COLORADO
Department of Health Care Policy & Financing

2016–2017 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

December 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Report Purpose and Overview

States with Medicaid program delivery systems that include managed care entities (MCEs) are required to annually provide an assessment of the MCEs' performance related to the quality of, timeliness of, and access to care and services provided by each MCE (42 CFR 438.364). Medicaid MCEs in Colorado include:

- Physical health plans, which are managed care organizations (MCOs), providing only medical services to Medicaid members.
- Behavioral health organizations (BHOs), which are prepaid inpatient health plans (PIHPs), providing only behavioral health services to Medicaid members.

To meet this requirement, Colorado's Department of Health Care Policy and Financing (the Department), the State's Medicaid agency, has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and to produce this external quality review (EQR) annual technical report. The Department administers and oversees the Medicaid program for the state of Colorado. The organizations that deliver Medicaid managed care and services in Colorado are listed in Table 1-1 and Table 1-2.

Table 1-1—Colorado Medicaid MCOs

Medicaid MCOs	Services Provided
Access Kaiser Permanente (Access KP)	Physical health primary outpatient, specialty, inpatient, and acute care.
Denver Health Medicaid Choice (DHMC)	Physical health primary outpatient, specialty, inpatient, and acute care.
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	Physical health primary outpatient, specialty, inpatient and acute care.

Table 1-2—Colorado Medicaid BHOs

Medicaid BHOs	Services Provided
Access Behavioral Care—Denver (ABC-D)	Behavioral health outpatient and inpatient services.
Access Behavioral Care—Northeast (ABC-NE)	Behavioral health outpatient and inpatient services.
Behavioral Healthcare, Inc. (BHI)	Behavioral health outpatient and inpatient services.
Colorado Health Partnerships, LLC (CHP)	Behavioral health outpatient and inpatient services.
Foothills Behavioral Health Partners, LLC (FBHP)	Behavioral health outpatient and inpatient services.

Scope of EQR Activities—Physical Health Plan

The physical health plans were subject to three federally mandated EQR activities and one optional activity. As set forth in 42 CFR 438.352, the mandatory activities were:

- **Monitoring for compliance with federal healthcare regulations.** Compliance monitoring was designed to determine the health plans' compliance with their contracts with the State and with State and federal managed care regulations. HSAG determined compliance through review of three standard areas developed based on federal managed care regulations and contract requirements.
- **Validation of performance measures.** Each health plan was responsible for conducting its own Healthcare Effectiveness Data and Information Set (HEDIS) audit and forwarding results to HSAG for inclusion in this report. To evaluate the accuracy of the performance measures reported by or on behalf of the health plans, HSAG validated each of the performance measures identified by the Department. 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 each designed, conducted, and reported in a methodologically sound manner.

The optional activity conducted for the physical health plans was:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.** Each health plan was responsible for conducting a survey of its members and forwarding the results to HSAG for inclusion in this report.

Scope of EQR Activities—Behavioral Health Organizations

The BHOs were subject to the three federally mandated EQR activities that HSAG conducted. As set forth in 42 CFR 438.352, the mandatory activities were:

- **Monitoring for compliance with federal healthcare regulations (compliance monitoring).** Compliance monitoring activities were designed to determine the BHOs' compliance with their contract with the State and with State and federal regulations through review of three standard areas developed based on federal managed care regulations and contract requirements.
- **Validation of performance measures.** To evaluate the accuracy of the performance measures reported by or on behalf of the BHOs, HSAG validated each of the performance measures identified by the Department. The validation also determined the extent to which Medicaid-specific performance measures calculated by the BHOs followed specifications established by the Department.
- **Validation of PIPs.** HSAG reviewed PIPs to ensure that each project was designed, conducted, and reported in a methodologically sound manner.

The optional activity conducted for the BHOs was:

- **Experience of Care and Health Outcomes (ECHO) survey.** HSAG administered and reported the results of the adult and child/parent ECHO surveys. HSAG included the behavioral health organizations' results from the survey for both adult and child populations in this report.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs and BHOs in each of the domains of quality of, timeliness of, and access to care and services.

Quality

The Centers for Medicare & Medicaid Services (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 operations characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement."[1-1]

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."[1-2] NCQA further states 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 BHO—e.g., processing appeals and providing timely care. In the final 2016 federal managed care regulations, CMS recognized 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.

Access

CMS defines "access" in the final 2016 regulations 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

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[1-2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.

the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[1-3]

Statewide Summary of Findings and Conclusions

Managed Care Organizations Providing Physical Healthcare

For the purposes of this statewide summary and related recommendations, findings related to Access KP are not considered. Access KP provided services during fiscal year (FY) 2016–2017 only, with its contract ending June 30, 2017, with the State. Therefore, statewide analysis and recommendations are provided resulting from findings for Colorado's two remaining MCOs: Denver Health Medicaid Choice (DHMC) and Rocky Mountain Health Plans Payment Reform Initiative for Medicaid Expansion (RMHP Prime). (Complete results of all EQRO activities, with summaries of strengths and opportunities for improvement for Access KP, are found in Section 3 of this report.) DHMC is an inner-city, federally qualified health center (FQHC); and RMHP Prime provides services for a specialized population in a small rural service area. Therefore, the two are difficult to compare. However, some common themes in strengths and opportunities for improvement are noted.

In the quality domain, both organizations demonstrated strong organizational structures and had procedures in place to process new requests for services in a timely manner. Further, both organizations conducted robust interrater reliability testing. Both organizations provided evidence of strong cultural competency training programs for internal staff. Additionally, both organizations developed methodologically sound PIPs that targeted specific performances measures that demonstrated opportunities for improvement in the access domain. DHMC's PIP was designed to improve access to primary care following an asthma-related emergency visit or inpatient hospitalization. RMHP Prime's project was designed to improve access to primary care for individuals recently discharged from a corrections facility.

Both organizations struggled to provide all populations with timely access to care; however, DHMC made significant changes designed to improve access to primary and urgent care, building an additional clinic and entering into contracts with community clinics based in retail stores; and RMHP Prime also engaged its rural community service agencies to provide care coordination activities designed to improve access to care and services. As a result, both organizations did report some substantial increases in the performance measures and CAHPS measures (when comparing rates to the previous measurement year) that were indicators of performance within the access domain.

Related to statewide CAHPS scores, both organizations reported adult rate increases in the *Getting Care Quickly* measure (DHMC's being substantial). Both health plans reported measure rates above the 2016 national averages for *Shared Decision Making* (adult population), and for *How Well Doctors*

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

Communicate and *Rating of Personal Doctor* (child population), indicating strong performance in the quality domain. Both organizations reported select performance measure rates increasing for well-child visits and immunizations; however, the rates that remain low (below the national 25th percentile) across health plans were for measures related to children and/or adolescents: documented well-care visits and documented care related to body mass index (BMI) and related lifestyle counseling; and for adults: access to preventive care, breast and cervical screenings, documentation regarding comprehensive diabetic care, and pre-and postpartum care; and for children, adolescents, and adults: care related to monitoring members on persistent medications.

Across the two organizations, several CAHPS measures that remained below the national averages were the *Rating of Health Plan* for the adult and child populations and the *Customer Service* and the *Rating of Specialist Seen Most Often* for the child population.[1-4]

Based on the compliance monitoring activities for FY 2016–2017, both organizations had developed procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and had some communication with providers and health plan staff members regarding those procedures. However, neither organization had adequately implemented procedures to ensure timely access to services for children identified as needing EPSDT services.

Behavioral Health Organizations

Related to the quality domain, all five BHOs demonstrated strong organizational structures, had procedures in place to process new requests for services in a timely manner, and conducted robust interrater reliability testing. All BHOs also provided evidence of strong cultural competency training programs for internal staff. Related to the timeliness and access to care domains, all BHOs provided evidence (during the on-site compliance reviews) of having robust cultural competency training programs for staff and of having made those available to providers. All BHOs developed methodologically sound PIPs that met the State's requirements for statewide PIPs. Three BHOs conducted PIPs related to improving adolescents' access to behavioral health providers following positive depression screenings. Two BHOs conducted a PIP related to improving access to behavioral health services for members following release from jail facilities.

All five BHOs reported substantial increases from the previous measurement year for at least one penetration rate by eligibility category. Experiencing increases were three BHOs for the *BCCP—Women Breast and Cervical Cancer* category, one BHO for the *Buy-In: Working Adult Disabled* category, and one BHO for the *Buy-In: Children With Disabilities* category. Three BHOs reported no performance measure rates with substantial decreases as compared to the previous measurement year. Only two of the

[1-4] For DHMC's adult and child populations, the *Customer Service* and *Shared Decision Making* composite measures and the *Rating of Specialist Seen Most Often* global rating had fewer than 100 responses for the measures. For RMHP Prime, the *Customer Service* composite measure for the adult population and all the global ratings and composite measures for the child population had fewer than 100 responses for the measures. In cases of fewer than 100 respondents for the CAHPS measures, caution should be exercised when interpreting results.

BHOs reported substantial decreases in performance measure rates, and these were related to follow-up at specific intervals after hospitalization for a mental health condition.

Based on ECHO measure results, for *Rating of All Counseling or Treatment* for the adult population, four of five BHOs experienced substantial rate improvements when compared to the previous year's rates. No clear patterns were found with ECHO measure rates related to the child population. Also, no discernable patterns were noted in opportunities for improvement related to ECHO results, with one BHO showing no substantial decrease in rates for the adult population and one BHO showing no rate decreases in either the child or adult population.

Based on the results of the FY 2016–2017 compliance monitoring activities, all five BHOs were required to conduct corrective actions that impacted the timeliness domain. These required actions had to do with misunderstanding or ineffective implementation of policies and procedures related to authorization and/or denial of requests for services or claims denials and untimely notices of action (NOAs) or error in implementing the due process for extension authorization decision timelines. Two BHOs also had not accurately implemented the requirement to provide an NOA related to a claims denial (for reasons other than provider procedural issues). Three BHOs had required corrective actions assigned to them that related to the quality domain: NOAs were not written at an easy-to-understand reading level. In addition, although the Department chose for HSAG not to score the EPSDT population for the BHOs, each BHO was provided recommendations related to this standard to help the BHOs understand their roles in ensuring that members in need of services related to EPSDT screening or developmental deficits receive the services they need.

While all five BHOs designed methodologically sound PIPs, four of the five projects each received an overall validation status of *Not Met*. Overall, no PIPs that progressed to the Outcomes stage demonstrated statistically significant improvement over the baseline rate at the first measurement. Demonstrating statistically significant improvement over baseline is a critical evaluation element in the PIP validation process; therefore, the *Not Met* score for this element determined the *Not Met* validation status for each of these PIPs.

Based on statewide performance measure results, as shown in Section 5, two BHOS reported all *Hospital Readmissions*-related rates *(Non-State and All Facilities)* below the statewide average for these measures. Measure rates for which three BHOs reported rates below the statewide average rates were *Hospital Readmissions Within 180 Days (all facilities)*; select *Penetration Rates by Age Group* and *Eligibility Categories, Engagement of Alcohol and Other Drug Dependence Treatment*; and several rates for *Follow-Up Appointments After Hospital Discharge for a Mental Health Condition.* Only two of the BHOs reported substantial decreases in performance measure rates, and these were related to follow-up for a mental health condition at specific intervals after hospitalization.

These rates primarily impact performance in the timeliness and access domains.

While all five BHOs designed methodologically sound PIPs, four of the five projects each received an overall validation status of *Not Met*. Overall, no PIPs that progressed to the Outcomes stage demonstrated statistically significant improvement over the baseline rate at the first measurement.

Demonstrating statistically significant improvement over baseline is a critical evaluation element in the PIP validation process; therefore, the *Not Met* score for this element determined the *Not Met* validation status for each of these PIPs.

Based on ECHO results for the BHOs, the two statewide adult rates that remained below 50 percent were *Rating of All Counseling or Treatment* and *Including Family*. For child statewide results, one rate—*Rating of all Counseling or Treatment*—remained below 50 percent. These rates may indicate poor performance statewide within aspects of the quality domain as well as opportunities for improvement.

Statewide Recommendations

As Colorado moves forward in implementing the second stage of its Accountable Care Collaborative (ACC) program and serving Medicaid members primarily through a fee-for-service (FFS) payment model, the Regional Accountable Entities (RAEs) will need to prioritize quality improvement initiatives. HSAG recommends that the Department consider identifying two or more priorities from the recommendations below for either statewide PIPs or recommended quality initiatives to be conducted for each managed care organization and/or RAE.

To improve statewide performance in the quality and access to care domains, the State may want to consider:

- Conducting a statewide network study to not only determine network adequacy but also to determine provider knowledge and understanding of timely access requirements related to scheduling care for Medicaid members, implementing, as needed, provider interactive workshops to further improve dissemination of information about appointment availability standards and customer service skills.
- When further evaluation is needed based on well-child visits or EPSDT screenings, conducting an evaluation of providers' adherence to the State's guidelines and direction provided by the Department related to referring children to specialists.
- Conducting a focus study to evaluate providers' knowledge and understanding of EPSDT regulations, how to document provision of these services, and/or how to document referral to specialty providers for provision of these services. Based on findings of this study, the State could develop provider training materials to assist the BHOs in supporting their providers in achieving compliance with the State's EPSDT regulations.
- Conducting performance measure calculation using the hybrid methodology for specific measures, such as BMI-related measures.
- Conducting a focus study to evaluate grievances received by RAEs, large-volume primary care medical providers (PCMPs) (e.g., FQHCs), the Medicaid Ombudsman's office, and the State's customer service department to determine percentage of complaints related to access to care and stratified by types of care.

- Requiring health plans, as applicable, to conduct PIPs related to rates below the Medicaid 25th percentile. Examples may be adult access to preventive care, diabetes care, pre- and postpartum care, and care related to monitoring members on persistent medications. Performance improvement techniques and tools can be useful in determining barriers to achieving outcomes, key drivers of measure rates, and root causes of low rates.
- Developing performance measures for the State's customer service center and/or authorization program and developing improvement initiatives based on measure results.
- Developing penetration rate requirements and performance measures for RAE operations and determining a method to evaluate performance related to penetration rates for specific eligibility categories.

2. Introduction

How This Report Is Organized

Section 1 describes the purpose and overview of this EQR annual technical report; authority under which it must be provided; and a brief overview of Colorado's Medicaid healthcare delivery system, its MCOs, and the EQR activities conducted during the year under review. This section also includes a statewide summary assessment of the quality of, timeliness of, and access to care and services provided by the Medicaid managed care delivery system as a whole.

Section 2 provides an overview of the methodology for each of the EQR activities performed and how conclusions were drawn to make an assessment regarding the quality of, timeliness of, and access to care and services for inclusion in this report.

Section 3 provides summary level results for each of the EQR activities performed for Medicaid MCOs providing physical health services. This information is presented by MCO and provides an activity-specific assessment related to the quality of, timeliness of, and access to care and services for each MCO.

Section 4 provides summary-level results for each of the EQR activities performed for Colorado's BHOs. This information is presented by BHO and provides an activity-specific assessment related to the quality of, timeliness of, and access to care and services for each BHO.

Section 5 includes statewide comparative results organized by EQR activity. Comparison tables include summary results for each health plan (MCOs and BHOs) and statewide averages. This section also identifies trends and commonalities to provide statewide conclusions and recommendations revealed through conducting each EQR activity.

Section 6 provides, for each EQR activity, an MCO-specific assessment of the extent to which the physical health MCOs were able to follow up on and complete any recommendations or corrective actions required as a result of the prior year's EQR activity.

Section 7 provides, for each EQR activity, a BHO-specific assessment of the extent to which the BHOs were able to follow up on and complete any recommendations or corrective actions required as a result of the prior year's EQR activity.

Methodology

This section describes the manner in which each activity was conducted and how the resulting data were aggregated and analyzed.

Compliance With Medicaid Managed Care Regulations (Compliance Monitoring)

For the FY 2016–2017 site review process, the Department requested a review of two areas of performance. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. A third standard area (EPSDT) was developed in collaboration with the Department but was not scored for the BHOs. 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 plans' administrative records to evaluate compliance with federal healthcare regulations related to denials of service and notices of action.

Objectives

Private accreditation organizations, state licensing agencies, and state Medicaid agencies 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. The objective of each site review was to provide meaningful information to the Department and the health plans regarding:

- The health plans' or BHOs' compliance with federal managed care regulations and contract requirements in the areas selected for review.
- Strengths, opportunities for improvement, recommendations, or corrective actions required to bring the health plans and BHOs into compliance with federal managed care regulations and contract requirements in the standard areas reviewed.
- The quality of, timeliness of, and access to care and services furnished by the health plans, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the health plans' or BHOs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

For the health plans and 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.[2-1] These activities are depicted in Table 2-1.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2017.

Table 2-1—Protocol Activities Performed for Compliance Monitoring

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 three 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 denials that occurred between January 1, 2016, and December 31, 2016. 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 managed care regulations. • 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

For this step,	HSAG completed the following activities:
	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 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 Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Committee meeting agendas, minutes, and reports
- 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/BHO staff members conducted on-site

How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for compliance monitoring to one or more of those domains. Each standard may involve the assessment of more than one domain due to the combination of individual requirements in each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality of, timeliness of, or access to care and services provided by the MCOs and BHOs. Table 2-2 depicts assignment of the standards to the domains.

Table 2-2—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standards	Quality	Timeliness	Access
Standard I—Coverage and Authorization of Services	X	X	
Standard II—Access and Availability		X	X
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (physical health plans only)	X		X

Validation of Performance Measures

Objectives

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—Access KP, 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 did the requirements for validating performance measures as set forth by CMS. Therefore, using the former's audit methodology complied with both NCQA and CMS specifications, allowing 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*.[2-2]

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.
- Detailed review of the health plan's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- On-site meetings at the health plan's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of the computer programming used to access administrative data sets, manipulate medical record review (MRR) data, and calculate HEDIS measures.
- Re-abstraction 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 2017 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 obtaining their respective HEDIS Final Audit Reports (FARs). The auditor's responsibility was to express an opinion on the health plan's performance 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.

[2-2] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies and Procedures, Volume 5*. Washington D.C.

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. Calculation of the measures was accomplished by using a number of sources, including claims/encounter data and enrollment/eligibility data.

- HSAG conducted the validation activities as outlined in the 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).[2-3] HSAG followed the same process for performance measure validation for each BHO. The process included the following steps.

For the validation of performance measure activities, HSAG conducted performance measure validation for each of the BHOs' measure rates. The Department required that the measurement year (MY) 2015–2016 (i.e., July 1, 2015–June 30, 2016) performance measures be validated during FY 2016–2017 based on the specifications outlined in the *BHO-HCPF Annual Performance Measures Scope Document*, which was drafted collaboratively by the BHOs and the Department.[2-4] 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, and all measure rates calculated using these specifications originated from claims/encounter data. For MY 2015–2016, several measures were HEDIS-like measures, and several other measures were developed by the Department and the BHOs. HSAG's pre-review and on-site review activities were as follows:

- **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.
  - Developed 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.
  - Asked each BHO and the Department to complete the ISCAT prior to the on-site reviews. 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.

[2-3] 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2017.

[2-4] Colorado Department of Health Care Policy and Financing. *BHO-HCPF Annual Performance Measures Scope Document: Fiscal Year 2016* (FY16).

  - Requested other documents in addition to the ISCAT, including source code for performance measure calculation, prior performance measure reports, and supporting documentation.
  - Performed other pre-review activities including review of the ISCAT and supporting documentation, scheduling and preparing the agendas for the on-site visits, and conducting conference calls with the BHOs to discuss the on-site visit activities and to address any ISCAT-related questions.

- **On-Site Review Activities**: HSAG conducted a site visit to each BHO to validate the processes used to collect and calculate performance measure data (using encounter data). HSAG also conducted a site visit to the Department to validate the processes used for calculating the penetration rate measures. The one-day on-site reviews 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 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 2016–2017 as part of the validation of performance measures:

- **FARs**: The FARs, produced by the health plans' licensed audit 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.

Behavioral Health—As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data for MY 2015–2016 as part of the validation of performance measures:

- **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 measures 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.

How Conclusions Were Drawn

Physical Health—At the end of the HEDIS audit season, the health plans submitted their FARs 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 7.0—Data Integration—Accurate HEDIS Reporting, Control Procedures That Support Measure Reporting Integrity

In the measure results tables presented in Section 3, HEDIS 2016 and HEDIS 2017 measure rates are presented for measures deemed *Reportable* (*R*) by the NCQA-licensed audit organization according to NCQA standards. With regard to the final measure rates for HEDIS 2016 and HEDIS 2017, a measure result of *Small Denominator* (*NA*) indicates that the health plan followed the specifications but the denominator was too small (i.e., less than 30) to report a valid rate. A measure result of *Biased Rate* (*BR*) indicates that the calculated rate was materially biased and therefore is not presented in this report. A measure result of *Not Reported* (*NR*) indicates that the health plan chose not to report the measure.

The health plans' 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. In the performance measure results tables, 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. However, caution should be exercised when interpreting results of the significance testing, given that statistically significant changes may not necessarily be clinically significant.

Measure results for HEDIS 2017 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2016 and are denoted in the measure results tables using the percentile rankings defined below in Table 2-3. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure were compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2016 since benchmarks for this measure are not published in Quality Compass.

Table 2-3—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, an em dash (—) indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined, either because the HEDIS 2017 measure rate was not reportable or because the measure did not have an applicable benchmark.

According to the Department's guidance, all measure rates presented in this report for the health plans are based on administrative data only. All HEDIS 2017 measures were reported using the administrative methodology per the Department's direction; therefore, the following items should be taken into consideration when reviewing HEDIS measure results:

- Health plans capable of obtaining supplemental data or capturing more complete data will generally report higher rates when using the administrative methodology. As a result, the HEDIS measure rates presented in this report may be more representative of data completeness than of measure performance for measures that can be reported using the hybrid methodology. Additionally, caution should be exercised when comparing administrative measure results to national benchmarks that were established using administrative and/or medical record review data. Table 2-4 presents the measures in this report that could be reported using the hybrid methodology.

Table 2-4—HEDIS Measures that Can Be Reported Using the Hybrid Methodology

HEDIS Measures
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
Prenatal and Postpartum Care
Cervical Cancer Screening
Adult BMI Assessment
Comprehensive Diabetes Care

- Caution should be exercised when evaluating results for measures reported using the hybrid methodology in HEDIS 2016 but reported administratively for HEDIS 2017, since those results likely underestimate performance.
- In Colorado, behavioral health services are carved out (i.e., provided by BHOs). Therefore, this carve-out should be considered when reviewing the health plan rates for behavioral health measures.

To draw conclusions about the quality and timeliness of, and access to, care provided by the physical health plans, HSAG assigned each of the components reviewed for performance measure validation (PMV) to one or more of these three domains. This assignment to domains is depicted in Table 2-5.

Table 2-5—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for Physical Health Plans

Performance Measures	Quality	Timeliness	Access
Childhood Immunization Status	✓	✓	
Immunizations for Adolescents	✓	✓	
Well-Child Visits in the First 15 Months of Life	✓	✓	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓	✓	
Adolescent Well-Care Visits	✓	✓	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Appropriate Testing for Children With Pharyngitis	✓		
Appropriate Testing for Children With Upper Respiratory Infection	✓		
Prenatal and Postpartum Care	✓	✓	✓
Children and Adolescents' Access to Primary Care Practitioners			✓
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	✓		
Persistence of Beta-Blocker Treatment After a Heart Attack	✓		
Comprehensive Diabetes Care	✓		✓
Statin Therapy for Patients With Diabetes	✓		
Statin Therapy for Patients With Cardiovascular Disease	✓		
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 Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	✓		

Performance Measures	Quality	Timeliness	Access
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 for Rheumatoid Arthritis	✓		✓
Ambulatory Care			✓
Inpatient Utilization—General Hospital/Acute Care			✓
Antibiotic Utilization			✓
Frequency of Selected Procedures (Procedures per 1,000 MM)			✓

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 noncompliant. 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 that the indicator was thereby given a designation of *Report*.

To draw conclusions about the quality and timeliness of, and access to, care provided by the BHOs, HSAG assigned each of the components reviewed for PMV to one or more of these three domains. This assignment to domains is depicted in Table 2-6.

Table 2-6—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for Behavioral Health Organizations

Performance Measures	Quality	Timeliness	Access
Hospital Readmissions Within 180 Days (All Facilities)	✓		
Mental Health Engagement		✓	✓
Adherence to Antipsychotics for Individuals With Schizophrenia		✓	✓
Overall Penetration Rates			✓
Penetration Rates by Age Group			✓
Penetration Rates by Medicaid Eligibility Category			✓
Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition (7 and 30 Days)		✓	✓
Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence (7 and 30 Days)		✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		✓	✓

Performance Measures	Quality	Timeliness	Access
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (Non-State and All Facilities)	✓		
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners		✓	✓
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only		✓	✓

Validation of Performance Improvement Projects

Objectives

As one of the mandatory EQR activities under the federal managed care regulations 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 Quality Assessment and Performance Improvement (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.[2-5] 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

[2-5] 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2017.

Forms standardized the process for submitting information regarding PIPs and ensured that all CMS protocol requirements were addressed.

HSAG, with the Department's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG reviewed each of the PIPs for the following 10 CMS protocol activities:

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

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.

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.

To draw conclusions about the quality and timeliness of, and access to, services provided by the Medicaid MCOs and BHOs, HSAG assigned each of the components reviewed for validation of PIPs to one or more of these three domains. 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 process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Other domains were assigned based on the content and outcome of the PIP. This assignment to domains is depicted in Table 2-7.

Table 2-7—Assignment of PIPs to the Quality, Timeliness, and Access to Care Domains

BHO	Performance Improvement Projects	Quality	Timeliness	Access
ABC-D	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	X	X	X
ABC-NE	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	X	X	X
BHI	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	X	X	X
CHP	*Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release*	X	X	X
FBHP	*Improving Transition From Jail to Community-Based Behavioral Health Treatment*	X	X	X
MCO	**Performance Improvement Projects**	**Quality**	**Timeliness**	**Access**
DHMC	*Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*	X	X	X
RMHP Prime	*Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*	X	X	X

Consumer Assessment of Healthcare Providers and Systems

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information about the level of satisfaction that members have with their healthcare experiences.

Technical Methods of Data Collection

Access KP, DHMC, and RMHP Prime were each required to arrange for conducting CAHPS surveys related to their specific organizations. The technical method of data collection for the physical health MCOs 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 member perspectives on care. To support the reliability and validity of the findings, NCQA requires standardized sampling and data collection procedures related to selection of members and distribution of surveys to those members. 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 CAHPS surveys ask members 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 survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their personal doctors, specialists, health plans, and all healthcare. 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 (+). Results of the CAHPS surveys for each Medicaid MCO are found in Section 3.

Description of Data Obtained

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.

Access KP, DHMC, and RMHP Prime provided HSAG with the data presented in the report. DSS Research, Morpace Inc., and Center for the Study of Services (CSS) administered the *CAHPS 5.0 Child Medicaid Health Plan Survey* for Access KP, DHMC and RMHP Prime, respectively. The health plans reported that NCQA methodology was followed in calculating these results.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to, services provided by the Medicaid MCOs, HSAG assigned each of the components reviewed for CAHPS to one or more of these three domains. This assignment to domains is depicted in Table 2-8.

Table 2-8—Assignment of CAHPS Measures to the Quality, Timeliness, and Access to Care Domains

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

Experience of Care and Health Outcomes Surveys

Objectives

The overarching objective of administering the ECHO surveys was to effectively and efficiently obtain information about the level of satisfaction that members experience related to their individual behavioral healthcare experiences.

Technical Methods of Data Collection

The technical method of data collection occurred through the administration of a modified version of the *Adult ECHO Survey, Managed Behavioral Healthcare Organization (MBHO), Version 3.0* (adult ECHO survey), which incorporates items from the Mental Health Statistics Improvement Program (MHSIP) survey, and a modified version of the *Child/Parent ECHO Survey, MBHO, Version 3.0* (child/parent ECHO survey), which incorporates items from the Youth Services Survey for Families (YSS-F) survey and the YSS. HSAG conducted the ECHO surveys on behalf of the Department. The surveys included 59 items in the adult ECHO survey and 69 items in the child ECHO survey, all of which assess member perspectives on the behavioral healthcare services received. HSAG used the ECHO sampling and data collection procedures to select members and distribute surveys and to ensure the comparability of resulting BHO data. HSAG administered the survey and collected the data for ABC-Denver, ABC-NE, BHI, CHP, and FBHP. HSAG aggregated data from survey respondents into a database for analysis. HSAG presents the 2016 and 2017 adult and child ECHO top-box rates for ABC-D, ABC-NE, BHI, CHP, and FBHP in the tables in Section 3.

The survey questions were categorized into 16 measures of satisfaction (adult survey) and 15 measures of satisfaction (child survey). These measures included one global rating, four composite scores, nine individual item measures in the adult survey and eight individual item measures in the child survey, and two MHSIP/YSS-F domain agreement measures. A series of questions from the MHSIP, YSS-F, and YSS surveys were added to the standard ECHO survey in order to meet the reporting needs of the Office of Behavioral Health (OBH). The global ratings reflected a respondent's overall satisfaction with counseling or treatment. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting treatment quickly and how well clinicians communicate). The individual item measures are individual questions that consider a specific area of care (e.g., office wait times and whether or not respondents were told about medication side effects). The MHSIP/YSS-F domains are a series of questions from the surveys that evaluate improved functioning and social connectedness. 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 individual item measures (nine in the adult survey and eight in the child survey), the percentage of respondents who chose a positive response was calculated. Response choices for the ECHO individual item measure questions in the adult and child Medicaid surveys fell into one of three categories: (1) "Never," "Sometimes," "Usually," and "Always;" (2) "No" and "Yes;" or (3) "A lot," "Somewhat," "A little," and "Not at all." A positive or top-box response for the individual item

measures was defined as a response of "Usually/Always," "Yes," or "Somewhat/A lot."[2-6] The percentage of top-box responses is referred to as a question summary rate for the individual item measures.

Description of Data Obtained

For the global rating, 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 four composite scores, the percentage of respondents who chose a positive response was calculated. Response choices for the ECHO composite questions in the adult and child surveys fell into one of three categories: (1) "Never," "Sometimes," "Usually," and "Always;" or (2) "No" and "Yes;" or (3) "Much better," "A little better," "About the same," "A little worse," and "Much worse." A positive or top-box response for the composites was defined as a response of "Usually/Always," "Yes," or "Much better/A little better." The percentage of top-box responses is referred to as a global proportion for the composite scores. Response choices for the ECHO MHSIP/YSS-F domain questions fell into one category. Options were: "Strongly agree," "Agree," "Neutral," "Disagree," "Strongly Disagree," and "Not Applicable." For purposes of calculating the results for the MHSIP/YSS-F domain agreement rates, global proportions were calculated for each domain. Questions comprising each domain are based on a 5-point Likert scale, with each response coded to score values as follows:

1 = Strongly Agree
2 = Agree
3 = Neutral
4 = Disagree
5 = Strongly Disagree

After applying this scoring methodology, the average score for each respondent is calculated for all questions that comprise the domain. Respondents with an average score less than or equal to 2.5 are considered "agreements" and assigned an agreement score of 1, whereas those respondents with an average score greater than 2.5 are considered "disagreements" and assigned an agreement score of zero. Respondent answers with fewer than 33 percent of responses within each MHSIP/YSS-F domain are excluded from the analysis.

How Conclusions Were Drawn

For the ECHO 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. For all BHOs, the cultural competency measure results were suppressed due to an inadequate number of respondents. To draw conclusions about the quality and timeliness of and access to services provided by the BHOs, HSAG assigned each of the

[2-6] For the individual item measure, "Privacy," a positive response is defined as "No."

components reviewed for the ECHO surveys to one or more of these three domains. This assignment to domains is depicted in Table 2-9.

Table 2-9—Assignment of ECHO Measures to the Quality, Timeliness, and Access to Care Domains

ECHO Topics	Quality	Timeliness	Access
Rating of All Counseling or Treatment	✓		
Getting Treatment Quickly	✓	✓	
How Well Clinicians Communicate	✓		
Perceived Improvement	✓		
Information About Treatment Options	✓		✓
Office Wait		✓	✓
Told About Medication Side Effects	✓		
Including Family (Adult Only)	✓		
Information to Manage Condition	✓		✓
Patient Rights Information	✓		
Patient Feels He or She Could Refuse Treatment	✓		
Privacy	✓		
Cultural Competency	✓		
Amount Helped	✓		
Improved Functioning	✓		✓
Social Connectedness	✓		

Aggregating and Analyzing Statewide Data

For each Medicaid physical health MCO and BHO (collectively health plans), HSAG analyzed the results obtained from each EQR mandatory activity; and, for the Medicaid physical health MCOs, HSAG also analyzed the CAHPS survey. From these analyses, HSAG determined which results were applicable to the domains of quality, timeliness, and access to care and services. HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about overall quality of, timeliness of, or access to care and services to be drawn for each health plan independently and statewide.

3. Evaluation of Colorado's Managed Care Organizations

Access Kaiser Permanente

Colorado Access entered into a contract with the Department for implementation of a Medicaid payment reform pilot program using a partial-benefit, full-risk, value-based capitation structure. The contract required Colorado Access to comply with federal Medicaid managed care regulations at 42 CFR 438 et seq. and allowed Colorado Access to subcontract any portion of the pilot program contract to Kaiser Foundation Health Plan of Colorado (Kaiser).

The payment reform contract between Colorado Access and the Department was effective July 2016. Fiscal year (FY) 2016–2017 represents the initial year of HSAG compliance reviews for the Colorado Access pilot program, Access KP.

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 3-1 presents the number of elements for each standard; the number of elements assigned scores of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*; and the overall compliance score for FY 2016–2017.

Table 3-1—Summary of Access KP Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	38	34	24	8	2	4	71%
II—Access and Availability	15	13	11	1	1	2	85%
IX—Subcontracts and Delegation	11	11	6	3	2	0	55%
Totals	**64**	**58**	**41**	**12**	**5**	**6**	**71%**

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

Table 3-2 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 2016–2017.

Table 3-2—Summary of Access KP Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	60	56	4	40	93%
Totals	**100**	**60**	**56**	**4**	**40**	**93%**

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

Strengths

Services covered under the Access KP contract were limited to 2,100 ambulatory primary and specialty care procedure codes. All covered services must have been provided within the Kaiser Permanente network. All other services needed by members were provided through Medicaid fee-for-service. Colorado Access delegated all Access KP utilization management (UM) activities to Kaiser. Kaiser's Resource Stewardship Utilization Management program and UM policies, procedures, and processes articulated Kaiser's intent to deliver services sufficient in amount, duration, and scope to meet members' needs. Kaiser's UM authorization processes were applied to the Access KP contracted services; and Kaiser demonstrated that KP used more than one utilization review system to determine medical necessity criteria when making UM decisions, that UM determinations were made by qualified clinicians consulting with requesting providers when necessary, and that members and providers were notified in writing of UM decisions. Kaiser conducted annual interrater reliability testing for staff and physician reviewers. UM policies addressed procedures for service authorization and timelines for UM decision making and notification. NOAs to members and providers included all required information.

