recredentialing	90	71	69	2	19	97%
Totals	**180**	**152**	**150**	**2**	**28**	**99%**

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

Strengths

BHI had policies and effective processes in place to ensure that it identifies members for case management (day-to-day management performed by a member's primary therapist) or care coordination (services performed by the BHO to remediate systems issues and barriers to care and to ensure the appropriate level of services). BHI uses a chart audit process to ensure that each member is assigned to a primary therapist who performs assessments and develops treatment plans that address all required

components. The audit process also confirms that therapists are coordinating with appropriate outside providers and agencies. BHI staff members reported that BHI revised its definition of medical necessity to incorporate EPSDT services. CMHCs have an EPSDT screening tool that is used when therapists suspect that a member has developmental issues, with referrals made based on results of the screening.

BHI had documents and processes to ensure provision of member rights lists and related communications to members, providers, and staff. BHI demonstrated active analysis of member grievances and member input to identify trends and opportunities for improvement. BHI's provider on-site audit tools included assessment of whether member rights are taken into account during the provision of services.

BHI had a well-defined credentialing program that included NCQA-compliant policies, procedures, and practices. BHI delegated credentialing and recredentialing activities to Colorado Access, although BHI retained the right to approve, suspend, or terminate providers. The delegate's credentialing records were well organized, and on-site record reviews demonstrated that primary source verification for credentialing was completed within the required time frames. BHI provided evidence demonstrating its monitoring and oversight of Colorado Access' credentialing activities. BHI's *Quality Improvement Program Description* addressed each required component. The annual quality report was comprehensive and addressed required activities—performance measures, monitoring results, and performance improvement projects—and BHI's additional quality initiatives. BHI used both ongoing monitoring and formal audits to assess quality and appropriateness of services. BHI reviewed its clinical practice guidelines regularly and posted them on its website. BHI developed easy-to-understand versions of the practice guidelines for members.

Recommendations

Based on findings from the site review activities, BHI was required to submit a corrective action plan that addressed the following:

Standard III—Coordination and Continuity of Care

- BHI's chart audit process did not evaluate whether or not the CMHCs' intake assessments addressed developmental needs. BHI was required to ensure that each member accessing services receives an individual assessment that addresses developmental needs.

Standard VIII—Credentialing and Recredentialing

- BHI was required to develop a mechanism to ensure that individual providers and non-accredited organizational providers are recredentialed every 36 months.

BHI: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of BHI's compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined BHI's performance across all four standards when evaluating the quality of care domain—defined as the degree to which an MCO or PIHP increases the likelihood of desired health outcomes—and found BHI's performance in this domain to be strong. BHI required its behavioral health providers to work with other providers and agencies to ensure coordinated health services for members and to eliminate duplicated services. BHI's intake process included health assessments and individualized treatment plans developed with member and family input. BHI distributed member rights to its members, staff, and providers and had processes to ensure that those rights are taken into account when furnishing services. BHI's credentialing and recredentialing program was designed to ensure a robust network of qualified providers. BHI's QAPI program described various mechanisms used for ongoing and formal monitoring of the appropriateness and quality of services.

Access: CMS defines "access" as "the timely use of services to achieve optimal outcomes." BHI had mechanisms to ensure that every member had a primary behavioral healthcare provider who was also responsible for coordinating with outside providers and agencies to ensure access to all appropriate and necessary services, including EPSDT-related services. BHI assigned members with complex needs to a care coordinator who provided additional assistance with coordinating services. BHI monitored the utilization of services and had processes to ensure appropriate use of services.

Colorado Health Partnerships, LLC

Findings

Table 5-8 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 5-8—Summary of Scores for the Standards for CHP

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	10	10	9	1	0	0	90%
IV—Member Rights and Protections	6	6	6	0	0	0	100%
VIII—Credentialing and Recredentialing	46	45	39	4	2	1	87%
X—Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**75**	**68**	**5**	**2**	**1**	**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 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

Table 5-9—Summary of Scores for the Record Reviews for CHP

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	83	83	0	7	100%
Recredentialing	90	73	69	4	17	95%
Totals	**180**	**156**	**152**	**4**	**24**	**97%**

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

Strengths

CHP had policies, procedures, and resources in place that addressed coordination and continuity of care for members and that included all State and federal requirements. Behavioral health providers and CHP staff members were jointly responsible for care coordination for members. The primary behavioral healthcare team was responsible for basic care coordination and CHP care coordination staff members were responsible for care coordination for members with intensive care coordination needs and for members of special populations. CHP communicated the basic care coordination responsibilities to the primary behavioral health providers, which included coordinating care with medical providers and exchanging relevant healthcare information with other providers and agencies such as community centered boards (CCBs), single entry points (SEPs), and departments of human services (DHS). CHP's provider manual informed providers that family health coordinators are available to assist members with access to EPSDT-related services.

CHP had several written policies and procedures that delineated member rights and described the processes and mechanisms used by CHP to educate members about their rights, how to exercise them, and the availability of assistance through the Office of Member and Family Affairs (OMFA). In its contracts and provider manual, CHP informed providers about member rights and CHP's expectation that rights be taken into consideration when furnishing services. CHP required its employees to participate in member rights training at the time of hire and again annually. CHP strongly encouraged its providers to participate in periodic face-to-face training forums covering topics such as member rights, compliance, cultural competency, and understanding Health First Colorado (Colorado's Medicaid Program). CHP also posted these presentations on its website.

CHP delegated credentialing and recredentialing of independent practitioners to ValueOptions/Beacon Health Options, Inc. (VO/Beacon), an NCQA-accredited credentialing verification organization (CVO). CHP and VO/Beacon had policies and procedures that addressed all aspects of the credentialing and recredentialing process, the range of actions available to CHP if a provider fails to meet minimum standards of quality, and the appeal process available to providers against whom CHP has taken action. VO/Beacon also had policies and procedures to address the credentialing and recredentialing process for contracted organizational providers. CHP's policies set standards for office-site quality, physical

accessibility and appearance, adequacy of space, and appropriate record-keeping and described the process for instituting actions to improve offices that do not meet the minimum standards.

The CHP QAPI program was a partnership model between CHP and its administrative service organization, VO/Beacon. CHP delegated all quality management functions to VO/Beacon. The Quality Assessment/Utilization Management (QA/UM) program description was comprehensive and incorporated all required components. The annual evaluation report included detailed results and analysis of ongoing monitoring of quality and appropriateness of care, utilization, performance measures, performance improvement projects, member satisfaction surveys, clinical guideline development, access to care, quality of care concerns, and other quality improvement activities. CHP submitted examples of numerous reports used for ongoing monitoring of member care and services. CHP monitored the CMHCs and Independent Provider Network (IPN) periodically through clinical documentation audits, performance indicators, and annual contract compliance audits.

Recommendations

Based on findings from the site review activities, CHP was required to submit a corrective action plan that addressed the following:

Standard III—Coordination and Continuity of Care

- CHP was required to enhance its policies and procedures and provider communications to more specifically address referral processes and the BHO's and providers' responsibility to provide referral assistance to members who need services not covered by the BHO but found to be needed as a result of EPSDT screening and diagnosis.

Standard VIII—Credentialing and Recredentialing

- If VO/Beacon chooses to use a preliminary review of potential applicants for determining which providers are allowed to submit credentialing applications, it must document the process. Documentation must include the criteria used to make determinations, any appeal rights available to providers denied the opportunity for application, and the mechanisms used to ensure nondiscriminatory practices.
- CHP was required to ensure that providers are recredentialed at least every 36 months.
- If and when VO/Beacon elects to substitute a CMS or State review in lieu of a site visit, it must confirm that the criteria used by CMS or the State encompasses all criteria used in its own assessment. Additionally, VO/Beacon must follow through to ensure that the organization sufficiently addresses all corrective actions required as a result of the CMS or State review.
- CHP was required to document that it evaluates (at least semiannually) credentialing and recredentialing reports submitted by its delegate.
- CHP was required to specify in its delegation agreement with VO/Beacon that it retains the right to approve, suspend, or terminate contracts with individual practitioners, providers, or sites.

CHP: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of CHP's compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined CHP's performance across all four standards when evaluating the quality of care domain—defined as the degree to which an MCO or PIHP increases the likelihood of desired health outcomes. CHP performed well in the quality domain. Similar to other Colorado BHOs, CHP required that its member's primary behavioral health provider coordinate with other providers and agencies to ensure coordinated, unduplicated services. CHP's intake process included health assessments and individualized treatment plans. CHP had multiple methods for distributing member rights lists to its members, staff, and providers and processes to ensure that those rights are taken into consideration when furnishing services. CHP's credentialing and recredentialing program was based on NCQA standards and guidelines; however, HSAG identified a few areas for improvement related to this standard. CHP had a robust QAPI program that included mechanisms for ongoing and formal monitoring of the appropriateness and quality of services.

Access: CMS defines "access" as "the timely use of services to achieve optimal outcomes." CHP offered a multispecialty network of primary and specialist providers and allowed members direct access to any network provider without authorization for outpatient services. CHP also frequently arranged access to out-of-network providers through single-case agreements. CHP ensured that every member had a primary behavioral healthcare provider responsible for coordinating with outside providers and agencies to ensure access to all appropriate and necessary services, including those afforded under the EPSDT program.

Foothills Behavioral Health Partners, LLC

Findings

Table 5-10 presents the number of elements for each standard; the number of elements assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2015–2016.

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

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III—Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV—Member Rights and Protections	6	6	6	0	0	0	100%
VIII—Credentialing and Recredentialing	46	45	42	3	0	1	93%

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
X—Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**75**	**72**	**3**	**0**	**1**	**96%**

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

Table 5-11 presents the number of elements for each record review; the number of elements assigned a score of *Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for the current year (FY 2015–2016).

Table 5-11—Summary of Scores for the Record Reviews for FBHP

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing	90	83	82	1	7	99%
Recredentialing	90	75	72	3	15	96%
Totals	**180**	**158**	**154**	**4**	**22**	**97%**

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

Strengths

FBHP is comprised of three equity partners: two community mental health centers (CMHCs—Mental Health Partners (MHP) and Jefferson Center for Mental Health (JCMH)—and a national behavioral health managed care company, VO/Beacon. Care coordination policies described the process for assigning all members with complex needs to one of two levels of care coordination—basic and complex—and defined the procedures and accountabilities for each level. FBHP staff estimated that its partner CMHCs provided the majority of both basic and complex care coordination services including coordination with other providers, community organizations, and agencies. VO/Beacon intensive care managers and the transitions coordinator also provided support for members with complex needs who received services from the IPN providers, programs for special populations, and transition of members from inpatient facilities in the Colorado Springs and Pueblo areas. FBHP policies and procedures and member and provider materials demonstrated assertive mechanisms for connecting members to EPSDT screenings and related services.

FBHP provided numerous policies and procedures from FBHP and its three equity partners—JCMH, MHP, and VO/Beacon—that demonstrated commitment to ensuring that all staff and providers take member rights into account when furnishing services. FBHP listed member rights in its member handbook and posted member rights lists at service sites and on its website. FBHP and its three equity partners required employees to participate in member rights training at the time of hire and again annually. FBHP required its providers to post and/or personally deliver to members a copy of member rights and Medicaid Ombudsman information.

FBHP delegated credentialing and recredentialing of independent practitioners and contracted organizational providers to VO/Beacon, an NCQA-accredited CVO. The signed delegation agreement included all requirements, including those associated with the use of protected health information (PHI). Policies delineated the process for ongoing monitoring of sanctions, complaints, and adverse events; the range of actions available to FBHP if a provider fails to meet minimum standards of quality; and the appeal process available to providers against whom FBHP has taken action.

FBHP had a comprehensive QAPI program description with defined organizational accountabilities and active engagement of the CMHCs in quality monitoring and improvement activities. FBHP had well-designed and detailed reports that demonstrated monitoring of a broad array of quality indicators such as utilization, access to care, member satisfaction, quality-of-care concerns, and medication management. FBHP's CMHCs participated in all quality oversight committees and were additionally responsible for performing medical record audits, reporting results, and following up with corrective actions as indicated. VO/Beacon performed medical record audits of IPN providers. FBHP also performed annual audits of its CMHCs' compliance with contract requirements.

Recommendations

Based on findings from the site review activities, FBHP was required to submit a corrective action plan that addressed the following:

Standard VIII—Credentialing and Recredentialing

- If VO/Beacon chooses to use a preliminary review of potential applicants for determining which providers are allowed to submit credentialing applications, it must document the process. Documentation must include the criteria used to make determinations, any appeal rights available to providers denied the opportunity for application, and the mechanisms used to ensure nondiscriminatory practices.
- FBHP was required to ensure that providers are recredentialed at least every 36 months.

FBHP: Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

HSAG determined that no compliance standards reviewed during FY 2015–2016 related to the timeliness domain. The following is a summary assessment of FBHP's compliance monitoring site review results related to the domains of quality and access.

Quality: HSAG examined performance across all four standards when evaluating the quality of care—defined as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes." FBHP required its behavioral health providers to coordinate with other providers and agencies to ensure the provision of appropriate, unduplicated services. FBHP's intake process included health assessments and individualized treatment plans developed with member and family input. FBHP distributed member rights to its members, staff, and providers and had processes to ensure that those rights were taken into account when furnishing services. FBHP's credentialing and recredentialing program ensured that its members could choose from a variety of qualified providers and included processes for ongoing monitoring of sanctions, complaints, and adverse events. As part of its QAPI program, FBHP measured

services and member care against established performance goals and trended key quality indicators quarterly and/or annually. Its Quality Improvement/Utilization Management Committee and Board of Managers meeting minutes documented ongoing oversight and analysis of QAPI program data and information.

Access: CMS defines "access" as "the timely use of services to achieve optimal outcomes." FBHP had mechanisms to ensure that every member had a primary behavioral healthcare provider responsible for coordinating with outside providers and agencies for helping members access all appropriate and necessary services, including EPSDT services. FBHP offered a multispecialty network of primary and specialist providers, and members could directly access any network provider without authorization for outpatient services.

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

Table 5-12—Statewide Scores for Standards

Standards	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
III—Coordination and Continuity of Care	70%	70%	90%	90%	100%	84%
IV—Member Rights and Protections	83%	83%	100%	100%	100%	93%
VIII—Credentialing and Recredentialing	93%	93%	96%	87%	93%	92%
X—Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%
Overall Statewide Compliance Score	**91%**	**91%**	**96%**	**91%**	**96%**	**93%**

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

Table 5-13—Statewide Scores for Record Reviews

Record Reviews	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Credentialing	100%	100%	100%	100%	99%	100%
Recredentialing	100%	100%	97%	95%	96%	97%
Overall Statewide Record Review Score	**100%**	**100%**	**99%**	**97%**	**97%**	**99%**

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

Statewide Summary Assessment Related to Quality, Timeliness, and Access for Compliance Monitoring

Quality: HSAG assigned all four standards to the quality domain and found that, overall, statewide performance was strong. HSAG found that BHOs employed multiple mechanisms to ensure that members, staff, and providers were familiar with and took member rights into account when furnishing services. All BHOs had comprehensive NCQA-compliant credentialing and recredentialing programs; however, some struggled with meeting the 36-month recredentialing time frame. HSAG also found that all BHOs had comprehensive QAPI programs fully compliant with State and federal regulations. The BHOs' performance was poorest on the Coordination and Continuity of Care standard, due in large part to the difficulties associated with understanding the role of behavioral health providers in arranging for and coordinating benefits and services afforded under the EPSDT program. HSAG suggested that all BHOs continue working with the Department to more clearly define the role of behavioral health providers and the BHOs in the screening and provision of EPSDT services and to develop and adopt practical and effective processes for ensuring the provision of EPSDT services as applicable to the behavioral health scope of services.