Colorado Access delegated provision of primary care and specialty services for Access KP members to Kaiser. Kaiser documented having an extensive network of primary care and specialist providers available to serve members in the Access KP service area. Kaiser processes included quarterly monitoring of practitioner panel status and appointment availability in order to determine any stress on provider network availability. Kaiser had processes to respond to any potential capacity issues through recruitment or relocation of providers as necessary. Kaiser's appointment scheduling guidelines were more stringent than those defined in the Access KP contract and were monitored quarterly by Kaiser. Kaiser demonstrated that it had a multifaceted national diversity policy and implemented those procedures locally to promote cultural competency among providers and staff. Kaiser offered verbal and written translation for member communications in numerous languages.

Colorado Access' delegation agreement with Kaiser specified that the following functions were delegated to Kaiser: care management, member communications, finance, claims payment, data management/information technology, member enrollment, utilization review, appeals and grievances processing, provider network management, and provision of primary and specialty services. The Kaiser delegation agreement addressed all required provisions, including activities delegated and reporting

requirements, sanctions and revocation, requirements to comply with applicable federal and State laws, and liability insurance requirements. Although not yet implemented at the time of the compliance review activities, Colorado Access' contract management plan defined multiple mechanisms for monitoring Kaiser's performance of delegated functions and included evaluation of deliverables, annual on-site reviews, and a comprehensive delegation audit of contract requirements to be performed every six months. Colorado Access and Kaiser had a joint operating committee that met weekly to discuss the implementation of the structural components of the contract.

Opportunities for Improvement and Required Actions

Based on findings from the site review activities, Colorado Access was required to submit a corrective action plan to ensure that Access KP addressed any areas where Access KP earned *Partially Met* or *Not Met* scores. [3-1]

For scores related to the Coverage and Authorization standard, Access KP was required to revise policies and procedures to clearly define the medical necessity criteria outlined in the State benefits package and to ensure that policies and procedures addressed the requirement to provide an NOA to the member at the time of claims denials (excluding denials related to provider procedural issues). Access KP was also required to provide all NOAs in languages and formats that ensure ease of understanding for the member (i.e., sixth-grade reading level where possible) and to provide the NOAs related to standard requests for services within the State-required timelines of 10 calendar days from receipt of the request for service.

Related to both the Coverage and Authorization of Services and the Access and Availability standards, Access KP needed to comply with EPSDT regulations. Access KP was required to: develop and implement written policies and procedures related to comprehensive EPSDT services and requirements for members ages 20 and under, develop EPSDT diagnosis and treatment referral requirements, educate providers about Healthy Communities, and advise providers of EPSDT services available through other entities.

Related to the Access and Availability standard, Access KP was required to revise policies and procedures to clearly specify that persons with special healthcare needs who use specialists frequently are permitted to maintain these types of specialists as primary care providers (PCPs) and are allowed direct access or receive standing referrals to specialists.

Related to the dynamic that for the Access KP program Colorado Access held the contract with the State and delegated all managed care administrative functions to Kaiser, for findings related to the Subcontracts and Delegation standard Colorado Access was required to revise its contract management plan to include a mechanism to ensure that its delegate (Kaiser) complies with the requirements of 42 CFR, Part 438 appropriate to the service(s) or activities delegated and be able to demonstrate accountability for those processes within Colorado Access operations.

[3-1] In response to the requirement to submit the corrective action plan, Access KP stated that the corrective action plan would not be submitted, due to the contract ending June 30, 2017.

Colorado Access was also required to implement oversight and monitoring as described in its delegation monitoring plan (and required by the contract with the State). Examples of monitoring activities that were not yet implemented included the design and implementation of an oversight audit, implementation of ongoing monitoring such as review of required deliverables with an analysis of findings, and imposition of corrective actions when appropriate. Colorado Access was required to ensure the conduct of oversight and monitoring of Kaiser for delegated Access KP program activities, particularly utilization review and management and care coordination. Access KP was also required to ensure that oversight activities include an assessment of all areas of responsibility delegated as well as an assessment of the performance of the applicable contract requirements.

Access KP: Summary Assessment of Quality, Timeliness, and Access for Compliance Monitoring

While HSAG recognizes that this was the first year for this unique program, Access KP's performance in the quality domain was poor. Access KP submitted Kaiser's UM policies and procedures rather than a set of policies and procedures specific to the Access KP program and relied on Kaiser's performance of all managed care administrative duties related to the program. Kaiser's documents did not adequately address requirements or processes related to medical necessity criteria applicable to Medicaid members, procedures related to providing EPSDT services, processes for consulting with requesting physicians, or content of NOAs. Additionally, Colorado Access' lack of oversight for Kaiser's operational processes related to contract requirements and federal Managed care regulations seriously impacted Access KP's performance in the quality domain.

Access KP's performance in the timeliness domain was mixed. Kaiser's Timeliness of UM Decision-Making and Notification policy addressed time frames for making standard and expedited decisions and related extensions; however, record reviews indicated that Kaiser did not consistently mail NOAs within the required time frames. Additionally, HSAG found that the policy omitted reference to other types of actions and related notification time frames applicable to Medicaid programs.

Access KP's performance in the access domain was mixed. Kaiser demonstrated that its network of providers was adequate to provide covered services to Access KP members and provided evidence that it monitored its network regularly, taking into consideration all elements required by both federal and State regulations for EPSDT service provision. Although Kaiser demonstrated that its network was adequate, HSAG found that member communications included inconsistent or inaccurate information regarding referrals, appointment standards, and access to non-Kaiser physicians—all of which could be confusing to Medicaid members. HSAG noted several of these inconsistencies between Kaiser's *Denver/Boulder Member Resource Guide* and the *Access KP Guide*, both of which Kaiser reported distributing to the Access KP membership.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

Access KP was fully compliant with all but one IS standard relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. Based on information in the 2017 HEDIS Compliance Audit Report, Access KP was not compliant with IS Standard 7 (Data Integration). The auditor noted that Access KP experienced data mapping issues and had significant challenges in producing final HEDIS rates and patient-level detail files to meet reporting and audit deadlines. Due to these issues, Access KP was unable to produce reportable rates for several measures. However, all but one of the measures presented in this report were assigned an audit designation of *Reportable (R).* The rate for that measure (*Inpatient Utilization*) was designated as *Not Reportable* (*NR)* as the health plan chose not to report the measure. Access KP's licensed HEDIS auditor recommended that Access KP implement processes to provide complete and accurate data in a timely manner for future reporting.

Pediatric Care Measure Results

Table 3-3 shows the HEDIS 2017 Pediatric Care measure results for Access KP and the percentile rankings for the HEDIS 2017 rates.

Table 3-3—Pediatric Care Measure Results for Access KP

Measures	HEDIS 2017 Rate	Percentile Ranking
Childhood Immunization Status+		
Combination 2	72.08%	25th–49th
Combination 3	71.29%	50th–74th
Combination 4	71.29%	50th–74th
Combination 5	62.57%	50th–74th
Combination 6	42.38%	50th–74th
Combination 7	62.57%	75th–89th
Combination 8	42.38%	50th–74th
Combination 9	37.03%	50th–74th
Combination 10	37.03%	50th–74th
Immunizations for Adolescents+		
Combination 1 (Meningococcal, Tdap)	84.80%	75th–89th
Combination 2 (Meningococcal, Tdap, HPV)	31.80%	—
Well-Child Visits in the First 15 Months of Life+		
*Zero Visits**	0.00%	≥90th
Six or More Visits	75.34%	≥90th
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	63.66%	10th–24th

Measures	HEDIS 2017 Rate	Percentile Ranking
Adolescent Well-Care Visits[+]		
Adolescent Well-Care Visits	54.80%	50th–74th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[+]		
BMI Percentile Documentation—Total	93.44%	≥90th
Counseling for Nutrition—Total	97.36%	≥90th
Counseling for Physical Activity—Total	97.36%	≥90th
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	95.67%	≥90th
Appropriate Treatment for Children With Upper Respiratory Infection[1]		
Appropriate Treatment for Children With Upper Respiratory Infection	99.29%	≥90th

[+] *Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.*
** For this indicator, a lower rate indicates better performance.*
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
[1] *Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).*

Strengths for Pediatric Care Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Childhood Immunization Status—Combination 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *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*
- *Appropriate Testing for Children With Pharyngitis*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

Opportunities for Improvement for Pediatric Care Measures

The following rate fell below the national Medicaid 25th percentile, indicating an area for improvement:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Recommendations for Pediatric Care Measures

The Access KP contract ended June 30, 2017; therefore, no recommendations related to performance measures are provided in this report for Access KP.

Access to Care and Preventive Screening Measure Results

Table 3-4 shows the HEDIS 2017 Access to Care and Preventive Screening measure results for Access KP and the percentile rankings for Access KP's HEDIS 2017 rates.

Table 3-4—Access to Care and Preventive Screening Measure Results for Access KP

Measures	HEDIS 2017 Rate	Percentile Ranking
Access to Care		
Prenatal and Postpartum Care[+]		
Timeliness of Prenatal Care	100.00%	≥90th
Postpartum Care	96.30%	≥90th
Children and Adolescents' Access to Primary Care Practitioners		
Ages 12 to 24 Months	91.25%	10th–24th
Ages 25 Months to 6 Years	78.88%	<10th
Ages 7 to 11 Years	80.91%	<10th
Ages 12 to 19 Years	82.11%	<10th
Adults' Access to Preventive/Ambulatory Health Services		
Total	73.59%	10th–24th
Preventive Screening		
Chlamydia Screening in Women		
Total	60.42%	50th–74th
Breast Cancer Screening		
Breast Cancer Screening	62.27%	50th–74th
Cervical Cancer Screening[+]		
Cervical Cancer Screening	64.43%	75th–89th
Non-Recommended Cervical Cancer Screening in Adolescent Females*		
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.10%	≥90th
Adult BMI Assessment[+]		
Adult BMI Assessment	98.30%	≥90th

[+] *Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.*

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

Strengths for Access to Care and Preventive Screening Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Cervical Cancer Screening*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Adult BMI Assessment*

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *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 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*

Recommendations for Access to Care and Preventive Screening Measures

The Access KP contract ended June 30, 2017; therefore, no recommendations related to performance measures are provided in this report for Access KP.

Mental/Behavioral Health Measure Results

Table 3-5 shows the HEDIS 2017 Mental/Behavioral Health measure results for Access KP and the percentile rankings for the HEDIS 2017 rates.

Table 3-5—Mental/Behavioral Health Measure Results for Access KP

Measures	HEDIS 2017 Rate	Percentile Ranking
Antidepressant Medication Management		
Effective Acute Phase Treatment	81.04%	≥90th
Effective Continuation Phase Treatment	54.29%	75th–89th
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	47.46%	50th–74th
Continuation and Maintenance Phase	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
Total	NA	—

NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

Strengths for Mental/Behavioral Health Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*

Opportunities for Improvement for Mental/Behavioral Health Measures

As evidenced by the fact that no Access KP rates fell below the national Medicaid 25th percentile, no opportunities for improvement were identified under the Mental/Behavioral Health measure domain.

Recommendations for Mental/Behavioral Health Measures

The Access KP contract ended June 30, 2017; therefore, no recommendations related to performance measures are provided in this report for Access KP.

Living With Illness Measure Results

Table 3-6 shows the HEDIS 2017 Living With Illness measure results for Access KP and the percentile rankings for the HEDIS 2017 rates.

Table 3-6—Living With Illness Measure Results for Access KP

Measures	HEDIS 2017 Rate	Percentile Ranking
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	92.45%	75th–89th
*HbA1c Poor Control (>9.0%)**	33.53%	75th–89th
HbA1c Control (<8.0%)	51.96%	50th–74th
Eye Exam (Retinal) Performed	66.33%	75th–89th
Medical Attention for Nephropathy	95.79%	≥90th
Blood Pressure Control (<140/90 mm Hg)	84.18%	≥90th
Statin Therapy for Patients With Diabetes		
Received Statin Therapy	68.57%	—
Statin Adherence 80%	61.86%	—
Statin Therapy for Patients With Cardiovascular Disease		
Received Statin Therapy—Total	78.00%	—
Statin Adherence 80%—Total	74.36%	—

Measures	HEDIS 2017 Rate	Percentile Ranking
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	99.69%	≥90th
Digoxin	NA	—
Diuretics	100.00%	≥90th
Total	99.73%	≥90th
Use of Imaging Studies for Low Back Pain[1]		
Use of Imaging Studies for Low Back Pain	78.38%	75th–89th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[1]		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	82.93%	≥90th
Pharmacotherapy Management of COPD Exacerbation		
Systemic Corticosteroid	NA	—
Bronchodilator	NA	—
Medication Management for People With Asthma		
Medication Compliance 50%—Total[2]	70.47%	75th–89th
Medication Compliance 75%—Total	39.60%	75th–89th
Asthma Medication Ratio		
Total	76.97%	≥90th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NA	—
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis		
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	84.85%	75th–89th

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

— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

+ Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.

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

[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).

[2] Indicates that the rate was compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2016 since benchmarks for this measure are not published in Quality Compass.

Strengths for Living With Illness Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics*, and *Total*
- *Use of Imaging Studies for Low Back Pain*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*
- *Asthma Medication Ratio—Total*
- *Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis*

Opportunities for Improvement for Living With Illness Measures

As evidenced by the fact that no Access KP rates fell below the national Medicaid 25th percentile, no opportunities for improvement were identified under the Living With Illness measure domain.

Recommendations for Living With Illness Measures

The Access KP contract ended June 30, 2017; therefore, no recommendations related to performance measures are provided in this report for Access KP.

Use of Services Measure Results

Table 3-7 shows the HEDIS 2017 Use of Services measure results for Access KP and the percentile rankings for Access KP's HEDIS 2017 rates. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 3-7—Use of Services Measure Results for Access KP

Measures	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)		
Outpatient Visits	213.06	<10th
*Emergency Department Visits**	0.25‡	≥90th
Inpatient Utilization—General Hospital/Acute Care		
Discharges per 1,000 Member Months (Total Inpatient)	NR	—
Days per 1,000 Member Months (Total Inpatient)	NR	—
Average Length of Stay (Total Inpatient)	NR	—
Discharges per 1,000 Member Months (Medicine)	NR	—
Days per 1,000 Member Months (Medicine)	NR	—
Average Length of Stay (Medicine)	NR	—
Discharges per 1,000 Member Months (Surgery)	NR	—
Days per 1,000 Member Months (Surgery)	NR	—
Average Length of Stay (Surgery)	NR	—
Discharges per 1,000 Member Months (Maternity)	NR	—
Days per 1,000 Member Months (Maternity)	NR	—
Average Length of Stay (Maternity)	NR	—
Antibiotic Utilization*		
Average Scripts PMPY for Antibiotics	0.43	≥90th
Average Days Supplied per Antibiotic Script	10.84	<10th
Average Scripts PMPY for Antibiotics of Concern	0.14	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.37%	≥90th
Frequency of Selected Procedures (Procedures per 1,000 Member Months)		
Bariatric Weight Loss Surgery (0–19 Male)	0.00	**
Bariatric Weight Loss Surgery (0–19 Female)	0.00	**
Bariatric Weight Loss Surgery (20–44 Male)	0.00	<50th
Bariatric Weight Loss Surgery (20–44 Female)	0.00	<25th
Bariatric Weight Loss Surgery (45–64 Male)	0.00	<50th
Bariatric Weight Loss Surgery (45–64 Female)	0.00	<25th
Tonsillectomy (0–9 Male & Female)	0.00	<10th
Tonsillectomy (10–19 Male & Female)	0.00	<10th
Hysterectomy, Abdominal (15–44 Female)	0.00	<10th
Hysterectomy, Abdominal (45–64 Female)	0.00	<10th
Hysterectomy, Vaginal (15–44 Female)	0.00	<10th
Hysterectomy, Vaginal (45–64 Female)	0.04	<10th
Cholecystectomy, Open (30–64 Male)	0.00	<25th
Cholecystectomy, Open (15–44 Female)	0.00	<50th
Cholecystectomy, Open (45–64 Female)	0.00	<50th

Measures	HEDIS 2017 Rate†	Percentile Ranking†
Cholecystectomy, Laparoscopic (30–64 Male)	0.00	<10th
Cholecystectomy, Laparoscopic (15–44 Female)	0.00	<10th
Cholecystectomy, Laparoscopic (45–64 Female)	0.00	<10th
Back Surgery (20–44 Male)	0.29	50th–74th
Back Surgery (20–44 Female)	0.57	≥90th
Back Surgery (45–64 Male)	0.66	50th–74th
Back Surgery (45–64 Female)	0.95	≥90th
Mastectomy (15–44 Female)	0.01	25th–49th
Mastectomy (45–64 Female)	0.00	<25th
Lumpectomy (15–44 Female)	0.01	<10th
Lumpectomy (45–64 Female)	0.04	<10th

** For this indicator, a lower rate indicates better performance.*
‡Access KP acknowledged that the reported rate for this measure may not be valid; therefore, exercise caution when interpreting these results.
*** Percentile ranking could not be determined because the values for 10th, 25th, 50th, 75th, and 90th percentiles were zero.*
† For measures in the Use of Services domain, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance.
NR (Not Reported) indicates Access KP did not report this measure as the health plan's scope did not include inpatient claims.
— Indicates that a percentile ranking was not determined because the HEDIS 2017 measure rate was not reportable or the measure did not have an applicable benchmark.

Access KP: Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

Reported rates for Access KP'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, Access KP's utilization results provide additional information that Access KP's may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Access KP: Summary Assessment of Quality, Timeliness, and Access for Validation of Performance Measures

Access KP's performance demonstrated strength with regard to the quality domain as evidenced by the following positively performing rates for the health plan:

- *Childhood Immunization Status—Combination 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *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*

- *Appropriate Testing for Children With Pharyngitis*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Cervical Cancer Screening*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Adult BMI Assessment*
- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy,* and *Blood Pressure Control (<140/90 mm Hg)*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Diuretics,* and *Total*
- *Use of Imaging Studies for Low Back Pain*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*
- *Asthma Medication Ratio—Total*
- *Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis*

Access KP's rate for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* suggested a potential area for improved quality of care.

For the timeliness domain, Access KP demonstrated areas of strength related to the following measures:

- *Childhood Immunization Status—Combination 7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *Six or More Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Access KP's rate for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* suggested a potential area for improved timeliness of care.

For the access to care domain, Access KP's performance was mixed. Of the 14 reportable rates related to this domain, the following rates suggested areas of strength:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care;* and
- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy,* and *Blood Pressure Control (<140/90 mm Hg)*

However, the following measures demonstrated areas of opportunity related to access to care:

- *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 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*

Validation of Performance Improvement Projects

Access KP did not submit a PIP for the 2016–2017 validation cycle.

Consumer Assessment of Healthcare Providers and Systems

Table 3-8 shows the adult Medicaid results achieved by Access KP for FY 2016–2017.

Table 3-8—Adult Medicaid Question Summary Rates and Global Proportions for Access KP

Measure	FY 2016–2017 Rate
Getting Needed Care	82.3%
Getting Care Quickly	78.2%
How Well Doctors Communicate	89.3%
Customer Service	87.8%
Shared Decision Making	77.2%
Rating of Personal Doctor	58.6%
Rating of Specialist Seen Most Often	68.9%
Rating of All Health Care	52.1%
Rating of Health Plan	57.7%

Strengths

Four of Access KP's measure rates for the adult Medicaid population were higher than the 2016 national averages:

- *Getting Needed Care*
- *Customer Service*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

None of these measure rates were at least 5 percentage points greater than the 2016 national averages.

Opportunities for Improvement

Access KP's 2017 rates for the adult Medicaid population were lower than the 2016 NCQA adult Medicaid national averages for five measures:

- *Getting Care Quickly*
- *How Well Doctors Communicate*

- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of All Health Care*

Of these, the *Rating of Personal Doctor* measure rate was at least 5 percentage points lower than the 2016 national average.

Recommendations

The Access KP contract with the Department ended June 30, 2017; therefore, no recommendations related to CAHPS measures are provided in this report for Access KP.

Access KP: Summary Assessment of Quality, Timeliness, and Access for CAHPS

All measures within the CAHPS survey addressed quality. In addition, *Getting Needed Care* addressed access to care and *Getting Care Quickly* addressed timeliness. Access KP did not administer the CAHPS Health Plan Survey to their child Medicaid population; therefore, only 2017 adult Medicaid results are presented.

Denver Health Medicaid Choice

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 3-9 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 2016–2017.

Table 3-9—Summary of DHMC Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	35	34	32	2	0	1	94%
II—Access and Availability	13	13	12	1	0	0	92%
XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	13	13	8	5	0	0	62%
Totals	**61**	**60**	**52**	**8**	**0**	**1**	**87%**

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

Table 3-10 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 2016–2017.

Table 3-10—Summary of DHMC Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	71	62	9	29	87%
Totals	**100**	**71**	**62**	**9**	**29**	**87%**

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

Strengths

DHMC policies and procedures incorporated the definition of "medical necessity" as defined in DHMC's contract with the Department. DHMC used InterQual and Hayes Knowledge Center (new technology) utilization review software for making medical necessity decisions and conducting interrater reliability testing for physician and non-physician staff annually. Policies and procedures accurately addressed time frames for making authorization decisions and defined processes for determining pre-service, post-service, continued stay, and expedited service authorizations. NOAs for denied services included all required information. DHMC's policies and procedures, member handbook, and provider manual accurately defined "emergency medical condition" and "emergency services." Utilization review, drug utilization

review, claims adjudication policies, and the member handbook stated that emergency services do not require authorization. DHMC did not require authorization for poststabilization care delivered within the Denver Health and Hospital Authority (DHHA) system of care. When a member received poststabilization care out of network, DHMC allowed the treating provider to determine when a member was sufficiently stable for discharge or transfer.

In FY 2013–2014, DHMC determined that its network was inadequate to meet the needs of its membership. DHMC then began revising existing processes and implementing new processes to improve access to covered services. During the 2016–2017 review period, DHMC expanded access by opening a new clinic offering primary and urgent care services and by extending office hours at three other clinic locations. DHMC also expanded capacity by contracting with Walgreens Healthcare Clinic and King Soopers' Little Clinics. Medicaid members were also permitted to access these clinics for urgent care appointments. DHMC submitted documents that demonstrated that covered services were available 24 hours a day, 7 days a week, when medically necessary; that scheduling guidelines were communicated in writing; and that providers were monitored to ensure compliance with access and scheduling standards. DHMC submitted numerous documents that demonstrated commitment to delivery of services in a culturally competent manner, including a Certificate of Distinction in Multicultural Health Care awarded by the NCQA.

The EPSDT Program policy addressed the comprehensive requirements for EPSDT services through policy statements that addressed Colorado's EPSDT regulations. DHMC used its provider manual as the primary source for communicating EPSDT policy provisions to providers. The provider manual included information on components of well-child checkups, the corresponding well-care schedule, immunization schedules, wraparound services, and the role of the EPSDT outreach coordinator. The DHMC member handbook described, in an easy-to-read manner, the benefits of EPSDT services, the types of services available, and how to access those services. DHMC had also developed a strategy for annual audit of a sample of medical records to determine compliance with select elements of the EPSDT periodicity schedule.

Opportunities for Improvement and Required Actions

Based on findings from the site review activities, DHMC was required to submit a corrective action plan to ensure that it addressed any areas where DHMC earned *Partially Met* or *Not Met* scores.

For scores related to the Coverage and Authorization of Services standard, DHMC was required to develop a mechanism to ensure that authorization decision makers consult with the requesting provider when necessary to obtain information needed for making an authorization decision. DHMC was also required to develop mechanisms to ensure that the reason for the denial is written in the NOA letters using easy-to-understand language.

For scores related to the Access and Availability standard, DHMC was encouraged to continue expanding network capacity until DHMC can ensure all members timely access to covered services.

While DHMC's EPSDT policy included required provisions of the State's EPSDT regulations, the policy was not clear as to procedures or how DHMC operationalized the policy. Staff from different operational units were unable to articulate related procedures or processes. DHMC was required to revise its policy to incorporate the complete and accurate definition of "medical necessity" for EPSDT services and to delineate procedures or to link the policy to related operational processes to adequately address providing EPSDT services. DHMC was required to enhance provider communications related to EPSDT services to incorporate the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule into provider communications and to more explicitly address provider responsibility to provide the service or to make a referral to another provider, to Healthy Communities, or to Denver Health's case managers or care coordinators to assist with the referral. DHMC was also required to ensure that providers are aware of the types of EPSDT services and referrals that do or do not require prior authorization and to clarify the process for obtaining authorization when necessary.

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

DHMC's performance in the quality domain was strong. Services delivered within the DHHA network required no authorization; however, DHMC reviewed authorization requests for all out-of-network services and for outpatient requests for durable medical equipment, consumable supplies, and home healthcare. DHMC's processes for conducting interrater reliability testing ensured consistent application of the criteria. HSAG found that DHMC had processes to ensure that a qualified clinician made utilization review decisions, that decisions were based on established criteria, and that the NOAs were mailed to the member and the provider and included the required information.

DHMC's performance in the timeliness domain was also strong. DHMC's policies and procedures accurately addressed time frames for making authorization decisions and defined processes for determining pre-service, post-service, continued stay, and expedited authorizations. HSAG found that authorization decisions were timely and that DHMC extended the decision time frame for authorization decisions when needed and accurately applied extension policies in applicable cases.

DHMC demonstrated substantial improvement in the access domain compared to its performance when HSAG had previously reviewed these standards (in SFY 2013–2014). DHMC has revised existing processes and implemented new processes and contracts along with having expanded clinic hours and having built new clinics to improve access. While DHMC reported compliance with provider-to-member ratios, other indicators used to measure availability of appointments and network adequacy (e.g., grievances, satisfaction surveys, and daily unmet demand reports) continued to indicate opportunities to improve further with regard to the adequacy of the provider network. HSAG encouraged DHMC to continue pursuing innovative ways to address capacity issues and suggested that it document these processes in writing as they are finalized.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2017 HEDIS Compliance Audit Report, DHMC was fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. However, the auditor identified some notable obstacles that DHMC encountered during validation.

Although it did not have any negative impact on HEDIS reporting, the auditor noted that DHMC experienced challenges with the data extract and formatting the data to the appropriate file layout. Due to the health plan's limited information technology resources, DHMC was unable to implement in a timely manner measure changes to file layouts and fields outlined by NCQA. The auditor recommended that DHMC's staff review measure changes to the HEDIS 2018 specifications and update the extraction documentation and logic in a timely manner. The auditor also recommended that a resource be identified and extensive testing of the extraction and mapping processes be conducted.

Pediatric Care Measure Results

Table 3-11 shows the HEDIS 2016 and HEDIS 2017 Pediatric Care measure results for DHMC and the percentile rankings for the HEDIS 2017 rates.

Table 3-11—Pediatric Care Measure Results for DHMC

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Childhood Immunization Status+			
Combination 2	75.92%	**72.57%^^**	25th–49th
Combination 3	75.40%	**71.58%^^**	50th–74th
Combination 4	74.99%	**71.42%^^**	50th–74th
Combination 5	64.68%	**59.46%^^**	50th–74th
Combination 6	52.87%	53.76%	75th–89th
Combination 7	64.42%	**59.35%^^**	50th–74th
Combination 8	52.67%	53.76%	≥90th
Combination 9	47.02%	46.50%	75th–89th
Combination 10	46.87%	46.50%	≥90th
Immunizations for Adolescents+			
Combination 1 (Meningococcal, Tdap)	76.72%	75.37%	50th–74th
Combination 2 (Meningococcal, Tdap, HPV)	—	24.88%	—
Well-Child Visits in the First 15 Months of Life+			
*Zero Visits**	7.69%	7.03%	<10th
Six or More Visits	3.36%	3.52%	<10th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
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%	**58.59%**^^	<10th
Adolescent Well-Care Visits[+]			
Adolescent Well-Care Visits	38.27%	**34.68%**^^	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[+,1]			
BMI Percentile Documentation—Total	78.83%	**7.68%**^^	<10th
Counseling for Nutrition—Total	77.37%	**1.08%**^^	<10th
Counseling for Physical Activity—Total	63.26%	**0.55%**^^	<10th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	76.34%	80.52%	50th–74th
Appropriate Treatment for Children With Upper Respiratory Infection[2]			
Appropriate Treatment for Children With Upper Respiratory Infection	97.48%	**96.04%**^^	75th–89th

[+] *Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.*
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] *Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.*
[2] *Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).*
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 of <0.05.

Strengths for Pediatric Care Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Childhood Immunization Status—Combinations 6, 8, 9, and 10*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

Opportunities for Improvement for Pediatric Care Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *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*
- *Adolescent Well-Care Visits*

- *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*

Additionally, rates for *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* decreased by 5 percentage points or more. Of note, although rates for select combination vaccinations for immunizations for children ranked above the national Medicaid 75th percentile, the *Childhood Immunization Status—Combinations 5* and *7* rates declined by approximately 5 percentage points, presenting opportunities for improvement. However, because the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Childhood Immunization Status* measures can be reported using the hybrid methodology, caution should be used when comparing DHMC's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Recommendations for Pediatric Care Measures

In addition to opportunities for improved documented well-care visits for children and adolescents, DHMC's rates indicate the need to improve administrative documentation of BMI, nutrition counseling, and physical activity counseling for children and adolescents.

DHMC may also focus efforts on determining root causes that led to performance declines for *Childhood Immunization Status—Combinations 5* and *7* in an effort to improve administrative documentation of immunizations overall for children.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Access to Care and Preventive Screening Measure Results

Table 3-12 shows the HEDIS 2016 and HEDIS 2017 Access to Care and Preventive Screening measure results for DHMC and the percentile rankings for the HEDIS 2017 rates.

Table 3-12—Access to Care and Preventive Screening Measure Results for DHMC

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Access to Care			
Prenatal and Postpartum Care+			
Timeliness of Prenatal Care	81.75%	**74.04%^^**	10th–24th
Postpartum Care	54.74%	**44.42%^^**	<10th
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	89.33%	88.32%	<10th
Ages 25 Months to 6 Years	73.66%	**71.74%^^**	<10th
Ages 7 to 11 Years	78.22%	**76.19%^^**	<10th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Ages 12 to 19 Years	79.00%	**76.40%^^**	<10th
Adults' Access to Preventive/Ambulatory Health Services			
Total	65.78%	**59.87%^^**	<10th
Preventive Screening			
Chlamydia Screening in Women			
Total	69.33%	68.73%	75th–89th
Breast Cancer Screening			
Breast Cancer Screening	49.17%	51.85%	10th–24th
Cervical Cancer Screening[+,1]			
Cervical Cancer Screening	56.93%	**45.77%^^**	10th–24th
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17%	0.06%	≥90th
Adult BMI Assessment[+,1]			
Adult BMI Assessment	84.43%	81.03%	25th–49th

[+] *Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.*
** For this indicator, a lower rate indicates better performance.*
[1] *Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.*
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 of <0.05.

Strengths for Access to Care and Preventive Screening Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Chlamydia Screening in Women—Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *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 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*

Additionally, rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*, *Adults' Access to Preventive/Ambulatory Health Services—Total*, and *Cervical Cancer Screening*

declined by 5 percentage points or more from the prior measurement year. However, because some of these measures can be reported using the hybrid methodology, caution should be used when comparing DHMC's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Recommendations for Access to Care and Preventive Screening Measures

HSAG recommends that DHMC conduct a thorough analysis of the root causes for poor performance in the areas of access to care and preventive screening. DHMC is urged to investigate causal areas linked to low performance, identify the most significant areas or populations of focus for which improvement interventions could be planned, and identify strategies and interventions for better outcomes, starting first with the areas for improvements anticipated to provide the highest impact to measure rates.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Mental/Behavioral Health Measure Results

Table 3-13 shows the HEDIS 2016 and HEDIS 2017 Mental/Behavioral Health measure results for DHMC and the percentile rankings for the HEDIS 2017 rates.

Table 3-13—Mental/Behavioral Health Measure Results for DHMC

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	46.35%	49.05%	25th–49th
Effective Continuation Phase Treatment	31.41%	31.02%	10th–24th
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	29.41%	26.88%	<10th
Continuation and Maintenance Phase	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[1]			
Total	4.55%	0.00%	≥90th

NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).

Strengths for Mental/Behavioral Health Measures

The following rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

Opportunities for Improvement for Mental/Behavioral Health Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Antidepressant Medication Management—Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

Recommendations for Mental/Behavioral Health Measures

HSAG recommends that DHMC analyze key drivers for the Mental/Behavioral Health rates to determine opportunities for improved care for members prescribed antidepressant medication and follow-up care for children on attention-deficit hyperactivity disorder (ADHD) medication.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Living With Illness Measure Results

Table 3-14 shows the HEDIS 2016 and HEDIS 2017 Living With Illness measure results for DHMC and the percentile rankings for the HEDIS 2017 rates.

Table 3-14—Living With Illness Measure Results for DHMC

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	—
Comprehensive Diabetes Care[+,1]			
Hemoglobin A1c (HbA1c) Testing	89.78%	**82.60%^^**	10th–24th
*HbA1c Poor Control (>9.0%)**	36.74%	**44.02%^^**	25th–49th
HbA1c Control (<8.0%)	48.66%	44.33%	25th–49th
Eye Exam (Retinal) Performed	55.96%	**45.70%^^**	25th–49th
Medical Attention for Nephropathy	89.29%	87.35%	10th–24th
Blood Pressure Control (<140/90 mm Hg)	73.72%	**57.41%^^**	25th–49th
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	—	59.83%	—
Statin Adherence 80%	—	54.71%	—

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	—	72.18%	—
Statin Adherence 80%—Total	—	54.17%	—
Annual Monitoring for Patients on Persistent Medications			
ACE Inhibitors or ARBs	85.22%	85.93%	25th–49th
Digoxin	NA	NA	—
Diuretics	85.05%	84.95%	10th–24th
Total	85.14%	85.46%	25th–49th
Use of Imaging Studies for Low Back Pain[2]			
Use of Imaging Studies for Low Back Pain	81.26%	**65.53%^^**	<10th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[2]			
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	45.54%	65.57%^	≥90th
Pharmacotherapy Management of COPD Exacerbation[2]			
Systemic Corticosteroid	61.54%	64.16%	25th–49th
Bronchodilator	73.08%	81.82%^	25th–49th
Medication Management for People With Asthma			
Medication Compliance 50%—Total[3]	39.76%	47.83%^	10th–24th
Medication Compliance 75%—Total	16.87%	22.64%^	10th–24th
Asthma Medication Ratio			
Total	32.39%	42.41%^	<10th
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	26.13%	22.47%	10th–24th
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis			
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	83.33%	86.49%	≥90th

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

— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.

+ Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.

[1] Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.

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

[2] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).

[3] Indicates that the rate was compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2016 since benchmarks for this measure are not published in Quality Compass.

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 of <0.05.