Access: HSAG found elements that addressed the access domain in three of the four standards reviewed: Coordination and Continuity of Care, Member Rights and Protections, and Quality Assessment and Performance Improvement. All five BHOs had policies that described the processes and persons responsible for coordinating care for all members and provided additional support services for members with complex needs. All BHOs allowed members direct access to behavioral health specialty providers and had processes to provide members access to out-of-network providers if and when covered services were not available in network. The BHOs' QAPI program included mechanisms to ensure that their networks were capable of providing members all necessary services.

Validation of Performance Measures

The Department required the collection and reporting of 12 performance measures for the validation process that occurred for FY 2015–2016. Four measures were HEDIS-like measures, and eight measures were developed by the Department and the BHOs. For these 12 measures, eight measures had multiple indicators, yielding a total of 38 rates for the current measurement year (MY) 2014–2015 (i.e., July 1, 2014–June 30, 2015). Only 28 measure indicators were comparable to the prior MY (i.e., July 1, 2013–June 30, 2014). All measures originated from claims/encounter data. The specifications for these measures were included in *BHO-HCPF Annual Performance Measures Scope Document*, drafted collaboratively by the BHOs and the Department.[5-1] This document contained both detailed information related to data collection and rate calculation for each measure under the scope of the audit and reporting requirements.

To make overall assessments about the quality and timeliness of, and access to, care provided by the BHOs, HSAG assigned each performance measure to one or more of the three domains, as shown in Table 5-14.

Table 5-14—Assignment of Performance Measures to Performance Domains

Performance Measure	Quality	Timeliness	Access
Hospital Readmissions Within 180 Days (all facilities)	✓		
Mental Health Engagement		✓	✓
Overall Penetration Rates			✓
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)			✓
Penetration Rates by Age Group			✓
*Penetration Rates by Medicaid Eligibility Category**			✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	✓
Hospital Readmissions Within 7, 30, and 90 Days Post-discharge (non-state and all facilities)	✓		
Members With Physical Health Well-Care Visits	✓		✓
Inpatient Utilization (Rate/1,000 Members, All Ages)			✓
Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition		✓	✓
Antidepressant Medication Management—Acute and Continuation Phases		✓	✓

*Descriptions of the indicators for this performance measure are provided in Table 5-15.

[5-1] *BHO-HCPF Annual Performance Measures Scope Document: Fiscal Year 2015* (FY15). Available at: https://www.colorado.gov/pacific/sites/default/files/BHO-HCPF%20Annual%20Performance%20Measures%20Scope%20Document%202015_1.pdf. Accessed on September 19, 2016.

In the performance measure results tables below, MY 2014–2015 measure rates are presented for measures deemed "Reportable" as a result of performance measure validation. MY 2014–2015 measure result of "Not Reportable (NR)" indicates that the BHO either chose not to report the measure or that the BHO's calculated rate was deemed materially biased as a result of performance measure validation and, therefore, the rate is not presented. A measure result of "Biased Rate (BR)" indicates that the BHO's calculated rate was deemed materially biased and, therefore, the rate is not presented. Of note, rate increases or decreases may not indicate better or worse performance.

An em dash (—) indicates that the measure was not presented in last year's technical report; therefore, a MY 2014–2015 measure rate is not presented in this year's report.

Table 5-15 below provides a description of the measure indicators within the penetration rate measure.

Table 5-15—Penetration Rates by Medicaid Eligibility Description and Category

Measure Indicator Description	Medicaid Eligibility Category Measure Indicator
Aid to Needy Disabled/Supplemental Security Income (Disabled Individuals 18 to 59 Years of Age)	*AND/AB-SSI*
Children Enrolled in a Baby Care Program and Who Are MAGI-Eligible Children	*BC Children*
Women Enrolled in a Breast and Cervical Cancer Program	*BCCP-Women Breast and Cervical Cancer*
Disabled Working Adults Enrolled in a Buy-In Program	*Buy-In: Working Adult Disabled*
Foster Care	*Foster Care*
Adults 65 Years of Age and Older (Old-Age Pension Act–A)	*OAP-A*
Disabled Adults 60 to 64 (Old-Age Pension Act–B) Supplemental Security Income	*OAP-B-SSI*
Adults With Modified Adjusted Gross Income (MAGI)	*MAGI Adults*
Children With Disabilities Disabled Buy-in Program	*Buy-In: Children With Disabilities*
MAGI Parents/Caretakers to 68 Percent Federal Poverty Level (FPL) and MAGI Parents/Caretakers 69 Percent to 133 Percent FPL	*MAGI Parents/Caretakers*
MAGI-Eligible Children	*MAGI Children*
MAGI-Pregnant Adults	*MAGI Pregnant*

Access Behavioral Care—Denver

Findings—System and Reporting Capabilities

HSAG identified no issues or concerns with how ABC-D received and processed enrollment data. Colorado Access, ABC-D's administrative service organization (ASO), continued to obtain the monthly eligibility full and daily change/update file from the Department via a secure File Transfer Protocol (FTP) site in a flat file format. Eligibility information was loaded into a data scrubber where several business rules were applied to ensure that only accurate enrollment information was loaded into QNXT, ABC-D's transactional system. Providers were able to log in to ABC-D's system and obtain eligibility information for members. Each member received a unique identification number. For measure production, enrollment information was reconciled with the monthly full file. In case of any discrepancy, real-time eligibility verification was available via the Department's portal. No major system or process changes were noted for the current reporting year.

ABC-D used QNXT, operated by TriZetto, as its claims processing system. Providers submitted claims electronically or on paper. Electronic claims were submitted to Colorado Access in a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 837 format. These files were loaded into QNXT via TriZetto's FTP site. Paper claims were scanned and posted on TriZetto's FTP site where, prior to being loaded into QNXT, they were converted into the 837 format using Optical Character Recognition (OCR) technology. The affiliated Community Mental Health Center (CMHC) submitted encounter data via FTP. The files were then loaded into QNXT. Nightly, TriZetto audited 2.5 percent of auto-adjudicated and 5 percent of manually-adjudicated claims. To further ensure data accuracy, ABC-D audited 7 percent of claims previously verified by TriZetto. ABC-D performed audits on 100 percent of facility claims exceeding the $10,000 threshold and professional claims exceeding the $5,000 threshold. In addition to claims/encounter data, ABC-D received pharmacy and inpatient data from the Department via FTP and loaded all into the data warehouse.

ABC-D submitted 837 encounter files and flat files to the Department, received error files within a few days of submission, and had adequate validation and reconciliation processes in place to ensure data completeness and data accuracy. Additionally, ABC-D had sufficient oversight of its processing vendor, TriZetto. Monthly meetings were in place to address any upcoming issues and collaboratively discuss solutions.

As in prior years, Colorado Access continued to manage data flow and calculate performance indicator rates. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measure Scope Document*. Several verification processes in place ensured that only accurate data were used for measure reporting.

Findings—Performance Measure Results

Table 5-16 shows the MY 2013–2014 and MY 2014–2015 performance measure results for ABC-D.

Table 5-16—Performance Measure Results for ABC-D

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]
Hospital Readmissions Within 180 Days (all facilities)*		
Hospital Readmissions Within 180 Days (all facilities)	—	25.55%
Mental Health Engagement		
Mental Health Engagement	34.55%	48.06%
Overall Penetration Rates		
Overall Penetration Rates	14.26%	16.46%
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)		
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)	14.55	16.33
Penetration Rates by Age Group		
Children 12 Years of Age and Younger	6.66%	6.93%
Adolescents 13 Through 17 Years of Age	16.31%	17.45%
Adults 18 Through 64 Years of Age	21.59%	22.78%
Adults 65 Years of Age or Older	8.48%	10.09%
Penetration Rates by Medicaid Eligibility Category		
AND/AB-SSI	39.31%	43.74%
BC Children	2.52%	2.07%
BCCP-Women Breast and Cervical Cancer	7.38%	5.01%
Buy-In: Working Adult Disabled	32.97%	33.78%
Foster Care	40.42%	34.46%
OAP-A	8.45%	9.87%
OAP-B-SSI	27.76%	32.66%
MAGI Adults	22.16%	20.57%
Buy-In: Children With Disabilities	14.21%	15.70%
MAGI Parents/Caretakers	—	16.95%
MAGI Children	—	8.62%
MAGI Pregnant	—	20.60%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment		
Initiation of AOD Treatment	—	44.41%
Engagement of AOD Treatment	—	31.88%
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (non-state and all facilities)*		
Non-State Hospitals—7 Days	2.86%	4.16%
Non-State Hospitals—30 Days	11.88%	12.83%
Non-State Hospitals—90 Days	18.35%	20.14%

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]
All Hospitals—7 Days	2.88%	5.22%
All Hospitals—30 Days	11.66%	13.92%
All Hospitals—90 Days	18.52%	21.52%
Members With Physical Health Well-Care Visits		
0–17 Years of Age	—	89.90%
18+ Years of Age	—	87.76%
Inpatient Utilization (Rate/1,000 Members, All Ages)		
Non-State Hospitals	4.78	6.44
All Hospitals	5.24	6.92
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition		
Non-State Hospitals—7 Days	46.15%	49.08%
Non-State Hospitals—30 Days	70.36%	65.57%
All Hospitals—7 Days	46.40%	48.65%
All Hospitals—30 Days	70.13%	65.15%
Antidepressant Medication Management—Acute and Continuation Phases		
Effective Acute Phase Treatment	—	53.03%
Effective Continuation Phase Treatment	—	48.18%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2013–2014 (i.e., July 1, 2013 through June 30, 2014). Of note, these rates were previously labeled "Fiscal Year (FY) 2014–2015" in the 2014–2015 External Quality Review Technical Report for Colorado Medicaid.

[2] Indicates that the rates contained within this column represent MY 2014–2015 (i.e., July 1, 2014 through June 30, 2015).

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

— Indicates that the measure was not presented in last year's technical report and, therefore, a MY 2013–2014 measure rate is not presented in this year's report.

Findings, Strengths, and Recommendations

ABC-D continued to operate as one of Colorado Access' lines of business. All administrative functions related to the performance measure validation processes were performed by Colorado Access. Although Colorado Access went through organizational changes in the past year, all staff members had extensive experience and knowledge of processes related to behavioral health measures and their reporting requirements. ABC-D and the Department continued to conduct monthly meetings addressing any issues with the 837 file submission. As a result, ABC-D's file rejection rate was less than 10 percent for the current MY. ABC-D continued to maintain its performance level throughout the year.

During the primary source verification process, a discrepancy was discovered in the numerator of positive case selections for *Antidepressant Medication Management—Acute and Continuation Phases*. ABC-D considered differences in service dates rather than supplied days of the medication. ABC-D's staff members were responsive, investigated the issue, and resubmitted corrected data prior to generation of this report. HSAG recommends that ABC-D apply these changes to future reporting years to avoid additional discrepancies in rates.

Of ABC-D's reported audited measure rates for MY 2014–2015, 28 of the 38 audited measure indicators were also reported for MY 2013–2014. Of these 28 measure indicators, 22 rates increased from the prior MY. Of note, lower rates for *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge* indicate better performance. Conversely, ABC-D experienced declines in rates from the prior year for 12 measure indicators, one of which declined by 5.96 percentage points, *Penetration Rates by Medicaid Eligibility Category—Foster Care*. Additionally, all six *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge* measure indicators declined from the prior year. HSAG recommends that ABC-D investigate the reasons behind these declines related to *Penetration Rates by Medicaid Eligibility Category—Foster Care* and *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge.* Specifically, HSAG recommends that ABC-D explore options to improve inpatient discharge planning in an effort to improve the hospital readmissions measure indicator rates.

ABC-D: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

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

Quality

ABC-D's quality-related performance was assessed based on rates for 11 audited measure indicators for the current MY. Of these 11 measures, six were also reported for MY 2013–2014. Rates related to post-discharge hospital readmissions varied, with 4.16 percent reported as the lowest percentage of hospital readmissions and 21.52 percent reported as the highest percentage of hospital readmissions, wherein a higher rate indicates poorer performance and opportunities for improvement. Of note, lower rates for *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge* indicate better performance.

Timeliness

ABC-D's timeliness-related performance was assessed based on rates for nine audited measure indicators for the current MY. Of these nine measures, five measure indicators were also reported for MY 2013–2014. Rates for mental health follow-up appointments varied from as low as 48.65 percent to as high as 65.57 percent. Rate changes may not indicate better or worse performance for *Mental Health Engagement*.

Access

ABC-D's access-related performance was evaluated based on rates for 31 audited measure indicators for the current MY. Of these 31 measures, 22 measure indicators were also reported for MY 2013–2014. Penetration rates specifically related to members who received one contact from the BHO related to mental health varied, with 2.07 percent as the lowest rate (for those children within the Baby Care Program) and 43.74 percent as the highest rate (for those members who require aid for the needy disabled, may receive supplemental security income, or are disabled individuals up to 59 years of age). Penetration rates further varied with the rate related to children 12 years of age and younger who

received one contact related to mental health at 6.93 percent as the lowest rate and the rate for adults 18 through 64 years of age who received the most contact related to mental health at 22.78 percent as the highest.

Access Behavioral Care—Northeast

Findings—System and Reporting Capabilities

MY 2014–2015 was the first year in which ABC-NE received a formal performance measure validation. HSAG identified no issues or concerns with how ABC-NE received and processed enrollment data. Colorado Access obtained the monthly eligibility full file and daily change/update file from the Department via a secure FTP site in a flat file format. Eligibility information was loaded into a data scrubber where several business rules were applied to ensure that only accurate enrollment information was loaded into QNXT, ABC-NE's transactional system. Providers were able to log in to ABC-NE's system and obtain eligibility information for members. Each member received a unique identification number. For measure production, enrollment information was reconciled with the monthly full file. In case of any discrepancy, real-time eligibility verification was available via the Department's portal.

ABC-NE used QNXT, operated by TriZetto, as its claims processing system. Providers submitted electronic or paper claims. Electronic claims were submitted to Colorado Access in a HIPAA-compliant 837 format. These files were loaded into QNXT via TriZetto's FTP site. Prior to being loaded in QNXT, the files were converted into an 837 format using OCR technology. Paper claims were then scanned and posted on TriZetto's FTP site. The affiliated CMHCs submitted encounter data via FTP. The files were then loaded into QNXT. Nightly, TriZetto audited 2.5 percent of auto-adjudicated and 5 percent of manually-adjudicated claims. To further ensure data accuracy, ABC-NE audited 7 percent of claims previously verified by TriZetto. ABC-NE performed audits on 100 percent of facility claims exceeding the $10,000 threshold and professional claims exceeding the $5,000 threshold. In addition to the claims/encounter data, ABC-NE received pharmacy and inpatient data from the Department via FTP and loaded the data into the data warehouse.

ABC-NE submitted 837 encounter files and flat files to the Department, received error files within a few days of submission, and had adequate validation and reconciliation processes in place to ensure data completeness and data accuracy. ABC-NE had sufficient oversight of its processing vendor, TriZetto. Monthly meetings were in place to address any upcoming issues and collaboratively discuss solutions.

Colorado Access managed data flow and calculated performance indicator rates. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measure Scope Document*. Several verification processes in place ensured that only accurate data were used for measure reporting.

Findings—Performance Measure Results

Table 5-17 shows the MY 2014–2015 performance measure results for ABC-NE.