Strengths for Living With Illness Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis*

Opportunities for Improvement for Living With Illness Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Comprehensive Diabetes Care—HbA1c Testing and Medical Attention for Nephropathy*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Use of Imaging Studies for Low Back Pain*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total and Medication Compliance 75%—Total*
- *Asthma Medication Ratio—Total*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*

Additionally, *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*, and *Use of Imaging Studies for Low Back Pain* rates declined by 5 percentage points or more from the prior measurement year. However, because some of these measures can be reported using the hybrid methodology, caution should be used when comparing DHMC's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Recommendations for Living With Illness Measures

HSAG recommends that DHMC assess strategies that can be linked to improved administrative documentation of care for members with diabetes, timely imaging studies for members with low back pain, and appropriate COPD testing, in addition to improvements in care for members on diuretic medications and members prescribed asthma medications.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Use of Services Measure Results

Table 3-15 shows the HEDIS 2016 and HEDIS 2017 Use of Services measure results for DHMC and the percentile rankings for DHMC's HEDIS 2017 rates. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2016 and 2017 are not indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 3-15—Use of Services Measure Results for DHMC

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	207.09	193.35	<10th
*Emergency Department Visits**	43.97	42.22	≥90th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	5.48	4.85	<10th
Days per 1,000 Member Months (Total Inpatient)	24.92	21.39	10th–24th
Average Length of Stay (Total Inpatient)	4.55	4.41	50th–74th
Discharges per 1,000 Member Months (Medicine)	3.06	2.63	25th–49th
Days per 1,000 Member Months (Medicine)	13.46	10.36	25th–49th
Average Length of Stay (Medicine)	4.41	3.94	50th–74th
Discharges per 1,000 Member Months (Surgery)	0.81	0.81	10th–24th
Days per 1,000 Member Months (Surgery)	7.12	7.11	25th–49th
Average Length of Stay (Surgery)	8.77	8.79	75th–89th
Discharges per 1,000 Member Months (Maternity)	2.61	2.07	10th–24th
Days per 1,000 Member Months (Maternity)	7.03	5.78	10th–24th
Average Length of Stay (Maternity)	2.69	2.79	50th–74th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	0.34	0.31	≥90th
Average Days Supplied per Antibiotic Script	9.33	9.28	50th–74th
Average Scripts PMPY for Antibiotics of Concern	0.10	0.09	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	28.12%	27.79%	≥90th
Frequency of Selected Procedures (Procedures per 1,000 Member Months)			
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	0.01	50th–74th
Bariatric Weight Loss Surgery (20–44 Female)	0.05	0.05	50th–74th
Bariatric Weight Loss Surgery (45–64 Male)	0.02	0.02	75th–89th
Bariatric Weight Loss Surgery (45–64 Female)	0.12	0.02	25th–49th
Tonsillectomy (0–9 Male & Female)	0.31	0.29	10th–24th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Tonsillectomy (10–19 Male & Female)	0.18	0.16	10th–24th
Hysterectomy, Abdominal (15–44 Female)	0.06	0.06	10th–24th
Hysterectomy, Abdominal (45–64 Female)	0.26	0.10	<10th
Hysterectomy, Vaginal (15–44 Female)	0.06	0.02	<10th
Hysterectomy, Vaginal (45–64 Female)	0.07	0.15	25th–49th
Cholecystectomy, Open (30–64 Male)	0.04	0.01	25th–49th
Cholecystectomy, Open (15–44 Female)	0.01	0.01	50th–89th
Cholecystectomy, Open (45–64 Female)	0.00	0.04	50th–74th
Cholecystectomy, Laparoscopic (30–64 Male)	0.09	0.05	<10th
Cholecystectomy, Laparoscopic (15–44 Female)	0.47	0.40	10th–24th
Cholecystectomy, Laparoscopic (45–64 Female)	0.33	0.33	10th–24th
Back Surgery (20–44 Male)	0.10	0.07	10th–24th
Back Surgery (20–44 Female)	0.05	0.03	<10th
Back Surgery (45–64 Male)	0.62	0.36	10th–24th
Back Surgery (45–64 Female)	0.23	0.33	25th–49th
Mastectomy (15–44 Female)	0.00	0.01	25th–49th
Mastectomy (45–64 Female)	0.23	0.06	10th–24th
Lumpectomy (15–44 Female)	0.04	0.07	10th–24th
Lumpectomy (45–64 Female)	0.19	0.19	10th–24th

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files: differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance.
** For this indicator, a lower rate indicates better performance.*
*** Percentile ranking could not be determined because the values for 10th, 25th, 50th, 75th, and 90th percentiles were zero.*

Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

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 further assess barriers or patterns of utilization when evaluating improvement interventions.

DHMC: Summary Assessment of Quality, Timeliness, and Access for Validation of Performance Measures

DHMC's rates on several measures demonstrated areas of strength in the quality domain. These included the following:

- *Childhood Immunization Status—Combinations 6, 8, 9,* and *10*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Chlamydia Screening in Women—Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis*

Nonetheless, several measures also suggested areas of improvement related to quality of care, including all of the following:

- *Childhood Immunization Status—Combinations 5* and *7*
- *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*
- *Adolescent Well-Care Visits*
- *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*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Antidepressant Medication Management—Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy,* and *Blood Pressure Control (<140/90 mm Hg);*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Use of Imaging Studies for Low Back Pain*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*
- *Asthma Medication Ratio—Total*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*

The measures related to the timeliness domain demonstrated mixed results. Of these 15 reportable rates, the *Childhood Immunization Status—Combinations 6, 8, 9,* and *10* rates suggested areas of strength for DHMC's timeliness of care. On the other hand, rates for the following measures demonstrated opportunities for improved timeliness of care:

- *Childhood Immunization Status—Combinations 5* and *7*
- *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*
- *Adolescent Well-Care Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

DHMC's measure rates in the access to care domain were generally low and demonstrated opportunities for improvement based on the following poor performing rates:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *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 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy,* and *Blood Pressure Control (<140/90 mm Hg)*

Many measures can be reported using the hybrid methodology; therefore, caution should be used when comparing DHMC's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.

Validation of Performance Improvement Projects

Table 3-16 displays the validation results for the DHMC PIP, *Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit,* validated during FY 2016–2017. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the projects. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving *Met* scores have satisfied the necessary technical requirements for specific elements. The validation results presented in Table 3-16 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This is the first year of validation for this PIP because the previous PIP topic's eligible population for the PIP was very small, and the baseline rate for Study Indicator 1 was 100 percent; for Study Indicator 2, the denominator was zero. During a technical assistance call with DHMC and the Department, it was decided that DHMC would implement this new topic, which was submitted in 2016. For this first year of validation, HSAG validated Activities I through VII.

Table 3-16—Performance Improvement Project Validation Results for DHMC

Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	*Not Assessed*	*Not Assessed*	*Not Assessed*
Implementation Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			***Not Assessed***	***Not Assessed***	***Not Assessed***
Percentage Score of Applicable Evaluation Elements *Met*			**100% (12/12)**	**0% (0/12)**	**0% (0/12)**

Overall, 100 percent of all applicable evaluation elements validated received scores of *Met*; therefore, HSAG assigned the PIP an overall validation status of *Met*.

Table 3-17 displays baseline data for DHMC's PIP. DHMC's goal is to increase the percentage of members' follow-up visits with primary care practitioners within 30 days after asthma-related emergency department visits, urgent care visits, or inpatient stays.

Table 3-17—Performance Improvement Project Outcomes for DHMC

PIP Study Indicator	Baseline Period (07/01/2015–06/30/2016)	Remeasurement 1 (07/01/2016–06/30/2017)	Remeasurement 2 (07/01/2017–06/30/2018)	Sustained Improvement
The percentage of follow-up visits with a primary care practitioner within 30 days after an asthma-related emergency department visit, urgent care visit, or inpatient stay.	63%			

DHMC's baseline rate for members 5 to 17 years of age with persistent asthma who had a follow-up visit with a primary care practitioner within 30 days of an asthma-related emergency department visit, urgent care visit, or inpatient stay was 63 percent. The MCO set a goal of achieving statistically significant improvement over the baseline and calculated that a numerator of 54 would be needed to achieve this goal, assuming that the denominator remains at 67. This calculation sets the Remeasurement 1 goal at 80.6 percent to achieve projected statistically significant improvement.

Strengths

DHMC designed a methodologically sound project. The sound study design allowed the MCO to progress to baseline data collection. DHMC reported accurate baseline data and provided a summary of findings.

Barriers/Interventions

The identification of barriers through causal/barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps in improving 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. At the time of submission, DHMC had not implemented interventions. The MCO's quality improvement processes and interventions will be evaluated in the next annual submission of DHMC's PIP.

Recommendations

As the PIP progresses, HSAG recommends the following to DHMC:

- Conduct a causal/barrier analysis using appropriate quality improvement processes, prioritize the identified barriers, and implement active interventions that are logically linked to the barriers and have the potential to impact outcomes.
- Evaluate the effectiveness of each individual intervention and include the evaluation results in Activity VIII.
- Make data-driven decisions when revising, continuing, or discontinuing interventions.
- Seek technical assistance from HSAG as needed.

DHMC: Summary Assessment of Quality, Timeliness, and Access for PIPs

As described in Section 2–Introduction, HSAG assigned DHMC's PIP, *Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*, to the domains of quality and timeliness of, and access to, care and services. The goal of the project was to increase the percentage of follow-up visits with a primary care practitioner within 30 days after asthma-related emergency department visits, urgent care visits, and inpatient stays. The PIP has the potential to improve the quality of asthma-related care for the MCO's members, minimize disruptions in asthma-related care, and ensure access to primary care for effective ongoing member management of asthma.

FY 2016–2017 was the first year of validation for the PIP, and the MCO reported baseline study indicator results. DHMC designed a scientifically sound project supported by the use of key research principles. The technical design of the PIP was sufficient to measure baseline results, allowing for successful progression to the next stage of the PIP process: developing interventions and determining results of the Remeasurement 1 period. The MCO's quality improvement processes and activities and Remeasurement 1 outcomes will be validated during the next PIP validation cycle, when HSAG will evaluate whether or not the PIP has demonstrated real improvement related to the three domains of care and services.

Consumer Assessment of Healthcare Providers and Systems

Table 3-18 shows the adult Medicaid results achieved by DHMC for FY 2016–2017 and the prior year (FY 2015–2016).

Table 3-18—Adult Medicaid Question Summary Rates and Global Proportions for DHMC

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	78.1%	76.1%
Getting Care Quickly	69.7%	76.1%
How Well Doctors Communicate	89.5%	92.6%
Customer Service	84.5%	86.6% +
Shared Decision Making	79.3%	82.6% +
Rating of Personal Doctor	71.5%	71.8%
Rating of Specialist Seen Most Often	67.2%	69.0% +
Rating of All Health Care	50.2%	61.7%
Rating of Health Plan	56.0%	57.4%

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 3-19 shows the child Medicaid results achieved by DHMC for FY 2016–2017 and the prior year (FY 2015–2016).

Table 3-19—Child Medicaid Question Summary Rates and Global Proportions for DHMC

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	80.6%	79.5%
Getting Care Quickly	85.8%	84.0%
How Well Doctors Communicate	93.6%	93.9%
Customer Service	88.2%	85.5% +
Shared Decision Making	75.8% +	74.3% +
Rating of Personal Doctor	80.7%	79.2%
Rating of Specialist Seen Most Often	75.0% +	66.7% +
Rating of All Health Care	66.9%	70.2%
Rating of Health Plan	73.3%	68.1%

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.

Strengths

For DHMC's adult Medicaid population, two measure rates increased substantially:

- *Getting Care Quickly* (6.4 percentage points)
- *Rating of All Health Care* (11.5 percentage points)

Six of the measures demonstrated slight increases (fewer than 5 percentage points each):

- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Five measures were higher than the 2016 national averages:

- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*

Of these, two measure rates were considered substantially higher, being more than 5 percentage points greater than the 2016 national averages:

- *Rating of Personal Doctor*
- *Rating of All Health Care*

For the DHMC's child Medicaid population, no measure rates increased substantially; however, two measures demonstrated slight increases (fewer than 5 percentage points each):

- *How Well Doctors Communicate*
- *Rating of All Health Care*

Three measures were higher than the 2016 national averages:

- *How Well Doctors Communicate*
- *Rating of Personal Doctor*
- *Rating of All Health Care*

No measure rates were at least 5 percentage points greater than the 2016 national averages; therefore, none were considered substantially higher.

Opportunities for Improvement

For the adult Medicaid population, DHMC had no substantial decreases in rates; however, one measure showed a slight decrease:

- *Getting Needed Care*

DHMC's 2017 rates for the adult Medicaid population were lower than the 2016 NCQA adult Medicaid national averages for four measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Rating of Health Plan*

Of these, no measures were at least 5 percentage points lower than the 2016 national averages.

For the child Medicaid population, DHMC had two substantial decreases in rates:

- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Five measures had slight decreases:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*

DHMC's 2017 rates for the child Medicaid population were lower than the 2016 NCQA child Medicaid national averages for six measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Recommendations

Although HSAG acknowledges that in the past year DHMC expanded its network by opening a new clinic that offers primary and urgent care and by executing contracts with community clinics outside of the DHHA system of care, improvements to member satisfaction on specific CAHPS rates remain needed. For the adult Medicaid population, measure rates were below the 2016 NCQA adult Medicaid national averages (although not substantially) for *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of Health Plan*.

For the child Medicaid population, measure rates were below the 2016 NCQA child Medicaid national averages for Getting Needed Care, Getting Care Quickly, Customer Service, Shared Decision Making, Rating of Specialist Seen Most Often, and Rating of Health Plan.[3-2]

To improve member perceptions related to these and to determine if additional healthcare providers are needed now that an increased infrastructure is in place, HSAG recommends that DHMC's quality improvement activities continue to. HSAG also recommends that DHMC build upon the improved provider manual content and consider implementing provider interactive workshops to providers and staff to further promote dissemination information about appointment availability standards and to advance customer service skills. DHMC might also improve access and capacity by expanding DHMC's telemedicine program. DHMC should continue to focus on evaluating and refining its appointment call center and scheduling processes. DHMC may also want to consider developing performance measures related to customer service activities and providing training programs that will impact outcomes related to these measures.

DHMC: Summary Assessment of 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, of the nine measures that impacted the quality domain, only one measure showed a slight decrease when compared to the previous year; two measures were substantially higher than in the previous measurement year; and six measures were slightly higher when compared to the previous year. When compared to the 2016 NCQA adult Medicaid national averages, five rates were slightly higher than the national average, and four measures remained slightly below the national average. Although results were mixed and improvements needed can be identified, DHMC's 2016–2017 adult Medicaid CAHPS rates indicated a positive performance in the quality domain.

For DHMC's child Medicaid population, of the nine measures that impacted the quality domain, two measures demonstrated slight increases in rates when compared to the previous year. Two measures showed substantial decreases in rates, and five measures showed slight decreases in rates. When compared to the 2016 NCQA child Medicaid national averages, three measures were above the national

[3-2] The following measures for DHMC's child Medicaid population had fewer than 100 respondents: *Customer Service*, *Shared Decision Making*, *and Rating of Specialist Seen Most Often*.

average, and six measures remained below the national average. These rates indicate more opportunity for improvement and fewer positive outcomes for the child Medicaid population.

For the *Getting Care Quickly* measure, which assessed timeliness, DHMC's rate for the adult Medicaid population demonstrated a substantial rate increase while the rate for the child Medicaid population showed a slight decrease, indicating mixed results for this measure and an opportunity for improvement.

For DHMC's rates within the Access domain, both the adult and child Medicaid population rates showed slight decreases, indicating continued need for quality improvement activities.

HSAG acknowledges that many of DHMC's quality initiatives designed to positively impact member perceptions and outcomes related to the domains of quality, timeliness, and access to care were initiated within SFY 2015–2016, and therefore may not have had sufficient implementation time to positively impact DHMC's 2016–2017 CAHPS measure rates. HSAG looks forward to future results that may show positive outcomes for DHMC's Medicaid populations.

Rocky Mountain Health Plans Medicaid Prime

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 3-20 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 2016–2017.

Table 3-20—Summary of RMHP Prime Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	34	34	32	2	0	0	94%
II—Access and Availability	13	13	13	0	0	0	100%
XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	13	13	12	1	0	0	92%
Totals	**60**	**60**	**57**	**3**	**0**	**0**	**95%**

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

Table 3-21 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 2016–2017.

Table 3-21—Summary of RMHP Prime Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	59	53	6	41	90%
Totals	**100**	**59**	**53**	**6**	**41**	**90%**

**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's policies and procedures described the processes and criteria that RMHP Prime used to ensure that services provided were medically necessary, appropriate to meet the member's needs, and cost-effective. RMHP Prime's policies and processes clearly communicated that all decisions to deny services based on medical necessity must be made by persons with the requisite clinical expertise and described criteria used to make medical necessity decisions. RMHP Prime's policies stated, and staff members confirmed, that UM staff participated in annual interrater reliability testing. The Preauthorization of Services policy and procedure addressed time frames for processing standard and expedited authorization requests, extension time frames, processes for providing notice to both the

member and the requesting provider, and processes for offering the requesting provider a peer-to-peer review. The policies also described the content that must be included in NOA letters. RMHP Prime's member handbook, provider manual, and emergency services policies and procedures included accurate definitions for "emergency medical conditions" and "emergency medical services." RMHP Prime's member handbook included examples of emergency medical conditions, stated that no prior authorization is required for emergency services, directed members to call 9-1-1 or go to the nearest emergency room for emergencies, and adequately defined "poststabilization services."

RMHP Prime provided documents that described its processes to maintain a network of providers adequate to meet the needs of its membership. RMHP Prime demonstrated that it considers anticipated enrollment; expected utilization; numbers, types, and specialties of providers; physical access for members with disabilities; and the geographic location of providers in relation to members. RMHP Prime informed members about appointment availability standards using the member handbook and member newsletters and used its provider manual, provider newsletters, and website to notify providers of requirements related to hours of operation, scheduling guidelines, and standards for access to care. RMHP Prime monitored providers' adherence to access and availability standards through use of audits, surveys, and monitoring member grievances. In addition to mandatory, annual, cultural competency training for all staff members, RMHP Prime required that staff members who interact with members (e.g., care managers) participate in additional cultural competency training. RMHP Prime's provider manual included a link to web-based training for which physicians could earn continuing education credit. RMHP Prime, in collaboration with the Colorado Cross-Disability Coalition (CCDC), has provided disability competency care training for more than 200 providers and those providers' staff members.

RMHP Prime had a comprehensive EPSDT policy that included State and federal regulations, described the processes for informing providers and members about the benefits of the EPSDT program, and delineated the responsibilities of RMHP Prime staff members. RMHP Prime informed members about the benefits available under the EPSDT program using the member handbook, member newsletters, well-care birthday card reminders, and additional reminders to those members identified as being past due for recommended well-care visits. The EPSDT policy stated that RMHP Prime had implemented the AAP Bright Futures periodicity schedule, which RMHP Prime included in the member handbook and the provider manual.

Opportunities for Improvement and Required Actions

Based on findings from the site review activities, RMHP Prime was required to submit a corrective action plan to ensure that it addressed any areas where RMHP Prime earned *Partially Met* or *Not Met* scores.

For scores related to the Coverage and Authorization standard, RMHP Prime was required to remove information from the denial letter template that implied that members are liable for payment and to provide members with NOAs for payment denial decisions, when appropriate.

For scores related to the EPSDT standard, RMHP Prime was required to develop and implement intermittent systematic communications with network providers regarding the State's EPSDT regulations and the well-care periodicity schedule.

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

RMHP Prime demonstrated strong performance in the quality domain. Its policies and procedures described the processes and criteria used to ensure that services provided were medically necessary, met members' needs, and were cost-effective. UM staff members participated in annual interrater reliability testing and met as a group to review and discuss individual cases as needed. RMHP Prime had a comprehensive EPSDT policy that described use of the AAP Bright Futures periodicity schedule.

RMHP Prime demonstrated strong performance in the timeliness domain. Its policies and procedures, provider manual, and member handbook accurately delineated the time frames for UM decisions and access to care. Evidence reviewed on-site demonstrated adherence to UM denial time frames and RMHP Prime monitoring of its provider network to ensure compliance with timely access standards.

Related to the Access domain, performance was generally positive. RMHP Prime provided evidence that it monitored and maintained a network of providers adequate to meet the needs of its members. RMHP Prime allowed members direct access to all in-network primary and specialty providers and had procedures for allowing members access to out-of-network providers for instances when in-network services were not available. The findings related to RMHP Prime's two access-related corrective actions required for this review year could have negative impact on member access to care.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2017 HEDIS Compliance Audit Report, RMHP Prime was fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. During review of the IS standards, the HEDIS auditor did not identify any notable issues that had negative impact on HEDIS reporting.

Pediatric Care Measure Results

Table 3-22 shows the HEDIS 2016 and HEDIS 2017 Pediatric Care measure results for RMHP Prime and the percentile rankings for the HEDIS 2017 rates.

Table 3-22—Pediatric Care Measure Results for RMHP Prime

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Childhood Immunization Status			
Combination 2	BR	NA	—
Combination 3	BR	NA	—
Combination 4	BR	NA	—
Combination 5	BR	NA	—
Combination 6	BR	NA	—
Combination 7	BR	NA	—
Combination 8	BR	NA	—
Combination 9	BR	NA	—
Combination 10	BR	NA	—
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)	BR	NA	—
Combination 2 (Meningococcal, Tdap, HPV)	—	NA	—
Well-Child Visits in the First 15 Months of Life			
*Zero Visits**	NA	NA	—
Six or More Visits	NA	NA	—
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	BR	67.35%	25th–49th
Adolescent Well-Care Visits[+]			
Adolescent Well-Care Visits	BR	15.57%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[+,1]			
BMI Percentile Documentation—Total	BR	2.40%	<10th
Counseling for Nutrition—Total	BR	14.00%	<10th
Counseling for Physical Activity—Total	BR	0.80%	<10th
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	89.14%	NA	—
Appropriate Treatment for Children With Upper Respiratory Infection[2]			
Appropriate Treatment for Children With Upper Respiratory Infection	94.98%	94.74%	75th–89th

BR (Biased Rate) indicates that RMHP Prime's rate for this measure was invalid and therefore is not presented.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
[+] Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.
[2] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).

Strengths for Pediatric Care Measures

The following rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Appropriate Treatment for Children With Upper Respiratory Infection*

Opportunities for Improvement for Pediatric Care Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Adolescent Well-Care Visits*
- *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*

Recommendations for Pediatric Care Measures

HSAG recommends that RMHP Prime analyze key drivers for measures that fell below the national Medicaid 25th percentile to determine any potential strategies that could be linked to improvements in well-care visits for adolescents and BMI, nutrition counseling, and physical activity counseling for children and adolescents in the health plan's administrative documentation. In addition, because the *Adolescent Well-Care Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures can be reported using the hybrid methodology, caution should be used when comparing RMHP Prime's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Access to Care and Preventive Screening Measure Results

Table 3-23 shows the HEDIS 2016 and HEDIS 2017 Access to Care and Preventive Screening measure results for RMHP Prime and the percentile rankings for the HEDIS 2017 rates.

Table 3-23—Access to Care and Preventive Screening Measure Results for RMHP Prime

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Access to Care			
Prenatal and Postpartum Care[+]			
Timeliness of Prenatal Care	BR	51.22%	<10th
Postpartum Care	BR	28.22%	<10th
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12 to 24 Months	NA	NA	—
Ages 25 Months to 6 Years	84.93%	90.57%	50th–74th
Ages 7 to 11 Years	91.67%	90.11%	25th–49th
Ages 12 to 19 Years	89.60%	86.06%	25th–49th
Adults' Access to Preventive/Ambulatory Health Services			
Total	71.69%	72.23%	10th–24th
Preventive Screening			
Chlamydia Screening in Women			
Total	46.27%	45.23%	10th–24th
Breast Cancer Screening			
Breast Cancer Screening	47.38%	47.80%	10th–24th
Cervical Cancer Screening[+,1]			
Cervical Cancer Screening	BR	40.88%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	4.04%	3.07%	25th–49th
Adult BMI Assessment[+,1]			
Adult BMI Assessment	BR	16.21%	<10th

[+] *Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.*
BR (Biased Rate) indicates that RMHP Prime's rate for this measure was invalid and therefore is not presented.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
** For this indicator, a lower rate indicates better performance.*
[1] *Changes in the rates should be interpreted with caution due to a change in the Department's reporting requirement from hybrid for HEDIS 2016 to administrative for HEDIS 2017.*
Performance comparisons are based on the Chi-square test of statistical significance, with a p value of <0.05.

Strengths for Access to Care and Preventive Screening Measures

No RMHP Prime rates ranked at or above the national Medicaid 75th percentile; however, RMHP Prime's rate for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* increased by 5 percentage points or more from the prior year, indicating strength in this area.

Opportunities for Improvement for Access to Care and Preventive Screening Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Chlamydia Screening in Women—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Adult BMI Assessment*

Recommendations for Access to Care and Preventive Screening Measures

HSAG recommends that RMHP Prime assess strategies that can be linked to improved administrative documentation regarding prenatal and postpartum care, access to primary care for children and adults, screening for chlamydia for women, breast and cervical cancer screenings, and BMI assessments for children and adults. However, because some of these measures can be reported using the hybrid methodology, caution should be used when comparing RMHP Prime's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Mental/Behavioral Health Measure Results

Table 3-24 shows the HEDIS 2016 and HEDIS 2017 Mental/Behavioral Health measure results for RMHP Prime and the percentile rankings for the HEDIS 2017 rates.

Table 3-24—Mental/Behavioral Health Measure Results for RMHP Prime

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Antidepressant Medication Management			
Effective Acute Phase Treatment	69.92%	**56.03%^^**	50th–74th
Effective Continuation Phase Treatment	57.47%	**36.21%^^**	25th–49th
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	35.19%	NA	—
Continuation and Maintenance Phase	NA	NA	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	0.00%	NA	—

** For this indicator, a lower rate indicates better performance.*
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
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 of <0.05.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.

Strengths for Mental/Behavioral Health Measures

No RMHP Prime rates ranked at or above the national Medicaid 75th percentile.

Opportunities for Improvement for Mental/Behavioral Health Measures

Both of RMHP Prime's reportable rates related to mental or behavioral health, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, decreased by 5 percentage points or more from the prior measurement year.

Recommendations for Mental/Behavioral Health Measures

HSAG recommends that RMHP Prime focus efforts on determining key drivers that may have led to performance decline in care for members on antidepressant medication and develop strategies that can be linked to improvements in this area.

Living With Illness Measure Results

Table 3-25 shows the HEDIS 2016 and HEDIS 2017 Living With Illness measure results for RMHP Prime and the percentile rankings for the HEDIS 2017 rates.

Table 3-25—Living With Illness Measure Results for RMHP Prime

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	—
Comprehensive Diabetes Care[+]			
Hemoglobin A1c (HbA1c) Testing	BR	86.05%	50th–74th
*HbA1c Poor Control (>9.0%)**	BR	74.00%	<10th
HbA1c Control (<8.0%)	BR	21.71%	<10th
Eye Exam (Retinal) Performed	BR	38.23%	10th–24th
Medical Attention for Nephropathy	BR	83.54%	<10th
Blood Pressure Control (<140/90 mm Hg)	BR	0.00%	<10th
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	—	43.48%	—
Statin Adherence 80%	—	62.75%	—
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	—	71.08%	—
Statin Adherence 80%—Total	—	66.10%	—
Annual Monitoring for Patients on Persistent Medications			
ACE Inhibitors or ARBs	84.54%	84.67%	10th–24th
Digoxin	NA	NA	—
Diuretics	84.17%	85.51%	25th–49th
Total	84.05%	84.78%	10th–24th
Use of Imaging Studies for Low Back Pain[1]			
Use of Imaging Studies for Low Back Pain	78.35%	74.17%	50th–74th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[1]			
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	42.11%	37.87%	75th–89th
Pharmacotherapy Management of COPD Exacerbation[1]			
Systemic Corticosteroid	53.99%	53.09%	10th–24th
Bronchodilator	57.06%	62.89%	<10th
Medication Management for People With Asthma			
Medication Compliance 50%—Total[2]	65.91%	63.41%	75th–89th
Medication Compliance 75%—Total	45.45%	34.63%	50th–74th
Asthma Medication Ratio			
Total	58.26%	56.35%	25th–49th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentile Ranking
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	35.42%	27.19%	25th–49th
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis			
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	65.00%	75.25%	50th–74th

NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year. This symbol may also indicate that a percentile ranking was not determined because the HEDIS 2017 rate was not reportable or the measure did not have an applicable benchmark.
+ Caution should be exercised when comparing administrative-only rates to national benchmarks that were calculated using the administrative and/or hybrid methodologies.
BR (Biased Rate) indicates that RMHP Prime's rate for this measure was invalid and therefore is not presented.
** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in NCQA's technical specifications, exercise caution when comparing HEDIS 2017 rates for this measure to rates calculated using prior years' technical specifications (e.g., historical rates and national benchmarks).
[2] Indicates that the rate was compared to NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2016 since benchmarks for this measure are not published in Quality Compass.

Strengths for Living With Illness Measures

The following rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*

Although RMHP Prime's *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* rate was below the national Medicaid 10th percentile, this rate improved by 5 percentage points or more, suggesting improved care in this area.

Opportunities for Improvement for Living With Illness Measures

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Comprehensive Diabetes Care—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)*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Total*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*

Additionally, RMHP Prime's performance demonstrated declines in appropriate COPD testing and care for members with asthma as rates for *Use of Spirometry Testing in the Assessment and Diagnosis of COPD* and *Medication Management for People With Asthma—Medication Compliance 75%—Total*

decreased by 5 percentage points or more from the prior measurement year. However, because the *Comprehensive Diabetes Care* measure rates can be reported using the hybrid methodology, caution should be used when comparing RMHP Prime's administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Recommendations for Living With Illness Measures

HSAG recommends that the health plan assess key drivers of performance for the measures noted preceding and develop initiatives for improving administrative documentation of care for members with diabetes and care for members on ACEs, ARBs, digoxin, or diuretics. HSAG also recommends that RMHP Prime analyze successes demonstrated for members with COPD on bronchodilators and evaluate potential strategies that could be linked to improved care related to this measure.

For all measures with rates below the national Medicaid 25th percentile, the Department recommends that the health plan develop quality improvement initiatives to increase each measure rate by a relative improvement rate of 10 percent toward the goal of the 90th percentile.

Use of Services Measure Results

Table 3-26 shows the HEDIS 2016 and HEDIS 2017 Use of Services measure results for RMHP Prime and the percentile rankings for RMHP Prime's HEDIS 2017 rates. Reported rates are not risk-adjusted; therefore, rate changes observed between HEDIS 2016 and 2017 are not indicative of performance improvement or decline. Percentile rankings were assigned to the HEDIS 2017 reported rates based on NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2016 and are presented for information purposes only.

Table 3-26—Use of Services Measure Results for RMHP Prime

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Ambulatory Care (Per 1,000 Member Months)			
Outpatient Visits	306.76	320.65	25th–49th
*Emergency Department Visits**	71.40	66.27	25th–49th
Inpatient Utilization—General Hospital/Acute Care			
Discharges per 1,000 Member Months (Total Inpatient)	9.35	9.66	75th–89th
Days per 1,000 Member Months (Total Inpatient)	32.70	35.32	50th–74th
Average Length of Stay (Total Inpatient)	3.50	3.66	10th–24th
Discharges per 1,000 Member Months (Medicine)	0.65	4.47	75th–89th
Days per 1,000 Member Months (Medicine)	2.53	16.38	50th–74th
Average Length of Stay (Medicine)	3.90	3.66	25th–49th
Discharges per 1,000 Member Months (Surgery)	6.37	2.36	75th–89th
Days per 1,000 Member Months (Surgery)	25.02	12.73	50th–74th
Average Length of Stay (Surgery)	3.93	5.39	10th–24th
Discharges per 1,000 Member Months (Maternity)	2.42	2.96	25th–49th

Measures	HEDIS 2016 Rate	HEDIS 2017 Rate†	Percentile Ranking†
Days per 1,000 Member Months (Maternity)	5.34	6.52	25th–49th
Average Length of Stay (Maternity)	2.21	2.20	<10th
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics	1.02	0.75	75th–89th
Average Days Supplied per Antibiotic Script	9.30	9.27	50th–74th
Average Scripts PMPY for Antibiotics of Concern	0.44	0.32	75th–89th
Percentage of Antibiotics of Concern of All Antibiotic Scripts	43.15%	42.10%	25th–49th
Frequency of Selected Procedures (Procedures per 1,000 Member Months)			
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)	0.05	0.01	50th–74th
Bariatric Weight Loss Surgery (20–44 Female)	0.11	0.09	75th–89th
Bariatric Weight Loss Surgery (45–64 Male)	0.06	0.02	75th–89th
Bariatric Weight Loss Surgery (45–64 Female)	0.16	0.25	≥90th
Tonsillectomy (0–9 Male & Female)	0.84	3.60	≥90th
Tonsillectomy (10–19 Male & Female)	0.33	0.16	10th–24th
Hysterectomy, Abdominal (15–44 Female)	0.15	0.10	25th–49th
Hysterectomy, Abdominal (45–64 Female)	0.26	0.23	25th–49th
Hysterectomy, Vaginal (15–44 Female)	0.49	0.59	≥90th
Hysterectomy, Vaginal (45–64 Female)	0.47	0.40	75th–89th
Cholecystectomy, Open (30–64 Male)	0.00	0.00	<25th
Cholecystectomy, Open (15–44 Female)	0.00	0.01	50th–89th
Cholecystectomy, Open (45–64 Female)	0.03	0.01	<50th
Cholecystectomy, Laparoscopic (30–64 Male)	0.35	0.33	50th–74th
Cholecystectomy, Laparoscopic (15–44 Female)	0.99	0.82	75th–89th
Cholecystectomy, Laparoscopic (45–64 Female)	0.91	0.70	50th–74th
Back Surgery (20–44 Male)	0.35	0.18	25th–49th
Back Surgery (20–44 Female)	0.24	0.29	75th–89th
Back Surgery (45–64 Male)	0.92	0.83	75th–89th
Back Surgery (45–64 Female)	0.58	0.78	75th–89th
Mastectomy (15–44 Female)	0.04	0.07	≥90th
Mastectomy (45–64 Female)	0.21	0.04	10th–24th
Lumpectomy (15–44 Female)	0.21	0.13	50th–74th
Lumpectomy (45–64 Female)	0.36	0.26	10th–24th

† For measures in the Use of Services domain, statistical tests across years were not performed because variances were not provided in the IDSS files: differences in rates were reported without statistical test results. In addition, higher or lower rates did not necessarily denote better or worse performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance.

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

*** Percentile ranking could not be determined because the values for 10th, 25th, 50th, 75th, and 90th percentiles were zero.*

Strengths, Opportunities for Improvement, and Recommendations for Use of Services Measures

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 further assess barriers or patterns of utilization when evaluating improvement interventions.

RMHP Prime: Summary Assessment of Quality, Timeliness, and Access for Validation of Performance Measures

While select rates reported by RMHP Prime indicated areas of strength with regard to quality of care (i.e., *Appropriate Treatment for Children With Upper Respiratory Infection*; *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*; and *Medication Management for People With Asthma—Medication Compliance 50%—Total*), several rates indicated opportunities for improved quality, including the following:

- *Adolescent Well-Care Visits; 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*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Car;*
- *Chlamydia Screening in Women—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Adult BMI Assessment*
- *Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment*
- *Comprehensive Diabetes Care—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)*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs and Total*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator*
- *Medication Management for People With Asthma—Medication Compliance 75%—Total*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*

Related to the timeliness domain, the following rates indicated areas for improvement for RMHP Prime:

- *Adolescent Well-Care Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

For the access domain, RMHP Prime's rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months to 6 Years* indicated positive performance, but the following rates indicate opportunities for improved access to care:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Comprehensive Diabetes Care—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)*

Validation of Performance Improvement Projects

Findings

Table 3-27 displays the validation results for the RMHP Prime PIP, *Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*, validated during FY 2016–2017. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met, Partially Met*, or *Not Met*. Elements receiving *Met* scores have satisfied the necessary technical requirements for specific elements. The validation results presented in Table 3-27 show the percentage of applicable evaluation elements, by activity, that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with HSAG validating Activities I through IX.

Table 3-27—Performance Improvement Project Validation Results for RMHP Prime

Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (2/2)	0% (0/2)	0% (0/2)
Design Total			**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

			Percentage of Applicable Elements		
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate 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 Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**89% (17/19)**	**0% (0/19)**	**11% (2/19)**

Overall, 89 percent of all applicable evaluation elements validated received scores of *Met*. HSAG assigned the PIP an overall validation status of *Not Met*.

Table 3-28 displays baseline and Remeasurement 1 data for RMHP Prime's PIP.

Table 3-28—Performance Improvement Project Outcomes for RMHP Prime

PIP 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 Medicaid Prime during the measurement year, and who had a visit with a primary care provider within 90 days of enrollment into Prime.	20.3%	32.9%		*Not Assessed*

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

For Remeasurement 1, the rate increased to 32.9 percent. This increase was not statistically significant, as evidenced by a *p* value of 0.0951. The goal remains at 35 percent. RMHP Prime indicated in its analysis of findings that it believes very strongly that individuals involved in the criminal justice system should receive care as soon as possible after their release date to ensure continuity of care for chronic medical and behavioral health conditions. While the MCO could not count all individuals as part of the official numerator criteria, RMHP Prime staff stated that this project has been successful in connecting recently released parolees with primary care visits.

Strengths

RMHP Prime designed a methodologically sound project. The sound study design allowed the MCO to progress to collecting data and implementing interventions. RMHP Prime accurately reported and summarized the first remeasurement study indicator results and used appropriate quality improvement tools to identify and prioritize barriers. The interventions developed and implemented were logically linked to the barriers and have the potential to impact study indicator outcomes.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps in improving outcomes. The MCO's choice of interventions, combination of intervention types, and sequence of implementing interventions are all 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 the following barriers to address:

- Parolees having an urgent/emergent medical or behavioral health need and lack the ability to navigate the system independently.
- Parolees are unable to identify PCMPs with which to schedule visits.
- Parolees lack reliable forms of communication—either no communication or limited telephonic communication.
- Parolees lack education and awareness of the importance of regularly visiting a PCMP to manage chronic health conditions or to maintain health.

To address these barriers, RMHP Prime implemented the following interventions:

- Parole office or parole office behavioral health specialist contacts the MCO when parolees have an identified urgent need. The MCO assigns a care coordinator to immediately assess needs and help coordinate care and services.

- Parole officer or parole office behavioral health specialist contacts the MCO with the parolee present and provides a warm hand-off referral to the care coordinator.
- The assigned care coordinator assesses each parolee for health needs and helps coordinate primary care, schedules the initial appointment, and ensures that the parolee attends the appointment.
- The MCO developed a health literacy module to be presented at the required parole orientation after the member's release from prison.

Recommendations

As the PIP progresses, HSAG recommends the following to RMHP Prime:

- Revisit the causal/barrier analysis and quality improvement processes at least annually to reevaluate barriers and develop new, active interventions, as needed.
- Continue to evaluate the effectiveness of each individual intervention and report the results in the next annual submission.
- Makes data-driven decisions when revising, continuing, or discontinuing interventions.
- Changes any Regional Care Collaborative Organization (RCCO) references to MCO references in Activity VIII.
- Seeks technical assistance from HSAG as needed.

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

As described in Section 2–Introduction, HSAG assigned RMHP Prime's PIP, *Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility,* to the domains of quality and timeliness of, and access to, care and services. The goal of the project is to increase the percentage of recently paroled members who have a visit with a primary care provider within 90 days of enrollment into RMHP Prime. The PIP has the potential to improve the quality of care for the MCO's members who were recently paroled from a corrections facility, minimize disruptions in care for those members, and increase access to primary care for effective management of any ongoing health conditions.

For the FY 2016–2017 validation cycle, RMHP Prime submitted Remeasurement 1 results; however, the Remeasurement 1 results did not demonstrate real improvement in the study indicator outcomes. The PIP was based on a methodologically sound design, and improvement activities were implemented appropriately; but the improvement in the rate of paroled members who completed primary care visits within 90 days of enrollment was not statistically significant at the first remeasurement. The PIP will be evaluated again during the next PIP validation cycle to determine if appropriate adjustments were made to achieve real improvement related to the three domains of care and services.

Consumer Assessment of Healthcare Providers and Systems

Table 3-29 shows the adult Medicaid results achieved by RMHP Prime for FY 2016–2017 and the prior year (FY 2015–2016).

Table 3-29—Adult Medicaid Question Summary Rates and Global Proportions for RMHP Prime

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	84.9%	86.7%
Getting Care Quickly	81.9%	84.6%
How Well Doctors Communicate	94.4%	88.8%
Customer Service	82.2% +	88.2% +
Shared Decision Making	77.0% +	83.4%
Rating of Personal Doctor	67.8%	55.6%
Rating of Specialist Seen Most Often	66.7% +	61.4%
Rating of All Health Care	48.8%	48.2%
Rating of Health Plan	55.0%	51.6%

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 3-30 shows the child Medicaid results achieved by RMHP Prime for FY 2016–2017 and the prior year (FY 2015–2016).

Table 3-30—Child Medicaid Question Summary Rates and Global Proportions for RMHP Prime

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Getting Needed Care	84.9% +	88.5% +
Getting Care Quickly	90.8% +	95.5% +
How Well Doctors Communicate	93.7% +	97.0% +
Customer Service	87.4% +	84.1% +
Shared Decision Making	94.6% +	91.7% +
Rating of Personal Doctor	72.5% +	80.3% +
Rating of Specialist Seen Most Often	65.1% +	57.5% +
Rating of All Health Care	55.7% +	56.1% +
Rating of Health Plan	61.9% +	64.7% +

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.

Strengths

For RMHP Prime's adult Medicaid population, two measure rates increased substantially:

- *Customer Service* (6.0 percentage points)
- *Shared Decision Making* (6.4 percentage points)

Two of the measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Needed Care*
- *Getting Care Quickly*

Four adult measures were higher than the 2016 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Customer Service*
- *Shared Decision Making*

Of these, one measure rate was more than 5 percentage points greater than the 2016 national average.

- *Getting Needed Care*

For RMHP Prime's child Medicaid population, one measure rate increased substantially:

- *Rating of Personal Doctor* (7.8 percentage points)

Five measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*
- *Rating of Health Plan*

For RMHP Prime's child Medicaid population, five measure rates were higher than the 2016 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of Personal Doctor*

Of these, three measure rates were more than 5 percentage points greater than the 2016 national averages.

- *Getting Care Quickly*
- *Shared Decision Making*
- *Rating of Personal Doctor*

Opportunities for Improvement

Three of RMHP Prime's adult Medicaid population measure rates decreased substantially:

- *How Well Doctors Communicate* (5.6 percentage points)
- *Rating of Personal Doctor* (12.2 percentage points)
- *Rating of Specialist Seen Most Often* (5.3 percentage points).

Two measures showed slight rate decreases:

- *Rating of All Health Care*
- *Rating of Health Plan*

RMHP Prime's 2017 rates for the adult Medicaid population were lower than the 2016 NCQA adult Medicaid national averages for five measures:

- *How Well Doctors Communicate*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

Of these, three measure rates were more than 5 percentage points lower than the 2016 national average.

- *Rating of Personal Doctor*
- *Rating of All Health Care*
- *Rating of Health Plan*

For RMHP Prime's child Medicaid population, one measure rate decreased substantially*:*

- *Rating of Specialist Seen Most Often* (7.6 percentage points)

Two measures showed slight rate decreases:

- *Customer Service*
- *Shared Decision Making*

RMHP Prime's 2017 rates for the child Medicaid population were lower than the 2016 NCQA child Medicaid national averages for four measures:

- *Customer Service*
- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*
- *Rating of Health Plan*

Of these, two measure rates were more than 10 percentage points lower than the 2016 national averages:

- *Rating of Specialist Seen Most Often*
- *Rating of All Health Care*

Recommendations

While HSAG acknowledges that RMHP Prime's CAHPS measure results showed substantial increases and rates higher than the national average on some measures, improvements to member satisfaction on specific CAHPS rates remain needed. For the adult Medicaid population, measure rates were below the 2016 NCQA adult Medicaid national averages for *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care*, and *Rating of Health Plan*. Three of these measures were substantially lower than the national averages and also showed a decrease in rates when compared to the previous measurement year.[3-3] For the child Medicaid population, measure rates were lower than the 2016 NCQA child Medicaid national averages for *Customer Service*, *Rating of Specialist Seen Most Often*, *Rating of All Health Care,* and *Rating of Health Plan*. Two of the preceding measures were substantially lower than the 2016 national averages.[3-4]

To impact these member perceptions, HSAG recommends that RMHP Prime further investigate physician communication skills and cultural competency skills. As evidenced during on-site compliance reviews, RMHP Prime had robust programs for training operational staff in cultural competency using a two-step approach and requiring additional training for staff members who directly interact with members. RMHP Prime may want to assess communication and cultural competency skills, specifically of providers, to determine provider training needs and implement targeted training based on results of its assessment. HSAG recommends that RMHP Prime leverage its Member Experience of Care Committee and consider expanding member participation or investigate how member participants can positively communicate with RMHP Prime's Medicaid membership to reach additional members. RMHP Prime may also want to consider developing performance measures related to customer service activities and providing training programs that will impact outcomes related to these measures.

[3-3] The following measure for RMHP's adult Medicaid population had fewer than 100 respondents, *Customer Service*.
[3-4] All measures for RMHP's child Medicaid population had fewer than 100 respondents.

For all measures that experienced a substantial decrease (more than 5 percentage points each) when compared to the previous measure year, the Department recommends that the health plan develop quality initiatives to improve member experience.

RMHP Prime: Summary Assessment of 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 RMHP Prime's adult Medicaid population, of the nine measures that impacted the quality domain, two measures showed substantial increases in rates when compared to the previous measurement year and two additional measure rates were slightly higher when compared to the previous measurement year. Each of these measure rates was higher than the 2016 NCQA adult Medicaid national averages, with one measure being substantially higher. Of the remaining five measures, three measures showed substantial rate decreases, and two measures showed slight rate decreases when compared to the previous measurement year. Although results were mixed and improvement needs can be identified, RMHP Prime made significant progress in measures that assess the quality domain.

For RMHP Prime's child Medicaid population, of the nine measures that assess the quality domain six measures showed measure rate increases when compared to the previous measure year, with one measure being substantially higher. Five measures rates were higher than the 2016 NCQA child Medicaid national averages. Of these, three measure rates were substantially higher than the national average. Three measure rates showed a decrease when compared to the previous measurement year, with one measure being substantially lower. The three measure rates that showed a decrease when compared to the previous measurement year were also below the national averages, with two measures being substantially lower. Again, RMHP Prime's performance in the quality domain for its child Medicaid population were somewhat mixed; however, six measure rates showed increases for this population as compared to four increases for the adult Medicaid population, which may indicate slightly stronger performance in the quality domain for RMHP Prime's child Medicaid population.

For the *Getting Care Quickly* measure, which assessed the timeliness domain, RMHP Prime's measure rate for both the adult and child Medicaid populations showed slight increases. In addition, for both the adult and child Medicaid populations the *Getting Care Quickly* rate was higher than the national average and was substantially higher for the child population.

For the *Getting Needed Care* measure, which assessed the access to care domain, RMHP Prime's measure rates for both the adult and child Medicaid populations showed slight increases. In addition, for both the adult and child Medicaid populations, the *Getting Needed Care* measure rate was higher than the national averages and was substantially higher for the adult Medicaid population.

4. Evaluation of Colorado's Behavioral Health Organizations

Access Behavioral Care—Denver

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-1 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 2016–2017.

Table 4-1—Summary of ABC-D Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	31	31	27	4	0	0	87%
II—Access and Availability	10	10	10	0	0	0	100%
XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Not Scored						
Totals	**41**	**41**	**37**	**4**	**0**	**0**	**90%**

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

Table 4-2 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 2016–2017.

Table 4-2—Summary of ABC-D Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	66	64	2	34	97%
Totals	**100**	**66**	**64**	**2**	**34**	**97%**

Strengths

ABC-D had policies and procedures related to UM processes and emergency services that addressed most requirements. ABC-D used InterQual criteria to screen requests for medical necessity and simultaneously applied a list of BHO-covered diagnoses/benefits to the clinical information contained in the member's record. UM reviewers referred all questionable cases to a clinically qualified medical director for final determination. ABC-D ensured consistent application of review criteria by UM staff and medical directors through interrater reliability audits. ABC-D's authorization and notification processes were highly

efficient, with many decisions—whether urgent or standard requests—made within one to three days of receipt of request. All NOA letters included the reason for the decision and offered treatment alternatives recommended by the medical director. Policies and procedures, the provider manual, and the member handbook accurately defined "emergency medical condition," including the prudent layperson definition. Policies and procedures and the member handbook stated that ABC-D pays emergency claims—in or out of network—without prior authorization, and the member handbook informed members that they are never liable for payment of emergency services.

ABC-D generated quarterly network adequacy reports that delineated the numbers, types, and physical locations of contracted providers as well as areas of cultural specialty and languages spoken and compared this data to the utilization patterns and physical locations of its members. ABC-D reviewed this information along with member grievances, provider appointment availability, results of ECHO surveys, expected Medicaid enrollment, and use of services when determining network provider adequacy. ABC-D notified providers about its expectation regarding hours of operation and appointment availability standards using new provider orientation, the provider manual, the provider website, and periodic mailings. ABC-D required that largest-volume providers submit regular access-to-care reports and monitored smaller-volume providers using secret shopper calls. ABC-D had a cultural competency plan that delineated goals for ensuring the provision of culturally and linguistically appropriate services. ABC-D required staff members to participate in annual cultural competency training and offered training to all contracted providers.

Colorado Access defined an EPSDT strategic plan for implementing comprehensive EPSDT requirements organization-wide, incorporating both BHOs and the two corresponding RCCOs. Various components of the EPSDT strategic plan were to be implemented throughout the 2017 calendar year. ABC-D had clearly outlined procedures for providing BHO care coordination to assist members with access to EPSDT services not covered by the BHO, including coordinating with community agencies and programs, arranging transportation, coordinating wraparound benefits, and coordinating with Healthy Communities. At the time of on-site review, care coordination for members needing services not covered by the BHO was the most well-developed aspect of ABC-D's EPSDT program. Colorado Access had been working closely with the Department to address all EPSDT requirements.

Opportunities for Improvement and Recommendations

Based on findings from the site review activities, ABC-D was required to submit a corrective action plan to ensure having addressed any areas where ABC-D earned *Partially Met* or *Not Met* scores.

For findings related to the Coverage and Authorization of Services, ABC-D was required to develop a mechanism to ensure that all information in the NOA letters to members are member-specific and written in language that ensures ease of understanding and to develop a mechanism to ensure that notices of action are mailed in the required time frames. ABC-D was also required to develop a process to ensure that members are not held responsible for poststabilization services or required to appeal these charges to alert the BHO that an out-of-network hospitalization was, in fact, a poststabilization admission following emergency services. In addition, ABC-D was also required to revise policies and procedures to reflect the mechanism to proactively discover the provision of poststabilization services

and ensure claims payment. Related to one untimely extension letter, HSAG recommended that ABC-D avoid noncompliance with meeting authorization time frames by implementing the extension process sooner.

HSAG made several recommendations related to ABC-D's implementation of EPSDT requirements, including: expediting implementation of Colorado Access' EPSDT strategic plan, enhancing the medical record audit tool used to monitor provider documentation related to EPSDT requirements, identifying additional mechanisms for systematic EPSDT communications with network providers, enhancing member communications regarding EPSDT services at the member point of service, and clarifying that providers should share member protected health information (PHI) with Healthy Communities.

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

ABC-D demonstrated mixed performance in the quality domain. Use of InterQual criteria and its processes to ensure consistent application of the review criteria by clinically qualified personnel provided consistency in UM decision making. The on-site review of denial records demonstrated that ABC-D complied with required UM processes as well as the requirement to ensure easy-to-understand language in NOA letters. Negatively impacting the quality domain; however, was the dynamic that claims payment denials did not comply with regulations regarding payment for poststabilization services. Out-of-network hospitalizations were not reviewed for the presence of an associated emergency service, and the claims system was not configured to flag the presence of both an emergency service and hospitalization on the same day. HSAG suggested that ABC-D could further enhance its performance in the quality domain by developing a process to ensure that procedures for claims denials do not inadvertently require members to either pay for hospitalization following an emergency service or force an appeal process.

ABC-D demonstrated strong performance in the timeliness domain. ABC-D's authorization and notification processes were efficient. ABC-D processed most requests for services within one to three days of receiving the request. Although one case reviewed on-site required additional review time, and HSAG found that ABC-D was unable to send the extension letter within the required time frame, staff were aware of the issue and procedures were well-defined.

ABC-D demonstrated strong performance in the access to care domain. ABC-D's policies and procedures described how it monitored and measured its network adequacy and provided materials demonstrating that its network was adequate to meet its members' needs., ABC-D staff members also described ongoing efforts to recruit specific areas of specialty services and providers fluent in non-English languages. ABC-D also provided evidence of arranging for members to receive services from out-of-network providers when in-network providers were not available.

Validation of Performance Measures

System and Reporting Capabilities

HSAG identified no issues or concerns with ABC-D's receipt and processing of enrollment data. Colorado Access continued to obtain monthly eligibility, full, and daily change/update files from the Department in a flat file format via a secure file transfer protocol (FTP) site. Eligibility information was loaded into a data scrubber where several business rules were applied to ensure that only accurate enrollment information was loaded into ABC-D's transactional system, QNXT, operated by TriZetto. QNXT transformed eligibility information from a flat file format to an 834 file format. Next, 834 files were provided to the BHO's affiliated community mental health centers (CMHCs). Providers logged in to QNXT and obtained eligibility information for members. For measure production, enrollment information was reconciled with the monthly eligibility full file. In case of any discrepancies with eligibility, real-time verification was available via the Department's portal. No major system or process changes were noted for the current reporting year.

HSAG identified no issues or concerns with the ways ABC-D received, processed, or reported claims and encounter data. No major changes were noted from the prior year. QNXT remained the claims processing system. Providers continued to submit 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 and 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 in QNXT, they were converted into the 837 file format using optical character recognition (OCR) software. The affiliated CMHC submitted encounter data via FTP. These files were 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 the claims/encounter data, ABC-D received pharmacy and inpatient data from the Department via FTP and loaded all data 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 at each data transfer point to ensure data completeness and data accuracy. Additionally, ABC-D had sufficient oversight of its processing vendor, TriZetto. Monthly meetings were held to address any data issues and collaboratively discuss solutions.

Colorado Access continued to manage 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. Claims and encounters were extracted from QNXT and loaded into an operational data store (ODS) database for rate calculation. Query language was applied to the data in ODS to identify each indicator's denominator and numerator cases. Several verification processes were in place to ensure data accuracy for measure reporting.

Measure Results

Table 4-3 shows the MY 2014–2015 and MY 2015–2016 measure results for ABC-D.

Table 4-3—Measure Results for ABC-D

Performance Measure	MY 2014-2015 Rate[1]	MY 2015-2016 Rate[2]
Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (Non-State and All Facilities)*		
Non-State Hospitals—7 Days	4.16%	3.34%
Non-State Hospitals—30 Days	12.83%	9.68%
Non-State Hospitals—90 Days	20.14%	16.16%
All Hospitals—7 Days	5.22%	3.21%
All Hospitals—30 Days	13.92%	9.30%
All Hospitals—90 Days	21.52%	15.52%
Hospital Readmissions Within 180 Days (All Facilities)*		
Hospital Readmissions Within 180 Days (All Facilities)	25.55%	23.53%
Adherence to Antipsychotics for Individuals With Schizophrenia		
Adherence to Antipsychotics for Individuals With Schizophrenia	—	47.58%
Overall Penetration Rates‡		
Overall Penetration Rates	16.46%	14.74%
Penetration Rates by Age Group‡		
Children 12 Years of Age and Younger	6.93%	6.23%
Adolescents 13 Through 17 Years of Age	17.45%	14.70%
Adults 18 Through 64 Years of Age	22.78%	19.80%
Adults 65 Years of Age or Older	10.09%	9.51%
Penetration Rates by Medicaid Eligibility Category‡		
AND/AB-SSI	43.74%	39.68%
BC Children	2.07%	2.43%
BCCP-Women Breast and Cervical Cancer	5.01%	16.03%
Buy-In: Working Adult Disabled	33.78%	35.99%
Foster Care	34.46%	34.59%
OAP-A	9.87%	9.13%
OAP-B-SSI	32.66%	32.59%
MAGI Adults	20.57%	17.82%
Buy-In: Children With Disabilities	15.70%	17.23%
MAGI Parents/Caretakers	16.95%	14.91%
MAGI Children	8.62%	7.52%
MAGI Pregnant	20.60%	19.02%
Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition		
7-Day Follow-Up	—	31.85%
30-Day Follow-Up	—	42.51%

Performance Measure	MY 2014-2015 Rate[1]	MY 2015-2016 Rate[2]
Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence		
7-Day Follow-Up	—	6.38%
30-Day Follow-Up	—	13.25%
Mental Health Engagement‡,3		
Mental Health Engagement	36.93%	35.49%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment‡,3		
Initiation of AOD Treatment	19.37%	35.01%
Engagement of AOD Treatment	13.43%	28.44%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners‡,3		
Non-State Hospitals—7 Days	45.24%	39.48%
Non-State Hospitals—30 Days	61.86%	56.37%
All Hospitals—7 Days	45.24%	39.55%
All Hospitals—30 Days	61.89%	56.97%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only		
Non-State Hospitals—7 Days	—	34.69%
Non-State Hospitals—30 Days	—	51.13%
All Hospitals—7 Days	—	34.41%
All Hospitals—30 Days	—	51.22%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2014–2015 (i.e., July 1, 2014–June 30, 2015).
[2] Indicates that the rates contained within this column represent MY 2015–2016 (i.e., July 1, 2015–June 30, 2016).
** For this measure, a lower rate may indicate more favorable performance.*
‡ The measure had specification changes from MY 2014–2015 to MY 2015–2016, so caution should be exercised when comparing measure rates between MY 2014–2015 and MY 2015–2016.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year.
[3] Indicates that the MY 2014–2015 rate was recalculated after the rate was validated and finalized for FY 2015–2016.

Strengths

As in prior years, ABC-D continued to operate as one of Colorado Access' lines of business; and all Colorado Access 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 hold monthly meetings to address any data-related issues and discuss solutions collaboratively. ABC-D also held monthly internal meetings to discuss incentive measure performance for the BHO Colorado Medicaid Community Mental Health Services Program. Since the prior year, paper claims submissions declined, leaving less room for human error. ABC-D developed a readiness process to receive eligibility files in an 834 file format, which will be implemented when the Department rolls out a new transactional system. In addition, to further ensure accuracy, and as part of its vendor oversight, ABC-D continued to validate claims data previously audited by TriZetto.

ABC-D experienced a significant increase in population size as a result of the Medicaid expansion; therefore, ABC-D's average number of monthly and annual claims processed increased.

From MY 2014–2015 to MY 2015–2016, the following rates demonstrated an improvement in performance by approximately 5 percentage points or more:

- *Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (non-state and all facilities)—All Hospitals—30 Days* and *All Hospitals—90 Days*
- *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment* and *Engagement of AOD Treatment*

Opportunities for Improvement

During the primary source verification process, HSAG raised concerns regarding the process in which numerator cases were identified for the *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure. ABC-D's data file showed that at least one member should have been counted as numerator positive for both the initiation and engagement rates. ABC-D staff members were responsive, investigated the issue, and resubmitted the revised rate prior to generating the final audit report.

From MY 2014–2015 to MY 2015–2016, the following rates demonstrated a decline in performance by approximately 5 percentage points or more:

- *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners—Non-State Hospitals—7 Days, Non-State Hospitals—30 Days, All Hospitals—7 Days,* and *All Hospitals—30 Days*

Recommendations

ABC-D should continue to communicate with the Department and other BHOs to ensure that all have the same understanding regarding reporting requirements. HSAG also suggests that ABC-D consider, when generating its data file, adding additional fields such as actual date of follow-up service—which would provide helpful information to assist in the quality-check process related to possibly missing members that should have been counted in the numerator. HSAG also recommends that ABC-D implement additional verification steps to further ensure data accuracy for measure reporting.

ABC-D is urged to conduct a thorough analysis of the root causes for declines in timely follow-up care for members with mental health conditions and to monitor performance in this area. HSAG suggests that ABC-D investigate causal areas linked to declines in this performance area, identify the most significant areas or populations of focus for which improvement interventions could be planned, and identify strategies and interventions for better outcomes, starting first with the areas for improvements anticipated to provide the highest impact to measure rates.

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

The measures that address the quality domain are *Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (Non-State and All Facilities)* and *Hospital Readmissions Within 180 Days (All Facilities)*. Of these seven reportable rates, six rates showed a slight decrease, with two rates showing a decrease of approximately 5 percentage points or more. For these measures, a lower rate indicates a more favorable performance and fewer hospital readmissions. In light of a significant population increase due to Medicaid expansion, these results indicate a strength for ABC-D related to the quality domain.

For the timeliness domain, ABC-D's performance was mixed. While both the rates for *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* demonstrated increases (i.e., 15 percentage points or more) when compared to the previous measurement year, the four rates for *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners* showed decreases (i.e., approximately 5 percentage points or more), indicating somewhat inconsistent performance and opportunities for improvement in the timeliness domain. Comparison for several rates from the prior measurement year in the timeliness domain (i.e., *Adherence to Antipsychotics for Individuals with Schizophrenia*, *Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition*, *Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence Treatment*, and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*) was not possible, as ABC-D was not required to report these rates during MY 2014–2015.

ABC-D's performance in the access domain also indicated opportunities for improvement. The measures that assessed the timeliness domain also had an impact on the access to care domain, indicating low performance in the access to care domain as well. The other rates assessing access to care (i.e., *Overall Penetration Rates*, *Penetration Rates by Age Group*, and *Penetration Rates by Medicaid Eligibility Category*) demonstrated slight decreases in most rates, except *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer*, which increased by 11.02 percentage points since the prior measurement year.

Validation of Performance Improvement Projects

Findings

Table 4-4 displays the validation results for the ABC-D PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*, validated during FY 2016–2017. This table illustrates the BHO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving *Met* scores have satisfied the necessary technical requirements for specific elements. The validation results presented in Table 4-4 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-4—Performance Improvement Project Validation Results for ABC-D

Stage	Activity		Percentage of Applicable Elements*		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	33% (1/3)	67% (2/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**78% (7/9)**	**22% (2/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**81% (17/21)**	**10% (2/21)**	**10% (2/21)**

**Percentage totals may not equal 100 due to rounding.*

Overall, 81 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Not Met*.

Table 4-5 displays baseline and Remeasurement 1 data for ABC-D's PIP. ABC-D's goal is to increase the percentage of eligible adolescent members who receive a behavioral health follow-up visit within 30 days of a positive depression screening completed by a medical provider.

Table 4-5—Performance Improvement Project Outcomes for ABC-D

PIP 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%	9.4%		*Not Assessed*

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 50.0 percent for the Remeasurement 1 period.

At the first remeasurement, the 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 9.4 percent. The Remeasurement 1 rate represented an increase of 9.4 percentage points from the baseline rate. The Remeasurement 1 results did not meet the Remeasurement 1 goal of 50.0 percent. The improvement from baseline to Remeasurement 1 was not statistically significant ($p = 1.000$).

Strengths

ABC-D designed a methodologically sound project. The sound PIP study design allowed the BHO to progress to baseline data collection and intervention development. The BHO accurately reported and analyzed the baseline study indicator results, completed a causal/barrier analysis, and set a goal for the Remeasurement 1 period. For the baseline causal/barrier analysis process, the BHO involved internal and external stakeholders in identifying and prioritizing barriers to improvement, using quality improvement processes such as interdisciplinary brainstorming, analysis of survey data, and use of a key driver diagram.

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 reported that one new barrier was identified during the Remeasurement 1 period. The health plan addressed 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
- Reduced likelihood of receiving claims for transition of care services from an increasing number of co-located medical and behavioral health providers

To address these barriers, ABC-D 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 current local resources for 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 by the collaborating RCCO in the BHO's services area.
- A provider and community forum providing organizations and stakeholders with information on Health First Colorado behavioral health systems, best practices, and current efforts to integrate care; and a behavioral health panel discussion.

ABC-D reported an increase from baseline to Remeasurement 1 in 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; however, the increase was not statistically significant. Related to the PIP topic, the BHO documented a number of challenges that had impacted the

ability to achieve statistically significant improvement over the baseline. The BHO reported an ongoing concern that the current coding and billing processes related to depression screening and follow-up behavioral health services impeded the identification of some members who successfully completed the transition of care. Specifically, the BHO documented that the statewide promotion of integrated care and co-located physical and behavioral health providers may actually make it more difficult to demonstrate improvement in completion rates for behavioral health follow-up appointments. Co-located providers appear to be conducting the follow-up visit immediately following a positive depression screen; therefore, some visits may occur concurrently and may not be billed for or may be difficult to identify through claims. The BHO reported being committed to continued investigation of barriers related to coding and billing and documented the initiation of more active interventions to improve study indicator outcomes in the subsequent remeasurement period.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Ensure the accuracy of the reported study indicator rates.
- Ensure that the PIP primarily incorporate interventions that actively engage members and/or providers and which are likely to impact the PIP outcomes.
- Explore resources for developing innovative interventions that have the potential to result in fundamental change and sustainable improvement. Following a technical assistance call, HSAG provided the health plan several resources that may assist in generating new ideas for interventions of greater impact.
- 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 quality improvement science techniques such as the Plan-Do-Study-Act (PDSA) model to evaluate and refine its improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation if deemed successful.
- Seek technical assistance from HSAG as needed.

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

As described in Section 2–Introduction, HSAG assigned ABC-D's PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider,* to the domains of quality and timeliness of, and access to, care and services. The goal of the project is to increase, of adolescent members who screened positive for depression with a medical health provider, the percentage that complete follow-up visits with behavioral health providers within 30 days. The PIP has the potential to improve the quality of depression-related care for the BHO's adolescent members, minimize delays in follow-up care for adolescent members who screen positive for depression, and increase access to behavioral healthcare for these members.

For the FY 2016–2017 validation cycle, ABC-D submitted Remeasurement 1 results; however, the Remeasurement 1 results did not demonstrate real improvement in the study indicator outcomes. Additionally, while the PIP was based on a methodologically sound design, errors occurred in the BHO's reporting and interpretation of Remeasurement 1 results. The PIP will be evaluated again during the next PIP validation cycle to determine if appropriate adjustments were made to achieve real improvement related to the three domains of care and services.

Experience of Care and Health Outcomes Surveys

Table 4-6 shows the adult ECHO survey results achieved by ABC-D for FY 2016-2017 and the prior year (FY 2015–2016).

Table 4-6—Adult ECHO Question Summary Rates and Global Proportions for ABC-D

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	45.9%	51.3%
Getting Treatment Quickly	73.5%	62.3%
How Well Clinicians Communicate	88.7%	87.8%
Perceived Improvement	56.0%	56.9%
Information About Treatment Options	60.7%	59.4%
Office Wait	77.2%	77.0%
Told About Medication Side Effects	75.3%	82.1%
Including Family	41.3%	42.0%
Information to Manage Condition	79.6%	80.7%
Patient Rights Information	85.6%	86.0%
Patient Feels He or She Could Refuse Treatment	82.4%	78.9%
Privacy	94.5%	90.0%
Cultural Competency	N/A	N/A
Amount Helped	85.6%	82.8%
Improved Functioning	54.4%	52.6%
Social Connectedness	59.9%	68.9%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Table 4-7 shows the child ECHO survey results achieved by ABC-D for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-7—Child ECHO Question Summary Rates and Global Proportions for ABC-D

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	46.9%	51.5%+
Getting Treatment Quickly	73.8%	75.5%
How Well Clinicians Communicate	92.1%	90.0%
Perceived Improvement	72.7%	74.8%
Information About Treatment Options	75.4%	75.0%
Office Wait	81.8%	77.4%
Told About Medication Side Effects	91.9%+	91.1%+
Information to Manage Condition	79.6%	70.4%+
Patient Rights Information	89.9%	92.9%+
Patient Feels He or She Could Refuse Treatment	82.6%	82.8%+
Privacy	95.1%	98.0%
Cultural Competency	N/A	N/A
Amount Helped	74.3%	80.5%
Improved Functioning	68.0%	66.0%
Social Connectedness	84.7%	91.9%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Strengths

For ABC-D's adult Medicaid population, three measure rates increased substantially: *Rating of All Counseling or Treatment* (5.4 percentage points), *Told About Medication Side Effects* (6.8 percentage points), and *Social Connectedness* (9.0 percentage points). Four of the measures demonstrated slight rate increases (less than 5 percentage points each): *Perceived Improvement, Including Family, Information to Manage Condition,* and *Patient Rights Information.*

For ABC-D's child Medicaid population, two measure rates increased substantially: *Amount Helped* (6.2 percentage points) and *Social Connectedness* (7.2 percentage points). Six of the measure rates demonstrated slight increases (fewer than 5 percentage points each): *Rating of All Counseling or Treatment, Getting Treatment Quickly, Perceived Improvement, Patient Rights Information, Patient Feels He or She Could Refuse Treatment,* and *Privacy.*

Opportunities for Improvement

One ABC-D adult Medicaid population measure rate decreased substantially: *Getting Treatment Quickly* (11.2 percentage points). Seven of the measures showed slight rate decreases (less than 5 percentage points each): *How Well Clinicians Communicate, Information About Treatment Options, Office Wait, Patient Feels He or She Could Refuse Treatment, Privacy, Amount Helped,* and *Improved Functioning.*

One ABC-D child Medicaid population measure rate decreased substantially: *Information to Manage Condition* (9.2 percentage points). Five of the measures showed slight rate decreases (less than 5 percentage points each): *How Well Clinicians Communicate, Information About Treatment Options, Office Wait, Told About Medication Side Effects,* and *Improved Functioning.*

Recommendations

HSAG identified several possible interventions that could be applied by ABC-D as appropriate to the BHO's population and organizational structure. HSAG's recommendations are focused on substantial decreases in measure rates for either the adult or child population and on any slight decreases in rates for measures common to both the adult and child populations.