Table 5-17—Performance Measure Results for ABC-NE

Performance Measure	MY 2014-2015 Rate[1]
Hospital Readmissions Within 180 Days (all facilities)*	
Hospital Readmissions Within 180 Days (all facilities)	13.26%
Mental Health Engagement	
Mental Health Engagement	48.66%
Overall Penetration Rates	
Overall Penetration Rates	13.77%
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)	
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)	16.73
Penetration Rates by Age Group	
Children 12 Years of Age and Younger	7.64%
Adolescents 13 Through 17 Years of Age	18.64%
Adults 18 Through 64 Years of Age	17.46%
Adults 65 Years of Age or Older	6.64%
Penetration Rates by Medicaid Eligibility Category	
AND/AB-SSI	33.11%
BC Children	2.05%
BCCP-Women Breast and Cervical Cancer	0.00%
Buy-In: Working Adult Disabled	24.93%
Foster Care	29.51%
OAP-A	6.70%
OAP-B-SSI	23.42%
MAGI Adults	15.88%
Buy-In: Children With Disabilities	14.53%
MAGI Parents/Caretakers	14.36%
MAGI Children	9.63%
MAGI Pregnant	16.08%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
Initiation of AOD Treatment	46.86%
Engagement of AOD Treatment	31.69%
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (non-state and all facilities)*	
Non-State Hospitals—7 Days	1.93%
Non-State Hospitals—30 Days	6.63%
Non-State Hospitals—90 Days	11.46%

Performance Measure	MY 2014-2015 Rate[1]
All Hospitals—7 Days	1.91%
All Hospitals—30 Days	6.57%
All Hospitals—90 Days	11.35%
Members With Physical Health Well-Care Visits	
0–17 Years of Age	91.41%
18+ Years of Age	89.99%
Inpatient Utilization (Rate/1,000 Members, All Ages)	
Non-State Hospitals	5.82
All Hospitals	5.88
Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition	
Non-State Hospitals—7 Days	41.24%
Non-State Hospitals—30 Days	60.00%
All Hospitals—7 Days	40.86%
All Hospitals—30 Days	59.75%
Antidepressant Medication Management—Acute and Continuation Phases	
Effective Acute Phase Treatment	69.88%
Effective Continuation Phase Treatment	61.45%

[1] Indicates that the rates contained within this column represent MY 2014–2015 (i.e., July 1, 2014 through June 30, 2015).

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

Findings, Strengths, and Recommendations

Beginning operations in July 2014, MY 2014–2015 was the first year that ABC-NE participated in the formal performance measure validation process; therefore, MY 2013–2014 is not presented in this report. ABC-NE continued to operate as one of Colorado Access' lines of business. All administrative functions related to the performance measure validation processes were performed by Colorado Access. Colorado Access' staff members had extensive experience and prior knowledge of processes related to behavioral health measures and reporting requirements. ABC-NE participated in monthly meetings with the Department, addressing any issues and working collaboratively on solutions. For MY 2014–2015, ABC-NE's file rejection rate was under 10 percent.

During the primary source verification, it was discovered that, in the process of selecting numerator-positive cases for *Antidepressant Medication Management—Acute and Continuation Phases*, ABC-NE considered the difference in service dates rather than days of supplied medications. ABC-NE's staff members were responsive, investigated the issue, and resubmitted corrected data prior to generation of this report. HSAG recommends that ABC-NE apply these changes to future reporting years to avoid additional discrepancies in reporting.

MY 2014–2015 was the first year that ABC-NE participated in the validation of performance measure activities; therefore, a comparison of rates to the prior year was not performed. Performance measure rates are provided for information purposes only.

ABC-NE: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

The following is a summary assessment of ABC-NE's performance measure results related to the domains of quality, timeliness, and access. As a result of MY 2014–2015 being the first year that ABC-NE participated in the validation of performance measure activities, a comparison of performance to the prior year was not performed.

Quality

ABC-NE's quality-related performance was assessed based on rates for 11 measure indicators in the current MY; however, as a result of MY 2014–2015 being the first year that ABC-NE participated in the validation of performance measure activities, a comparison of performance to the prior year was not performed. Rates related to post-discharge hospital readmissions varied with 1.91 percent reported as the lowest percentage of hospital readmissions and 11.46 percent reported as the highest percentage of hospital readmissions.

Timeliness

ABC-NE's timeliness-related performance was assessed based on rates for nine measure indicators in the current MY; however, as a result of MY 2014–2015 being the first year that ABC-NE participated in the validation of performance measure activities, a comparison of performance to the prior year was not performed. Rates related to mental health follow-up appointments varied, with 40.86 percent as the lowest percentage and 60.00 percent as the highest percentage.

Access

ABC-NE's access-related performance was evaluated based on rates for 31 measure indicators in the current MY; however, as a result of MY 2014–2015 being the first year that ABC-NE participated in the validation of performance measure activities, a comparison of performance to the prior year was not performed. Rates related to penetration of members—specifically, members who received one contact from the BHO related to mental health—varied, with 0.00 percent as the lowest rate for those women participating in the breast and cervical cancer program and 33.11 percent as the highest rate for those members who require aid for the needy disabled, may receive supplemental security income, or are disabled individuals up to 59 years of age. Penetration rates further varied with the rate related to adults 65 years of age or older who received one contact related to mental health at 6.64 percent as the lowest rate and the rate for adolescents 13 through 17 years of age who received the most contact related to mental health at 18.64 percent as the highest rate.

Behavioral Healthcare, Inc.

Findings—System and Reporting Capabilities

HSAG identified no issues or concerns with how BHI received and processed enrollment data. Colorado Access (BHI's ASO) obtained a monthly eligibility full file and daily change/update file from the Department via a secure FTP site in a flat file format. Eligibility information was loaded into a data scrubber, where several business rules were applied to ensure that only accurate enrollment information was loaded into QNXT, BHI's transactional system. Providers were able to log in to BHI's system and obtain eligibility information for members. Each member received a unique identification number. For measure production, enrollment information was reconciled with the monthly full file. In case of any discrepancy, real-time eligibility verification was available via the Department's portal. No major system or process changes were noted for the current reporting year.

BHI used QNXT, operated by TriZetto, as its claims processing system. Providers submitted electronic and paper claims. Electronic claims were submitted to Colorado Access in a HIPAA-compliant 837 format. These files were loaded into QNXT via TriZetto's FTP site. Paper claims were scanned and posted on TriZetto's FTP site where, prior to being loaded into QNXT, they were converted into the 837 format using the OCR technology. The affiliated CMHCs submitted encounter data via FTP. The files were then loaded into QNXT. Nightly, TriZetto audited 2.5 percent of auto-adjudicated and 5 percent of manually-adjudicated claims. BHI added an additional validation to further ensure data accuracy by auditing 7 percent of claims previously verified by TriZetto. BHI performed audits on 100 percent of facility claims exceeding the $10,000 threshold and professional claims exceeding the $5,000 threshold. In addition to claims/encounter data, BHI received pharmacy and inpatient data from the Department via FTP and loaded the data into the data warehouse.

BHI submitted 837 encounter files and flat files to the Department, received error files within a few days of submission, and had adequate validation and reconciliation processes in place to ensure data completeness and data accuracy. BHI had sufficient oversight of its processing vendor, TriZetto. Monthly meetings were in place to address any upcoming issues and collaboratively discuss solutions.

BHI used the same processes as in the prior year to manage data flow and calculate performance indicator rates. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measure Scope Document*. Several verification processes in place ensured that only accurate data were used for measure reporting.

Findings—Performance Measure Results

Table 5-18 shows the MY 2013–2014 and MY 2014–2015 performance measure results for BHI.

Table 5-18—Performance Measure Results for BHI

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]
Hospital Readmissions Within 180 Days (all facilities)*		
Hospital Readmissions Within 180 Days (all facilities)	—	14.76%
Mental Health Engagement		
Mental Health Engagement	35.96%	54.80%
Overall Penetration Rates		
Overall Penetration Rates	12.04%	12.79%
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)		
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)	12.46	15.85
Penetration Rates by Age Group		
Children 12 Years of Age and Younger	6.54%	6.62%
Adolescents 13 Through 17 Years of Age	16.04%	17.23%
Adults 18 Through 64 Years of Age	17.62%	16.94%
Adults 65 Years of Age or Older	6.08%	7.88%
Penetration Rates by Medicaid Eligibility Category		
AND/AB-SSI	32.75%	34.03%
BC Children	2.16%	1.43%
BCCP-Women Breast and Cervical Cancer	10.53%	15.01%
Buy-In: Working Adult Disabled	27.84%	27.23%
Foster Care	34.53%	33.98%
OAP-A	5.99%	7.72%
OAP-B-SSI	23.76%	25.57%
MAGI Adults	18.70%	15.07%
Buy-In: Children With Disabilities	14.24%	15.67%
MAGI Parents/Caretakers	—	14.03%
MAGI Children	—	8.34%
MAGI Pregnant	—	14.44%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment	—	48.75%
Engagement of AOD Treatment	—	35.70%
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (non-state and all facilities)*		
Non-State Hospitals—7 Days	3.20%	1.85%
Non-State Hospitals—30 Days	7.71%	6.78%
Non-State Hospitals—90 Days	12.95%	12.08%

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]
All Hospitals—7 Days	3.50%	1.78%
All Hospitals—30 Days	8.11%	6.55%
All Hospitals—90 Days	13.48%	11.88%
Members With Physical Health Well-Care Visits		
0–17 Years of Age	—	87.93%
18+ Years of Age	—	86.52%
Inpatient Utilization (Rate/1,000 Members, All Ages)		
Non-State Hospitals	3.29	2.93
All Hospitals	3.84	3.26
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition		
Non-State Hospitals—7 Days	52.43%	56.20%
Non-State Hospitals—30 Days	70.58%	73.63%
All Hospitals—7 Days	54.55%	57.43%
All Hospitals—30 Days	71.34%	74.43%
Antidepressant Medication Management—Acute and Continuation Phases		
Effective Acute Phase Treatment	—	49.60%
Effective Continuation Phase Treatment	—	44.92%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2013–2014 (i.e., July 1, 2013 through June 30, 2014). Of note, these rates were previously labeled "Fiscal Year (FY) 2014–2015" in the 2014–2015 External Quality Review Technical Report for Colorado Medicaid.

[2] Indicates that the rates contained within this column represent MY 2014–2015 (i.e., July 1, 2014 through June 30, 2015).

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

— Indicates that the measure was not presented in last year's technical report and, therefore, a MY 2013–2014 measure rate is not presented in this year's report.

Findings, Strengths, and Recommendations

As in prior years, BHI continued to maintain an excellent relationship with Colorado Access, BHI's ASO. Although Colorado Access went through organizational changes in the past year, all staff members had extensive experience and knowledge of processes related to behavioral health measures and their reporting requirements. BHI and the Department continued to conduct monthly meetings addressing any issues with 837 file submission. As a result of this, BHI's file rejection rate was less than 10 percent for the current MY. BHI continued to maintain its performance level throughout the year.

During the primary source verification process, a discrepancy was discovered in the numerator-positive case selections for *Antidepressant Medication Management—Acute and Continuation Phases*. BHI considered the difference in service dates rather than days of supplied medication. The staff members were responsive, investigated the issue, and resubmitted the corrected data prior to generation of this report.

HSAG recommends that BHI continue to work with the Department and the other BHOs to clarify the definition of "new members" in the scope document for *Mental Health Engagement*.

Of BHI's reported audited measure rates for MY 2014–2015, 28 of the 38 audited measure indicators were also reported for MY 2013–2014. Of these 28 measure indicators, 15 rates increased from the prior MY. Of note, lower rates for *Hospital Readmissions Within 7, 30, and 90 Days Post-discharge* indicate better performance. All six of the *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge* measure indicators declined from the prior year (this measure is an inverse measure, wherein an increase over the prior year's rates suggests poorer performance). Conversely, BHI experienced declined rates from the prior year for seven measure indicators. HSAG recommends that BHI investigate the reasons behind these declines and increase utilization.

BHI: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

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

Quality

BHI's quality-related performance was assessed based on rates for 11 audited measure indicators for the current MY. Of these 11 measures, six measure indicators were also reported for MY 2013–2014. Rates related to post-discharge hospital readmissions varied, with 1.85 percent reported as the lowest percentage of hospital readmissions and 12.08 percent reported as the highest percentage of hospital readmissions, where a higher rate indicates poorer performance and opportunities for improvement. Additionally, all rates within the post-discharge hospital readmissions measure improved from the prior year.

Timeliness

BHI's timeliness-related performance was assessed based on rates for nine audited measure indicators for the current MY. Of these nine measures, five measure indicators were also reported for MY 2013–2014. Rates related to mental health follow-up appointments varied, with 56.20 percent as the lowest percentage and 74.43 percent as the highest percentage. The remaining measure indicators in this domain cannot be compared to the prior year and are for information purposes only.

Access

BHI's access-related performance was evaluated based on rates for 31 audited measure indicators for the current MY. Of these 31 measures, 22 measure indicators were also reported for MY 2013–2014. Penetration rates specifically related to members who received one contact from the BHO related to mental health varied, with 1.43 percent as the lowest rate (for those children within the Baby Care Program) and 34.03 percent as the highest rate (for those members who require aid for the needy disabled, may receive supplemental security income, or are disabled individuals up to 59 years of age). Penetration rates further varied with the rate related to children 12 years of age and younger who received one contact related to mental health at 6.62 percent as the lowest rate and the rate for

adolescents 13 through 17 years of age who received the most contact related to mental health at 17.23 percent as the highest rate.

Colorado Health Partnerships, LLC

Findings—System and Reporting Capabilities

HSAG identified no issues or concerns with how CHP received and processed enrollment data. CHP maintained the same process for obtaining and processing eligibility information as that used in the prior year. The monthly eligibility full file and daily change/update files were received in flat file format from the Department via a secure FTP site. Manual validation was performed, ensuring that only accurate enrollment information was loaded into Connection Administrative System (CAS), CHP's data warehouse, via CareConnect. Enrollment data were distributed to the appropriate CMHC via FileConnect. Providers, staff members, and CMHCs were able to perform real-time eligibility verification via the Department's portal. Each member received a unique identification number. No major system or process changes were noted for the current reporting year.

All claims/encounter data were housed and processed in CAS. Providers submitted electronic or paper claims. Electronic claims entered by providers were downloaded daily via a provider connect using automated processes. Paper claims were scanned using OCR technology. All claims were received in a HIPAA-compliant 837 format. Affiliated CMHCs submitted encounter data via FileConnect. CHP continued to use the data report card to monitor the CMHCs' data quality and completeness. Nightly, 3 percent of the manually processed claims were audited for quality and payment accuracy. CHP performed audits on 100 percent of claims exceeding the $5,000 threshold. In addition to the claims/encounters data, CHP received pharmacy and inpatient data from the Department via FTP and loaded the data into CAS.

CHP submitted 837 encounter files and flat files to the Department, received error files within a few days of submission, and had adequate validation and reconciliation processes in place to ensure data completeness and data accuracy.

CHP used the same processes as in the prior year to manage data flow and calculate performance indicator rates. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measures Scope Document*. Several verification processes in place ensured data completeness and data accuracy.

Findings—Performance Measure Results

Table 5-19 shows the MY 2013–2014 and MY 2014–2015 performance measure results for CHP.

Table 5-19—Performance Measure Results for CHP

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]
Hospital Readmissions Within 180 Days (all facilities)*		
Hospital Readmissions Within 180 Days (all facilities)	—	21.22%
Mental Health Engagement		
Mental Health Engagement	37.44%	48.29%
Overall Penetration Rates		
Overall Penetration Rates	13.94%	14.83%
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)		
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)	8.83	10.22
Penetration Rates by Age Group		
Children 12 Years of Age and Younger	6.66%	6.69%
Adolescents 13 Through 17 Years of Age	16.55%	16.84%
Adults 18 Through 64 Years of Age	20.07%	19.53%
Adults 65 Years of Age or Older	6.08%	9.81%
Penetration Rates by Medicaid Eligibility Category		
AND/AB-SSI	30.17%	33.35%
BC Children	1.95%	2.06%
BCCP-Women Breast and Cervical Cancer	17.65%	7.37%
Buy-In: Working Adult Disabled	22.81%	25.17%
Foster Care	30.16%	29.95%
OAP-A	6.04%	9.80%
OAP-B-SSI	19.14%	24.15%
MAGI Adults	22.25%	17.31%
Buy-In: Children With Disabilities	9.94%	11.52%
MAGI Parents/Caretakers	—	17.07%
MAGI Children	—	8.40%
MAGI Pregnant	—	22.15%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment	—	49.76%
Engagement of AOD Treatment	—	44.02%
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (non-state and all facilities)*		
Non-State Hospitals—7 Days	3.16%	3.44%
Non-State Hospitals—30 Days	10.04%	10.01%
Non-State Hospitals—90 Days	16.57%	16.57%

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]
All Hospitals—7 Days	3.33%	3.41%
All Hospitals—30 Days	10.35%	9.83%
All Hospitals—90 Days	17.07%	16.29%
Members With Physical Health Well-Care Visits		
0–17 Years of Age	—	91.35%
18+ Years of Age	—	89.69%
Inpatient Utilization (Rate/1,000 Members, All Ages)		
Non-State Hospitals	4.88	5.55
All Hospitals	5.66	5.68
Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition		
Non-State Hospitals—7 Days	50.61%	45.06%
Non-State Hospitals—30 Days	68.74%	65.86%
All Hospitals—7 Days	50.00%	44.90%
All Hospitals—30 Days	68.85%	65.81%
Antidepressant Medication Management—Acute and Continuation Phases		
Effective Acute Phase Treatment	—	55.32%
Effective Continuation Phase Treatment	—	36.33%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2013–2014 (i.e., July 1, 2013 through June 30, 2014). Of note, these rates were previously labeled "Fiscal Year (FY) 2014–2015" in the 2014–2015 External Quality Review Technical Report for Colorado Medicaid.

[2] Indicates that the rates contained within this column represent MY 2014–2015 (i.e., July 1, 2014 through June 30, 2015).

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

— Indicates that the measure was not presented in last year's technical report and, therefore, a MY 2013–2014 measure rate is not presented in this year's report.

Findings, Strengths, and Recommendations

CHP experienced multiple staff changes during the current MY. New staff members brought extensive experience related to behavioral health policies and procedures. Monthly quality meetings continued, with representatives from several departments and affiliated CMHCs attending to address any issues and collaboratively work on solutions.

As a result of the robust validation process and excellent communication with the Department on outstanding issues, CHP's file rejection rate was less than 10 percent for the current MY.

The encounter data report card continued to provide excellent monitoring of the eight mental health centers' performance on timeliness and accuracy. This report card was distributed to each CMHC for review and the opportunity to correct any issue—ensuring that only complete and accurate data were submitted to the Department.

When completing future Information Systems Capabilities Assessment Tool (ISCAT) forms, HSAG suggests that CHP ensure that the document contains accurate and current information. During the

primary source verification, it was noted that an incorrect intake date was captured for the selected member in *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.*

In addition, after further clarification, CHP was instructed to correct the denominator for *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement of AOD Treatment* to be compliant with the measure specification outlined in the scope document. The staff members were responsive, corrected the issue, and resubmitted the revised rate prior to generation of this report.

HSAG recommends that CHP continue to work with the Department and the other BHOs to clarify the definition of "new members" in the scope document for *Mental Health Engagement*.

Of CHP's reported audited measure rates for MY 2014–2015, 28 of the 38 audited measure indicators were also reported for MY 2013–2014. Of these 28 measure indicators, 15 rates increased from the prior MY. Three of the six *Hospital Readmissions Within 7, 30, and 90 Days Post-discharge* measure indicators declined from the prior year, including *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge—Non-State Hospitals—30 Days, All Hospitals—30 Days,* and *All Hospitals—90 Days.* Of note, lower rates for *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge* indicate better performance. Conversely, CHP experienced declined rates from the prior year for 10 measure indicators, including a 10.28 percentage decline for *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer*. HSAG recommends that CHP investigate the reasons behind these declines and increase utilization related to *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer.* Specifically, HSAG recommends that CHP explore options to improve inpatient discharge planning in an effort to improve the hospital recidivism measure indicator rates.

CHP: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

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

Quality

CHP's quality-related performance was assessed based on rates for 11 audited measure indicators for the current MY. Of these 11 measures, six measure indicators were also reported for MY 2013–2014. Rates related to post-discharge hospital readmissions varied with 3.41 percent reported as the lowest percentage of hospital readmissions and 16.57 percent reported as the highest percentage of hospital readmissions, where a higher rate indicates poorer performance and opportunities for improvement. Additionally, three of the six rates within the post-discharge hospital readmissions measure indicator declined from the prior year.

Timeliness

CHP's timeliness-related performance was assessed based on rates for nine audited measure indicators for the current MY. Of these nine measures, five measure indicators were also reported for MY 2013–2014. Rates related to mental health follow-up appointments varied, with 44.90 percent as the lowest percentage and 65.86 percent as the highest.

Access

CHP's access-related performance was evaluated based on rates for 31 audited measure indicators for the current MY. Of these 31 measures, 22 measure indicators were also reported for MY 2013–2014. Penetration rates specifically related to members who received one contact from the BHO related to mental health varied, with 2.06 percent as the lowest rate (for those children within the Baby Care Program) and 33.35 percent as the highest rate (for those members who require aid for the needy disabled, may receive supplemental security income, or are disabled individuals up to 59 years of age). Penetration rates further varied with the rate related to children 12 years of age and younger who received one contact related to mental health at 6.69 percent as the lowest rate and the rate for adults 18 through 64 years of age who received the most contact related to mental health at 19.53 percent as the highest rate.

Foothills Behavioral Health Partners, LLC

Findings—System and Reporting Capabilities

HSAG identified no issues or concerns with how FBHP received and processed enrollment data. FBHP maintained the same process for obtaining and processing eligibility information as used in the prior year. Monthly eligibility full files and daily change/update files were received in a flat file format from the Department via a secure FTP site. Manual validation was performed ensuring that only accurate enrollment information was loaded into CAS, FBHP's data warehouse, via CareConnect. Enrollment data were distributed to the appropriate CMHC via FileConnect. Providers, staff members, and CMHCs were able to perform real-time eligibility verification via the Department's portal. Each member received a unique identification number. No major system or process changes were noted for the current reporting year.

All claims/encounter data were housed and processed in CAS. Providers submitted electronic or paper claims. Electronic claims entered by providers were downloaded daily via a provider connect using an automated process. Paper claims were scanned using OCR technology. All claims were received in a HIPAA-compliant 837 format. Affiliated CMHCs submitted encounter data via FileConnect. FBHP continued to use the data report card to monitor the CMHCs' performance. Demonstrating a robust quality check, FBHP added an additional validation to further ensure that only complete and accurate data were loaded into the claims system. Nightly, 3 percent of the manually processed claims were audited for quality and payment accuracy. FBHP performed audits on 100 percent of claims exceeding the $5,000 threshold. In addition to the claims/encounters data, FBHP received pharmacy and inpatient data from the Department via FTP and loaded the data into CAS.

FBHP submitted 837 encounter files and flat files to the Department, received error files within a few days of submission, and had adequate validation and reconciliation processes in place to ensure data completeness and data accuracy.

FBHP used the same processes as in the prior year to manage data flow and calculate performance indicator rates. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. Several verification processes in place ensured data completeness and data accuracy.

Findings—Performance Measure Results

Table 5-20 shows the MY 2013–2014 and MY 2014–2015 performance measure results for FBHP.

Table 5-20—Performance Measure Results FBHP

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]
Hospital Readmissions Within 180 Days (all facilities)*		
Hospital Readmissions Within 180 Days (all facilities)	—	16.83%
Mental Health Engagement		
Mental Health Engagement	41.60%	48.29%
Overall Penetration Rates		
Overall Penetration Rates	16.84%	16.47%
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)		
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)	8.81	9.80
Penetration Rates by Age Group		
Children 12 Years of Age and Younger	11.48%	12.33%
Adolescents 13 Through 17 Years of Age	20.82%	19.46%
Adults 18 Through 64 Years of Age	21.34%	18.87%
Adults 65 Years of Age or Older	7.16%	7.00%
Penetration Rates by Medicaid Eligibility Category		
AND/AB-SSI	33.92%	35.34%
BC Children	2.62%	2.93%
BCCP-Women Breast and Cervical Cancer	7.28%	11.78%
Buy-In: Working Adult Disabled	44.81%	37.28%
Foster Care	33.90%	34.58%
OAP-A	7.14%	6.78%
OAP-B-SSI	25.01%	26.98%
MAGI Adults	23.55%	16.99%
Buy-In: Children With Disabilities	20.74%	19.46%
MAGI Parents/Caretakers	—	15.42%
MAGI Children	—	13.13%

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]
MAGI Pregnant	—	17.64%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment	—	41.29%
Engagement of AOD Treatment	—	35.50%
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (non-state and all facilities)*		
Non-State Hospitals—7 Days	2.83%	1.94%
Non-State Hospitals—30 Days	6.74%	6.91%
Non-State Hospitals—90 Days	13.26%	12.61%
All Hospitals—7 Days	2.73%	1.83%
All Hospitals—30 Days	7.00%	6.99%
All Hospitals—90 Days	13.14%	12.47%
Members With Physical Health Well-Care Visits		
0–17 Years of Age	—	83.81%
18+ Years of Age	—	86.94%
Inpatient Utilization (Rate/1,000 Members, All Ages)		
Non-State Hospitals	4.51	5.86
All Hospitals	5.75	6.61
Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition		
Non-State Hospitals—7 Days	50.77%	52.19%
Non-State Hospitals—30 Days	68.31%	65.96%
All Hospitals—7 Days	52.04%	53.46%
All Hospitals—30 Days	68.66%	66.43%
Antidepressant Medication Management—Acute and Continuation Phases		
Effective Acute Phase Treatment	—	60.00%
Effective Continuation Phase Treatment	—	44.39%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2013–2014 (i.e., July 1, 2013 through June 30, 2014). Of note, these rates were previously labeled "Fiscal Year (FY) 2014–2015" in the 2014–2015 External Quality Review Technical Report for Colorado Medicaid.

[2] Indicates that the rates contained within this column represent MY 2014–2015 (i.e., July 1, 2014 through June 30, 2015).

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

— Indicates that the measure was not presented in last year's technical report and, therefore, a MY 2013–2014 measure rate is not presented in this year's report.

Findings, Strengths, and Recommendations

Although FBHP experienced several staff changes during the current MY, new staff members brought prior knowledge of policies and procedures related to behavioral health. Monthly quality meetings remained in place, wherein representatives from the finance department, information technology team, clinical team, and the two affiliated CMHCs were present to address any issues and collaborate on solutions.

As a result of FBHP's excellent validation process and communication with the Department, the file rejection rate was under 10 percent for the current MY.

FBHP continued to monitor its two CMHCs' timeliness and data accuracy via a report card. This report card was distributed to the CMHCs monthly, providing an opportunity to reconcile encounter data and ensure that complete and accurate data were submitted to the Department. In addition, FBHP had an extra layer of quality check wherein the BHO validated each CMHC's data prior to submitting it to Beacon Health Options (FBHP's ASO) to generate the report card.

For the next MY, HSAG suggests that FBHP ensure that all documents are completed with current and accurate information. During primary source verification it was noted that an incorrect intake date was captured when the denominator was calculated for *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*. In addition, after further clarification, FBHP was instructed to correct the denominator for *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement of AOD Treatment* to be compliant with the measure specification outlined in the scope document. The FBHP staff members were responsive, investigated the issue, and resubmitted the revised rate prior to generation of this report. Additionally, HSAG recommends that FBHP continue to work with the Department and the other BHOs to clarify the definition of "new members" in the scope document for *Mental Health Engagement*.

Of FBHP's reported audited measure rates for MY 2014–2015, 28 of the 38 audited measure indicators were also reported for MY 2013–2014. Of these 28 measure indicators, 13 rates increased from the prior MY. Five of the six of the *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge* measure indicators declined from the prior year, *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge—Non-State Hospitals—7 Days, Non-State Hospitals—90 Days, All Hospitals—7 Days, All Hospitals—30 Days,* and *All Hospitals—90 Days.* Of note, lower rates for *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge* indicate better performance. Conversely, FBHP experienced declined rates from the prior year for 11 measure indicators, including a 7.53 percentage decline for *Penetration Rates by Medicaid Eligibility Category—Buy-In: Working Adult Disabled* and a 6.56 percentage decline for *Penetration Rates by Medicaid Eligibility Category—MAGI Adults.* HSAG recommends that FBHP investigate the reasons behind these declines and increase utilization related to *Penetration Rates by Medicaid Eligibility Category—Buy-In: Working Adult Disabled* and *MAGI Adults.*

FBHP: Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

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

Quality

FBHP's quality-related performance was assessed based on rates for 11 audited measure indicators for the current MY. Of these 11 measures, six measure indicators were also reported for MY 2013–2014. Rates related to post-discharge hospital readmissions varied, with 1.83 percent reported as the lowest percentage and 12.61 percent reported as the highest percentage, where a higher rate indicates poorer performance and opportunities for improvement. Additionally, five of the six rates within the post-discharge hospital readmissions measure indicator declined from the prior year.

Timeliness

FBHP's timeliness-related performance was assessed based on rates for nine audited measure indicators for the current MY. Of these nine measures, five measure indicators were also reported for MY 2013–2014. Rates related to mental health follow-up appointments varied, with 52.19 percent as the lowest percentage and 66.43 percent as the highest.

Access

FBHP's access-related performance was evaluated based on rates for 31 audited measure indicators for the current MY. Of these 31 measures, 22 measure indicators were also reported for MY 2013–2014. Penetration rates specifically related to members who received one contact from the BHO related to mental health varied, with 2.93 percent as the lowest rate (for those children within the Baby Care Program) and 37.28 percent as the highest rate (for those members who are disabled working adults). Penetration rates further varied with the rate related to adults 65 years of age or older who received one contact related to mental health at 7.00 percent as the lowest rate and the rate for adolescents 13 through 17 years of age who received the most contact related to mental health at 19.46 percent as the highest rate.

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

Table 5-21 shows the MY 2013–2014 and MY 2014–2015 statewide weighted average performance measure results and the BHO rate range.