For ABC-D's adult Medicaid population and related to performance in *Getting Treatment Quickly,* HSAG offers the following observations and recommendations:

- A decrease in rates for *Getting Treatment Quickly* could be an indicator of (a) decreasing capacity in the network compared to overall demand for services; (b) provider's lack of familiarity or compliance with appointment access standards; or (c) issues in the scheduling systems of providers.
  - To address *network capacity*, BHOs could work more closely with providers to conduct a detailed assessment of its provider network, considering the total number of practitioners, locations, provider workloads, and available capacity for members within the network. BHOs might also work with providers to expand the array of practitioners or therapeutic service alternatives available to members to diminish the demand for individual therapies, when appropriate to members' needs. Such alternatives might include expanding: access to behavioral health providers in primary care offices, community-based programs, and treatment modalities integrated with the CMHCs, group therapies, and support groups. ABC-D and its network providers might also consider increasing telephonic or other technology-based communications with some members to provide intermittent interventions when needed to decrease the need for formal appointments with providers, and exploring expanded use of walk-in clinics and services.
  - To address *appointment access standards*, ABC-D could conduct a provider communications campaign to alert providers to the findings of the ECHO survey, re-educate providers on access standards for Medicaid members, seek input from providers and members on possible solutions, and establish a more intensive monitoring mechanism to identify particular sources of member access issues or member dissatisfaction with access to appointments.
  - To address *scheduling issues*, ABC-D could apply practice support staff to evaluate each major provider's scheduling mechanisms and systems and implement improvements as needed. This

might also include training schedulers to assess the urgency of an appointment request and providing schedulers with information to direct members to alternative sources of service when appropriate.

For ABC-D's child Medicaid population and related to performance in the *Information to Manage Condition* measure, HSAG offers the following observations and recommendations:

- ABC-D should work with providers to determine and provide condition-specific written information to members and families of members, consider implementing a call-in advice line for members and families, and support implementation of a self-management plan with individual members. In addition, providers should be encouraged to link members with complex needs each to a BHO, other agency, or provider care manager to provide interim and ongoing information and support.

For both ABC-D's adult and child Medicaid populations and related to performance in *How Well Clinicians Communicate, Information About Treatment Options, Office Wait,* and *Improved Functioning,* HSAG offers the following observations and recommendations:

- The *How Well Clinicians Communicate* measure could be impacted by many variables, including cultural competency, a clinician's communication style, time factors influencing the length of engagement with the member, or a member's willingness to engage. Considering verbal, written, phone, electronic, telehealth, or other options for communication, providers should query members regarding their communication preferences. ABC-D might consider provider training forums or developing procedures that encourage providers to ensure that members *understand* communications, explore creative mechanisms for member engagement, provide an option for an alternative clinician when there appears to be clinician/member disconnect, or offer auxiliary communication aides when necessary. Providers might also increase follow-up contacts—phone or electronic—and outreach efforts to some members to ensure understanding. Peer support staff could be assigned to provide like-minded or similar cultural or condition support to members. Clinicians might also consider assigning a care manager to conduct ongoing follow-up with individual members, answer questions, or act as a liaison between the clinician and the member. Member perceptions regarding how well clinicians communicate may also be influenced by how well the member's clinician communicates with other providers involved in the member's care. To that end, ABC-D and its providers might evaluate mechanisms for internal flow of communications among providers, ensure that adequate clinical information is accessible by multiple providers, and ensure that the member has a consistent treating clinician.
- For *Information About Treatment Options,* HSAG notes that this element is a factor in shared decision making with individual members regarding personal treatment choices and is a required member right for Medicaid members. Appropriate to the member's condition, treatment planning with the member should include the types of treatment alternatives available. Providers should ensure that member's alternatives are discussed, and that member choices are respected and included in the individual treatment plan. In addition, ABC-D could supplement individual provider communications about treatment options through other member information sources such as web-based general information about treatment alternatives offered in the network or in the community, printed materials for distribution at the point of service, care manager interactions, or trained

customer service staff. ABC-D should work with providers to reinforce the need for providing members with information about appropriate treatment options and develop a collaborative plan for improving this measure.

- *Office Wait* may also be an indicator of the need to evaluate and improve scheduling mechanisms related to patient flow, scheduling intervals, and any "bottlenecks" in the system. ABC-D might consider prioritizing members or employing phone consultations or use of other telecommunications as additional mechanisms to address office wait times. Office procedures should include acknowledging and explaining to individual members any delays that occur.
- The *Improved Functioning* measure is a possible quality outcome indicator considered from the member's perspective, and may indicate the need for quality improvement initiatives by a provider. HSAG recommends that providers develop interim short-term goals with individual members as a mechanism to facilitate the members' perceptions of progress toward those goals and to review or revise those goals with the member at appropriate intervals. ABC-D should consider implementing ongoing measures to monitor members' perceptions of functional improvement, possibly through an exit interview when discontinuing treatment or through interim assessments with members in long-term treatment. If concerning trends are identified, ABC-D should work with providers and members to identify more detailed potential causes and implement performance improvement initiatives, as indicated. When identified decreases in ratings are related to the child population, these measures might indicate the need for the BHO to evaluate the adequacy or expertise within the network to address child behavioral health issues. If indicated, the BHO might consider increasing provider training forums, increasing telehealth links to child behavioral health specialists, or directing members to targeted child behavioral health resources.

ABC-D: Summary Assessment of Quality, Timeliness, and Access for ECHO

For ABC-D's adult population, of the 14 measures evaluated for the quality domain, three measure rates were substantially higher than the previous year and four additional measure rates demonstrated slight increases when compared to the previous year. One measure rate decreased substantially from the previous year, while seven additional measure rates showed slight decreases when compared to the previous year. Overall results for the quality domain were mixed, and improvements needed can be identified.

For ABC-D's child Medicaid population, of the 13 measures evaluated for the quality domain, two measures demonstrated substantially higher rates than the previous year and six additional measure rates demonstrated slight increases when compared to the previous year. One measure showed a substantial decrease in rates from the previous year, and five measures showed slight decreases when compared to the previous year. Similar to the adult population findings, overall results for the quality domain were mixed and improvements needed can be identified.

For the two measures that assessed timeliness—*Getting Treatment Quickly* and *Office Wait*—one measure rate substantially decreased and one measure rate slightly decreased for the ABC-D's adult Medicaid population, while one measure increased slightly and one measure decreased slightly for the child Medicaid population. Overall results for the timeliness domain indicated improvements needed.

For the four measures evaluated for the access domain (*Information About Treatment Options*, *Office Wait*, *Information to Manage Condition*, and *Improved Functioning*), Access Behavioral Health—Denver's rates for adult Medicaid members slightly decreased for three of the measures and slightly increased for one the measures when compared to the previous year. For ABC-D's child population, the rate substantially decreased for one measure and slightly decreased for the additional three measures compared to the previous year. Most access domain measures were trending downward, indicating need for improvements related to the timeliness domain.

Access Behavioral Care—Northeast

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-8 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 2016–2017.

Table 4-8—Summary of ABC-NE Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	31	31	26	5	0	0	84%
II—Access and Availability	10	10	10	0	0	0	100%
XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Not Scored						
Totals	**41**	**41**	**36**	**5**	**0**	**0**	**88%**

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

Table 4-9 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 2016–2017.

Table 4-9—Summary of ABC-NE Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	58	54	4	42	93%
Totals	**100**	**58**	**54**	**4**	**42**	**93%**

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

Strengths

The policies and procedures for ABC-D and ABC-NE are applicable to both lines of business; therefore, findings for the on-site review are generally consistent between ABC-D and ABC-NE.

ABC-NE had policies and procedures related to UM processes and emergency services that addressed most requirements. ABC-NE used InterQual criteria to screen requests for medical necessity and simultaneously applied a list of BHO-covered diagnoses/benefits to the clinical information contained in the member's record. UM reviewers referred all questionable cases to a clinically qualified medical director for final determination. ABC-NE ensured consistent application of review criteria by UM staff

and medical directors through interrater reliability audits. ABC-NE's authorization and notification processes were highly efficient, with many decisions—whether urgent or standard requests—made within one to three days of receipt of request for services. All NOA letters included the reason for the decision and offered treatment alternatives recommended by the medical director. Policies and procedures, the provider manual, and the member handbook accurately defined "emergency medical condition," including reference to the prudent layperson definition. Policies and procedures and the member handbook stated that ABC-NE pays emergency claims—in or out of network—without prior authorization, and the member handbook informed members that they are never liable for payment of emergency services.

ABC-NE generated quarterly network adequacy reports that delineated the numbers, types, and physical locations of contracted providers as well as areas of cultural specialty and languages spoken and compared this data to the utilization patterns and physical locations of its members. ABC-NE reviewed this information along with member grievances, provider appointment availability, results of ECHO surveys, and expected Medicaid enrollment and use of services. ABC-NE notified providers about its expectations related to hours of operation and appointment availability standards using new provider orientation, the provider manual, the provider website, and periodic mailings. ABC-NE required that largest-volume providers submit regular access-to-care reports and monitored smaller-volume providers using secret shopper calls. ABC-NE had a cultural competency plan that delineated goals for ensuring the provision of culturally and linguistically appropriate services. ABC-NE required that staff members participate in annual cultural competency training and offered training to all contracted providers.

Colorado Access defined an EPSDT strategic plan for implementing comprehensive EPSDT requirements organization-wide, incorporating both BHOs and the two corresponding RCCOs. Various components of the EPSDT strategic plan were to be implemented throughout the 2017 calendar year. ABC-NE had clearly outlined procedures for providing BHO care coordination to assist members with access to EPSDT services not covered by the BHO, including coordinating with community agencies and programs, arranging transportation, coordinating wraparound benefits, and coordinating with Healthy Communities. At the time of on-site review, care coordination for members needing services not covered by the BHO was the most well-developed aspect of ABC-NE's EPSDT program. Colorado Access had been working closely with the Department to address all EPSDT requirements.

Opportunities for Improvement and Recommendations

Based on findings from the site review activities, ABC-NE was required to submit a corrective action plan to ensure that it addressed any areas where ABC-NE earned *Partially Met* or *Not Met* scores.

To address findings in the Coverage and Authorization of Services standard, ABC-NE was required to develop a mechanism to ensure that the BHO provides members written notice of any decision to deny a service authorization request within the required time frames and to ensure that information in the NOA letter is member-specific and written in language that ensures ease of understanding. ABC-NE was also required to develop a process to ensure that members are not held responsible for poststabilization services or required to appeal these charges to alert the BHO that an out-of-network hospitalization was, in fact, a poststabilization admission following emergency services. In addition, ABC-D was also

required to revise policies and procedures to reflect the mechanism to proactively discover the provision of poststabilization services and ensure claims payment. Related to one untimely extension letter, HSAG recommended that ABC-D avoid noncompliance with meeting authorization time frames by implementing the extension process sooner.

HSAG made several recommendations related to ABC-NE's implementation of EPSDT requirements, including: expediting implementation of Colorado Access' EPSDT strategic plan, enhancing the medical record audit tool used to monitor provider documentation related to EPSDT requirements, identifying additional mechanisms for systematic EPSDT communications with network providers, enhancing member communications regarding EPSDT services at the member point of service, and clarifying that providers should share member PHI with Healthy Communities.

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

ABC-NE demonstrated strong performance in the quality domain. ABC-NE used InterQual criteria to determine medical necessity and a list of covered diagnoses when reviewing authorization requests. Staff members with clinically appropriate expertise followed written processes to ensure consistent application of the review criteria. HSAG found evidence that ABC-NE offered providers peer-to-peer consultations prior to issuing service denials. Record reviews demonstrated that ABC-NE was 100 percent compliant with ensuring that its authorization decisions were based on established criteria and made by qualified providers, and that it wrote most NOAs using easy-to-understand language. In addition to explaining the reason for the denial, ABC-NE included alternative treatment options that should be considered.

While in one case reviewed on-site ABC-NE had not sent the NOA within the required time frame, ABC-NE demonstrated effective procedures for processing requests for services member notification—both expedited and standard—within three days of receipt of the request.

ABC-NE also demonstrated strong performance in the access domain. ABC-NE demonstrated that it had a sufficient number of providers to ensure its members access to covered services. ABC-NE continued recruitment efforts for psychiatrists, providers specializing in substance use disorders, intensive home-based treatment, and providers fluent in non-English languages. ABC-NE implemented single case agreements when needed to ensure adequate access.

Validation of Performance Measures

System and Reporting Capabilities

HSAG identified no issues or concerns with the ways in which ABC-NE received and processed enrollment data. Colorado Access continued to obtain monthly eligibility full and daily change/update files from the Department in a flat file format via a secure FTP site. 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, operated by TriZetto. QNXT transformed eligibility information from flat file to 834 file format. Next, 834 files were provided to ABC-NE's CMHCs. Providers continued to have the ability 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.

HSAG identified no issues or concerns with how ABC-NE received, processed, or reported claims and encounter data. No major changes were noted in the ways that ABC-NE received, processed, validated, and transferred claims/encounter data from the prior year. QNXT remained the claims processing system. As in prior years, providers continued to submit claims electronically or on paper. 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 in QNXT, they were converted into the 837 file format using OCR software. The affiliated CMHCs submitted encounter data via the FTP site. These files were 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 the FTP and loaded all data into the data warehouse.

ABC-NE submitted 837 encounter files and flat files to the Department via FTP site monthly. An adequate validation process was in place to ensure data accuracy. ABC-NE had sufficient oversight of its processing vendor, TriZetto. Monthly meetings were held to address any data issues and collaboratively discuss solutions.

ABC-NE had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy.

ABC-NE 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. Claims and encounters were extracted from QNXT and loaded into an ODS database for rate calculation. Query language was applied to the data in ODS to identify each indicator's denominator and numerator cases. Several verification processes were in place to ensure data accuracy for measure reporting.

Measure Results

Table 4-10 shows the MY 2014–2015 measure results for ABC-NE.

Table 4-10—Measure Results for ABC-NE

Performance Measure	MY 2014–2015 Rate[1]	MY 2015–2016 Rate[2]
Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (Non-State and All Facilities)*		
Non-State Hospitals—7 Days	1.93%	1.86%
Non-State Hospitals—30 Days	6.63%	6.04%
Non-State Hospitals—90 Days	11.46%	11.15%
All Hospitals—7 Days	1.91%	1.85%
All Hospitals—30 Days	6.57%	6.01%
All Hospitals—90 Days	11.35%	11.09%
Hospital Readmissions Within 180 Days (All Facilities)*		
Hospital Readmissions Within 180 Days (All Facilities)	13.26%	16.48%
Adherence to Antipsychotics for Individuals With Schizophrenia		
Adherence to Antipsychotics for Individuals With Schizophrenia	—	56.06%
Overall Penetration Rates‡		
Overall Penetration Rates	13.77%	14.02%
Penetration Rates by Age Group‡		
Children 12 Years of Age and Younger	7.64%	7.41%
Adolescents 13 Through 17 Years of Age	18.64%	18.34%
Adults 18 Through 64 Years of Age	17.46%	17.66%
Adults 65 Years of Age or Older	6.64%	7.57%
Penetration Rates by Medicaid Eligibility Category‡		
AND/AB-SSI	33.11%	33.87%
BC Children	2.05%	2.45%
BCCP-Women Breast and Cervical Cancer	0.00%	27.93%
Buy-In: Working Adult Disabled	24.93%	26.35%
Foster Care	29.51%	29.27%
OAP-A	6.70%	7.52%
OAP-B-SSI	23.42%	23.62%
MAGI Adults	15.88%	16.12%
Buy-In: Children With Disabilities	14.53%	27.92%
MAGI Parents/Caretakers	14.36%	15.21%
MAGI Children	9.63%	9.51%
MAGI Pregnant	16.08%	15.95%

Performance Measure	MY 2014–2015 Rate[1]	MY 2015–2016 Rate[2]
Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition		
7-Day Follow-Up	—	23.19%
30-Day Follow Up	—	33.77%
Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence		
7-Day Follow-Up	—	8.80%
30-Day Follow-Up	—	16.08%
Mental Health Engagement‡,3		
Mental Health Engagement	41.90%	42.71%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment‡,3		
Initiation of AOD Treatment	48.59%	46.78%
Engagement of AOD Treatment	33.03%	34.44%
Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners‡,3		
Non-State Hospitals—7 Days	38.16%	36.21%
Non-State Hospitals—30 Days	57.11%	54.21%
All Hospitals—7 Days	38.16%	36.11%
All Hospitals—30 Days	57.11%	53.94%
Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only		
Non-State Hospitals—7 Days	—	24.80%
Non-State Hospitals—30 Days	—	42.22%
All Hospitals—7 Days	—	24.91%
All Hospitals—30 Days	—	42.46%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2014–2015 (i.e., July 1, 2014–June 30, 2015).
[2] Indicates that the rates contained within this column represent MY 2015–2016 (i.e., July 1, 2015–June 30, 2016).
** For this measure, a lower rate may indicate more favorable performance.*
‡ The measure had specification changes from MY 2014–2015 to MY 2015–2016, so caution should be exercised when comparing measure rates between MY 2014–2015 and MY 2015–2016.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year.
[3] Indicates that the MY 2014–2015 rate was recalculated after the rate was validated and finalized for FY 2015–2016.

Strengths

As in prior years, ABC-NE continued to operate as one of Colorado Access' lines of business, and Colorado Access' staff members had extensive experience and knowledge of processes related to behavioral health measures and their reporting requirements. ABC-NE and the Department continued to convene monthly meetings to address any data-related issues and discuss solutions collaboratively. ABC-NE also held monthly internal meetings to discuss incentive measure performance for the BHO Colorado Medicaid Community Mental Health Services Program. Since the prior year, paper claims submissions declined, leaving less room for human error. ABC-NE developed a readiness process to receive eligibility files in an 834 file format, which will be implemented when the Department rolls out a

new transactional system. In addition, to further ensure accuracy, and as part of its vendor oversight, ABC-NE continued to validate claims data previously audited by TriZetto.

ABC-NE experienced a significant increase in population size as a result of the Medicaid expansion; therefore, ABC-NE's average number of monthly and annual claims processed increased.

From MY 2014–2015 to MY 2015–2016, the following measures demonstrated an improvement in performance by 5 percentage points or more, indicating areas of strength for ABC-NE:

- *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer* and *Buy-In: Children With Disabilities*

Opportunities for Improvement

From MY 2014–2015 to MY 2015–2016, no ABC-NE rates declined by 5 percentage points or more, suggesting stable performance from the prior year.

Recommendations

ABC-NE should continue to communicate with the Department and other BHOs to ensure that all have the same understanding regarding reporting requirements. HSAG also suggests that ABC-NE, when generating its data file, consider adding additional fields such as actual date of follow-up service—which would provide helpful information to assist in the quality-check process.

During the primary source verification process, HSAG discovered that the MY 2014–2015 and MY 2015–2016 rates for the *Mental Health Engagement* measure included several cases that should have been excluded due to members not meeting the negative diagnosis history requirement. ABC-NE staff members were responsive, investigated the issue, and resubmitted a revised rate prior to generating this report. ABC-NE should implement additional verification steps to further ensure data accuracy for the next reporting period.

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

The measures that address the quality domain are *Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (Non-State and All Facilities)* and *Hospital Readmissions Within 180 Days (All Facilities)*. With the exception of the *Hospital Readmissions Within 180 Days (All Facilities)* rate showing a slight increase when compared to the previous measurement year, ABC-NE's rates related to the quality domain remained stable (i.e., less than 1 percentage point change when compared to the previous measurement year). For these measures, a lower rate indicates a more favorable performance and fewer hospital readmissions. In light of a significant population increase due to Medicaid expansion, these results indicate a strength for ABC-NE related to the quality domain.

For the timeliness domain, ABC-NE's performance remained stable from the prior measurement year. Rates for *Mental Health Engagement, Initiation and Engagement of Alcohol and Other Drug*

Dependence, and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners* varied slightly, with five of the eight rates decreasing by approximately 3 percentage points or less. No comparisons for several rates from the prior measurement year in the timeliness domain (i.e., *Adherence to Antipsychotics for Individuals With Schizophrenia*; *Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition; Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence Treatment;* and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*) were possible, as ABC-NE was not required to report these rates during MY 2014–2015.

The measures that assessed the timeliness domain also had an impact on the access to care domain. The other measures that assess the access to care domain (i.e., *Overall Penetration Rates, Penetration Rates by Age Group,* and *Penetration Rates by Medicaid Eligibility Category*) demonstrated stable performance, with 15 rates demonstrating approximately a 1 percentage point change from the previous measurement year. Notable exceptions were the *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer* and the *Penetration Rates by Medicaid Eligibility Category—Buy-In: Children With Disabilities* rates, as these demonstrated an increase of 25 and 10 percentage points or more, respectively, indicating improvement in these rates.

Validation of Performance Improvement Projects

Findings

Table 4-11 displays the validation results for the ABC-NE PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider,* validated during FY 2016–2017. This table illustrates the BHO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met,* or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for specific elements. The validation results presented in Table 4-11 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with the BHO completing Activities I through VIII.

Table 4-11—Performance Improvement Project Validation Results for ABC-NE

Stage	Activity		Percentage of Applicable Elements*		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate 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 Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
	X.	Sustained Improvement Achieved	*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)**

** Percentage totals may not equal 100 due to rounding.*

Overall, 100 percent of all applicable evaluation elements validated each received a score of *Met*. HSAG assigned the PIP an overall validation status of *Met*.

Table 4-12 displays baseline data for ABC-NE's PIP. The BHO repeated the baseline measurement period in calendar year (CY) 2015 because it was unable to calculate a baseline rate in 2014.

Table 4-12—Performance Improvement Project Outcomes for ABC-NE

PIP Study Indicator	Baseline Period[1] (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.	0.0%			

[1]*The BHO was unable to report a baseline study indicator result using data from 2014; therefore, the baseline period was shifted to CY 2015.*

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 0.0 percent. The BHO set a goal of 15.0 percent for the Remeasurement 1 period.

Strengths

ABC-NE designed a methodologically sound project. The sound PIP study design allowed the BHO to progress to the Implementation stage of the PIP process. The BHO reported calendar year (CY) 2015 baseline study indicator results for the current validation cycle because a baseline rate for CY 2014 could not be calculated with a denominator of zero. The BHO continued causal/barrier analysis during the updated baseline measurement period, which included discussions and brainstorming by key stakeholders. The BHO and other stakeholders revisited and updated the key driver diagram and barrier prioritization tool based on ongoing causal/barrier analyses conducted during CY 2015. The outcomes of the ABC-NE PIP will be evaluated during the next validation cycle, when the BHO reports results of the first remeasurement.

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 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
- Reduced likelihood of receiving claims for transition of care services from an increasing number of co-located medical and behavioral health providers

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 current local resources for 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 members 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 by the collaborating RCCO in the BHO's service area.
- A provider and community forum providing organizations and stakeholders with information on Health First Colorado 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 screenings 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 can incorporate supplemental data analysis into the narrative interpretation of its 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 quality improvement science techniques 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.
- Seek technical assistance from HSAG as needed.

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

As described in Section 2–Introduction, HSAG assigned ABC-NE's PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*, to the domains of quality and timeliness of, and access to, care and services. The goal of the project is to increase, of adolescent members who screened positive for depression with a medical health provider, the percentage that complete follow-up visits with behavioral health providers within 30 days. The PIP has the potential to improve the quality of depression-related care for the BHO's adolescent members, minimize delays in follow-up care for adolescent members who screen positive for depression, and increase access to behavioral healthcare for these members.

For the FY 2016–2017 validation cycle, ABC-NE submitted baseline study indicator results. ABC-NE designed a scientifically sound project supported by the use of key research principles and used appropriate improvement processes for the baseline measurement period. The BHO's quality improvement activities and Remeasurement 1 outcomes will be validated during the next PIP validation cycle, when HSAG will evaluate whether the PIP has demonstrated real improvement related to the three domains of care and services.

Experience of Care and Health Outcomes Surveys

Table 4-13 shows the adult ECHO survey results achieved by ABC-NE for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-13—Adult ECHO Question Summary Rates and Global Proportions for ABC-NE

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	49.4%	55.6%
Getting Treatment Quickly	68.8%	69.8%
How Well Clinicians Communicate	90.2%	88.9%
Perceived Improvement	61.5%	63.4%
Information About Treatment Options	64.2%	54.1%
Office Wait	82.5%	83.1%
Told About Medication Side Effects	79.5%	73.2%
Including Family	48.2%	49.7%
Information to Manage Condition	76.5%	78.8%
Patient Rights Information	89.8%	85.6%
Patient Feels He or She Could Refuse Treatment	81.9%	78.6%
Privacy	92.3%	94.5%
Cultural Competency	N/A	N/A

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Amount Helped	84.8%	84.2%
Improved Functioning	54.0%	57.9%
Social Connectedness	69.0%	64.7%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Table 4-14 shows the child ECHO survey results achieved by ABC-NE for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-14—Child ECHO Question Summary Rates and Global Proportions for ABC-NE

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	43.4%	41.5%
Getting Treatment Quickly	70.5%	66.3%
How Well Clinicians Communicate	87.2%	85.5%
Perceived Improvement	71.6%	74.9%
Information About Treatment Options	73.0%	74.4%
Office Wait	85.2%	80.2%
Told About Medication Side Effects	83.7%+	80.8%+
Information to Manage Condition	71.0%	69.7%
Patient Rights Information	93.1%	87.9%
Patient Feels He or She Could Refuse Treatment	87.7%	87.9%
Privacy	95.9%	98.4%
Cultural Competency	N/A	N/A
Amount Helped	77.5%	78.3%
Improved Functioning	63.9%	65.5%
Social Connectedness	79.7%	89.2%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Strengths

For ABC-NE's adult Medicaid population, one measure rate increased substantially, *Rating of All Counseling or Treatment* (6.2 percentage points). Seven measure rates demonstrated slight increases (less than 5 percentage points each): *Getting Treatment Quickly, Perceived Improvement, Office Wait, Including Family, Information to Manage Condition, Privacy,* and *Improved Functioning.*

For ABC-NE's child Medicaid population, one measure rate increased substantially, *Social Connectedness* (9.5 percentage points). Six measure rates demonstrated slight increases (less than 5 percentage points each): *Perceived Improvement, Information About Treatment Options, Patient Feels He or She Could Refuse Treatment, Privacy, Amount Helped,* and *Improved Functioning.*

Opportunities for Improvement

Two ABC-NE adult Medicaid population measure rates decreased substantially: *Information About Treatment Options* (10.1 percentage points) and *Told About Medication Side Effects* (6.3 percentage points). Five measures showed slight rate decreases (decreases less than 5 percentage points): *How Well Clinicians Communicate, Patient Rights Information, Patient Feels He or She Could Refuse Treatment, Amount Helped,* and *Social Connectedness.*

Two ABC-NE child Medicaid population measure rates decreased substantially: *Office Wait* (5.0 percentage points) and *Patient Rights Information* (5.2 percentage points). Five measures showed slight rate decreases (decreases less than 5 percentage points): *Rating of All Counseling or Treatment, Getting Treatment Quickly, How Well Clinicians Communicate, Told About Medication Side Effects,* and *Information to Manage Condition.*

Recommendations

HSAG identified several possible interventions that could be applied by ABC-NE as appropriate to the BHO's population and organizational structure. HSAG recommendations focused on substantial decreases in measure rates for either the adult or child population and on any slight decreases in rates for measures common to both the adult and child populations.

For ABC-NE's adult Medicaid population and related to performance in *Information About Treatment Options* and *Told About Medication Side Effects,* HSAG offers the following observations and recommendations:

- For *Information About Treatment Options,* HSAG notes that this element is a factor in shared decision making with individual members regarding personal treatment choices and is a federally required member right for Medicaid members. Appropriate to the member's condition, treatment planning with the member should include the types of treatment alternatives available. Providers should ensure that a member's alternatives are discussed and that member choices are respected and included in the individual treatment plan. In addition, ABC-NE could supplement individual provider communications about treatment options through other member information sources such as web-based general information about treatment alternatives offered in the network or in the

community, printed materials for distribution at the point of service, care manager interactions, or trained customer service staff. ABC-NE should work with providers to reinforce the need for providing members with information about appropriate treatment options and develop a collaborative plan for improving rates for this measure.

- For the *Told About Medication Side Effects* measure, providers should be encouraged to review with members and families of members any possible side effects of newly prescribed medications, including any potential interactions with other medications that the member may be receiving. Members should be queried about any perceived side effects at the time of interval appointments with the provider. While written "hand-out" information for common behavioral health medications is encouraged, HSAG cautions that the information must be written in easy-to-understand language and that packaging inserts for pharmaceutical products would not meet this requirement.

For ABC-NE's child Medicaid population and related to performance in the *Office Wait* and *Patient Rights Information* measures, HSAG offers the following observations and recommendations:

- *Office Wait* may also be an indicator of the need to evaluate and improve scheduling mechanisms related to patient flow, scheduling intervals, and any "bottlenecks" in the system. ABC-NE might consider prioritizing children or employing phone consultations or use of other telecommunications as additional mechanisms to address office wait times. Office procedures should include acknowledging and explaining to individual members any delays that occur.
- For the *Patient Rights Information* measure, providers should be encouraged to employ a routine mechanism to distribute to members' families patient rights information beyond the member rights information printed in the member handbook. Providers might consider documenting family acknowledgement of receipt and understanding of the patient's rights. Practitioners and staff must also observe and protect patient rights when serving members; therefore, ABC-NE might consider encouraging family members to use the grievance process if they state feeling that any member rights have not been respected.

ABC-NE: Summary Assessment of Quality, Timeliness, and Access for ECHO

For ABC-NE's adult population, of the 14 measures evaluated for the quality domain, one measure rate was substantially higher than the previous year and six additional measures demonstrated slight increases when compared to the previous year. Two measure rates decreased substantially from the previous year, while five additional measure rates showed slight decreases when compared to the previous year. Overall results for the quality domain were mixed, and improvements needed can be identified.

For ABC-NE's child Medicaid population, of the 13 measures evaluated for the quality domain, one measure demonstrated a substantially higher rate than the previous year and six additional measures demonstrated slight increases when compared to the previous year. One measure rate showed a substantial decrease from the previous year, and five measure rates showed slight decreases when compared to the previous year. Similar to findings for the adult population, overall results for the quality domain were mixed and improvements needed can be identified.

For the two measures that assessed timeliness—*Getting Treatment Quickly* and *Office Wait*— rates increased slightly for ABC-NE's adult Medicaid population; while one rate substantially decreased, and one rate demonstrated a slight decrease for the child Medicaid population compared to the previous year. Overall results for the timeliness domain were mixed but indicated a downward trend for the child population, and improvements needed can be identified.

For the four measures evaluated for the access domain, Access Behavioral Health—Northeast's rates for adult Medicaid members slightly increased for three measures and substantially decreased for one measure when compared to the previous year. For ABC-NE's child population, the rates increased slightly for two measures while demonstrating a substantial decrease for one measure and a slight decrease for one measure. Overall results for the access domain were mixed and improvements needed can be identified.

Behavioral Healthcare, Inc.

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-15 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 2016–2017.

Table 4-15—Summary of BHI Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	31	31	27	4	0	0	87%
II—Access and Availability	10	10	10	0	0	0	100%
XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Not Scored						
Totals	**41**	**41**	**37**	**4**	**0**	**0**	**90%**

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

Table 4-16 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 2016–2017.

Table 4-16—Summary of BHI Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	65	61	4	35	94%
Totals	**100**	**65**	**61**	**4**	**35**	**94%**

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

Strengths

BHI UM policies and procedures stated that BHI based authorizations on a determination of medical necessity using established criteria and/or confirmation of a BHO-covered diagnosis or benefit. UM decision makers considered clinical judgement, recent evaluations, treating provider's recommendations, and member's response to prior treatments. BHI referred all decisions to deny authorization to a licensed behavioral health clinician overseen by BHI's chief medical officer, a board-certified psychiatrist. UM staff consulted with the requesting provider as needed to obtain more information appropriate to

authorization decisions and offered peer-to-peer consultation to providers who disagreed with the UM Department's decisions. BHI conducted interrater reliability assessments at least annually and team interrater reliability huddle sessions, case studies, and review of alternative treatment recommendations to improve consistency in decisions among the team weekly. Policies and procedures addressed time frames for making authorization decisions per requirements. BHI monitored timeliness of authorization decisions through internal audits monthly and annually. BHI sent a written NOA to the member and provider for each denied service. NOAs included a custom description of the reason for the denial, suggested alternative treatments available, included all required content, and were available in English and Spanish or other languages upon request. Policies and procedures, the provider manual, and the member handbook accurately defined "emergency medical condition" and included reference to the prudent layperson definition. Policies and procedures and the member handbook stated that BHI pays emergency claims without prior authorization—in or out of network—and the member handbook informed members that they are never liable for payment of emergency services or post-stabilization services. The Emergency and Post-Stabilization Services policy included all requirements for provision and payment for emergency and post-stabilization services as outlined in the requirements.

BHI's Network Adequacy policy described the mechanisms that BHI used to measure the adequacy of its network and stated that BHI would consider anticipated enrollment, expected use of services, geographic locations of providers and members, numbers of single case agreements, member surveys, and grievances related to access and availability. Staff members reported that while BHI is confident that its provider network is sufficient to meet the needs of its membership, it maintains an open network and continues to welcome new providers—especially providers specifically requested by members and those who reflect the cultural diversity of its membership. BHI requires that its providers adhere to the appointment standards for emergency, urgent, and routine services and publishes the appointment standards in the provider manual, member handbook, and on its website. BHI requires that its CMHCs submit access-to-care data quarterly, conduct provider site visits that include review of appointment standards, and monitor member grievances regarding access. BHI had a cultural competency plan that outlined goals for ensuring the provision of culturally competent services, and staff members provided evidence of having conducted annual self-assessments that measured progress toward meeting the goals. In addition to annual cultural compliance training required of BHI staff members, BHI hired a consultant in 2016 to provide staff members with an additional, intensive four-hour cultural competency training. BHI offers cultural competency training to all providers and helps sponsor educational sessions—open to providers, members, and the community—offered by the CMHCs.

Policies adequately outlined processes for BHI care coordinators to assist members eligible for EPSDT services with obtaining needed referrals or services. BHI identified a member of its care management staff as an EPSDT specialist. The BHI member handbook described all benefits of EPSDT preventive services and identified Healthy Communities as a resource to assist members with obtaining services. The provider manual stated that providers must refer members who need EPSDT screening to their primary care providers (PCPs). UM policies and procedures incorporated the EPSDT definition of "medical necessity" and criteria for approval of EPSDT services into authorization decisions. Throughout the year, BHI made significant efforts to implement processes to address BHI responsibilities related to EPSDT.

Opportunities for Improvement and Recommendations

Based on findings from the site review activities, BHI was required to submit a corrective action plan to ensure that it addressed any areas where BHI earned *Partially Met* or *Not Met* scores.

Related to the Coverage and Authorization of Services standard, BHI was required to review and revise its UM policies and procedures and the provider manual (1) to ensure that BHI initiates peer-to-peer consultations or requests for additional information prior to issuing an NOA, and (2) to clarify that a peer-to-peer consultation conducted after an NOA has been issued is considered part of the appeal process and must be treated as such. BHI was also required to revise policies and procedures related to extending time frames for service authorization decisions, to ensure that service authorization decisions and notifications are accomplished within the required time frames, and to implement a process to ensure that the information included in the individual member NOA is member-specific and written at an easy-to-understand level.