Table 5-21—Performance Measure Results for Statewide Weighted Average

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]	BHO Rate Range
Hospital Readmissions Within 180 Days (all facilities)*			
Hospital Readmissions Within 180 Days (all facilities)	—	19.42%	13.26%-25.55%
Mental Health Engagement			
Mental Health Engagement	37.11%	49.80%	48.06%-54.80%
Overall Penetration Rates			
Overall Penetration Rates	13.86%	14.67%	12.79%-16.47%
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)			
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)	10.92	13.34	9.80-16.73
Penetration Rates by Age Group			
Children 12 Years of Age and Younger	7.24%	7.46%	6.62%-12.33%
Adolescents 13 Through 17 Years of Age	16.94%	17.58%	16.84%-19.46%
Adults 18 Through 64 Years of Age	19.92%	19.14%	16.94%-22.78%
Adults 65 Years of Age or Older	6.80%	8.70%	6.64%-10.09%
Penetration Rates by Medicaid Eligibility Category			
AND/AB-SSI	33.11%	35.50%	33.11%-43.74%
BC Children	2.20%	1.98%	1.43%-2.93%
BCCP-Women Breast and Cervical Cancer	12.52%	7.90%	0.00%-15.01%
Buy-In: Working Adult Disabled	30.76%	28.74%	24.93%-37.28%
Foster Care	33.48%	32.11%	29.51%-34.58%
OAP-A	6.75%	8.60%	6.70%-9.87%
OAP-B-SSI	22.86%	26.40%	23.42%-32.66%
MAGI Adults	21.60%	17.18%	15.07%-20.57%
Buy-In: Children With Disabilities	14.06%	14.40%	11.52%-19.46%
MAGI Parents/Caretakers	—	15.76%	14.03%-17.07%
MAGI Children	—	9.11%	8.34%-13.13%
MAGI Pregnant	—	18.68%	14.44%-22.15%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			
Initiation of AOD Treatment	—	47.10%	41.29%-49.76%
Engagement of AOD Treatment	—	37.63%	31.69%-44.02%
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (non-state and all facilities)*			
Non-State Hospitals—7 Days	3.06%	2.94%	1.85%-4.16%

Performance Measure	MY 2013-2014 Rate[1]	MY 2014-2015 Rate[2]	BHO Rate Range
Non-State Hospitals—30 Days	9.46%	9.21%	6.63%-12.83%
Non-State Hospitals—90 Days	15.70%	15.38%	11.46%-20.14%
All Hospitals—7 Days	3.18%	3.10%	1.78%-5.22%
All Hospitals—30 Days	9.61%	9.32%	6.55%-13.92%
All Hospitals—90 Days	15.98%	15.47%	11.35%-21.52%
Members With Physical Health Well-Care Visits			
0–17 Years of Age	—	89.07%	83.81%-91.41%
18+ Years of Age	—	88.44%	86.52%-89.99%
Inpatient Utilization (Rate/1,000 Members, All Ages)			
Non-State Hospitals	4.36	5.13	2.93-6.44
All Hospitals	5.08	5.43	3.26-6.92
Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition			
Non-State Hospitals—7 Days	50.15%	47.87%	41.24%-56.20%
Non-State Hospitals—30 Days	69.34%	66.08%	60.00%-73.63%
All Hospitals—7 Days	50.51%	48.18%	40.86%-57.43%
All Hospitals—30 Days	69.53%	66.23%	59.75%-74.43%
Antidepressant Medication Management—Acute and Continuation Phases			
Effective Acute Phase Treatment	—	55.56%	49.60%-69.88%
Effective Continuation Phase Treatment	—	42.91%	36.33%-61.45%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2013–2014 (i.e., July 1, 2013 through June 30, 2014). Of note, these rates were previously labeled "Fiscal Year (FY) 2014–2015" in the 2014–2015 External Quality Review Technical Report for Colorado Medicaid.

[2] Indicates that the rates contained within this column represent MY 2014–2015 (i.e., July 1, 2014 through June 30, 2015).

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

— Indicates that the measure was not presented in last year's technical report and, therefore, a MY 2013–2014 measure rate is not presented in this year's report.

Findings, Strengths, and Recommendations

For the current MY, all five BHOs experienced staff and/or organizational changes. New staff members brought extensive experience related to behavioral health policies and procedures. Due to the robust validation process, the file rejection rate was under 10 percent for each of the five BHOs.

HSAG recommends that the BHOs continue to work with the Department to clarify the definition of "new members" in the scope document for *Mental Health Engagement*. In addition, HSAG also recommends that the BHOs implement additional verification processes to further ensure that only valid data are being used for rate calculation. HSAG recommends that all BHOs continue to work closely with the Department to resolve any discrepancies between the flat files and the 837 encounter files.

Of the statewide measure rates for MY 2014–2015, 28 of the 38 audited measure indicators were also calculated for MY 2013–2014. Of these 28 measure indicators, 11 rates increased from the prior MY. Of

the Medicaid statewide average reported audited measure rates for MY 2014–2015, 18 of the 28 audited measure indicators experienced increased rates from the prior MY. All six of the *Hospital Readmissions Within 7, 30, and 90 Days Post-discharge* measure indicators declined from the prior year. Of note, lower rates for *Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge* indicate better performance. Conversely, the Medicaid statewide average experienced declined rates from the prior year for 10 measure indicators, wherein the majority of declines were related to penetration rates and mental health follow-up appointments. HSAG recommends that all BHOs and the Department investigate the reasons behind these declines and increase utilization related to *Penetration Rates by Medicaid Eligibility Category* and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition.*

Statewide Summary Assessment Related to Quality, Timeliness, and Access for Validation of Performance Measures

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

Quality

Quality-related performance was assessed statewide based on rates for 11 measure indicators for the current MY. Of these 11 measures, six measure indicators were also reported for MY 2013–2014. Rates related to post-discharge hospital readmissions varied, with 2.94 percent reported as the lowest percentage and 15.47 percent reported as the highest percentage, where a higher rate indicates poorer performance and opportunities for improvement. Additionally, all rates within the post-discharge hospital readmissions measure indicator declined from the prior year.

Timeliness

Timeliness-related performance was assessed statewide based on rates for nine measure indicators for the current MY. Of these nine measures, five were also reported for MY 2013–2014. Rates related to mental health follow-up appointments varied, with 47.87 percent as the lowest percentage and 66.23 percent as the highest.

Access

Access-related performance was evaluated statewide based on rates for 31 measure indicators for the current MY. Of these 31 measures, 22 measure indicators were also reported for MY 2013–2014. Penetration rates specifically related to members who received one contact from the BHO related to mental health varied, with 1.98 percent as the lowest rate (for those children within the Baby Care Program) and 35.50 percent as the highest rate (for those members who require aid for the needy disabled, may receive supplemental security income, or are disabled individuals up to 59 years of age). Penetration rates further varied with the rate related to children 12 years of age and younger who received one contact related to mental health at 7.46 percent as the lowest rate and the rate for adults 18 through 64 years of age who received the most contact related to mental health at 19.14 percent as the highest rate.

Validation of Performance Improvement Projects

For FY 2015–2016, HSAG validated one PIP for each of the five BHOs. Table 5-22 lists the PIP topics identified by each BHO.

Table 5-22—FY2015–2016 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

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 second validation year for the PIP. ABC-D reported baseline study indicator results and completed Activities I through VIII of the PIP Summary Form.

Table 5-23 provides a summary of ABC-D's PIP validation results for the FY 2015–2016 validation cycle.

Table 5-23—Performance Improvement Project Validation Results for ABC-D

Study Stage	Activity	Percentage 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	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	100% (5/5)	0% (0/5)	0% (0/5)
Implementation Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percentage Score of Applicable Evaluation Elements Met		**100% (17/17)**	**0% (0/17)**	**0% (0/17)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI) and the Implementation stage (Activities VII through VIII) were validated. Activity IX in the Outcomes stage will be validated next year, when the BHO reports Remeasurement 1 results.

Table 5-24 provides a summary of ABC-D's PIP outcomes for the FY 2015–2016 validation cycle.

Table 5-24—Performance Improvement Project Outcomes for ABC-D
PIP Topic: *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*

Study Indicator	Baseline Period (01/01/2014–12/31/2014)	Remeasurement 1 (01/01/2015–12/31/2015)	Remeasurement 2 (01/01/2016–12/31/2016)	Sustained Improvement
The percentage of eligible adolescent members who screened positive for depression with a medical health provider and completed a follow-up visit with a behavioral health provider within 30 days.	0%			

The baseline rate of adolescent members who screened positive for depression with a medical provider and received a follow-up visit with a behavioral health provider within 30 days was 0 percent. The BHO set a goal of 50 percent for the Remeasurement 1 period.

Strengths

ABC-D designed a scientifically sound project supported by the use of 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. ABC-D reported and interpreted its baseline study indicator results accurately. The BHO used appropriate quality improvement tools to conduct its causal/barrier analysis, prioritized barriers, and implemented interventions with potential to have a positive impact on the study indicator outcomes. The BHO had begun evaluating interventions for effectiveness, which will allow the BHO to use intervention evaluation results to refine improvement strategies throughout the life of the PIP.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The BHO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to overall success in improving PIP outcomes.

For the *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP, ABC-D identified the following barriers to a successful transition of care:

- Incorrect coding and billing practices for depression screening by behavioral health and primary care providers
- Provider challenges in navigating the behavioral health system
- Lack of an established workflow process following a positive depression screen

To address these barriers, ABC-D implemented the following interventions:

- For primary care providers and practice managers in RCCO regions 3 and 5, a training on proper billing and coding for depression screening. A "how to" flyer for providers was distributed as part of the training.
- Online provider newsletters providing information on available behavioral health resources and crisis centers. The BHO sent monthly "online RCCO News Flashes" to primary care providers, community organizations, hospitals, and specialists to update RCCO providers on the latest online newsletter. The newsletters provided resource information on integrated physical and behavioral healthcare, crisis referral resources, and BHO contact information.
- Creation of a *Depression Screening Clinic Workflow* tool that medical clinics could adopt to standardize and refine the process for responding to positive depression screenings and referring to behavioral health providers. The workflow tool was distributed to stakeholder groups as a resource for improving the depression screening and care transition process.
- A webinar about Colorado Crisis Services hosted with the collaborating RCCO in the BHO's service area.
- A provider and community forum providing organizations and stakeholders with information on Colorado Medicaid behavioral health systems, best practices and current efforts to integrate care, and a behavioral health panel discussion.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Continue to collect supplemental self-reported data from federally qualified health center (FQHC) partners to monitor whether or not providers are consistently submitting claims for depression screening and behavioral health visits. While ABC-D should maintain consistent administrative data collection methods for each annual measurement of the study indicator rate, the BHO may incorporate supplemental data analysis into the narrative interpretation of study indicator results.
- Evaluate the effectiveness of each implemented intervention. Obtaining evaluation results for each intervention will allow the BHO to make data-driven decisions about which interventions have the greatest impact on the study indicator and how best to direct resources to achieve optimal improvement.
- Use techniques based on quality improvement science such as the PDSA model to evaluate and refine improvement strategies. Interventions may be tested on a small scale, evaluated, and then expanded to full implementation if deemed successful.

ABC-D: Summary Assessment Related to Quality, Timeliness, and Access for PIPs

While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation 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 the use of appropriate QI activities to support improvement of PIP outcomes.

Access Behavioral Care—Northeast

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 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 second validation year for the PIP, and ABC-NE completed Activities I through VIII of the PIP Summary Form.

Table 5-25 provides a summary of ABC-NE's PIP validation results for the FY 2015–2016 validation cycle.

Table 5-25—Performance Improvement Project Validation Results for ABC-NE

Study Stage	Activity	Percentage 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	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	100% (2/2)	0% (0/2)	0% (0/2)
Implementation Total		**100% (5/5)**	**0% (0/5)**	**0% (0/5)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percentage Score of Applicable Evaluation Elements Met		**100% (14/14)**	**0% (0/14)**	**0% (0/14)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI) and the Implementation stage (Activities VII and VIII) were validated.

Table 5-26 provides a summary of ABC-NE's PIP outcomes for the FY 2015–2016 validation cycle.

Table 5-26—Performance Improvement Project Outcomes for ABC-NE
PIP Topic: *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*

Study Indicator	Baseline Period* (01/01/2015–12/31/2015)	Remeasurement 1 (01/01/2016–12/31/2016)	Remeasurement 2 (01/01/2017–12/31/2017)	Sustained Improvement
The percentage of eligible adolescent members who screened positive for depression with a medical health provider and completed a follow-up visit with a behavioral health provider within 30 days.				

* The BHO was unable to report a baseline study indicator result using data from 2014; therefore, the baseline period was shifted to CY 2015. Baseline results will be reported next year based on the new baseline measurement period.

ABC-NE accurately reported that a baseline study indicator rate could not be calculated for calendar year (CY) 2014 because the study indicator's denominator was zero. For next year's annual PIP submission, the BHO will report the baseline study indicator results based on data from CY 2015. The BHO will set a goal for the Remeasurement 1 period based on the baseline results.

Strengths

ABC-NE designed a scientifically sound project supported by the use of 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 BHO used appropriate quality improvement tools to conduct its causal/barrier analysis, prioritized barriers, and implemented interventions with potential to have a positive impact on the study indicator outcomes. The BHO had begun evaluating interventions for effectiveness, which will allow the BHO to use intervention evaluation results to refine improvement strategies throughout the life of the PIP.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The BHO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to overall success in improving PIP outcomes.

For the *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP, ABC-NE identified the following barriers to a successful transition of care:

- Incorrect provider coding and billing practices for depression screening
- Provider challenges in navigating the behavioral health system
- Lack of an established workflow process following a positive depression screen

To address these barriers, ABC-NE implemented the following interventions:

- Online provider newsletters providing information on available behavioral health resources and crisis centers. The BHO sent monthly "online RCCO News Flashes" to primary care providers, community organizations, hospitals, and specialists to update RCCO providers on the latest online newsletter. The newsletters provided resource information on integrated physical and behavioral healthcare, crisis referral resources, and BHO contact information.
- Creation of a *Depression Screening Clinic Workflow* tool that medical clinics could adopt to standardize and refine the process for responding to positive depression screenings and referring to behavioral health providers. The workflow tool was distributed to stakeholder groups as a resource for improving the depression screening and care transition process.
- A webinar about Colorado Crisis Services hosted with the collaborating RCCO in the BHO's service area.
- A provider and community forum providing organizations and stakeholders with information on Colorado Medicaid behavioral health systems, best practices and current efforts to integrate care, and a behavioral health panel discussion.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Continue to collect supplemental self-reported data from FQHC partners to monitor whether or not providers are consistently submitting claims for depression screening and behavioral health visits. While ABC-NE should maintain consistent administrative data collection methods for each annual measurement of the study indicator rate, the BHO may incorporate supplemental data analysis into the narrative interpretation of study indicator results.
- Evaluate the effectiveness of each implemented intervention. Obtaining evaluation results for each intervention will allow the BHO to make data-driven decisions about which interventions have the greatest impact on the study indicator and how best to direct resources to achieve optimal improvement.
- Use techniques based on quality improvement science such as the PDSA model to evaluate and refine improvement strategies. Interventions may be tested on a small scale, evaluated, and then expanded to full implementation if deemed successful.

ABC-NE: Summary Assessment Related to Quality, Timeliness, and Access for PIPs

While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation 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 the use of appropriate QI activities to support improvement of PIP outcomes.

Behavioral Healthcare, Inc.

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 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 second validation year for the PIP. BHI reported baseline study indicator results and completed Activities I through VIII of the PIP Summary Form.

Table 5-27 provides a summary of BHI's PIP validation results for the FY 2015–2016 validation cycle.

Table 5-27—Performance Improvement Project Validation Results for BHI

Study Stage	Activity	Percentage 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	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	100% (5/5)	0% (0/5)	0% (0/5)
Implementation Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total		***Not Assessed***	***Not Assessed***	***Not Assessed***
Percentage Score of Applicable Evaluation Elements Met		**100% (17/17)**	**0% (0/17)**	**0% (0/17)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI) and the Implementation stage (Activities VII through VIII) were validated. Activity IX in the Outcomes stage will be validated next year, when the BHO reports Remeasurement 1 results.

Table 5-28 provides a summary of BHI's PIP outcomes for the FY 2015–2016 validation cycle.

Table 5-28—Performance Improvement Project Outcomes for BHI
PIP Topic: *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*

Study Indicator	Baseline Period (01/01/2014–12/31/2014)	Remeasurement 1 (01/01/2015–12/31/2015)	Remeasurement 2 (01/01/2016–12/31/2016)	Sustained Improvement
The percentage of eligible adolescent members who screened positive for depression with a medical health provider and completed a follow-up visit with a behavioral health provider within 30 days.	23.7%			

The baseline rate of adolescent members who screened positive for depression with a medical provider and received a follow-up visit with a behavioral health provider within 30 days was 23.7 percent. The BHO set a goal of 40.7 percent for the Remeasurement 1 period.

Strengths

BHI designed a scientifically sound project supported by the use of 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. BHI reported and interpreted its baseline study indicator results accurately. The BHO used appropriate quality improvement tools to conduct its causal/barrier analysis, prioritized barriers, and implemented interventions with the potential to have a positive impact on the study indicator outcomes. The BHO had begun evaluating interventions for effectiveness, which will allow the BHO to use intervention evaluation results to refine improvement strategies throughout the life of the PIP.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The BHO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to overall success in improving PIP outcomes.

For the *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP, BHI identified the following barriers to a successful transition of care:

- Incorrect coding and billing practices for depression screening by behavioral health and primary care providers
- Provider challenges in navigating the behavioral health system
- Lack of an established workflow process following a positive depression screen

To address these barriers, BHI implemented the following interventions:

- For primary care providers and practice managers in RCCO regions 3 and 5, a provider training on proper billing and coding for depression screening. A "how to" flyer for providers was distributed as part of the training.
- Online provider newsletters providing information on available behavioral health resources and crisis centers. The BHO sent monthly "online RCCO News Flashes" to primary care providers, community organizations, hospitals, and specialists to update RCCO providers on the latest online newsletter. The newsletters provided resource information on integrated physical and behavioral healthcare, crisis referral resources, and BHO contact information.
- Creation of a *Depression Screening Clinic Workflow* tool that medical clinics could adopt to standardize and refine the process for responding to positive depression screenings and referring to behavioral health providers. The workflow tool was distributed to stakeholder groups as a resource for improving the depression screening and care transition process.
- A webinar about Colorado Crisis Services hosted with the collaborating RCCO in the BHO's services area.
- A provider and community forum providing organizations and stakeholders with information on Colorado Medicaid behavioral health systems, best practices and current efforts to integrate care, and a behavioral health panel discussion.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Ensure that study indicator rates are calculated, rounded, and reported accurately and consistently throughout the PIP documentation. HSAG generally recommends reporting study indicator rates to only one decimal place, although this is not mandatory.
- Continue to collect supplemental self-reported data from FQHC partners to monitor whether or not providers are consistently submitting claims for depression screening and behavioral health visits. While BHI should maintain consistent administrative data collection methods for each annual measurement of the study indicator rate, the BHO may incorporate supplemental data analysis into the narrative interpretation of study indicator results.
- Evaluate the effectiveness of each implemented intervention. Obtaining evaluation results for each intervention will allow the BHO to make data-driven decisions about which interventions have the greatest impact on the study indicator and how best to direct resources to achieve optimal improvement.
- Use techniques based on quality improvement science such as the PDSA model to evaluate and refine improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation if deemed successful.

BHI: Summary Assessment Related to Quality, Timeliness, and Access for PIPs

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. BHI earned a *Met* validation status, demonstrating a strong application of PIP study design principles and the use of appropriate QI activities to support improvement of PIP outcomes.

Colorado Health Partnerships, LLC

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, who attend a behavioral health appointment within 30 days of release. This was the second validation year for the PIP. CHP reported baseline study indicator results and completed Activities I through VIII of the PIP Summary Form.

Table 5-29 provides a summary of CHP's PIP validation results for the FY 2015–2016 validation cycle.

Table 5-29—Performance Improvement Project Validation Results for CHP

Study Stage	Activity	Percentage 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	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
	Implementation Total	**100% (6/6)**	**0% (0/6)**	**0% (0/6)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	Outcomes Total	***Not Assessed***	***Not Assessed***	***Not Assessed***
Percentage Score of Applicable Evaluation Elements Met		**100% (15/15)**	**0% (0/15)**	**0% (0/15)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI) and the Implementation stage (Activities VII and VIII) were validated. Activity IX in the Outcomes stage will be validated next year, when the BHO reports Remeasurement 1 results.

Table 5-30 provides a summary of CHP's PIP outcomes for the FY 2015–2016 validation cycle.

Table 5-30—Performance Improvement Project Outcomes for CHP
PIP Topic: *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release*

Study Indicator	Baseline Period (01/01/2014–12/31/2014)	Remeasurement 1 (01/01/2015–12/31/2015)	Remeasurement 2 (01/01/2016–12/31/2016)	Sustained Improvement
The percentage of jail-to-community releases from selected jails for eligible members, with an identified behavioral health issue, that are followed by a covered outpatient behavioral health service within 30 days of release.	14.7%			

For eligible members with an identified behavioral health issue, the baseline rate of jail-to-community releases followed by a covered outpatient behavioral health service within 30 days of release was 14.7 percent.

Strengths

CHP designed a scientifically sound project supported by the use of 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. CHP reported and interpreted baseline study indicator results accurately. The BHO used appropriate quality improvement tools to conduct its causal/barrier analysis, prioritized barriers, and developed interventions with the potential to have a positive impact on the study indicator outcomes. The BHO had not progressed to the point of evaluating intervention effectiveness for the baseline PIP submission.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The BHO's choice of interventions, combination of intervention types, and sequence of implementing interventions are essential to overall success in improving PIP outcomes.

For the *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release* PIP, CHP identified two primary barriers to a successful jail-to-community transition of care:

- Communication challenges between the BHO, the jails, and providers
- Difficulty obtaining data from both jails and providers

To address these barriers, CHP is in the process of planning and implementing the following interventions:

- Collaboration with jail leadership to execute appropriate data-sharing agreements to obtain member demographic and release data in accordance with HIPAA.
- A regular jail release data feed established by Beacon Health Options (CHP's managed behavioral healthcare partner) through Appriss or JusticeConnect data systems, to facilitate data availability for the BHO's providers once appropriate data agreements are executed.
- Strengthening relationships between providers and local jails and developing a regular communication process to share member release status.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Review the Remeasurement 1 goal to ensure that it represents a statistically significant improvement over the baseline rate, given the estimated Remeasurement 1 denominator.
- Evaluate the effectiveness of each implemented intervention. Obtaining evaluation results for each intervention will allow the BHO to make data-driven decisions about which interventions have the greatest impact on the study indicator and how best to direct resources to achieve optimal improvement.
- Use techniques based on quality improvement science such as the PDSA model to evaluate and refine improvement strategies. Interventions may be tested on a small scale, evaluated, and then expanded to full implementation if deemed successful.

CHP: Summary Assessment Related to Quality, Timeliness, and Access for PIPs

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. CHP earned a *Met* validation status, demonstrating a strong application of PIP study design principles and the use of appropriate QI activities to support improvement of PIP outcomes.

Foothills Behavioral Health Partners, LLC

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, who attend a behavioral health appointment within seven days of release. This was the second validation year for the PIP. FBHP reported baseline study indicator results and completed Activities I through VIII of the PIP Summary Form.

Table 5-31 provides a summary of FBHP's PIP validation results for the FY 2015–2016 validation cycle.

Table 5-31—Performance Improvement Project Validation Results for FBHP

Study Stage	Activity	Percentage 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	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Interventions and Improvement Strategies	100% (5/5)	0% (0/5)	0% (0/5)
	Implementation Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Outcomes	IX. Real Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X. Sustained Improvement	*Not Assessed*	*Not Assessed*	*Not Assessed*
	Outcomes Total	***Not Assessed***	***Not Assessed***	***Not Assessed***
	Percentage Score of Applicable Evaluation Elements Met	**100% (17/17)**	**0% (0/17)**	**0% (0/17)**

Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI) and the Implementation stage (Activities VII and VIII) were validated. Activity IX in the Outcomes stage will be validated next year, when the BHO reports Remeasurement 1 results.

Table 5-32 provides a summary of FBHP's PIP outcomes for the FY 2015–2016 validation cycle.

Table 5-32—Performance Improvement Project Outcomes for FBHP
PIP Topic: *Improving Transition From Jail to Community-Based Behavioral Health Treatment*

Study Indicator	Baseline Period (01/01/2014–12/31/2014)	Remeasurement 1 (01/01/2015–12/31/2015)	Remeasurement 2 (01/01/2016–12/31/2016)	Sustained Improvement
The percentage of eligible members released from selected jails, with an identified behavioral health issue, who receive a specified covered outpatient behavioral health service within 30 business days of release.	31.9%			

The baseline rate of eligible members released from jail with an identified behavioral health issue who received a specified covered behavioral health service within 30 days was 31.9 percent. The BHO set a goal for the Remeasurement 1 period of a statistically significant increase over the baseline rate; the BHO estimated that a Remeasurement 1 rate of 35 percent would be a statistically significant increase based on the baseline denominator for the study indicator.

Strengths

FBHP designed a scientifically sound project supported by the use of 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. FBHP reported and interpreted its baseline study indicator results accurately. The BHO used appropriate quality improvement tools, including brainstorming and process mapping, to conduct its causal/barrier analysis; prioritize barriers; and implement interventions with the potential to have a positive impact on study indicator outcomes. Additionally, the BHO implemented interventions in a timely manner and had processes in place to evaluate the effectiveness of the interventions and their impact on the study indicator.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The BHO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to overall success in improving PIP outcomes.

For the *Improving Transition From Jail to Community-Based Behavioral Health Treatment* PIP, FBHP identified four barriers to a successful jail-to-community transition of care:

- Lack of a key contact and referral process for substance abuse treatment upon jail release

- Lack of resources to meet members' basic needs (housing, transportation, crisis services) upon jail release
- Insufficient jail-based behavioral health services
- A mental health center screening and intake process that is not accessible for recently released members

To address these barriers, FBHP developed the following interventions:

- Established at Arapahoe House, a local substance abuse treatment provider, a key contact person to accept calls and referrals for substance abuse follow-up appointments for members being prepared for release from jail.
- Developed educational materials about community resources to be distributed to inmates being released, those inmates' friends, and inmates' families.
- Hired a mental health clinician to provide initial intake assessments at the jail prior to release for those inmates in need of behavioral health services.
- Developed a mental health center screening, referral, and follow-up process tailored to the needs of inmates. The process is initiated during incarceration and continues after release to track member attendance at prescheduled intake appointments. The process includes outreach services for those members who do not attend their intake appointments.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Continue to use techniques based on quality improvement science such as the PDSA model as part of its improvement strategies.
- Continue ongoing intervention-specific evaluations of effectiveness and use evaluation results to make data-driven decisions about continuing, revising, or discontinuing interventions in order to achieve optimal improvement of the study indicator outcomes.

FBHP: Summary Assessment Related to Quality, Timeliness, and Access for PIPs

While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation 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 the use of appropriate QI activities to support improvement of PIP outcomes.

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

Table 5-33 shows the health plans' overall performance based on HSAG's validation of the FY 2015–2016 PIPs submitted for validation.

Table 5-33—Summary of Each BHO's PIP Validation Scores and 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 the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release*	100	100	*Met*
FBHP	*Improving Transition From Jail to Community-Based Behavioral Health Treatment*	100	100	*Met*

The validation scores and validation status across the five PIPs demonstrated strong performance in the PIP Design and Implementation stages, meeting 100 percent of all evaluation elements. Consequently, each PIP received a *Met* validation status.

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. The five PIPs validated by HSAG each earned a *Met* validation status, demonstrating a sound application of design principles necessary to produce valid and reliable PIP results and comprehensive QI processes and activities needed to support desired improvement.

6. Assessment of BHO Follow-Up on Prior Recommendations

Introduction

The Department required each BHO to address recommendations and required actions following EQR activities conducted in FY 2014–2015. This section of the report presents an assessment of how effectively the BHOs addressed the improvement recommendations or required actions from the previous year.

Access Behavioral Care–Denver

Compliance Monitoring Site Review

As a result of the FY 2014–2015 site reviews, ABC-D was required to address two elements in Standard V—Member Information and three elements in Standard VI—Grievance System. ABC-D submitted its CAP to HSAG and the Department in April 2015. HSAG and the Department reviewed the proposed plan of correction and approved it as written. ABC-D began submitting documents that demonstrated implementation of the plan in July 2015. HSAG and the Department reviewed documents submitted by ABC-D to demonstrate implementation of the plan at several intervals between July and October 2015 and determined in November 2015 that ABC-D had successfully completed all corrective actions.

Validation of Performance Measures

During the MY 2013–2014 review, HSAG recommended that ABC-D monitor its performance related to all six of the hospital readmissions measures and specifically the *Hospital Readmissions Within 7, 30, and 90 Days Post-discharge—All Hospitals—90 Days* measure indicator. ABC-D reported that it convened weekly structured meetings for adults and children wherein 7- and 30-day readmissions were specifically addressed, including more complex cases. ABC-D advised that these meetings were used as a springboard for possible interventions and strategies to reduce the BHO's overall readmissions. All of ABC-D's readmissions measure indicator rates increased from MY 2013–2014 to MY 2014–2015, indicating performance decline. Additionally, during the MY 2013–2014 review, HSAG recommended that ABC-D monitor its performance related to the following utilization measure indicators: *Emergency Department Utilization for Mental Health Condition* and *Inpatient Utilization—Non-State Hospitals*. ABC-D reported that it has identified a care manager in a psychiatric emergency department to assist in coordinating outpatient referrals to reduce admissions to the hospital from the emergency department. In addition, ABC-D collaborated with providers and members to provide medically necessary treatment in the least restrictive setting. ABC-D advised that this relationship allowed for identification of appropriate outpatient and subacute programs in order to reduce necessary inpatient treatment. Both of these measure indicators related to emergency department utilization for mental health patients, and inpatient utilization increased slightly. Since additional time may be needed to see the effects of efforts and interventions implemented by the BHO to improve care, HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

HSAG validated Activities I through VI for ABC-D's *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP during FY 2014–2015. The PIP received an overall validation score of 100 percent and a *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Access Behavioral Care–Northeast

Compliance Monitoring Site Review

As a result of the FY 2014–2015 site reviews, ABC-NE was required to address two elements in Standard V—Member Information and three elements in Standard VI—Grievance System. ABC-NE submitted its CAP to HSAG and the Department in April 2015. HSAG and the Department reviewed the proposed plan of correction and approved it as written. ABC-NE began submitting documents that demonstrated implementation of the plan in July 2015. HSAG and the Department reviewed documents submitted by ABC-NE to demonstrate implementation of the plan at several intervals between July and October 2015 and determined in November 2015 that ABC-NE had successfully completed all corrective actions.

Validation of Performance Measures

MY 2014–2015 was the first year that ABC-NE participated in the validation of performance measure activities. Therefore, a comparison of rates to the prior year was not performed, and recommendations were not presented in last year's report.

Validation of Performance Improvement Projects

HSAG validated Activities I through VI for ABC-NE's *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP during FY 2014–2015. The PIP received an overall validation score of 100 percent and a *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Behavioral Healthcare, Inc.

Compliance Monitoring Site Review

As a result of the FY 2014–2015 site review, BHI was required to address one *Partially Met* element in Standard V—Member Information, seven *Partially Met* elements in Standard VI—Grievance System, and two *Partially Met* elements in Standard VII—Provider Participation and Program Integrity. BHI submitted its CAP to HSAG and the Department in May 2015. HSAG and the Department reviewed the proposed plan of correction and approved it as written. BHI began submitting documents that demonstrated implementation of the plan in July 2015. HSAG and the Department reviewed documents submitted by BHI to demonstrate implementation of the plan at several intervals between July and

December 2015 and determined in December 2015 that BHI had successfully completed all corrective actions.