HSAG made several recommendations related to further BHI's implementation of EPSDT requirements, including: expanding both oral and written mechanisms for communicating information about EPSDT services to members; ensuring that BHI care coordinators are actively involved in coordinating services for members, and not routinely deferring to Healthy Communities; working with the corresponding RCCO to integrate BHO and primary care objectives and resources for delivery of EPSDT services; clarifying and expanding the audit tool for monitoring documentation of EPSDT requirements; more clearly delineating EPSDT services and requirements in the provider manual; consistently including EPSDT referral information in notice of action letters to members; developing effective "systematic" (regular and periodic) communications with network providers regarding the Department's EPSDT requirements; and facilitating provision of periodic health screens.

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

Although BHI's performance in the quality domain was mixed, its policies and procedures described authorization and NOA processes. While the clinical aspects of the process and required clinical expertise were adequately addressed and HSAG found that the elements of the process adequately described in policies and procedures were implemented as written, HSAG also found that the more intricate aspects of time frames (e.g. those related to termination, suspension, or reduction of services and extending service authorization time frames) were not adequately addressed in policies and procedures and not consistently implemented, resulting in several instances of noncompliance.

Related to the timeliness domain, BHI's performance was also mixed. While several policies addressed the utilization review processes and related time frames, related time frames existed across different policies, which could result in staff members misunderstanding the process as a whole. While BHI monitored the timeliness of authorization decisions using monthly and annual audits, the audits were not adequate review for the totality of requirements. HSAG suggested that BHI either consolidate information related to service authorization time frames and for mailing NOAs into one policy or ensure that each policy includes complete and consistent information.

BHI's performance in the access to care domain was strong. BHI had mechanisms used to ensure an adequate network to meet its members' needs. BHI staff members stated that in FY 2016 its network adequacy report indicated a need for additional providers specializing in substance abuse disorders and that, as a result, BHI focused its recruitment efforts toward that need and has contracted with eight additional provider organizations since that time. Staff reported that BHI maintains an open network and continues to welcome new providers—particularly those requested by members and those who reflect the cultural diversity of BHI's membership.

Validation of Performance Measures

System and Reporting Capabilities

HSAG identified no issues or concerns with the ways that BHI received and processed enrollment data. Colorado Access, BHI's administrative services organization (ASO), continued to obtain monthly eligibility full and daily change/update files from the Department in a flat file format via a secure FTP site. 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, the BHI's transactional system operated by TriZetto. QNXT transformed eligibility information from flat file to 834 file format. Next, 834 files were provided to BHI's affiliated CMHCs. Providers continued to have the ability to log into 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, BHI was able to perform real-time eligibility verification via the Department's portal.

HSAG identified no issues or concerns with how BHI received, processed, or reported claims and encounter data. No major changes were noted in the ways that BHI received, processed, validated, or transferred claims/encounter data from the prior year. QNXT remained the claims processing system for BHI. As in prior years, providers continued to submit claims electronically or on paper. 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 in QNXT, they were converted into the 837 file format using OCR software. The affiliated CMHCs submitted encounter data via FTP. These files were loaded into QNXT. Nightly, TriZetto audited 2.5 percent of auto-adjudicated and 5 percent of manually adjudicated claims. To further ensure data accuracy, BHI audited 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 the claims/encounter data, BHI received pharmacy and inpatient data from the Department via FTP and loaded all data into the data warehouse.

BHI submitted 837 encounter files and flat files to the Department via FTP site monthly. BHI had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy. BHI had sufficient oversight of its processing vendor, TriZetto. Monthly meetings were held to address any data 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. Claims and encounters were extracted from QNXT and loaded into an ODS database for rate calculation. Query language was applied to the data in ODS to identify each indicator's denominator and numerator cases. Several verification processes were in place to ensure data accuracy for measure reporting.

Measure Results

Table 4-17 shows the MY 2014–2015 and MY 2015–2016 measure results for BHI.

Table 4-17—Measure Results for BHI

Performance Measure	MY 2014–2015 Rate[1]	MY 2015–2016 Rate[2]
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (Non-State and All Facilities)*		
Non-State Hospitals—7 Days	1.85%	2.20%
Non-State Hospitals—30 Days	6.78%	7.02%
Non-State Hospitals—90 Days	12.08%	12.17%
All Hospitals—7 Days	1.78%	2.32%
All Hospitals—30 Days	6.55%	6.89%
All Hospitals—90 Days	11.88%	12.00%
Hospital Readmissions Within 180 Days (All Facilities)*		
Hospital Readmissions Within 180 Days (All Facilities)	14.76%	18.01%
Adherence to Antipsychotics for Individuals With Schizophrenia		
Adherence to Antipsychotics for Individuals With Schizophrenia	—	59.38%
Overall Penetration Rates‡		
Overall Penetration Rates	12.79%	12.53%
Penetration Rates by Age Group‡		
Children 12 Years of Age and Younger	6.62%	6.70%
Adolescents 13 Through 17 Years of Age	17.23%	17.43%
Adults 18 Through 64 Years of Age	16.94%	15.92%
Adults 65 Years of Age or Older	7.88%	6.35%
Penetration Rates by Medicaid Eligibility Category‡		
AND/AB-SSI	34.03%	32.83%
BC Children	1.43%	1.92%
BCCP-Women Breast and Cervical Cancer	15.01%	14.74%
Buy-In: Working Adult Disabled	27.23%	29.65%
Foster Care	33.98%	31.51%
OAP-A	7.72%	6.21%
OAP-B-SSI	25.57%	23.74%
MAGI Adults	15.07%	14.23%

Performance Measure	MY 2014–2015 Rate[1]	MY 2015–2016 Rate[2]
Buy-In: Children With Disabilities	15.67%	20.85%
MAGI Parents/Caretakers	14.03%	13.76%
MAGI Children	8.34%	8.76%
MAGI Pregnant	14.44%	14.31%
Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition		
7-Day Follow-Up	—	31.73%
30-Day Follow-Up	—	41.51%
Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence		
7-Day Follow-Up	—	9.93%
30-Day Follow-Up	—	17.80%
Mental Health Engagement‡,[3]		
Mental Health Engagement	44.32%	43.33%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment‡,[3]		
Initiation of AOD Treatment	37.55%	46.09%
Engagement of AOD Treatment	26.81%	36.03%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners‡,[3]		
Non-State Hospitals—7 Days	41.77%	41.82%
Non-State Hospitals—30 Days	58.11%	57.14%
All Hospitals—7 Days	42.79%	42.68%
All Hospitals—30 Days	59.44%	57.71%
Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only		
Non-State Hospitals—7 Days	—	32.51%
Non-State Hospitals—30 Days	—	49.48%
All Hospitals—7 Days	—	33.24%
All Hospitals—30 Days	—	50.00%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2014–2015 (i.e., July 1, 2014–June 30, 2015).
[2] Indicates that the rates contained within this column represent MY 2015–2016 (i.e., July 1, 2015–June 30, 2016).
** For this measure, a lower rate may indicate more favorable performance.*
‡ The measure had specification changes from MY 2014–2015 to MY 2015–2016, so caution should be exercised when comparing measure rates between MY 2014–2015 and MY 2015–2016.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year.
[3] Indicates that the MY 2014–2015 rate was recalculated after the rate was validated and finalized for FY 2015–2016.

Strengths

As in prior years, Colorado Access continued as BHI's ASO, and all staff members had extensive experience and knowledge of processes related to behavioral health measures and the reporting requirements. BHI and the Department continued to conduct monthly meetings to address any data-related issues and to discuss solutions collaboratively. BHI also held monthly internal meetings to discuss incentive measure performance for the Health First Colorado's Community Mental Health Services Program. Since the prior year, paper claims submission declined, leaving less room for human error. BHI developed a readiness process to receive eligibility files in an 834 file format, which will be implemented when the Department rolls out the new system. In addition, to further ensure accuracy and as part of its vendor oversight, BHI continued to validate claims data previously audited by TriZetto.

BHI experienced a significant increase in population size as a result of the Medicaid expansion; therefore, BHI's average number of monthly and annual claims processed increased.

From MY 2014–2015 to MY 2015–2016, the following rates demonstrated an improvement in performance by 5 percentage points or more, indicating areas of strength for BHI:

- *Penetration Rates by Medicaid Eligibility Category—Buy-In: Children With Disabilities*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment* and *Engagement of AOD Treatment*

Opportunities for Improvement

From MY 2014–2015 to MY 2015–2016, no BHI rates declined by 5 percentage points or more, suggesting stable performance overall.

Recommendations

BHI should continue to communicate with the Department and other BHOs to ensure that all have the same understanding regarding reporting requirements. HSAG also suggests that BHI, when generating its data file, consider adding additional fields such as actual date of follow-up service—which would provide helpful information to assist in the quality-check process. While BHI experienced few substantial changes in its rates as compared to the previous measurement year, HSAG recommends that BHI analyze key drivers of particular penetration rates and develop strategies based on this analysis.

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

The measures that address the quality domain are *Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (Non-State and All Facilities)* and *Hospital Readmissions Within 180 Days (All Facilities)*. These seven rates for BHI showed a slight increase as compared to the previous measurement year. For these measures, a lower rate indicates a more favorable performance and fewer hospital readmissions. In

light of a significant population increase due to Medicaid expansion, these results indicate a strength for BHI related to the quality domain.

For the timeliness domain, BHI's performance remained relatively stable from the prior measurement year. Rates for *Mental Health Engagement* and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners* varied by less than 2 percentage points. The rates for *Initiation and Engagement of Alcohol and Other Drug Dependence*, however, increased by 5 percentage points or more, demonstrating improvement in this area. Comparison for several rates from the prior measurement year in the timeliness domain (i.e., *Adherence to Antipsychotics for Individuals With Schizophrenia*; *Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition; Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence Treatment;* and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*) was not possible as BHI was not required to report these rates during MY 2014–2015.

The measures that assessed the timeliness domain also had an impact on the access to care domain, indicating stable performance in this domain as well. The other rates that assessed the access to care domain (i.e., *Overall Penetration Rates*, *Penetration Rates by Age Group*, and *Penetration Rates by Medicaid Eligibility Category*) demonstrated stable performance, with 11 rates demonstrating approximately 1 percentage point change from the previous measurement year. One notable exception was the *Penetration Rates by Medicaid Eligibility Category—Buy-In: Children With Disabilities* rate, as this rate increased by 5.18 percentage points.

Validation of Performance Improvement Projects

Findings

Table 4-18 displays the validation results for the BHI PIP validated during FY 2016–2017. This table illustrates the BHO's overall application of the PIP process and achieved success in improving outcomes. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for specific elements. The validation results presented in Table 4-18 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-18—Performance Improvement Project Validation Results for BHI

Stage	Activity		Percentage of Applicable Elements*		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**89% (8/9)**	**11% (1/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**86% (18/21)**	**5% (1/21)**	**10% (2/21)**

**Percentage totals may not equal 100 due to rounding.*

Overall, 86 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Not Met*.

Table 4-19 displays baseline and Remeasurement 1 data for BHI's *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP. BHI's Remeasurement 1 goal was to increase by 5 percentage points the percentage of eligible adolescent members who receive a behavioral health follow-up visit within 30 days of a positive depression screening completed by a medical provider, from 23.7 percent to 28.7 percent.

Table 4-19—Performance Improvement Project Outcomes for BHI

PIP 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%	19.5%		*Not Assessed*

At the first remeasurement, the 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 19.5 percent. The Remeasurement 1 rate represented a decline of 4.2 percentage points from the baseline rate. The Remeasurement 1 results did not meet the revised Remeasurement 1 goal of 28.7 percent.

Strengths

BHI designed a methodologically sound project. The sound PIP study design allowed the BHO to progress to data collection and intervention development. The BHO accurately reported the baseline and Remeasurement 1 study indicator rates; however, statistical testing results comparing the annual measurements were not accurately reported. For the baseline causal/barrier analysis process, the BHO, using quality improvement processes such as interdisciplinary brainstorming, analysis of survey data, and use of a key driver diagram involved internal and external stakeholders in identifying and prioritizing barriers to improvement. The BHO reported that the barriers identified during the baseline measurement period were unchanged during the Remeasurement 1 period; no new barriers were identified.

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 reported that no new barriers were identified during the Remeasurement 1 period. The health plan continued to address 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
- Reduced likelihood of receiving claims for transition of care services from an increasing number of co-located medical and behavioral health providers

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 screenings and 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 current local resources for 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 by the collaborating RCCO in the BHO's services area.
- A provider and community forum providing organizations and stakeholders with information on Health First Colorado behavioral health systems, best practices, and current efforts to integrate care; and a behavioral health panel discussion.
- A presentation to primary care providers that described the e-referral program being developed to allow primary care and medical providers to electronically refer patients for behavioral health services through a secure portal on BHI**'s** website.

BHI reported a decline from baseline to Remeasurement 1 in 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 documented a number of challenges related to the PIP topic that impacted the ability to achieve improvement in the study indicator outcomes. The BHO reported an ongoing concern that the current coding and billing processes related to depression screening and follow-up behavioral health services impeded the identification of some members who successfully completed the transition of care. Specifically, BHI documented that the statewide promotion of integrated care and co-located physical and behavioral health providers may actually make it more difficult to demonstrate improvement in completion rates for behavioral health follow-up appointments. Co-located providers appear to be conducting the follow-up visit immediately following a positive depression screen; therefore, some visits may occur concurrently and may not be billed for or may be difficult to identify through claims. The BHO reported being committed to continued investigation of barriers related to coding and billing, and documented the initiation of more active interventions to improve study indicator outcomes in the subsequent remeasurement period.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Review statistical testing procedures for comparing baseline and remeasurement study indicator results, and ensure that *p* values are reported accurately.
- Ensure that the PIP primarily incorporates interventions that actively engage members and/or providers and which are likely to impact the PIP outcomes.
- Explore resources for developing innovative interventions that have the potential to result in fundamental change and sustainable improvement. Following a technical assistance call, HSAG provided the health plan several resources that may assist in generating new ideas for interventions of greater impact.
- 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 quality improvement science techniques such as the PDSA model to evaluate and refine its improvement strategies. Interventions can be tested on a small scale, evaluated, and then expanded to full implementation if deemed successful.
- Seek technical assistance from HSAG as needed.

BHI: Summary Assessment of Quality, Timeliness, and Access for PIPs

As described in Section 2—Introduction, HSAG assigned BHI's PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*, to the domains of quality and timeliness of, and access to, care and services. The goal of the project is to increase, of adolescent members who screened positive for depression with a medical health provider, the percentage that complete follow-up visits with behavioral health providers within 30 days. The PIP has the potential to improve the quality of

depression-related care for the BHO's adolescent members, minimize delays in follow-up care for adolescent members who screen positive for depression, and increase access to behavioral healthcare for these members.

For the FY 2016–2017 validation cycle**,** BHI submitted Remeasurement 1 study indicator results; however, the Remeasurement 1 results did not demonstrate real improvement in the study indicator outcomes. Additionally, while the PIP was based on a methodologically sound design, errors existed in the BHO's reported Remeasurement 1 statistical testing results. The PIP will be evaluated again during the next PIP validation cycle to determine if appropriate adjustments were made to achieve real improvement related to the three domains of care and services.

Experience of Care and Health Outcomes Surveys

Table 4-20 shows the adult ECHO survey results achieved by BHI for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-20—Adult ECHO Question Summary Rates and Global Proportions for BHI

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	39.9%	47.3%
Getting Treatment Quickly	60.7%	61.1%
How Well Clinicians Communicate	86.4%	86.0%
Perceived Improvement	53.8%	65.6%
Information About Treatment Options	54.6%	63.4%
Office Wait	82.2%	82.5%
Told About Medication Side Effects	71.9%	73.9%
Including Family	45.9%	47.4%
Information to Manage Condition	67.6%	74.3%
Patient Rights Information	85.4%	90.1%
Patient Feels He or She Could Refuse Treatment	83.3%	82.0%
Privacy	92.3%	93.3%
Cultural Competency	N/A	N/A
Amount Helped	80.3%	80.6%
Improved Functioning	51.4%	56.6%
Social Connectedness	67.0%	65.8%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Table 4-21 shows the child ECHO survey results achieved by BHI for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-21—Child ECHO Question Summary Rates and Global Proportions for BHI

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	38.1%	44.1%
Getting Treatment Quickly	64.7%	64.8%
How Well Clinicians Communicate	86.3%	87.1%
Perceived Improvement	67.4%	65.3%
Information About Treatment Options	67.9%	68.7%
Office Wait	86.7%	84.7%
Told About Medication Side Effects	89.9%+	83.9%+
Information to Manage Condition	67.9%	68.8%
Patient Rights Information	91.5%	87.6%
Patient Feels He or She Could Refuse Treatment	89.0%	84.1%
Privacy	93.3%	96.3%
Cultural Competency	N/A	N/A
Amount Helped	76.4%	72.6%
Improved Functioning	60.5%	59.0%
Social Connectedness	86.6%	84.1%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Strengths

For BHI's adult Medicaid population, five measure rates increased substantially: *Rating of All Counseling or Treatment* (7.4 percentage points), *Perceived Improvement* (11.8 percentage points), *Information About Treatment Options* (8.8 percentage points), *Information to Manage Condition* (6.7 percentage points), and *Improved Functioning* (5.2 percentage points). Seven of the measure rates demonstrated slight increases (less than 5 percentage points each): *Getting Treatment Quickly, Office Wait, Told About Medication Side Effects, Including Family, Patient Rights Information, Privacy,* and *Amount Helped*.

For BHI's child Medicaid population, one measure rate increased substantially: *Rating of All Counseling or Treatment* (6.0 percentage points). Five of the measures demonstrated slight increases (less than 5 percentage points each): *Getting Treatment Quickly, How Well Clinicians Communicate, Information About Treatment Options, Information to Manage Condition,* and *Privacy*.

Opportunities for Improvement

No BHI's adult Medicaid population measure rates decreased substantially. Three measures showed slight rate decreases (less than 5 percentage points each) compared to the previous year: *How Well Clinicians Communicate, Patient Feels He or She Could Refuse Treatment,* and *Social Connectedness.*

One of BHI's child Medicaid population measure rates decreased substantially: *Told About Medication Side Effects* (6.0 percentage points). Seven measures showed slight rate decreases (less than 5 percentage points each) compared to the previous year: *Perceived Improvement, Office Wait, Patient Rights Information, Patient Feels He or She Could Refuse Treatment, Amount Helped, Improved Functioning,* and *Social Connectedness.*

Recommendations

HSAG identified several possible interventions that could be applied by BHI as appropriate to the BHO's population and organizational structure. HSAG recommendations focused on substantial decreases in measure rates for either the adult or child population and on any slight decreases in rates for measures common to both the adult and child populations.

BHI's adult Medicaid population experienced no substantial decreases in any measure rates. HSAG encourages BHI to continue initiatives that appear to be positively impacting rates for several adult-related measures.

For BHI's child Medicaid population and related to performance in the *Told About Medication Side Effects* measure, HSAG offers the following observations and recommendations:

- For the *Told About Medication Side-Effects* measure, providers should be encouraged to review with the member's family any possible side effects of newly prescribed medications, including any potential interactions with other medications the member may be receiving. Members and families should be queried about any perceived side effects at the time of interval appointments with the provider. While written "hand-out" information for common behavioral health medications is encouraged, HSAG cautions that the information must be written in easy-to-understand language and that packaging inserts for pharmaceutical products would not meet this requirement.

For both BHI's adult and child Medicaid populations and related to performance in *Patient Feels He or She Could Refuse Treatment,* HSAG offers the following observations and recommendations:

- For the *Patient Feels He or She Could Refuse Treatment* measure, providers should be aware that this may also an element of basic member rights. A patient feeling that he or she may not refuse treatment could be related to communication barriers with the practitioner, member preferred treatment not being available, or member not being allowed to cancel appointments. In order to foster more positive member perceptions or to improve provider communications related to a member's right to refuse treatment, BHI might consider working with providers to implement a mechanism to not only discuss individual treatment options but to also have members acknowledge and agree to the individual treatment plan whenever initiated or altered. If concerns persist, BHI

might consider investigating key drivers related to this measure or discussing with members their reasons for perceiving that they could not refuse treatment, then identifying any detailed patterns for improvement.

BHI: Summary Assessment of Quality, Timeliness, and Access for ECHO

For BHI's adult Medicaid population, of the 14 measures evaluated for the quality domain, five rates were substantially higher than the previous year and six additional measure rates demonstrated slight increases when compared to the previous year. No BHI's adult Medicaid population measure rates decreased substantially, and only three measures showed slight rate decreases from the previous year. Results for BHI's adult population in the quality domain were positive and trending substantially upward overall.

For BHI's child Medicaid population, of the 13 measures evaluated for the quality domain one measure demonstrated a substantially higher rate than the previous year and five additional measures demonstrated slight increases when compared to the previous year. One measure showed a substantial decrease in rates from the previous year, and six measures showed slight decreases when compared to the previous year. Overall results for the child population in the quality domain were mixed and improvements needed can be identified.

For the two measures that assessed timeliness—*Getting Treatment Quickly* and *Office Wait*—both measures slightly increased for BHI's adult Medicaid population, while one rate slightly increased and one measure demonstrated a slight decrease for the child Medicaid population compared to the previous year. Overall results for the timeliness domain were mixed but indicated a slightly upward trend.

For the four measures evaluated for the access domain, BHI's rates for adult Medicaid members increased substantially for three measures and increased slightly for one measure when compared to the previous year. For BHI's child population, the rates increased slightly for two measures and decreased slightly for two other measures. Overall rates for the access domain were positive and primarily trending upward.

Colorado Health Partnerships, LLC

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-22 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 2016–2017.

Table 4-22—Summary of CHP Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	31	29	27	2	0	2	93%
II—Access and Availability	10	10	10	0	0	0	100%
XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Not Scored						
Totals	**41**	**39**	**37**	**2**	**0**	**2**	**95%**

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

Table 4-23 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 2016–2017.

Table 4-23—Summary of CHP Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	60	59	1	40	98%
Totals	**100**	**60**	**59**	**1**	**40**	**98%**

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

Strengths

CHP delegated all authorization activities to its administrative services partner, Beacon Health Options (Beacon). Beacon had UM policies and procedures that addressed all major elements of authorization requirements. UM staff applied established level of care guidelines to determine medical necessity for all intensive levels of care. All requests that did not meet criteria were referred to a CHP medical director or clinical peer advisor for final determination of medical necessity. CHP conducted annual interrater reliability testing and quarterly clinical care manager and clinical peer advisor audits to ensure

that criteria, available documentation, and reviewer interpretations were consistently applied among all UM staff. Staff members stated that UM staff contact the requesting provider when necessary to obtain additional information prior to making a UM decision. NOAs sent to the member with a copy sent to the requesting provider included required content, were written in language easy to understand, and were available in English and Spanish or other languages upon request. Policies, procedures, and provider and member materials accurately defined "emergency medical condition" and "services" and communicated that emergency services were available in or out of network without authorization. Staff members stated that emergency services are never questioned for medical necessity, but that all emergency room (ER) claims were retrospectively reviewed for the presence of a BHO-covered diagnosis. Policies and procedures accurately addressed payment of emergency and poststabilization services, per requirements.

CHP also delegated management of its provider network to its partner, Beacon. Beacon had policies and procedures that described the processes for monitoring its provider network to ensure that all members have access to the full spectrum of covered services. Beacon considered locations, numbers, types, and specialties of providers as well as languages spoken and whether or not providers were accepting new members. Beacon collected and monitored grievances related to members' abilities to access services. Beacon also used various member and provider surveys to gauge member and provider perceptions of the availability of services. During the on-site interview, CHP staff members described innovative methods used to expand its network capacity. CHP offered providers incentives to geographically expand service areas, and CHP expanded its participation in the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program. CHP also partnered with Ieso Digital Health to pilot a tele-chat program that provides members with one-on-one cognitive behavioral therapy through a typed conversation between the member and a qualified therapist in a secure online therapy room. CHP had well-publicized policies that delineated the standards for timely access and that required providers' adherence to those standards. CHP provided documentation that demonstrated ongoing monitoring of both CMHCs and independent providers to ensure compliance as well as evidence of follow-up with providers who failed to meet the described expectations. CHP's cultural competency plan outlined goals and objectives, described management accountability and oversight mechanisms, and is updated annually to ensure cohesiveness with its network's changing demographics. CHP offered cultural competency training to all providers and made PowerPoint presentations available on its website. Furthermore, CHP monitored its members' perceptions of the cultural competence of services using member surveys, monitoring grievance reports, and member forums.

CHP had developed a comprehensive EPSDT policy that addressed all components of the EPSDT requirements for the BHO and provided a good foundation for implementing EPSDT requirements. Most responsibilities for EPSDT requirements were implemented by CMHCs or providers. The policy, provider manual, and provider training addressed provider responsibilities for EPSDT services, including: determining if the member is getting EPSDT screenings, assisting the member as needed with obtaining a PCP, communicating with the member's PCP regarding results of screenings, providing any behavioral health screenings indicated resulting from PCP screenings and referral, and documentation requirements for EPSDT services. Throughout the year, CHP had made significant efforts to implement the BHO's responsibilities related to EPSDT and had initiated a pilot program with one of its CMHCs and the area RCCO to implement an integrated care coordination process related to delivery of EPSDT services.

Opportunities for Improvement and Recommendations

Based on findings from the site review activities, CHP was required to submit a corrective action plan to ensure that it addressed any areas where CHP earned *Partially Met* or *Not Met* scores.

To address findings related to the Coverage and Authorization of Services, CHP was required to revise policies to clarify reasons why CHP can extend authorization time frames and to clarify the process for ensuring that CHP sends members and providers an NOA for claims denials (not related to provider procedural issues) on the day the of the decision or within a reasonable time thereafter.

While CHP had a policy statement that comprehensively addressed EPSDT requirements, procedures and processes for staff and providers were either incomplete or lacked clarity regarding how to implement the policy. HSAG made several recommendations to further CHP's implementation of EPSDT requirements, including: enhancing ongoing and periodic communications to members about the EPSDT services available and how to access them; enhancing internal procedures, provider communications, and training to clarify expectations and mechanisms for assisting EPSDT-eligible members with obtaining all applicable components of periodic health screens; more clearly integrating the definition of "medical necessity" for EPSDT and related authorization criteria into operational UM procedures; improving provider and member communications and internal procedures regarding resources for accessing EPSDT diagnostic and treatment services not covered by the BHO, including active involvement of BHO care coordinators to assist members and/or providers in obtaining non-covered services; enhancing provider and staff instructions regarding mechanisms or accountabilities for completing the member referral process and providing member PHI to Healthy Communities; and developing mechanisms for systematic (i.e., regular and periodic) communication with network providers regarding comprehensive EPSDT services and responsibilities.

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

CHP's performance in the quality domain was mixed. While Beacon's UM policies and procedures addressed all major elements of the required component of an authorization program that met regulations, HSAG noted on-site that 67 percent of all CHP 2016 denials were sent for the reason of "not a covered diagnosis." The frequency and circumstances related to CHP's denials for "not a covered diagnosis" raised some questions as to consistency and appropriateness of the covered diagnosis determinations. HSAG referred the cases to the Department for further evaluation.

CHP's performance in the timeliness domain was also mixed. CHP's policies and procedures accurately depicted the time frames related to authorization decisions and notification to both member and provider. HSAG's on-site review demonstrated compliance with these requirements, however, CHP's two required actions were both related to timeliness. HSAG reviewed the requirements with CHP and Beacon staff members during the on-site review in order to clarify interpretation of the regulations.

CHP delegated management of its provider network to its partner, Beacon. Beacon provided evidence of a comprehensive program to monitor and maintain a provider network adequate to meet the needs of its members. CHP staff members described innovative methods used to expand its network capacity as

including offering incentives to providers who expand their geographic service area, increased participation in the C-PACK program, and a newly implemented "telechat" pilot program. These innovative solutions demonstrated strong performance in the access domain.

Validation of Performance Measures

System and Reporting Capabilities

HSAG had no concerns with CHP's receipt and processing of enrollment data. CHP maintained the same process for obtaining and processing eligibility information as the prior year. Both daily change/update and monthly eligibility files were received from the Department in a flat file format via secure FTP site. Manual validation was performed to ensure that only accurate enrollment information was loaded into the Connection Administrative System (CAS), CHP's data warehouse, via CareConnect. CHP continued to distribute enrollment data to the appropriate CMHCs via FileConnect. Providers, staff members, and CMHCs continued to use real-time eligibility verification via the Department's portal. Each member received and maintained a unique member identification number. However, if a member was given a new/different Medicaid identification number by the State, then the internal ID of Beacon (CHP's partner) was modified and synced to the member's history.

HSAG identified no issues or concerns with the ways that CHP received, processed, or reported claims and encounter data. No major system or process changes were noted for the current reporting year. All claims/encounter data were housed and processed in the CAS. Providers submitted claims electronically or on paper. Electronic claims submitted by providers were downloaded daily using an automated process. Paper claims were scanned using OCR technology. All claims were received in a HIPAA-compliant 837 file format. Affiliated CMHCs submitted encounter data via FileConnect. CHP continued to use the data report card to monitor the CMHCs' data quality and completeness. Quality checks were in place, which included performing audits on 100 percent of claims exceeding the $5,000 threshold. Nightly, 3 percent of manually processed claims were audited for quality and payment accuracy.

CHP submitted 837 encounter files and flat files to the Department and received an error file for each within a few days of submission. CHP had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy.

CHP used the same processes as last 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 were in place to ensure data completeness and data accuracy.

Measure Results

Table 4-24 shows the MY 2014–2015 and MY 2015–2016 measure results for CHP.

Table 4-24—Measure Results for CHP

Performance Measure	MY 2014–2015 Rate[1]	MY 2015–2016 Rate[2]
Hospital Readmissions Within 7, 30, and 90 Days Post-Discharge (Non-State and All Facilities)*		
Non-State Hospitals—7 Days	3.44%	3.06%
Non-State Hospitals—30 Days	10.01%	9.83%
Non-State Hospitals—90 Days	16.57%	16.06%
All Hospitals—7 Days	3.41%	2.99%
All Hospitals—30 Days	9.83%	9.66%
All Hospitals—90 Days	16.29%	15.92%
Hospital Readmissions Within 180 Days (All Facilities)*		
Hospital Readmissions Within 180 Days (All Facilities)	21.22%	21.14%
Adherence to Antipsychotics for Individuals With Schizophrenia		
Adherence to Antipsychotics for Individuals With Schizophrenia	—	60.13%
Overall Penetration Rates‡		
Overall Penetration Rates	14.83%	14.86%
Penetration Rates by Age Group‡		
Children 12 Years of Age and Younger	6.69%	7.16%
Adolescents 13 Through 17 Years of Age	16.84%	17.16%
Adults 18 Through 64 Years of Age	19.53%	18.63%
Adults 65 Years of Age or Older	9.81%	12.11%
Penetration Rates by Medicaid Eligibility Category‡		
AND/AB-SSI	33.35%	34.15%
BC Children	2.06%	4.44%
BCCP-Women Breast and Cervical Cancer	7.37%	11.99%
Buy-In: Working Adult Disabled	25.17%	26.19%
Foster Care	29.95%	29.53%
OAP-A	9.80%	11.99%
OAP-B-SSI	24.15%	26.62%
MAGI Adults	17.31%	16.48%
Buy-In: Children With Disabilities	11.52%	13.24%
MAGI Parents/Caretakers	17.07%	16.40%
MAGI Children	8.40%	8.96%
MAGI Pregnant	22.15%	19.91%

Performance Measure	MY 2014–2015 Rate[1]	MY 2015–2016 Rate[2]
Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition		
7-Day Follow-Up	—	33.88%
30-Day Follow-Up	—	43.78%
Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence		
7-Day Follow-Up	—	12.46%
30-Day Follow-Up	—	19.65%
Mental Health Engagement‡,3		
Mental Health Engagement	43.73%	42.68%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment‡,3		
Initiation of AOD Treatment	43.04%	41.40%
Engagement of AOD Treatment	33.17%	30.40%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners‡,3		
Non-State Hospitals—7 Days	45.15%	44.81%
Non-State Hospitals—30 Days	66.05%	63.80%
All Hospitals—7 Days	44.79%	44.40%
All Hospitals—30 Days	66.02%	63.64%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only		
Non-State Hospitals—7 Days	—	20.88%
Non-State Hospitals—30 Days	—	42.77%
All Hospitals—7 Days	—	20.60%
All Hospitals—30 Days	—	42.58%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2014–2015 (i.e., July 1, 2014–June 30, 2015).
[2] Indicates that the rates contained within this column represent MY 2015–2016 (i.e., July 1, 2015–June 30, 2016).
** For this measure, a lower rate may indicate more favorable performance.*
‡ The measure had specification changes from MY 2014–2015 to MY 2015–2016, so caution should be exercised when comparing measure rates between MY 2014–2015 and MY 2015–2016.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year.
[3] Indicates that the MY 2014–2015 rate was recalculated after the rate was validated and finalized for FY 2015–2016.

Strengths

CHP experienced a significant increase in population size as a result of the Medicaid expansion; as a result, CHP's average number of monthly and annual claims processed increased. Via the report card, CHP continued monitoring the contracted CMHCs that were specific to encounters. The report card included stratifications by provider modifiers and pivot tables for in-depth exploration of data-related issues. The report card was also used to reconcile with the CMHCs on the submissions every month.

Quarterly mini-audits were conducted by CHP to confirm that members were meeting all requirements for inclusion in each measure. For each mini-audit, eight to 10 cases per measure were selected for review.

CHP developed a readiness process to receive eligibility files in an 834 file format, which will be implemented when the Department rolls out its new system. CHP continued to conduct monthly teleconferences with HCPF Medicaid Management Information System (MMIS) and Rates staff to address any outstanding issues and to discuss any future changes or upgrades scheduled. As in prior years, several administrative functions were delegated to CHP's partner, Beacon.

From MY 2014–2015 to MY 2015–2016, the following rate demonstrated an improvement in performance by approximately 5 percentage points or more, indicating an area of strength for CHP:

- *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer*

Opportunities for Improvement

During primary source verification, HSAG noted that paid and nonpaid claims were possibly used to calculate the *Mental Health Engagement* measure. After further clarification, CHP was instructed to recalculate the *Mental Health Engagement* measure rate. The CHP staff members were responsive, investigated the issue, and resubmitted the revised rate prior to generation of this report.

From MY 2014–2015 to MY 2015–2016, no CHP rates declined by 5 percentage points or more, suggesting stable performance overall.

Recommendations

CHP should ensure that the scope document is reviewed in its entirety and continue to communicate with the Department and other BHOs to ensure that all have the same understanding regarding reporting requirements. For the next measurement year, CHP should consider adding additional columns to the Member Level Detail file to capture all dates relevant to each measure. This would provide a complete picture of all eligible services.