Validation of Performance Measures

During the MY 2013–2014 review, HSAG recommended that BHI monitor its performance for the following measure indicators: *Penetration Rates by Medicaid Eligibility Category—Buy-in: Working Adults With Disabilities* and *Modified Adjusted Gross Income (MAGI) Adults, Emergency Room Utilization for Mental Health Condition,* and *Follow-Up After Hospitalization for Mental Illness—Non-State Hospital—7 Days* and *All Hospital—7 Days.* The rates for *Emergency Room Utilization for Mental Health Condition*, *Follow-Up After Hospitalization for Mental Illness—Non-State Hospital—7 Days,* and *All Hospital—7 Days* increased slightly, indicating performance decline for the *Emergency Room Utilization for Mental Health Condition* measure and performance improvement for *Follow-Up After Hospitalization for Mental Illness—Non-State Hospital—7 Days,* and *All Hospital—7 Days*. Additionally, the rate for *Penetration Rates by Medicaid Eligibility Category—Buy-In: Working Adult Disabled* remained stable, and the rate for *MAGI Adults* declined. Additional time may be needed to see the effects of efforts and interventions implemented by the BHO to improve care; therefore, HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014-2015 was the first year for BHI's *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP. Validated for Activities I through VI, the PIP received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Colorado Health Partnerships, LLC

Compliance Monitoring Site Review

Based on the FY 2014–2015 site review, CHP was required to address six *Partially Met* elements related to the grievance system. CHP submitted its CAP to HSAG and the Department in April 2015 and began submitting documents that demonstrated implementation of its plan in May. HSAG and the Department worked closely with CHP to ensure that the BHO fully addressed and implemented all aspects of the required actions. HSAG and the Department determined in November 2015 that CHP had addressed all required actions.

Validation of Performance Measures

During the MY 2013–2014 review, HSAG recommended that CHP monitor its performance related to *Inpatient Utilization* measure indicators and investigate the reasons for these declines. CHP reported that it sought to focus on integration of behavioral and physical healthcare, developing a study that would facilitate communication between mental and physical health providers and specifically targeting improvement of diabetes testing for Medicaid members taking antipsychotic medications. CHP reported

having sites with medical providers located at the same physical locations as the behavioral health providers so that onsite diabetes testing can be provided as necessary. It is unclear if this assisted in decreasing CHP's inpatient utilization; however, the inpatient utilization rates increased from MY 2013–2014 to MY 2014–2015, but by less than one per 1,000 members.

While HSAG did not recommend CHP to monitor its emergency department visits in MY 2013–2014, CHP reported a goal of reducing emergency department use by its members. CHP reported that its data showed that over 25 percent of emergency department visits were attributed to members without access to behavioral health services. As a result, CHP advised that it continued to reach out to its Medicaid members by sending letters to those members who had had an emergency department visit at least twice and had not sought services related to behavioral health within six months prior to the most recent emergency department visit. CHP reported having observed an increase in emergency department visits, which is consistent with the rate increase presented in this report. Additional time may be needed to see the effects of efforts and interventions implemented by the BHO to improve care; therefore, HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

HSAG validated Activities I through VI for CHP's *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release* PIP during FY 2014–2015. The PIP received an overall validation score of 100 percent and a *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Foothills Behavioral Health Partners, LLC

Compliance Monitoring Site Review

As a result of the FY 2014–2015 site review, FBHP was required to addressed six *Partially Met* elements in Standard VI—Grievance System. FBHP submitted its CAP to HSAG and the Department in April 2015. After making minor adjustments requested by HSAG and the Department, FBHP began submitting documents that demonstrated that the BHO had implemented its plan. HSAG and the Department reviewed all documents carefully and in October 2015 determined that FBHP had successfully addressed all required actions.

Validation of Performance Measures

During the MY 2013–2014 review, HSAG recommended that FBHP monitor its performance related to *Penetration Rate by Medicaid Eligibility Category—BC Children, BCCP-Women Breast and Cervical Cancer, Buy-In: Working Adults Disabled,* and *Modified Adjusted Gross Income.* FBHP reported that it prepared a summary analysis comparing performance measure results and shared them with the Department, its own quality improvement/utilization management (QI/UM) committee, and its QI team. FBHP advised that it focused efforts on LEAN events, follow-up work groups with clinical program managers to drive improvements in assessments and referrals, and transition coordination. FBHP's rate for *Penetration Rate by Medicaid Eligibility Category—BC Children* increased slightly, and FBHP's

rate for *BCCP-Women Breast and Cervical Cancer* almost doubled. Conversely, the *Penetration Rate by Medicaid Eligibility Category—MAGI Adults* rate decreased by more than six percentage points. Additional time may be needed to see the effects of efforts and interventions implemented by the BHO to improve care; therefore, HSAG will continue to monitor HEDIS rates related to these areas in future years.

Validation of Performance Improvement Projects

FY 2014–2015 was the first year for FBHP's *Improving Transition From Jail to Community-Based Behavioral Health Treatment* PIP. Validated for Activities I through VI, the PIP received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status. HSAG identified no deficiencies and made no recommendations.

Appendix A. EQR Activities—Compliance Monitoring Site Reviews

Introduction

This appendix describes the manner in which, in accordance with 42 CFR 438.358, HSAG conducted the compliance monitoring site review activities and aggregated and analyzed the resulting data.

For the FY 2015–2016 site review process, the Department requested a review of four areas of performance. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. HSAG developed a strategy and monitoring tools to review compliance with federal managed care regulations and managed care contract requirements related to each standard. HSAG also reviewed the health plan's administrative records to evaluate implementation of federal healthcare regulations and compliance with NCQA requirements effective July 2015.

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 healthcare. 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, healthcare 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 key committee meeting minutes to determine compliance with federal healthcare regulations and implementation of the organizations' policies. As part of Standard VIII—Credentialing and Recredentialing, HSAG conducted an on-site review of 10 credentialing records and 10 recredentialing records to evaluate implementation of federal healthcare regulations and compliance with NCQA requirements, effective July 2015. HSAG incorporated the record review results into the findings for the credentialing and recredentialing standards. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score.

Also during the on-site portion of each 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 2015–2016.

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 health plans and BHOs.
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 four standards and on-site record reviews. 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 plan/BHO also submitted a list of all of the health plan's/BHO's credentialing and recredentialing records that occurred between January 1, 2013, and December 31, 2015. 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 federal healthcare regulations and compliance with NCQA credentialing and recredentialing standards and guidelines.

For this step,	HSAG completed the following activities:
	• 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 that 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 2015–2016 Site Review Report template to compile the findings and incorporated information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined strengths, opportunities for improvement, and required actions based on the review findings.
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

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
- Member handbook and informational materials
- Staff training materials and documentation of attendance
- Applicable correspondence
- Records or files related to administrative tasks
- Interviews with key health plan staff members conducted on-site

Data Aggregation, Analysis, and How Conclusions Were Drawn

Upon completion of each site review, HSAG aggregated all information and analyzed the findings from the document review, record reviews, and on-site interviews. Findings were scored using a *Met, Partially Met, Not Met,* or *Not Applicable* methodology for each requirement. 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 was 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, 2015, and December 31, 2015, 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/BHO received a score of *M (Met), N (Not Met),* or *NA (Not Applicable)* for each required element. 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, which was documented by HSAG in the corrective action plan (CAP) template approved by the Department. The CAP template was included in the final report to the health plan/BHO and the Department, and was used by the health plan/BHO 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.

HSAG HEALTH SERVICES ADVISORY GROUP

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/BHO.
- Determine the extent to which the specific performance measures calculated by the health plan/BHO (or on behalf of the health plan/BHO) 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 Prime had existing business relationships with licensed audit 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.*[B-1]

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.

[B-1] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

- 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 2016 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 audit organizations. All licensed organizations followed NCQA's methodology in conducting 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).[B-2] 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 review of the ISCAT and supporting documentations, scheduling and preparing the agendas for the on-site visits, and conducting conference calls with the BHOs to discuss the on-site visit activities and to address any ISCAT-related questions.
- **On-site Review Activities**: HSAG conducted a site visit to each BHO to validate the processes used to collect and calculate performance measure data (using encounter data) and a site visit to the Department to validate the performance measure calculation process for the penetration rate measures. The on-site reviews, which lasted one day, included:
  - An opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
  - Evaluation of system compliance, including a review of the information systems assessment, focusing on the processing of claims, encounter, member, and provider data. HSAG performed primary source verification on a random sample of members, validating enrollment and encounter data for a given date of service within both the membership and encounter data system. Additionally, HSAG evaluated the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
  - Review of processes used for collecting, storing, validating, and reporting the performance measure data. This session, which was designed to be interactive with key BHO and Department staff members, allowed HSAG to obtain a complete picture of the degree of compliance with

---

[B-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: 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: Sept 30, 2016.

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 2015–2016 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 MY 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 5 contains information about BHO-specific performance measure rates and validation status.

Hybrid Measure Rates for HEDIS 2016

As previously mentioned, several performance measures were collected and reported by DHMC and RMHP Prime using the hybrid methodology. However, RMHP Prime reported that inaccurate hybrid rates were provided by its HEDIS compliance auditor. As such, RMHP Prime's rates for all hybrid measures were deemed invalid by the health plan and are denoted as "Biased Rate (BR)" throughout this report and are not presented in this section. Rates reported administratively in this report but collected by DHMC using the hybrid methodology are presented in Table B-1.

Table B-1—DHMC's HEDIS 2016 Hybrid Measure Rates

Performance Measures	DHMC
Childhood Immunization Status	
Combination 2	79.81%
Combination 3	79.56%
Combination 4	78.83%
Combination 5	68.37%
Combination 6	59.37%
Combination 7	67.88%
Combination 8	59.12%
Combination 9	52.55%
Combination 10	52.55%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap/Td)	79.56%
Well-Child Visits in the First 15 Months of Life	
*Zero Visits**	5.11%
Six or More Visits	47.45%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	62.77%

*Lower rates indicate better performance for this measure.

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 one of the mandatory EQR activities under the BBA at 42 CFR 438.358, the State is required to validate the PIPs conducted by its contracted health plans/BHOs. The Department contracted with HSAG to meet this validation requirement. As part of its QAPI program, each health plan/BHO was required by the Department to conduct PIPs in accordance with 42 CFR 438.240. The purpose of conducting 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/BHO processes was designed to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation was to determine each health plan/BHO'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 performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

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.[C-1] Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, which each health plan and each BHO 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.

[C-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.

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/BHOs 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/BHOs 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.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the health plans/BHOs' 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.

- **Final Audit Reports**. The final audit reports, produced by the health plans/BHOs' licensed organizations, provided information on the health plans/BHOs' 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 required measures for reporting had obtained a "pass" status.
- **Rate Files From Previous Years and Current Year**. Final rates provided by health plans/BHOs either in IDSS format or a special rate reporting template were reviewed to determine trending patterns and rate reasonability.

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/BHOs 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/BHOs' 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/BHOs 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 for the health plans 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 set for the child population. Each health plan used a certified vendor to conduct the CAHPS surveys on behalf of the health plan. The surveys included a set of standardized items (58 items for the *CAHPS 5.0 Adult Medicaid Health Plan Survey* and 48 items for the *CAHPS 5.0 Child Medicaid Health Plan Survey*) 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. HSAG aggregated data from survey respondents into a database for analysis.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctors, specialists, health plans, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the adult and child Medicaid surveys fell into one of 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.

Description of Data Obtained

DHMC and RMHP Prime provided HSAG with the data presented in the report. Morpace and CSS administered the *CAHPS 5.0 Child Medicaid Health Plan Survey* for DHMC and RMHP Prime, respectively. The health plans reported that NCQA methodology was followed in calculating these results.

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.

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

Introduction

This appendix presents tables with detailed findings for all health plans and BHOs for each EQR activity performed in FY 2015–2016.

Results From the Compliance Monitoring Site Reviews

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

Table E-1—Standard Scores for Physical Health Plans

Description of Standard	DHMC	RMHP Prime	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 (2016)	92%	100%	96%
Standard IV—Member Rights and Protections (2016)	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 (2016)	98%	100%	99%
Standard IX—Subcontracts and Delegation (2015)	100%	100%	100%
Standard X—Quality Assessment and Performance Improvement (2016)	88%	100%	94%
Overall Compliance Scores	**90%**	**92%**	**91%**

Standards presented in black were reviewed in FY 2015–2016. Standards presented in red were reviewed in FY 2014–2015. Standards presented in green were reviewed in FY 2013–2014.

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

Description of Standard	DHMC	RMHP Prime	Statewide Average
Appeals (2015)	73%	98%	88%
Credentialing (2016)	100%	100%	100%
Denials (2014)	98%	86%	90%
Grievances (2015)	78%	98%	94%
Recredentialing (2016)	100%	100%	100%
Overall Record Review Scores	**95%**	**97%**	**96%**

Reviews presented in black were reviewed in FY 2015–2016. Reviews presented in red were reviewed in FY 2014–2015. Reviews presented in green were reviewed in FY 2013–2014.

Table E-3 and Table E-4 combined show the summary compliance monitoring scores and record review scores for each BHO as well as statewide averages. Statewide average scores were calculated by dividing the total number of elements *Met* across all five BHOs by the total number of applicable elements across all five BHOs.

Table E-3—Standard Scores for Behavioral Health Organizations

Description of Standard	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 (2016)	70%	70%	90%	90%	100%	84%
Standard IV—Member Rights and Protections (2016)	83%	83%	100%	100%	100%	93%
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 (2016)	93%	93%	96%	87%	93%	92%
Standard IX—Subcontracts and Delegation (2015)	100%	100%	100%	100%	100%	100%
Standard X—Quality Assessment and Performance Improvement (2016)	100%	100%	100%	100%	100%	100%
Overall Compliance Scores	**92%**	**91%**	**90%**	**93%**	**95%**	**92%**

Standards presented in black were reviewed in FY 2015–2016. Standards presented in red were reviewed in FY 2014–2015. Standards presented in green were reviewed in FY 2013–2014.

— Indicates that no rate is available for FY 2013–2014 because ABC-NE did not begin operations until July 1, 2014.

Table E-4—Record Review Scores for Behavioral Health Organizations

Description of Standard	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Appeals (2015)	93%	100%	74%	84%	92%	94%
Credentialing (2016)	100%	100%	100%	100%	99%	100%
Denials (2014)	100%	—	92%	100%	100%	98%
Grievances (2015)	93%	94%	100%	87%	100%	88%
Recredentialing (2016)	100%	100%	97%	95%	96%	97%
Overall Record Review Scores	**98%**	**99%**	**93%**	**95%**	**98%**	**96%**

Reviews presented in black were reviewed in FY 2015–2016. Reviews presented in red were reviewed in FY 2014–2015. Reviews presented in green were reviewed in FY 2013–2014.

— Indicates that no rate is available for FY 2013–2014 because ABC-NE did not begin operations until July 1, 2014.

Results From the Validation of Performance Measures

Table E-5 presents performance measure results for each health plan and the statewide average for HEDIS 2015 and HEDIS 2016.