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

The measures that address the quality domain are *Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (Non-State and All Facilities)* and *Hospital Readmissions Within 180 Days (All Facilities)*. Each of these rates decreased approximately 1 percentage point from the previous measurement year's performance. For these measures, a lower rate indicates a more favorable performance and fewer hospital readmissions. In light of a significant population increase due to Medicaid expansion, these results indicate a strength for CHP related to the quality domain.

For the timeliness domain, CHP's performance remained relatively stable from the prior measurement year. Rates for *Mental Health Engagement, Initiation and Engagement of Alcohol and Other Drug Dependence,* and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners* varied by less than 3 percentage points. Comparison for several rates from the prior measurement year in the timeliness domain (i.e., *Adherence to Antipsychotics for Individuals With Schizophrenia*; *Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition; Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence Treatment;* and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*) was not possible as CHP was not required to report these rates during MY 2014–2015.

The measures that assessed the timeliness domain also had an impact on the access to care domain, indicating stable performance in this domain as well. The other rates that assessed the access to care domain (i.e., *Overall Penetration Rates, Penetration Rates by Age Group,* and *Penetration Rates by Medicaid Eligibility Category*) demonstrated stable performance, with approximately 1 percentage point change from the previous measurement year with 10 rates. One notable exception was the *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer* rate, as this rate increased by approximately 5 percentage points.

Validation of Performance Improvement Projects

Findings

Table 4-25 displays the validation results for the CHP PIP, *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release,* validated during FY 2016–2017. This table illustrates the BHO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving *Met* scores have satisfied the necessary technical requirements for specific elements. The validation results presented in Table 4-25 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-25—Performance Improvement Project Validation Results for CHP

Stage	Activity		Percentage of Applicable Elements*		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**90% (19/21)**	**0% (0/21)**	**10% (2/21)**

**Percentage totals may not equal 100 due to rounding.*

Overall, 90 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Not Met*.

Table 4-26 displays baseline and Remeasurement 1 data for CHP's PIP. CHP's goal is to increase the percentage of jail-to-community releases for eligible members, with an identified behavioral health issue, that are followed by a covered outpatient behavioral health service within 30 days of release.

Table 4-26—Performance Improvement Project Outcomes for CHP

PIP 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.	22.6%	17.4%		*Not Assessed*

In the Remeasurement 1 PIP submission**,** CHP reported an updated baseline study indicator result, based on additional information obtained from newly participating counties. The updated baseline rate of jail-to-community releases for eligible members, with an identified behavioral health issue, that were followed by a covered outpatient behavioral health service within 30 days of release was 22.6 percent.

The Remeasurement 1 rate of jail-to-community releases for eligible members, with an identified behavioral health issue, that were followed by a covered outpatient behavioral health service within 30 days of release was 17.4 percent. The Remeasurement 1 rate declined 5.2 percentage points from the baseline rate. The Remeasurement 1 goal of 19.2 percent was not met.

Strengths

CHP designed and implemented a methodologically sound project. The BHO accurately reported and analyzed the baseline and Remeasurement 1 study indicator results, completed a causal/barrier analysis, and implemented timely and active interventions during the Remeasurement 1 period. CHP evaluated the Remeasurement 1 interventions and used the intervention evaluation results to guide next steps for improvement strategies. The BHO received a *Met* score for 100 percent of the applicable evaluation elements in both the Design stage (Activities I through VI) and the Implementation stage (Activities VII and VIII) 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 *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release* PIP, CHP identified the following barriers to a successful jail-to-community transition of care:

- Communication challenges among the BHO, the jails, and providers.
- Difficulty obtaining data from both jails and providers.
- Lack of knowledge among behavioral health provider staff regarding how to access timely jail release data to facilitate scheduling of the behavioral health appointment for newly released members.

To address these barriers, CHP implemented the following interventions:

- Obtained data sharing agreements with 42 of the 43 counties served by the BHO.
- Worked alongside the jail-based behavioral health services programs located in county jails to provide education on the goal of the PIP and to facilitate identification of members being released from jail in need of follow-up behavioral health services.
- Provided training and technical assistance to behavioral health facility staff on the process and tools for obtaining data necessary to identify members being released from jail in need of follow-up behavioral health services.
- Held monthly PIP task force meetings with behavioral health facility staff to promote the shared goal of the PIP (identifying newly released members in need of behavioral health services) and facilitate ongoing monitoring of progress toward meeting the goal for all eligible members.

In the Outcomes stage of the PIP, CHP reported a decline from baseline to Remeasurement 1 in the percentage of members, with an identified behavioral health issue, that were followed by a covered outpatient behavioral health service within 30 days of release. The BHO documented a number of challenges related to the PIP topic that impacted the ability to achieve improvement in the study indicator outcomes. The PIP encountered substantial obstacles and unanticipated delays in obtaining the data necessary to identify members eligible for the PIP. CHP reported that before it could actively work on improving the behavioral health service follow-up rate for members released from jail, data access issues needed to be addressed. The State of Colorado does not have a central data repository for jail booking activity; therefore, the BHO had to obtain a business associate agreement (BAA) with each of the 42 participating counties in order to be compliant with HIPAA when accessing health data from the county jails. The delays in obtaining comprehensive data access for the PIP limited the BHO's ability to monitor progress toward the goal during the Remeasurement 1 period. Now that many of the data access barriers have been addressed, the BHO is monitoring the PIP's progress monthly with key stakeholders. With access to the necessary data in place, the BHO has set the foundation for focusing on the remaining

barriers related to improving the rate of behavioral health visits among members newly released from jail and on improving the PIP's future outcomes.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Address all of HSAG's feedback regarding documentation in the PIP Summary Form as noted in points of clarification in the PIP Validation Tool.
- When setting an attainable Remeasurement 2 goal for the study indicator, take into account the baseline and Remeasurement 1 study indicator results and consider the challenges related to the PIP topic.
- Continue to incorporate interventions that directly address identified barriers, actively engage members and/or providers, and are likely to impact the PIP outcomes.
- Continue to evaluate interventions as they are being implemented using quality improvement science techniques such as the PDSA model as part of its improvement strategies, in order to allow for refinement of the improvement strategies throughout the measurement period.
- Seek technical assistance from HSAG as needed.

CHP: Summary Assessment of Quality, Timeliness, and Access for PIPs

As described in Section 2–Introduction, HSAG assigned CHP's PIP, *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release,* to the domains of quality and timeliness of, and access to, care and services. The goal of the project is to increase the percentage of members recently released from jail, with an identified behavioral health issue, that receive a covered outpatient behavioral health service within 30 days of release. The PIP has the potential to improve the quality of behavioral healthcare for the BHO's members who were recently released from jail, minimize disruptions in behavioral healthcare during the transition from jail to community-based care, and increase access to behavioral health providers for those members.

For the FY 2016–2017 validation cycle, CHP submitted Remeasurement 1 results; however, the Remeasurement 1 results did not demonstrate real improvement in the study indicator outcomes. The PIP was based on a methodologically sound design, and improvement activities were implemented appropriately; however, a decline occurred in the rate of members who completed a behavioral care visit within 30 days of released from jail from baseline to the first remeasurement. The PIP will be evaluated again during the next PIP validation cycle to determine if appropriate adjustments were made to achieve real improvement related to the three domains of care and services.

Experience of Care and Health Outcomes Surveys

Table 4-27 shows the adult ECHO survey results achieved by CHP for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-27—Adult ECHO Question Summary Rates and Global Proportions for CHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	41.4%	40.0%
Getting Treatment Quickly	60.0%	69.6%
How Well Clinicians Communicate	86.2%	89.4%
Perceived Improvement	55.6%	58.9%
Information About Treatment Options	59.4%	60.8%
Office Wait	74.9%	83.8%
Told About Medication Side Effects	80.3%	77.6%
Including Family	40.8%	45.5%
Information to Manage Condition	74.1%	71.5%
Patient Rights Information	88.1%	83.1%
Patient Feels He or She Could Refuse Treatment	86.2%	81.1%
Privacy	93.6%	95.1%
Cultural Competency	N/A	N/A
Amount Helped	82.2%	80.0%
Improved Functioning	48.4%	53.3%
Social Connectedness	62.6%	65.7%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Table 4-28 shows the child ECHO survey results achieved by CHP for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-28—Child ECHO Question Summary Rates and Global Proportions for CHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	46.6%	41.7%
Getting Treatment Quickly	71.4%	68.1%
How Well Clinicians Communicate	86.0%	85.5%
Perceived Improvement	71.5%	65.4%
Information About Treatment Options	72.4%	68.2%
Office Wait	86.4%	83.9%
Told About Medication Side Effects	86.2%+	88.3%+
Information to Manage Condition	68.6%	68.4%
Patient Rights Information	87.9%	88.7%
Patient Feels He or She Could Refuse Treatment	82.2%	88.0%
Privacy	93.6%	96.8%
Cultural Competency	N/A	N/A
Amount Helped	78.0%	79.2%
Improved Functioning	63.1%	58.0%
Social Connectedness	85.0%	78.7%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Strengths

For CHP's adult Medicaid population, two measure rates increased substantially: *Getting Treatment Quickly* (9.6 percentage points) and *Office Wait* (8.9 percentage points). Seven of the measures demonstrated slight increases (less than 5 percentage points each): *How Well Clinicians Communicate, Perceived Improvement, Information About Treatment Options, Including Family, Privacy, Improved Functioning,* and *Social Connectedness*.

For CHP's child Medicaid population, one measure rate increased substantially: *Patient Feels He or She Could Refuse Treatment* (5.8 percentage points). Four of the measures demonstrated slight increases (less than 5 percentage points each): *Told About Medication Side Effects, Patient Rights Information, Privacy,* and *Amount Helped.*

Opportunities for Improvement

Two CHP adult Medicaid population measure rates decreased substantially: *Patient Rights Information* (5.0 percentage points) and *Patient Feels He or She Could Refuse Treatment* (5.1 percentage points). Four measures showed slight rate decreases (less than 5 percentage points each) compared to the previous year: *Rating of All Counseling or Treatment, Told About Medication Side Effects, Information to Manage Condition,* and *Amount Helped.*

Three CHP child Medicaid population measure rates decreased substantially: *Perceived Improvement* (6.1 percentage points), *Improved Functioning* (5.1 percentage points), and *Social Connectedness* (6.3 percentage points). Six measures showed slight rate decreases (less than 5 percentage points each) compared to the previous year: *Rating of All Counseling or Treatment, Getting Treatment Quickly, How Well Clinicians Communicate, Information About Treatment Options, Office Wait,* and *Information to Manage Condition.*

Recommendations

HSAG identified several possible interventions that could be applied by CHP as appropriate to the BHO's population and organizational structure. HSAG's recommendations focused on substantial decreases in measure rates for either the adult or child population and on any slight decreases in rates for measures common to both the adult and child populations.

For CHP's adult Medicaid population and related to performance in *Patient Rights Information* and *Patient Feels He or She Could Refuse Treatment,* HSAG offers the following observations and recommendations:

- For the *Patient Rights Information* measure, providers should be encouraged to employ a routine mechanism to distribute to members patient rights information beyond the member rights information printed in the member handbook. Providers might consider documenting member acknowledgement of receipt and member understanding of patient rights. Practitioners and staff must also observe and protect patient rights when serving members; therefore, CHP might consider encouraging members to use the grievance process if any states feeling that member rights have not been respected.
- For the *Patient Feels He or She Could Refuse Treatment* measure, providers should be aware that this may also be an element of basic member rights. A patient feeling that he or she may not refuse treatment could be related to factors such as communication barriers with the practitioner, member preferred treatment not being available, or member not being allowed to cancel appointments. In order to foster more positive member perceptions or to improve provider communications related to a member's right to refuse treatment, CHP might consider working with providers to implement a mechanism to not only discuss individual treatment options but to also have members acknowledge and agree to the individual treatment plan whenever initiated or altered. If concerns persist, the BHO might consider investigating key drivers related to this measure or discussing with members their reasons for perceiving that they could not refuse treatment, then identifying any detailed patterns for improvement.

For CHP's child Medicaid population and related to performance in *Perceived Improvement*, *Improved Functioning*, and *Social Connectedness*, HSAG offers the following observations and recommendations:

- The *Improved Functioning* and *Perceived Improvement* measures are possible quality outcome indicators considered from the member's perspective, and may indicate the need for quality improvement initiatives by a provider. HSAG recommends that providers develop interim short-term goals with individual members as a mechanism to facilitate the member's or family's perception of progress toward those goals, and to review or revise them with the member at appropriate intervals. CHP should consider implementing ongoing measures to monitor members' or families' perceptions of improvement, possibly through an exit interview when discontinuing treatment or through interim assessments with members in long-term treatment. If concerning trends are identified, CHP should work with providers, members, and families to identify more detailed potential causes and to implement performance improvement initiatives, as indicated. When identified decreases in ratings are related to the child population, these measures might indicate the need for CHP to evaluate the adequacy or expertise within the network to address child behavioral health issues. If indicated, the BHO might consider increasing provider training forums, increasing telehealth links to child behavioral health specialists, or directing members to targeted child behavioral health resources.
- For the *Social Connectedness* measure of a family's social support connections other than the provider, providers might ensure that the member/family care service plan include a thorough assessment of the member's social determinants of health (i.e., food, finances, clothing, housing) as well as emotional supports for or deterrents to the family. CHP and providers could work collaboratively to refer families to community services and social support groups, consider having a BHO or provider call-in line for members' families, assign a care manager for ongoing support, or consider expanding adjunct group therapy for families of children with behavioral health needs.

For both CHP's adult and child Medicaid populations and related to performance in *Rating of All Counseling or Treatment* and *Information to Manage Condition*, HSAG offers the following observations and recommendations:

- For the *Information to Manage Condition* measure, HSAG recommends that CHP work with providers to determine and provide condition-specific written information to members and members' families, consider implementing a call-in advice line for members and families, and support implementation of a self-management plan with individual members and families of children. In addition, providers should be encouraged to link a member with complex needs to a BHO, other agency, or provider care manager to provide interim and ongoing information and support to individual members and their families.
- *Rating of All Counseling or Treatment* is an overall quality outcome indicator considered from the member's perspective that may indicate the need for quality improvement initiatives by a provider and could be related to a number of variables including access, communications, or perceived treatment outcomes. As such, CHP should work with providers to investigate key factors contributing to this measure or discuss with members reasons for diminished rating of counseling or treatment and identify any detailed patterns for improvement.

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

For CHP's adult Medicaid population, of the 14 measures evaluated for the quality domain, one rate was substantially higher than the previous year and seven additional measures demonstrated slight increases when compared to the previous year. Two of the adult Medicaid population measure rates decreased substantially, and four measures showed slight rate decreases from the previous year. Results for Medicaid adults in the quality domain were mixed, and continued improvements needed can be identified.

For CHP's child Medicaid population, of the 13 measures evaluated for the quality domain, one measure demonstrated a substantially higher rate than the previous year and four additional measures demonstrated slight increases when compared to the previous year. Three measures showed substantial decreases in rates from the previous year, and five measures showed slight decreases when compared to the previous year. Overall results for the child population in the quality domain were mixed, and improvements needed can be identified.

For the two measures that assessed timeliness—*Getting Treatment Quickly* and *Office Wait*—both measures increased substantially for CHP's adult Medicaid population, while both rates demonstrated a slight decrease for the child Medicaid population compared to the previous year. Overall results for the timeliness domain were mixed, indicating an upward trend for adults and a slightly downward trend for the child population.

For the four measures evaluated for the access domain, CHP's rates for adult Medicaid members increased substantially for one measure, increased slightly for two measures, and decreased slightly for one measure when compared to the previous year. For CHP's child population, the rates increased substantially for one measure, and decreased slightly for three measures. Findings on individual measures were not similar in the adult and child populations. Overall rates for the access domain were mixed, and improvements needed can be identified.

Foothills Behavioral Health Partners, LLC

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-29 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 2016–2017.

Table 4-29—Summary of FBHP Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I—Coverage and Authorization of Services	31	28	25	3	0	3	89%
II—Access and Availability	10	10	10	0	0	0	100%
XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Not Scored						
Totals	**41**	**38**	**35**	**3**	**0**	**3**	**92%**

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

Table 4-30 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 2016–2017.

Table 4-30—Summary of FBHP Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	62	57	5	38	92%
Totals	**100**	**62**	**57**	**5**	**38**	**92%**

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

Strengths

FBHP delegated all authorization activities to Beacon. Beacon had UM policies and procedures that addressed all major elements of authorization requirements. UM staff applied established level-of-care guidelines to determine medical necessity for all higher levels of care. UM staff referred all requests that did not meet criteria to an FBHP medical director or clinical peer advisor for final determination. Beacon conducted annual interrater reliability testing and audited clinical care managers and clinical peer advisors quarterly to ensure that criteria, available documentation, and reviewer interpretations

were consistently applied among all UM staff. Staff members stated that UM staff contacted the requesting provider when necessary to obtain additional information prior to making a UM decision. NOAs sent to the member, with a copy sent to the requesting provider, included required content, were written in language easy to understand, and were available in English and Spanish or other languages upon request. Policies, procedures, and provider and member materials accurately defined "emergency medical condition" and "services" and communicated that emergency services were available in or out of network without authorization. Policies and procedures also accurately addressed payment of emergency and poststabilization services, per requirements. Staff members stated that FBHP never questions emergency services based on medical necessity but that all ER claims are retrospectively reviewed to ensure that the root cause of the emergency was related to a BHO-covered diagnosis.

FBHP delegates the maintenance and monitoring of its provider network to Beacon. Beacon's Network Design and Access Standards policy described the processes used to ensure FBHP's members ready access to the full spectrum of covered services. FBHP staff members discussed recent efforts to improve network adequacy by improving the relationships between its independent provider network and the CMHCs. FBHP's research indicated that members who sought services from an independent provider were less likely to engage in services and programs offered at CMHCs. By fostering relationships between independent providers and CMHCs, FBHP hopes to help independent providers understand the breadth of ancillary services available through the CMHCs and how to help members access those services. FBHP required its contracted providers and CMHCs to provide access to emergency services, maintain minimum hours of operation, and ensure the availability of covered services 24 hours a day, 7 days a week. FBHP provided evidence of having conducted regular monitoring to ensure compliance and appropriate follow-up with providers who failed to meet the standards. FBHP's cultural competency plan delineated FBHP's objectives and the departments responsible for implementing and monitoring a plan to ensure culturally and linguistically competent services. FBHP monitored its providers to ensure that all cultural considerations are noted in member records and offered training to help providers identify cultural considerations aside from language. FBHP recently updated training materials to help address some cultural issues commonly encountered by people in the lesbian, gay, bisexual, and transgender community. FBHP staff also addressed increased awareness of cultural issues encountered by its aging community.

FBHP operated the EPSDT program as defined in policies and procedures originated by Beacon, FBHP, and FBHP's partner CMHCs (Mental Health Partners [MHP] and Jefferson County Mental Health [JCMH]). FBHP assigned most responsibilities for implementing EPSDT to the CMHCs/providers. Policies, the provider manual, and provider trainings outlined the behavioral health providers' responsibilities related to EPSDT, including: informing members of EPSDT services, determining whether or not screenings have been provided to members 20 years of age and under, linking members to PCPs to perform EPSDT screening, obtaining results of EPSDT screenings from PCPs, providing assessment and treatment planning for any mental health/substance abuse issues identified through screening, and documentation requirements and sharing of PHI with Healthy Communities. FBHP monitored the CMHCs' implementation of select components of the EPSDT program through periodic audits. FBHP notified members of the availability of EPSDT services through member handbooks and other member communications implemented by the CMHCs. Throughout the year, FBHP had made significant efforts to work with partner CMHCs and other community organizations to define and

implement processes that address the BHO's responsibilities related to EPSDT. Each CMHC was working with a partner FQHC on implementing an integrated behavioral/physical health home. FBHP also described evolving relationships with the corresponding RCCO as well as with county Healthy Communities organizations regarding coordination of EPSDT services for members.

Opportunities for Improvement and Recommendations

Based on findings from the site review activities, FBHP was required to develop mechanisms to ensure that the information in the NOA to the member and provider accurately coincides with the determination of approved or denied days as noted in the denial record. FBHP was also required to clarify policies and procedures and ensure that FBHP sends members and providers an NOA for denial of claims payment at the time of its decision. In addition, FBHP was required to modify language in its policies and procedures related to reasons why FBHP can extend authorization time frames.

While FBHP had several policies related to EPSDT requirements, policies and procedures were not cohesive or were incomplete regarding accountabilities for implementation. In addition, provider training and medical record monitoring tools lacked comprehensiveness regarding all components of EPSDT screenings and requirements. HSAG made several recommendations related to FBHP's implementation of EPSDT requirements, including: enhancing procedures, provider communications, and training to thoroughly address expectations and mechanisms to ensure that EPSDT-eligible members obtain all applicable components of periodic health screens; enhancing monitoring tools to ensure that results of member screenings and examinations are recorded in the members' medical records; ensuring that its UM contractor (Beacon) integrates the definition of "medical necessity" for EPSDT and related authorization criteria into operational UM procedures; improving provider and member communications and developing cohesive procedures for accessing EPSDT diagnostic and treatment services not covered by the BHO, including active involvement of BHO care coordinators to assist members and/or providers in obtaining non-covered services; enhancing provider and staff instructions regarding mechanisms or accountabilities for completing the member referral process and providing member PHI to Healthy Communities; and developing mechanisms for systematic (i.e., regular and periodic) communication with network providers regarding comprehensive EPSDT services and responsibilities.

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

CMS defines quality as, "…the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through its structural and operations characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement." FBHP delegated all authorization activities to Beacon. Beacon's UM policies and procedures addressed all major elements of authorization requirements. Denial records reviewed on-site demonstrated 100 percent compliance with the requirements to send written notice of action to the member and requesting provider, to ensure that staff members making authorization decisions have appropriate clinical expertise, and to include in NOAs required content in an easy-to-understand language and format. HSAG noted that seven of 10 FBHP denial records reviewed on-site and 64 percent of all FBHP 2016 denials were categorized as "not a covered diagnosis." The frequency

and circumstances related to FBHP's denials for "not a covered diagnosis" raised some questions as to consistency and appropriateness of the covered diagnosis determinations. Additionally, HSAG noted three cases where FBHP retroactively denied services that it had previously approved. HSAG noted that this practice may be out of compliance with Colorado revised statutes. HSAG referred all of these cases to the Department for further evaluation.

When determining a BHO's performance in the timeliness domain, HSAG applied NCQA's definition which states, "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation." FBHP's performance in the timeliness domain was mixed. FBHP's policies and procedures clearly delineated the time frames related to authorization decisions and notification to both member and provider; however, HSAG's review of 10 denial records demonstrated compliance with these time requirements six out of 10 times. Additionally, two of FBHP's three required actions related to the timeliness domain. HSAG reviewed the requirements with FBHP and Beacon staff members during the on-site review in order to clarify interpretation of the regulations. HSAG is confident that FBHP will quickly and thoroughly address the identified issues.

Using the CMS definition of "access," HSAG assessed FBHP's performance based on how well it demonstrated and reported on outcomes information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services). FBHP delegated management of its provider network to its partner, Beacon. Beacon provided evidence of a comprehensive program to monitor and maintain a provider network adequate to meet the needs of its members. FBHP staff members also described a recent initiative designed to expand members' access to services. By fostering relationships between independent providers and CMHCs, FBHP aims to help independent providers understand the breadth of ancillary services available through the CMHCs and how to help members access those services. This innovative approach to expanding access, combined with 100 percent compliance with federal and State regulations related to Access and Availability, demonstrated FBHP's strong performance in the access domain.

Validation of Performance Measures

System and Reporting Capabilities

HSAG identified no issues or concerns with FBHP's receipt and processing of data with respect to eligibility. FBHP maintained the same process for obtaining and processing eligibility information as used in prior years. Both daily change/update and monthly full eligibility files were received from the Department in a flat file format via secure FTP site. Manual validation was performed to ensure that only accurate enrollment information was loaded into the CAS, the FBHP's data warehouse, via CareConnect. FBHP continued to distribute enrollment data to the appropriate CMHCs via FileConnect. Providers, staff members, and CMHCs continued to use real-time eligibility verification via the Department's portal. Each member received and maintained a unique member identification number. However, if a member was given a new/different Medicaid identification number by the State, then Beacon's (FBHP's LLC partner) internal ID was modified and synced to the member's history.

HSAG identified no issues or concerns with the ways that FBHP received, processed, or reported claims and encounter data. No major system or process changes were noted for the current reporting year. All claims/encounter data were housed and processed in the CAS. Providers submitted claims electronically or on paper. Electronic claims submitted by providers were downloaded daily using an automated process. Paper claims were scanned using OCR technology. All claims were received in a HIPAA-compliant 837 file format. Affiliated CMHCs submitted encounter data via FileConnect. FBHP continued to use the data report card to monitor the CMHCs' performance. Robust quality checks were in place, which included performing audits on 100 percent of claims exceeding the $5,000 threshold. Nightly, 3 percent of manually processed claims were audited for quality and payment accuracy.

FBHP submitted 837 encounter files and flat files to the Department and received an error file for each 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 last 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 were in place to ensure data completeness and data accuracy.

Measure Results

Table 4-31 shows the MY 2014–2015 and MY 2015–2016 measure results for FBHP.

Table 4-31—Measure Results for FBHP

Performance Measure	MY 2014–2015 Rate[1]	MY 2015–2016 Rate[2]
Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (Non-State and All Facilities)*		
Non-State Hospitals—7 Days	1.94%	3.33%
Non-State Hospitals—30 Days	6.91%	9.49%
Non-State Hospitals—90 Days	12.61%	15.84%
All Hospitals—7 Days	1.83%	3.66%
All Hospitals—30 Days	6.99%	9.60%
All Hospitals—90 Days	12.47%	15.72%
Hospital Readmissions Within 180 Days (All Facilities)*		
Hospital Readmissions Within 180 Days (All Facilities)	16.83%	19.26%
Adherence to Antipsychotics for Individuals With Schizophrenia		
Adherence to Antipsychotics for Individuals With Schizophrenia	—	61.84%
Overall Penetration Rates‡		
Overall Penetration Rates	16.47%	17.37%
Penetration Rates by Age Group‡		
Children 12 Years of Age and Younger	12.33%	13.89%
Adolescents 13 Through 17 Years of Age	19.46%	22.05%
Adults 18 Through 64 Years of Age	18.87%	18.81%
Adults 65 Years of Age or Older	7.00%	8.53%
Penetration Rates by Medicaid Eligibility Category‡		
AND/AB-SSI	35.34%	36.11%
BC Children	2.93%	4.14%
BCCP-Women Breast and Cervical Cancer	11.78%	16.10%
Buy-In: Working Adult Disabled	37.28%	45.02%
Foster Care	34.58%	37.05%
OAP-A	6.78%	8.18%
OAP-B-SSI	26.98%	30.17%
MAGI Adults	16.99%	16.63%
Buy-In: Children With Disabilities	19.46%	23.66%
MAGI Parents/Caretakers	15.42%	15.92%
MAGI Children	13.13%	15.23%
MAGI Pregnant	17.64%	19.10%

Performance Measure	MY 2014–2015 Rate[1]	MY 2015–2016 Rate[2]
Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition		
7-Day Follow-Up	—	37.98%
30-Day Follow-Up	—	49.62%
Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence		
7-Day Follow-Up	—	12.22%
30-Day Follow-Up	—	19.88%
Mental Health Engagement‡,3		
Mental Health Engagement	43.66%	45.89%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment‡,3		
Initiation of AOD Treatment	39.71%	40.95%
Engagement of AOD Treatment	29.52%	30.17%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners‡,3		
Non-State Hospitals—7 Days	53.42%	47.66%
Non-State Hospitals—30 Days	66.15%	65.58%
All Hospitals—7 Days	55.15%	47.73%
All Hospitals—30 Days	67.14%	66.01%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only		
Non-State Hospitals—7 Days	—	30.52%
Non-State Hospitals—30 Days	—	46.10%
All Hospitals—7 Days	—	30.67%
All Hospitals—30 Days	—	46.50%

[1] Indicates that the rates contained within this column represent measurement year (MY) 2014–2015 (i.e., July 1, 2014–June 30, 2015).
[2] Indicates that the rates contained within this column represent MY 2015–2016 (i.e., July 1, 2015–June 30, 2016).
** For this measure, a lower rate may indicate more favorable performance.*
‡ The measure had specification changes from MY 2014–2015 to MY 2015–2016, so caution should be exercised when comparing measure rates between MY 2014–2015 and MY 2015–2016.
— Indicates that the rate is not presented in this report as the Department did not require the health plans to report this rate for the respective reporting year.
[3] Indicates that the MY 2014–2015 rate was recalculated after the rate was validated and finalized for FY 2015–2016.

Strengths

FBHP experienced a significant increase in population size as a result of the Medicaid expansion; therefore, FBHP's average number of monthly and annual claims processed increased. Via the report card, FBHP continued monitoring the two contracted CMHCs specific to encounters. FBHP moved from receiving monthly data report cards reflective of the previous month to a monthly report card reflective of the entire fiscal year. The report card included stratifications by provider modifiers and pivot tables for in-depth exploration of data-related issues. The report card was also used to reconcile with the CMHCs on their monthly submissions. In addition, FBHP employed an extra layer of quality checks wherein FBHP validated each CMHC's data prior to submitting the data to Beacon to generate the report

card. Quarterly mini-audits were conducted by FBHP to confirm that members were meeting all requirements to be included in each measure. For each mini-audit, eight to 10 cases per measure were selected for review.

FBHP developed a readiness process to receive eligibility files in an 834 file format, which will be implemented when the Department rolls out its new system. FBHP continued to hold monthly teleconferences with MMIS and Rates staff to address any outstanding issues and to discuss any future changes or upgrades scheduled.

From MY 2014–2015 to MY 2015–2016, the following rate demonstrated an improvement in performance by 7.74 percentage points, indicating an area of strength for FBHP:

- *Penetration Rates by Medicaid Eligibility Category—Buy-In: Working Adult Disabled*

Opportunities for Improvement

During the primary source verification, HSAG noted that paid and nonpaid claims were possibly used to calculate the *Mental Health Engagement* measure. After further clarification, FBHP was instructed to recalculate the *Mental Health Engagement* measure rate 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.

From MY 2014–2015 to MY 2015–2016, the following rates demonstrated declines in performance by 5 percentage points or more each, suggesting opportunities for improvement for FBHP:

- *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners—Non-State Hospitals—7 Days* and *All Hospitals—7 Days*

Recommendations

FBHP should ensure that the scope document is reviewed in its entirety and continue to communicate with the Department and other BHOs to ensure that all have the same understanding regarding reporting requirements.

FBHP should conduct a thorough analysis of the root causes for decline in rates for timely follow-up care for members with mental health conditions and increase oversight of performance in this area. HSAG suggests that FBHP analyze reasons linked to the reduction in these rates, identify the most significant areas or populations of focus for which improvement interventions could be planned, and identify strategies and interventions for better outcomes, starting with the areas for improvements likely to create the highest impact and change.

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

The measures that address the quality domain are *Hospital Readmissions Within 7, 30, and 90 Days Post Discharge (Non-State and All Facilities)* and *Hospital Readmissions Within 180 Days (All Facilities)*. Each of these rates increased by approximately 3 percentage points or less when compared to the previous measurement year's performance. For these measures, a lower rate indicates a more favorable performance and fewer hospital readmissions. In light of a significant population increase due to Medicaid expansion, these results indicate a strength for FBHP related to the quality domain.

For the timeliness domain, FBHP's performance was somewhat mixed from the prior measurement year. Rates for *Mental Health Engagement* and *Initiation and Engagement of Alcohol and Other Drug Dependence* remained stable, varying by approximately 2 percentage points or less each. Of note, the two rates for *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners—Non-State Hospitals—7 Days and All Hospitals—7 Days* decreased by 5 percentage points or more each from the previous measurement year, suggesting opportunities for improvement. Comparison for several rates from the prior measurement year in the timeliness domain (i.e., *Adherence to Antipsychotics for Individuals With Schizophrenia*; *Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition; Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence Treatment;* and *Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*) was not possible as FBHP was not required to report these rates during MY 2014–2015.

The measures that assessed the timeliness domain also had an impact on the access to care domain, indicating relatively stable performance in this domain as well. The other rates that assessed the access to care domain (i.e., *Overall Penetration Rates, Penetration Rates by Age Group,* and *Penetration Rates by Medicaid Eligibility Category*) demonstrated stable performance with approximately 3 percentage points difference each from the previous measurement year, for 14 rates. One notable exception was the *Penetration Rates by Medicaid Eligibility Category—Buy-In: Working Adult Disabled* rate, as this rate increased by 7.74 percentage points or more.

Validation of Performance Improvement Projects

Findings

Table 4-32 displays the validation results for the FBHP PIP, *Improving Transition From Jail to Community-Based Behavioral Health Treatment*, validated during FY 2016–2017. This table illustrates the BHO's overall application of the PIP process, implementation of interventions, and achieved success in improving study indicator outcomes. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving *Met* scores have satisfied the necessary technical requirements for specific elements. The validation results presented in Table 4-32 show, by activity, the percentage of applicable evaluation elements that received each score. Additionally, HSAG

calculated a score for each stage and an overall score across all activities. This was the third validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-32—Performance Improvement Project Validation Results for FBHP

Stage	Activity		Percentage of Applicable Elements		
			Met	*Partially Met*	*Not Met*
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	*Not Applicable*
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (3/3)	0% (0/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	33% (1/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**33% (1/3)**	**0% (0/3)**	**67% (2/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**90% (19/21)**	**0% (0/21)**	**10% (2/21)**

Overall, 90 percent of all applicable evaluation elements validated received a score of *Met*. HSAG assigned the PIP an overall validation status of *Not Met*.

Table 4-33 displays baseline and Remeasurement 1 data for FBHP's PIP. FBHP's goal is to increase the percentage of eligible members released from jail, with an identified behavioral health issue, who received a specified covered behavioral health service within 30 days of release.

Table 4-33—Performance Improvement Project Outcomes for FBHP

PIP 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.	32.1%	32.3%		*Not Assessed*

In the Remeasurement 1 PIP submission, the BHO reported an updated baseline rate to reflect that 32.1 percent of eligible members released from jail, with an identified behavioral health issue, received a specified covered behavioral health service within 30 days. 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 35.0 percent would be a statistically significant increase based on the baseline denominator for the study indicator.

At Remeasurement 1, the BHO reported that 32.3 percent of eligible members released from jail, with an identified behavioral health issue, received a specified covered behavioral health service within 30 days. The increase of 0.2 percentage point from baseline to Remeasurement 1 was not statistically significant ($p = 0.8647$). The Remeasurement 1 rate did not meet the goal of 35.0 percent.

Strengths

FBHP designed and implemented a methodologically sound project. The BHO accurately reported and analyzed the baseline and Remeasurement 1 study indicator results, completed a causal/barrier analysis, and implemented timely and active interventions during the Remeasurement 1 period. FBHP evaluated the Remeasurement 1 interventions and used the intervention evaluation results to guide next steps for improvement strategies. The BHO received a *Met* score for 100 percent of the applicable evaluation elements in both the Design stage (Activities I through VI) and the Implementation stage (Activities VII and VIII) 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 *Improving Transition From Jail to Community-Based Behavioral Health Treatment* PIP, FBHP identified the following 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 (e.g., 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.
- Lack of an established outreach process to follow up with members who do not show up for a scheduled behavioral health service after release from jail.