Table E-5—HEDIS 2015–2016 Performance Measure Results for Each Health Plan and Statewide Average[1]

Performance Measures	DHMC	RMHP Prime[§]	Statewide Weighted Average[1]
Pediatric Care			
Childhood Immunization Status			
Combination 2	75.92%	BR	75.92%
Combination 3	75.40%	BR	75.40%
Combination 4	74.99%	BR	74.99%
Combination 5	64.68%	BR	64.68%
Combination 6	52.87%	BR	52.87%
Combination 7	64.42%	BR	64.42%
Combination 8	52.67%	BR	52.67%
Combination 9	47.02%	BR	47.02%
Combination 10	46.87%	BR	46.87%
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	76.72%	BR	76.72%
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	7.69%	NA	7.69%
Six or More Visits	3.36%	NA	3.36%

HSAG HEALTH SERVICES ADVISORY GROUP

Performance Measures	DHMC	RMHP Prime§	Statewide Weighted Average[1]
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.87%	BR	60.87%
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	38.27%	BR	38.27%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Assessment—Ages 3 to 11 Years	82.95%	BR	82.95%
BMI Assessment—Ages 12 to 17 Years	71.43%	BR	71.43%
BMI Assessment—Total	78.83%	BR	78.83%
Counseling for Nutrition—Ages 3 to 11 Years	82.20%	BR	82.20%
Counseling for Nutrition—Ages 12 to 17 Years	68.71%	BR	68.71%
Counseling for Nutrition—Total	77.37%	BR	77.37%
Counseling for Physical Activity—Ages 3 to 11 Years	61.74%	BR	61.74%
Counseling for Physical Activity—Ages 12 to 17 Years	65.99%	BR	65.99%
Counseling for Physical Activity—Total	63.26%	BR	63.26%
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	76.34%	89.14%	81.12%
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	97.48%	94.98%	96.85%
Access to Care and Preventive Screening			
Prenatal and Postpartum Care**			
Timeliness of Prenatal Care	81.75%	BR	81.75%
Postpartum Care	54.74%	BR	54.74%
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	89.33%	NA	89.30%
Ages 25 Months to 6 Years	73.66%	84.93%	73.74%
Ages 7 to 11 Years	78.22%	91.67%	78.33%
Ages 12 to 19 Years	79.00%	89.60%	79.12%
Adults' Access to Preventive/Ambulatory Health Services—Total			
Ages 20 to 44 Years	60.52%	68.38%	64.77%
Ages 45 to 64 Years	73.59%	76.95%	75.44%
Ages 65 Years and Older	78.35%	89.05%	81.40%
Total	65.78%	71.69%	68.91%
Chlamydia Screening in Women			
Ages 16 to 20 Years	69.43%	43.70%	65.47%
Ages 21 to 24 Year	69.18%	46.86%	57.23%
Total	69.33%	46.27%	60.91%

Performance Measures	DHMC	RMHP Prime§	Statewide Weighted Average[1]
Breast Cancer Screening			
Breast Cancer Screening	49.17%	47.38%	48.70%
Cervical Cancer Screening			
Cervical Cancer Screening	56.93%	BR	56.93%
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17%	4.04%	0.66%
Adult BMI Assessment			
Adult BMI Assessment	84.43%	BR	84.43%
Mental/Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	46.35%	69.92%	56.96%
Effective Continuation Phase Treatment	31.41%	57.47%	43.14%
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	29.41%	35.19%	31.97%
Continuation and Maintenance Phase	NA	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Ages 1 to 5 Years	NA	NA	NA
Ages 6 to 11 Years	NA	NA	NA
Ages 12 to 17 Years	3.23%	NA	2.13%
Total	4.55%	0.00%	2.70%
Living With Illness			
Controlling High Blood Pressure			
Controlling High Blood Pressure	63.99%	BR	63.99%
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	75.00%
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	89.78%	BR	89.78%
*HbA1c Poor Control (>9.0%)**	36.74%	BR	36.74%
HbA1c Control (<8.0%)	48.66%	BR	48.66%
Eye Exam (Retinal) Performed	55.96%	BR	55.96%
Medical Attention for Nephropathy	89.29%	BR	89.29%
Blood Pressure Controlled (<140/90 mm Hg)	73.72%	BR	73.72%
Annual Monitoring for Patients on Persistent Medications			
ACE Inhibitors or ARBs	85.22%	84.54%	84.92%
Digoxin	NA	NA	58.06%
Diuretics	85.05%	84.17%	84.65%
Total	85.14%	84.05%	84.65%

Performance Measures	DHMC	RMHP Prime§	Statewide Weighted Average[1]
Use of Imaging Studies for Low Back Pain			
Use of Imaging Studies for Low Back Pain	81.26%	78.35%	79.96%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis			
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	45.54%	42.11%	43.16%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	61.54%	53.99%	58.22%
Bronchodilator	73.08%	57.06%	66.04%
Medication Management for People With Asthma			
Medication Compliance 50%—Ages 5 to 11 Years	30.47%	NA	30.58%
Medication Compliance 50%—Ages 12 to 18 Years	36.13%	NA	37.65%
Medication Compliance 50%—Ages 19 to 50 Years	46.26%	66.67%	52.58%
Medication Compliance 50%—Ages 51 to 64 Years	78.26%	NA	80.77%
Medication Compliance 50%—Total	39.76%	65.91%	43.20%
Medication Compliance 75%—Ages 5 to 11 Years	9.01%	NA	9.50%
Medication Compliance 75%—Ages 12 to 18 Years	14.84%	NA	15.43%
Medication Compliance 75%—Ages 19 to 50 Years	21.77%	50.00%	30.52%
Medication Compliance 75%—Ages 51 to 64 Years	47.83%	NA	48.08%
Medication Compliance 75%—Total	16.87%	45.45%	20.63%
Asthma Medication Ratio			
Ages 5 to 11 Years	39.53%	NA	41.22%
Ages 12 to 18 Years	29.21%	NA	30.65%
Ages 19 to 50 Years	25.74%	58.82%	35.54%
Ages 51 to 64 Years	33.77%	NA	33.33%
Total	32.39%	58.26%	36.00%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.13%	35.42%	27.94%
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis			
Disease-Modifying Anti–Rheumatic Drug Therapy in Rheumatoid Arthritis	83.33%	65.00%	73.37%

Performance Measures	DHMC	RMHP Prime§	Statewide Weighted Average[1]
Living With Illness			
Ambulatory Care Visits (Per 1,000 Member Months)			
Outpatient Visits—Total	207.09	306.76	239.20
*Emergency Department Visits—Total**	43.97	71.40	52.81
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	5.48	9.35	6.73
Days per 1,000 Member Months (Total Inpatient)	24.92	32.70	27.43
Average Length of Stay (Total Inpatient)	4.55	3.50	4.08
Discharges per 1,000 Member Months (Medicine)	3.06	0.65	2.28
Days per 1,000 Member Months (Medicine)	13.46	2.53	9.94
Average Length of Stay (Medicine)	4.41	3.90	4.36
Discharges per 1,000 Member Months (Surgery)	0.81	6.37	2.60
Days per 1,000 Member Months (Surgery)	7.12	25.02	12.89
Average Length of Stay (Surgery)	8.77	3.93	4.95
Discharges per 1,000 Member Months (Maternity)	2.61	2.42	2.53
Days per 1,000 Member Months (Maternity)	7.03	5.34	6.31
Average Length of Stay (Maternity)	2.69	2.21	2.49
Antibiotic Utilization—All Ages*			
Average Scripts PMPY for Antibiotics	0.34	1.02	0.56
Average Days Supplied per Antibiotic Script	9.33	9.30	9.31
Average Scripts PMPY for Antibiotics of Concern	0.10	0.44	0.21
Percentage of Antibiotics of Concern of All Antibiotic Scripts	28.12%	43.15%	36.89%
Frequency of Selected Procedures (Per 1,000 Member Months)			
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	0.05	0.03
Bariatric Weight Loss Surgery (20–44 Female)	0.05	0.11	0.08
Bariatric Weight Loss Surgery (45–64 Male)	0.02	0.06	0.04
Bariatric Weight Loss Surgery (45–64 Female)	0.12	0.16	0.14
Tonsillectomy (0–9 Male & Female)	0.31	0.84	0.32
Tonsillectomy (10–19 Male & Female)	0.18	0.33	0.19
Hysterectomy, Abdominal (15–44 Female)	0.06	0.15	0.10
Hysterectomy, Abdominal (45–64 Female)	0.26	0.26	0.26
Hysterectomy, Vaginal (15–44 Female)	0.06	0.49	0.26
Hysterectomy, Vaginal (45–64 Female)	0.07	0.47	0.31
Cholecystectomy, Open (30–64 Male)	0.04	0.00	0.02
Cholecystectomy, Open (15–44 Female)	0.01	0.00	0.00

Performance Measures	DHMC	RMHP Prime§	Statewide Weighted Average[1]
Cholecystectomy, Open (45–64 Female)	0.00	0.03	0.02
Cholecystectomy (Laparoscopic) (30–64 Male)	0.09	0.35	0.24
Cholecystectomy (Laparoscopic) (15–44 Female)	0.47	0.99	0.71
Cholecystectomy (Laparoscopic) (45–64 Female)	0.33	0.91	0.67
Back Surgery (20–44 Male)	0.10	0.35	0.26
Back Surgery (20–44 Female)	0.05	0.24	0.15
Back Surgery (45–64 Male)	0.62	0.92	0.79
Back Surgery (45–64 Female)	0.23	0.58	0.44
Mastectomy (15–44 Female)	0.00	0.04	0.02
Mastectomy (45–64 Female)	0.23	0.21	0.22
Lumpectomy (15–44 Female)	0.04	0.21	0.12
Lumpectomy (45-64 Female)	0.19	0.36	0.29

* Lower rates indicate better performance for this measure.

** The Department's HEDIS 2015 reporting requirements for this measure were hybrid for the health plans and administrative for FFS. Comparison of the health plan and FFS rates may not accurately reflect performance differences as the data collection methodology differed.

§ Due to changes in member eligibility for children in RMHP Prime, rates that include children in the eligible population may not be comparable to those of DHMC or FFS.

BR indicates that RMHP Prime's reported rate was invalid; therefore, the rate is not presented.

[1] SMCN rates were deemed invalid, and therefore were not included.

NA indicates that the health plan or plans followed the specifications but the denominator was too small (<30) to report a valid rate.

NB indicates that the health plan did not offer the benefit required by the measure.

Table E-6 includes MY 2014–2015 performance measure results for each BHO as well as the statewide average for each performance measure.

Table E-6—MY 2014–2015 Performance Measure Results for Each BHO and Statewide Average

Performance Measure	ABC–D	ABC–NE	BHI	CHP	FBHP	Statewide Average
Hospital Readmissions Within 180 Days (all facilities)*						
Hospital Readmissions Within 180 Days (all facilities)	25.55%	13.26%	14.76%	21.22%	16.83%	19.42%
Mental Health Engagement						
Mental Health Engagement	48.06%	48.66%	54.80%	48.29%	48.29%	49.80%
Overall Penetration Rates						
Overall Penetration Rates	16.46%	13.77%	12.79%	14.83%	16.47%	14.67%
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)						
Emergency Department Utilization for Mental Health Condition (Rate/1,000 Members, All Ages)	16.33	16.73	15.85	10.22	9.80	13.34
Penetration Rates by Age Group						
Children 12 Years of Age and Younger	6.93%	7.64%	6.62%	6.69%	12.33%	7.46%
Adolescents 13 Through 17 Years of Age	17.45%	18.64%	17.23%	16.84%	19.46%	17.58%
Adults 18 Through 64 Years of Age	22.78%	17.46%	16.94%	19.53%	18.87%	19.14%
Adults 65 Years of Age or Older	10.09%	6.64%	7.88%	9.81%	7.00%	8.70%
Penetration Rates by Medicaid Eligibility Category						
AND/AB-SSI	43.74%	33.11%	34.03%	33.35%	35.34%	35.50%
BC Children	2.07%	2.05%	1.43%	2.06%	2.93%	1.98%
BCCP-Women Breast and Cervical Cancer	5.01%	0.00%	15.01%	7.37%	11.78%	7.90%
Buy-In: Working Adult Disabled	33.78%	24.93%	27.23%	25.17%	37.28%	28.74%
Foster Care	34.46%	29.51%	33.98%	29.95%	34.58%	32.11%
OAP-A	9.87%	6.70%	7.72%	9.80%	6.78%	8.60%
OAP-B-SSI	32.66%	23.42%	25.57%	24.15%	26.98%	26.40%
MAGI Adults	20.57%	15.88%	15.07%	17.31%	16.99%	17.18%
Buy-In: Children With Disabilities	15.70%	14.53%	15.67%	11.52%	19.46%	14.40%
MAGI Parents/Caretakers	16.95%	14.36%	14.03%	17.07%	15.42%	15.76%
MAGI Children	8.62%	9.63%	8.34%	8.40%	13.13%	9.11%
MAGI Pregnant	20.60%	16.08%	14.44%	22.15%	17.64%	18.68%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment						
Initiation of AOD Treatment	44.41%	46.86%	48.75%	49.76%	41.29%	47.10%
Engagement of AOD Treatment	31.88%	31.69%	35.70%	44.02%	35.50%	37.63%

Performance Measure	ABC–D	ABC–NE	BHI	CHP	FBHP	Statewide Average
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (non-state and all facilities)*						
Non-State Hospitals—7 Days	4.16%	1.93%	1.85%	3.44%	1.94%	2.94%
Non-State Hospitals—30 Days	12.83%	6.63%	6.78%	10.01%	6.91%	9.21%
Non-State Hospitals—90 Days	20.14%	11.46%	12.08%	16.57%	12.61%	15.38%
All Hospitals—7 Days	5.22%	1.91%	1.78%	3.41%	1.83%	3.10%
All Hospitals—30 Days	13.92%	6.57%	6.55%	9.83%	6.99%	9.32%
All Hospitals—90 Days	21.52%	11.35%	11.88%	16.29%	12.47%	15.47%
Members With Physical Health Well-Care Visits						
0–17 Years of Age	89.90%	91.41%	87.93%	91.35%	83.81%	89.07%
18+ Years of Age	87.76%	89.99%	86.52%	89.69%	86.94%	88.44%
Inpatient Utilization (Rate/1,000 Members, All Ages)						
Non-State Hospitals	6.44	5.82	2.93	5.55	5.86	5.13
All Hospitals	6.92	5.88	3.26	5.68	6.61	5.43
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition						
Non-State Hospitals—7 Days	49.08%	41.24%	56.20%	45.06%	52.19%	47.87%
Non-State Hospitals—30 Days	65.57%	60.00%	73.63%	65.86%	65.96%	66.08%
All Hospitals—7 Days	48.65%	40.86%	57.43%	44.90%	53.46%	48.18%
All Hospitals—30 Days	65.15%	59.75%	74.43%	65.81%	66.43%	66.23%
Antidepressant Medication Management—Acute and Continuation Phases						
Effective Acute Phase Treatment	53.03%	69.88%	49.60%	55.32%	60.00%	55.56%
Effective Continuation Phase Treatment	48.18%	61.45%	44.92%	36.33%	44.39%	42.91%

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

Results From the Validation of Performance Improvement Projects

Table E-7 lists the PIP study conducted by each physical health plan and the corresponding summary scores and validation status.

Table E-7—Summary of Each Health Plan's PIP Validation Scores and Validation Status

Health Plan	PIP Topic	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
DHMC	*Improving Follow-Up Communication Between Referring Providers and Pediatric Obesity Specialty Clinics*	93%	100%	*Met*
RMHP Prime	*Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*	100%	100%	*Met*

Table E-8 lists the PIP study conducted by each BHO and the corresponding summary scores and validation status.

Table E-8—Summary of Each BHO's PIP Validation Scores and Validation Status

BHO	PIP Topic	% 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) Surveys

Table E-9 shows each physical health plan's and the statewide average summary rates and global proportions for the adult Medicaid CAHPS survey.

Table E-9—Adult Medicaid Question Summary Rates and Global Proportions

Measure	DHMC	RMHP Prime	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 (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.

Table E-10 shows each physical health plan's and the statewide average summary rates and global proportions for the child Medicaid CAHPS survey.

Table E-10—Child Medicaid Question Summary Rates and Global Proportions

Measure	DHMC	RMHP Prime	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 (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.