To address these barriers, FBHP developed the following interventions:

- Established a key contact for scheduling follow-up appointments with a local substance abuse treatment provider for members being prepared for release from jail.
- Developed educational materials about community resources, to be distributed to inmates being released and to their friends and families.
- Hired a mental health clinician to provide initial intake assessments to 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 pre-scheduled intake appointments. The process includes outreach services for those members who do not attend their intake appointments.

In the Outcomes stage of the PIP, FBHP reported an increase from baseline to Remeasurement 1 in the rate of eligible members released from jail, with an identified behavioral health issue, who received a specified covered behavioral health service within 30 days; however, the increase was not statistically significant. The BHO summarized some of the process improvements that have been achieved through the PIP despite the lack of statistically significant improvement in outcomes. Specifically, FBHP noted that the BHO has fostered partnerships with the county jails and the Department of Human Services to facilitate identification of eligible members. The partnerships developed among local agencies have improved communication to support the transition of care for eligible members. Additionally, improvement strategies have increased awareness of behavioral health resources among members and established a link between jail-based services and community-based services. The BHO initiated several

new interventions in the subsequent measurement period (CY 2016) to address the remaining barriers to improving the rate of behavioral health visits among members newly released from jail.

Recommendations

As the PIP progresses, HSAG recommends that the BHO:

- Address all of HSAG's feedback regarding documentation in the PIP Summary Form as noted in points of clarification in the PIP Validation Tool.
- Continue to incorporate interventions that directly address identified barriers, actively engage members and/or providers, and are likely to impact the PIP outcomes.
- Continue to use quality improvement science techniques 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.
- Seek technical assistance from HSAG as needed.

FBHP: Summary Assessment of Quality, Timeliness, and Access for PIPs

As described in Section 2—Introduction, HSAG assigned FBHP's PIP, *Improving Transition From Jail to Community-Based Behavioral Health Treatment*, to the domains of quality and timeliness of, and access to, care and services. The goal of the project is to increase the percentage of members recently released from jail, with an identified behavioral health issue, that receive a covered outpatient behavioral health service within 30 days of release. The PIP has the potential to improve the quality of behavioral healthcare for the BHO's members who were recently released from jail, minimize disruptions in behavioral healthcare during the transition from jail to community-based care, and increase access to behavioral health providers for those members.

For the FY 2016–2017 PIP validation cycle, FBHP submitted Remeasurement 1 results; however, the Remeasurement 1 results did not demonstrate real improvement in the study indicator outcomes. The PIP was based on a methodologically sound design, and improvement activities were implemented appropriately; but the improvement in the rate of members released from jail, with an identified behavioral health issue, who completed a behavioral health visit within 30 days of release was not a statistically significant at the first remeasurement. The PIP will be evaluated again during the next PIP validation cycle to determine if appropriate adjustments were made to achieve real improvement related to the three domains of care and services.

Experience of Care and Health Outcomes Surveys

Table 4-34 shows the adult ECHO survey results achieved by FBHP for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-34—Adult ECHO Question Summary Rates and Global Proportions for FBHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	37.9%	49.4%
Getting Treatment Quickly	65.4%	67.3%
How Well Clinicians Communicate	84.5%	89.2%
Perceived Improvement	51.4%	60.3%
Information About Treatment Options	62.1%	60.6%
Office Wait	79.2%	88.0%
Told About Medication Side Effects	71.5%	77.9%
Including Family	38.9%	40.8%
Information to Manage Condition	68.0%	79.0%
Patient Rights Information	83.5%	87.4%
Patient Feels He or She Could Refuse Treatment	78.9%	85.8%
Privacy	94.4%	97.2%
Cultural Competency	N/A	N/A
Amount Helped	83.1%	81.8%
Improved Functioning	44.5%	54.9%
Social Connectedness	57.5%	60.6%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Table 4-35 shows the child ECHO survey results achieved by FBHP for FY 2016–2017 and the prior year (FY 2015–2016).

Table 4-35—Child ECHO Question Summary Rates and Global Proportions for FBHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate
Rating of All Counseling or Treatment	35.9%	42.2%
Getting Treatment Quickly	72.6%	68.6%
How Well Clinicians Communicate	87.3%	88.8%
Perceived Improvement	68.2%	76.8%
Information About Treatment Options	73.1%	75.6%
Office Wait	88.8%	86.3%
Told About Medication Side Effects	90.9%	86.6%+
Information to Manage Condition	68.6%	70.4%
Patient Rights Information	90.7%	93.5%
Patient Feels He or She Could Refuse Treatment	88.2%	92.8%
Privacy	96.9%	98.7%
Cultural Competency	N/A	N/A
Amount Helped	76.3%	73.4%
Improved Functioning	62.9%	65.6%
Social Connectedness	84.8%	88.3%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Strengths

For FBHP's adult Medicaid population, seven measure rates increased substantially: *Rating of All Counseling or Treatment* (11.5 percentage points), *Perceived Improvement* (8.9 percentage points), *Office Wait* (8.8 percentage points), *Told About Medication Side Effects* (6.4 percentage points), *Information to Manage Condition* (11.0 percentage points), *Patient Feels He or She Could Refuse Treatment* (6.9 percentage points), and *Improved Functioning* (10.4 percentage points). Six of the measures demonstrated slight increases (less than 5 percentage points each): *Getting Treatment Quickly, How Well Clinicians Communicate, Including Family, Patient Rights Information, Privacy,* and *Social Connectedness.*

For FBHP's child Medicaid population, two measure rates increased substantially: *Rating of All Counseling or Treatment* (6.3 percentage points) and *Perceived Improvement* (8.6 percentage points). Eight measures demonstrated slight increases (less than 5 percentage points each): *How Well Clinicians Communicate, Information About Treatment Options, Information to Manage Condition, Patient Rights*

Information, Patient Feels He or She Could Refuse Treatment, Privacy, Improved Functioning, and *Social Connectedness.*

Opportunities for Improvement

No FBHP adult Medicaid population measure rates decreased substantially. Two measures showed slight rate decreases (less than 5 percentage points each) compared to the previous year: *Information About Treatment Options* and *Amount Helped.*

No FBHP child Medicaid population measure rates decreased substantially. Four measures showed slight rate decreases (less than 5 percentage points each) compared to the previous year: *Getting Treatment Quickly, Office Wait, Told About Medication Side Effects,* and *Amount Helped.*

Recommendations

HSAG identified several possible interventions that could be applied by FBHP as appropriate to the BHO's population and organizational structure. HSAG's recommendations focused on substantial decreases in measure rates for either the adult or child population and on any slight decreases in rates for measures common to both the adult and child populations.

FBHP's adult Medicaid population experienced no substantial decrease in rates for any measures. HSAG encourages FBHP to continue initiatives that appear to be positively impacting rates in many adult-related measures.

FBHP's child Medicaid population experienced no substantial decrease in rates for any measures. HSAG encourages FBHP to continue initiatives that appear to be positively impacting rates in child-related measures.

For both FBHP's adult and child Medicaid populations, slight decreases in *Amount Helped* may indicate similar quality outcome concerns. HSAG offers the following observations and recommendations:

- The *Amount Helped* measure is a possible quality outcome indicator considered from the member's perspective, and may indicate the need for quality improvement initiatives by a provider. HSAG recommends that providers develop interim short-term goals with individual members as a mechanism to facilitate the member's or family's perception of progress toward those goals, and to review or revise them with the member at appropriate intervals. FBHP might consider implementing ongoing measures to monitor members' or families' perceptions of improvement, possibly through an exit interview when discontinuing treatment or through interim assessments with members in long-term treatment. If concerning trends are identified, FBHP should work with providers, members, and families to identify more detailed potential causes and implement performance improvement initiatives, as indicated. When identified decreases in ratings are related to the child population, these measures might indicate the need for the BHO to evaluate adequacy or expertise within the network to address child behavioral health issues. If indicated, FBHP might consider increasing provider training forums, increasing telehealth links to child behavioral health specialists, or directing members to targeted child behavioral health resources.

FBHP: Summary Assessment of Quality, Timeliness, and Access for ECHO

For FBHP's adult Medicaid population, 14 measures evaluated for the quality domain, improved either substantially (6 measures) or slightly (6 additional measures) when compared to the previous year. No adult Medicaid population measure rates decreased substantially. Two of the adult Medicaid population measure rates decreased slightly (less than 2 percentage points) from the previous year. Overall, results for the FBHP adult population are trending substantially upward.

For FBHP's child Medicaid population, 13 measures evaluated for the quality domain improved over the previous year. Two measures demonstrated substantially higher rates than the previous year, and eight additional measures demonstrated slight increases when compared to the previous year. No child Medicaid population measure rates decreased substantially. Three measures showed slight rate decreases when compared to the previous year. Overall results for the child population in the quality domain are trending upward, although improvements needed can be identified.

For the two measures that assessed timeliness—*Getting Treatment Quickly* and *Office Wait*—one measure rate increased substantially and one measure rate increased slightly for the FBHP's adult Medicaid population, while both rates for the child Medicaid population demonstrated slight decreases from the previous measurement year. As the rates for *Getting Treatment Quickly* remain in the upper 60 percentage-point range, continued improvement efforts are indicated.

For the four measures evaluated for the access domain, FBHP's rates related to adult Medicaid members increased substantially for three measures and decreased slightly for one measure, compared to the previous year. For FBHP's child population, the rates increased slightly for three measures and demonstrated a slight decrease for one measure. Overall rates for the access domain were largely trending upward.

5. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 5-1—Statewide Results for Medicaid Managed Care MCO Standards

Description of Standard	Access KP	DHMC	RMHP Prime	Statewide Average
Standard I—Coverage and Authorization of Services (2017)	**71%**	**94%**	**94%**	**86%**
Standard II—Access and Availability (2017)	**85%**	**92%**	**100%**	**92%**
Standard III—Coordination and Continuity of Care (2016)	NA	92%	100%	96%
Standard IV—Member Rights and Protections (2016)	NA	100%	80%	90%
Standard V—Member Information (2015)	NA	93%	80%	87%
Standard VI—Grievance System (2015)	NA	65%	88%	77%
Standard VII—Provider Participation and Program Integrity (2015)	NA	100%	93%	97%
Standard VIII—Credentialing and Recredentialing (2016)	NA	98%	100%	99%
Standard IX—Subcontracts and Delegation (2015 for DHMC and RMHP Prime, **2017 for Access KP**)	**55%**	100%	100%	100%
Standard X—Quality Assessment and Performance Improvement (2016)	NA	88%	100%	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (2017 for DHMC and RMHP Prime only)	NA	**62%**	**92%**	**77%**

Note: Bold text indicates which standards HSAG reviewed during FY 2016–2017.

Table 5-2—Statewide Results for Medicaid Managed Care MCO Record Reviews

Record Reviews	Access KP	DHMC	RMHP Prime	Statewide Average
Appeals (2015)	NA	73%	98%	88%
Credentialing (2016)	NA	100%	100%	100%
Denials (2017)	**93%**	**87%**	**90%**	**90%**
Grievances (2015)	NA	78%	98%	94%
Recredentialing (2016)	NA	100%	100%	100%

Note: Bold text indicates which standard HSAG reviewed during FY 2016–2017.

Table 5-3—Statewide Results for Medicaid Managed Care BHO Standards

Description of Standard	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Standard I—Coverage and Authorization of Services (2017)	**87%**	**84%**	**87%**	**93%**	**89%**	**88%**
Standard II—Access and Availability (2017)	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
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%
XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Not Scored	Not Scored	Not Scored	Not Scored	Not Scored	Not Scored

Note: Bold text indicates which standards HSAG reviewed during FY 2016–2017.

Table 5-4—Statewide Results for Medicaid Managed Care BHO Record Reviews

Record Reviews	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 (2017)	**97%**	**93%**	**94%**	**98%**	**92%**	**95%**
Grievances (2015)	93%	94%	100%	87%	100%	88%
Recredentialing (2016)	100%	100%	97%	95%	96%	97%

Note: Bold text indicates which standards HSAG reviewed during FY 2016–2017.

Statewide Conclusions and Recommendations for Compliance Monitoring

For the 2015–2016 standards reviewed, all Colorado health plans (inclusive of MCOs and BHOs) demonstrated improved performance in complying with State and federal regulations. All health plans reviewed had written policies and procedures that delineated criteria used to make authorization decisions, demonstrated that qualified clinicians made decisions to deny services, and provided evidence of having applied interrater reliability testing annually.

All except one health plan demonstrated having provider networks adequate to serve the needs of members, and all health plans expressed intentions to continue growing their networks. Colorado health plans demonstrated creative mechanisms to expand network capacity, including the addition of telemedicine and provider incentives for expanding access, as well as by fostering relationships between independent network providers and CMHCs.

All plans described efforts to add providers with culturally diverse experiences to the networks. In addition, Colorado health plans have built strong cultural competency training programs designed for employees, providers, and the general public. These training programs addressed a variety of populations and special communities, including the deaf and hard of hearing and lesbian, gay, bisexual, transgender (LGBT) populations. Needs expressed by organizations working for the needs of special populations (e.g., the CCDC, Area Agency on Aging, and refugee and ethnic support organizations) were also addressed in the trainings.

While all Colorado health plans continue to demonstrate a strong understanding of federal and State Medicaid managed care regulations, HSAG noted a few performance areas requiring statewide improvement. Effective August 30, 2016, Colorado updated the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8. This update created a uniform definition of "medical necessity" to be used across all applicable Medical Assistance programs and included the addition of EPSDT-specific criteria. HSAG encouraged all health plans to immediately update internal policies and procedures to reflect this combined definition.

HSAG continues to see improvement in health plan compliance with ensuring that member information is written using easy-to-understand language; however, room for improvement continues, particularly in member-specific communications such as NOAs.

HSAG noted that while policies accurately described time frames related to notifying members and providers about UM decisions, on-site record reviews showed that in practice several health plans struggled to meet these time frames. Additionally, some lingering confusion regarding appropriate timing for peer-to-peer consultations seemed apparent.

Validation of Performance Measures

In Table 5-5 and Table 5-6, plan-specific and statewide weighted averages are presented for the Medicaid MCOs and BHOs. Given that the MCOs varied in membership size, the statewide average rate for each measure was weighted based on the health plans' eligible populations. For the health plans with rates reported as *Small Denominator* (*NA*), the numerators, denominators, and eligible populations were included in the calculations of the statewide rate. The health plan rates reported as *Biased Rate* (*BR*) or *Not Reported* (*NR*) were excluded from the statewide rate calculation.

Table 5-5—MCO and Statewide Results

Performance Measures	Access KP	DHMC	RMHP Prime[§]	Statewide Weighted Average
Pediatric Care				
Childhood Immunization Status				
Combination 2	72.08%	72.57%	NA	72.43%
Combination 3	71.29%	71.58%	NA	71.48%
Combination 4	71.29%	71.42%	NA	71.36%
Combination 5	62.57%	59.46%	NA	60.05%
Combination 6	42.38%	53.76%	NA	51.34%
Combination 7	62.57%	59.35%	NA	59.97%
Combination 8	42.38%	53.76%	NA	51.34%
Combination 9	37.03%	46.50%	NA	44.49%
Combination 10	37.03%	46.50%	NA	44.49%
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	84.80%	75.37%	NA	77.21%
Combination 2 (Meningococcal, Tdap, HPV)	31.80%	24.88%	NA	26.24%
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	0.00%	7.03%	NA	6.01%
Six or More Visits	75.34%	3.52%	NA	14.01%
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	63.66%	58.59%	67.35%	59.69%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	54.80%	34.68%	15.57%	37.83%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Assessment—Total	93.44%	7.68%	2.40%	27.40%
Counseling for Nutrition—Total	97.36%	1.08%	14.00%	23.42%
Counseling for Physical Activity—Total	97.36%	0.55%	0.80%	22.88%
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	95.67%	80.52%	NA	87.50%

Performance Measures	Access KP	DHMC	RMHP Prime§	Statewide Weighted Average
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	99.29%	96.04%	94.74%	96.98%
Access to Care and Preventive Screening				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	100.00%	74.04%	51.22%	63.05%
Postpartum Care	96.30%	44.42%	28.22%	37.45%
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	91.25%	88.32%	NA	89.47%
Ages 25 Months to 6 Years	78.88%	71.74%	90.57%	73.09%
Ages 7 to 11 Years	80.91%	76.19%	90.11%	77.19%
Ages 12 to 19 Years	82.11%	76.40%	86.06%	77.70%
Adults' Access to Preventive/Ambulatory Health Services				
Total	73.59%	59.87%	72.23%	67.55%
Chlamydia Screening in Women				
Total	60.42%	68.73%	45.23%	60.37%
Breast Cancer Screening				
Breast Cancer Screening	62.27%	51.85%	47.80%	52.46%
Cervical Cancer Screening				
Cervical Cancer Screening	64.43%	45.77%	40.88%	44.89%
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.10%	0.06%	3.07%	0.23%
Adult BMI Assessment				
Adult BMI Assessment	98.30%	81.03%	16.21%	56.21%
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	81.04%	49.05%	56.03%	58.99%
Effective Continuation Phase Treatment	54.29%	31.02%	36.21%	38.31%
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	47.46%	26.88%	NA	33.78%
Continuation and Maintenance Phase	NA	NA	NA	34.09%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	NA	0.00%	NA	0.00%
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NA	76.00%

Performance Measures	Access KP	DHMC	RMHP Prime§	Statewide Weighted Average
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	92.45%	82.60%	86.05%	85.56%
*HbA1c Poor Control (>9.0%)**	33.53%	44.02%	74.00%	54.64%
HbA1c Control (<8.0%)	51.96%	44.33%	21.71%	36.27%
Eye Exam (Retinal) Performed	66.33%	45.70%	38.23%	45.89%
Medical Attention for Nephropathy	95.79%	87.35%	83.54%	87.12%
Blood Pressure Controlled (<140/90 mm Hg)	84.18%	57.41%	0.00%	38.12%
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	68.57%	59.83%	43.48%	55.97%
Statin Adherence 80%	61.86%	54.71%	62.75%	58.44%
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	78.00%	72.18%	71.08%	72.49%
Statin Adherence 80%—Total	74.36%	54.17%	66.10%	62.85%
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	99.69%	85.93%	84.67%	87.87%
Digoxin	NA	NA	NA	64.86%
Diuretics	100.00%	84.95%	85.51%	87.80%
Total	99.73%	85.46%	84.78%	87.70%
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	78.38%	65.53%	74.17%	71.58%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	82.93%	65.57%	37.87%	44.38%
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	NA	64.16%	53.09%	60.52%
Bronchodilator	NA	81.82%	62.89%	75.52%
Medication Management for People With Asthma				
Medication Compliance 50%—Total	70.47%	47.83%	63.41%	55.08%
Medication Compliance 75%—Total	39.60%	22.64%	34.63%	28.15%
Asthma Medication Ratio				
Total	76.97%	42.41%	56.35%	50.92%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NA	22.47%	27.19%	25.17%
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis				
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	84.85%	86.49%	75.25%	80.77%

Performance Measures	Access KP	DHMC	RMHP Prime§	Statewide Weighted Average
Use of Services				
Ambulatory Care (Per 1,000 Member Months)				
Outpatient Visits—Total	213.06	193.35	320.65	230.63
*Emergency Department Visits**	0.25‡	42.22	66.27	41.77‡
Inpatient Utilization—General Hospital/Acute Care				
Discharges per 1,000 Member Months (Total Inpatient)	NR	4.85	9.66	6.39
Days per 1,000 Member Months (Total Inpatient)	NR	21.39	35.32	25.85
Average Length of Stay (Total Inpatient)	NR	4.41	3.66	4.05
Discharges per 1,000 Member Months (Medicine)	NR	2.63	4.47	3.22
Days per 1,000 Member Months (Medicine)	NR	10.36	16.38	12.28
Average Length of Stay (Medicine)	NR	3.94	3.66	3.81
Discharges per 1,000 Member Months (Surgery)	NR	0.81	2.36	1.31
Days per 1,000 Member Months (Surgery)	NR	7.11	12.73	8.91
Average Length of Stay (Surgery)	NR	8.79	5.39	6.82
Discharges per 1,000 Member Months (Maternity)	NR	2.07	2.96	2.43
Days per 1,000 Member Months (Maternity)	NR	5.78	6.52	6.07
Average Length of Stay (Maternity)	NR	2.79	2.20	2.50
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics	0.43	0.31	0.75	0.45
Average Days Supplied per Antibiotic Script	10.84	9.28	9.27	9.53
Average Scripts PMPY for Antibiotics of Concern	0.14	0.09	0.32	0.16
Percentage of Antibiotics of Concern of All Antibiotic Scripts	33.37%	27.79%	42.10%	34.94%
Frequency of Selected Procedures (Per 1,000 Member Months)				
Bariatric Weight Loss Surgery (0–19 Male)	0.00	0.00	0.00	0.00
Bariatric Weight Loss Surgery (0–19 Female)	0.00	0.00	0.00	0.00
Bariatric Weight Loss Surgery (20–44 Male)	0.00	0.01	0.01	0.01
Bariatric Weight Loss Surgery (20–44 Female)	0.00	0.05	0.09	0.06
Bariatric Weight Loss Surgery (45–64 Male)	0.00	0.02	0.02	0.02
Bariatric Weight Loss Surgery (45–64 Female)	0.00	0.02	0.25	0.12
Tonsillectomy (0–9 Male & Female)	0.00	0.29	3.60	0.25
Tonsillectomy (10–19 Male & Female)	0.00	0.16	0.16	0.13
Hysterectomy, Abdominal (15–44 Female)	0.00	0.06	0.10	0.07
Hysterectomy, Abdominal (45–64 Female)	0.00	0.10	0.23	0.14
Hysterectomy, Vaginal (15–44 Female)	0.00	0.02	0.59	0.23
Hysterectomy, Vaginal (45–64 Female)	0.04	0.15	0.40	0.24
Cholecystectomy, Open (30–64 Male)	0.00	0.01	0.00	0.00
Cholecystectomy, Open (15–44 Female)	0.00	0.01	0.01	0.01

Performance Measures	Access KP	DHMC	RMHP Prime§	Statewide Weighted Average
Cholecystectomy, Open (45–64 Female)	0.00	0.04	0.01	0.02
Cholecystectomy, Laparoscopic (30–64 Male)	0.00	0.05	0.33	0.17
Cholecystectomy, Laparoscopic (15–44 Female)	0.00	0.40	0.82	0.49
Cholecystectomy, Laparoscopic (45–64 Female)	0.00	0.33	0.70	0.44
Back Surgery (20–44 Male)	0.29	0.07	0.18	0.14
Back Surgery (20–44 Female)	0.57	0.03	0.29	0.22
Back Surgery (45–64 Male)	0.66	0.36	0.83	0.62
Back Surgery (45–64 Female)	0.95	0.33	0.78	0.65
Mastectomy (15–44 Female)	0.01	0.01	0.07	0.03
Mastectomy (45–64 Female)	0.00	0.06	0.04	0.04
Lumpectomy (15–44 Female)	0.01	0.07	0.13	0.08
Lumpectomy (45–64 Female)	0.04	0.19	0.26	0.20

§ Due to differences in eligibility for children in RMHP Prime compared to eligibility for children in the other Medicaid MCOs, rates that include children in the considered eligible population may not be comparable between RMHP Prime and the other Medicaid MCOs.
** For this indicator, a lower rate indicates better performance.*
‡ Access KP acknowledged that the reported rate for this measure may not be valid; therefore, exercise caution when interpreting these results.
NA (Small Denominator) indicates that the health plan followed the specifications but the denominator was too small (<30) to report a valid rate.

Table 5-6—BHO and Statewide Results

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	3.34%	1.86%	2.20%	3.06%	3.33%	2.83%
Non-State Hospitals—30 Days	9.68%	6.04%	7.02%	9.83%	9.49%	8.73%
Non-State Hospitals—90 Days	16.16%	11.15%	12.17%	16.06%	15.84%	14.69%
All Hospitals—7 Days	3.21%	1.85%	2.32%	2.99%	3.66%	2.85%
All Hospitals—30 Days	9.30%	6.01%	6.89%	9.66%	9.60%	8.59%
All Hospitals—90 Days	15.52%	11.09%	12.00%	15.92%	15.72%	14.46%
Hospital Readmissions Within 180 Days (All Facilities)*						
Hospital Readmissions Within 180 Days (All Facilities)	23.53%	16.48%	18.01%	21.14%	19.26%	20.14%
Adherence to Antipsychotics for Individuals With Schizophrenia						
Adherence to Antipsychotics for Individuals With Schizophrenia	47.58%	56.06%	59.38%	60.13%	61.84%	57.29%
Overall Penetration Rates						
Overall Penetration Rates	14.74%	14.02%	12.53%	14.86%	17.37%	14.48%
Penetration Rates by Age Group						
Children 12 Years of Age and Younger	6.23%	7.41%	6.70%	7.16%	13.89%	7.67%
Adolescents 13 Through 17 Years of Age	14.70%	18.34%	17.43%	17.16%	22.05%	17.60%

Performance Measure	ABC–D	ABC–NE	BHI	CHP	FBHP	Statewide Average
Adults 18 Through 64 Years of Age	19.80%	17.66%	15.92%	18.63%	18.81%	18.13%
Adults 65 Years of Age or Older	9.51%	7.57%	6.35%	12.11%	8.53%	9.36%
Penetration Rates by Medicaid Eligibility Category						
AND/AB-SSI	39.68%	33.87%	32.83%	34.15%	36.11%	35.03%
BC Children	2.43%	2.45%	1.92%	4.44%	4.14%	3.13%
BCCP-Women Breast and Cervical Cancer	16.03%	27.93%	14.74%	11.99%	16.10%	16.14%
Buy-In: Working Adult Disabled	35.99%	26.35%	29.65%	26.19%	45.02%	31.07%
Foster Care	34.59%	29.27%	31.51%	29.53%	37.05%	31.70%
OAP-A	9.13%	7.52%	6.21%	11.99%	8.18%	9.16%
OAP-B-SSI	32.59%	23.62%	23.74%	26.62%	30.17%	27.47%
MAGI Adults	17.82%	16.12%	14.23%	16.48%	16.63%	16.20%
Buy-In: Children With Disabilities	17.23%	27.92%	20.85%	13.24%	23.66%	19.86%
MAGI Parents/Caretakers	14.91%	15.21%	13.76%	16.40%	15.92%	15.34%
MAGI Children	7.52%	9.51%	8.76%	8.96%	15.23%	9.46%
MAGI Pregnant	19.02%	15.95%	14.31%	19.91%	19.10%	17.81%
Follow-Up Appointments After Emergency Department Visits for a Mental Health Condition						
7-Day Follow-Up	31.85%	23.19%	31.73%	33.88%	37.98%	32.20%
30-Day Follow-Up	42.51%	33.77%	41.51%	43.78%	49.62%	42.51%
Follow-Up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence						
7-Day Follow-Up	6.38%	8.80%	9.93%	12.46%	12.22%	9.93%
30-Day Follow-Up	13.25%	16.08%	17.80%	19.65%	19.88%	17.24%
Mental Health Engagement						
Mental Health Engagement	35.49%	42.71%	43.33%	42.68%	45.89%	42.41%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment						
Initiation of AOD Treatment	35.01%	46.78%	46.09%	41.40%	40.95%	41.40%
Engagement of AOD Treatment	28.44%	34.44%	36.03%	30.40%	30.17%	31.49%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners						
Non-State Hospitals—7 Days	39.48%	36.21%	41.82%	44.81%	47.66%	42.41%
Non-State Hospitals—30 Days	56.37%	54.21%	57.14%	63.80%	65.58%	60.09%
All Hospitals—7 Days	39.55%	36.11%	42.68%	44.40%	47.73%	42.44%
All Hospitals—30 Days	56.97%	53.94%	57.71%	63.64%	66.01%	60.27%
Follow-Up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only						
Non-State Hospitals—7 Days	34.69%	24.80%	32.51%	20.88%	30.52%	27.31%
Non-State Hospitals—30 Days	51.13%	42.22%	49.48%	42.77%	46.10%	45.84%
All Hospitals—7 Days	34.41%	24.91%	33.24%	20.60%	30.67%	27.40%
All Hospitals—30 Days	51.22%	42.46%	50.00%	42.58%	46.50%	46.03%

** For this measure, a lower rate may indicate more favorable performance.*

Statewide Conclusions and Recommendations for Validation of MCO Performance Measures

Pediatric Care Measures

The following statewide average rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Childhood Immunization Status—Combinations 6 8, 9, and 10*
- *Appropriate Testing for Children With Pharyngitis*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

The following rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *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*
- *Adolescent Well-Care Visits*
- *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*

Additionally, rates for *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* declined by 5 percentage points or more each from the prior year. As a result, HSAG recommends that the Medicaid health plans assess potential improvements in documented well-child visits and well-care visits, as well as in documenting BMI, nutrition counseling, and physical activity counseling for children and adolescents.

Of note, the rate for *Well-Child Visits in the First 15 Months of Life—Six or More Visits* fell below the national Medicaid 10th percentile; however, this rate did improve by 5 percentage points or more, indicating improvement from the prior year. Therefore, the Medicaid health plans are recommended to analyze strategies that can be linked to continued improvements in well-child visits for infants.

Many measures identified as areas of improvement can be reported using the hybrid methodology; therefore, caution should be used when comparing the statewide weighted average administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Access to Care and Preventive Screening Measures

The following statewide average rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*

The following statewide average rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *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 Years*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Cervical Cancer Screening*
- *Adult BMI Assessment*

As a result, HSAG recommends that the Medicaid health plans analyze strategies that can be linked to improving administrative documentation of prenatal and postpartum care, access to care, cervical cancer screenings, and documented BMI assessments for adults. Of note, because the *Prenatal and Postpartum Care*, *Cervical Cancer Screening*, and *Adult BMI Assessment* measures can be reported using the hybrid methodology, caution should be used when comparing the statewide weighted average administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Mental/Behavioral Health Measures

The following statewide average rate ranked at or above the national Medicaid 75th percentile, indicating an area of strength:

- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*

The following statewide average rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase*

HSAG recommends that the health plans analyze opportunities for improved follow-up care for children prescribed ADHD medication.

Living With Illness Measures

The following statewide average rates ranked at or above the national Medicaid 75th percentile, indicating areas of strength:

- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis*

Further, rates that assessed the Medicaid managed healthcare plans' monitoring for members on digoxin and treatment for members with rheumatoid arthritis improved by 5 percentage points or more each from the prior year.

Conversely, the following statewide average rates fell below the national Medicaid 25th percentile, indicating areas for improvement:

- *Persistence of Beta-Blocker Treatment After a Heart Attack*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*
- *Asthma Medication Ratio—Total*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*

Comprehensive Diabetes Care measure indicators can be reported using the hybrid methodology; therefore, caution should be used when comparing these statewide weighted average administrative rates to national benchmarks that were calculated using the administrative and/or hybrid methodology.

Additionally, the following rates declined by 5 percentage points or more each; therefore, HSAG recommends that the Medicaid managed care health plans assess root causes for low performance related to documented care for members with diabetes and appropriate imaging studies for members with low back pain.

- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- *HbA1c Control (<8.0%)*
- *Eye Exam (Retinal) Performed*
- *Blood Pressure Control (<140/90 mm Hg)*
- *Use of Imaging Studies for Low Back Pain*

Of note, the following rates increased by 5 percentage points or more each, indicating focus areas for continued improvement in care provided to both members with COPD who were on a bronchodilator and members with asthma.

- *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Medication Compliance 75%—Total*
- *Asthma Medication Ratio—Total*

Use of Services Measures

Reported rates for statewide weighted averages for the Use of Services measure domain 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, the statewide weighted average utilization results provide additional information that Medicaid managed care plans may use to further assess barriers or patterns of utilization when evaluating improvement interventions.

Statewide Conclusions and Recommendations for Validation of BHO Performance Measures

For the current reporting period, all five BHOs continued to use staff with extensive experience and knowledge of processes related to behavioral health measures and related reporting requirements. In addition, all five BHOs had sufficient vendor oversight to further ensure data accuracy for performance measure reporting. HSAG recommends that the BHOs review the scope document in its entirety and continue to communicate with the Department and other BHOs to ensure that all BHOs have the same understanding of reporting requirements. In addition, HSAG also recommends that the BHOs implement additional verification processes to further ensure data accuracy for measure reporting.

From MY 2014–2015 to MY 2015–2016, the following rates demonstrated an improvement in performance by 5 percentage points or more each, indicating areas of strength statewide:

- *Penetration Rates by Medicaid Eligibility Category—BCCP-Women Breast and Cervical Cancer* and *Buy-In: Children With Disabilities*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment* and *Engagement of AOD Treatment*

From MY 2014–2015 to MY 2015–2016, no statewide rates declined by 5 percentage points or more, suggesting stable performance overall.

Validation of Performance Improvement Projects

Statewide Results for Validation of MCO PIPs

Table 5-7—FY 2016–2017 PIP Validation Scores for the MCOs

Health Plan	PIP Topic	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
DHMC	*Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*	100%	100%	*Met*
RMHP Prime	*Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*	89%	82%	*Not Met*

Statewide Results for Validation of BHO PIPs

Table 5-8—FY 2016–2017 PIP Validation Scores for the BHOs

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*	81%	73%	*Not 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*	86%	73%	*Not Met*
CHP	*Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release*	90%	82%	*Not Met*
FBHP	*Improving Transition From Jail to Community-Based Behavioral Health Treatment*	90%	82%	*Not Met*

Statewide Conclusions and Recommendations for PIPs

Of the two Medicaid MCOs and five BHOs that submitted PIPs for validation in FY 2016–2017, one MCO (DHMC) and one BHO (ABC-NE) each received an overall *Met* validation status. The remaining MCO and BHOs received a *Not Met* validation status for each of their PIPs. The primary difference between the PIPs that received *Met* validation status and those that received *Not Met* status was the stage to which each PIP had progressed. The two PIPs that each received a *Met* validation status had progressed through the Implementation stage, reporting baseline study indicator results only, and were not assessed for achieving statistically significant improvement in the Outcomes stage of the PIP. The five PIPs that each received a *Not Met* validation status had progressed to reporting Remeasurement 1 results and were evaluated for achieving statistically significant improvement in the Outcomes stage. No PIPs that progressed to the Outcomes stage demonstrated statistically significant improvement over the baseline rate at the first remeasurement. Demonstrating statistically significant improvement over baseline is a critical evaluation element in HSAG's PIP validation process; therefore, the *Not Met* score for this evaluation element determined the overall *Not Met* validation status for each of the PIPs.

Two common barriers contributed to the difficulty in achieving a *Met* validation status: lack of access to data and the need to build working relationships between separate systems of care. The overarching state-wide topic established for all PIPs—Transitions of Care—challenged the health plans to explore a plan-specific PIP topic beyond those based on standard reporting measures such as HEDIS. Some of the plan-specific PIP topics required health plans to establish data-sharing relationships with various partners in order to be able to measure PIP progress. For example, PIPs that dealt with the transition of care from a corrections facility to the community had to establish formal data-sharing agreements with the justice system to gain access to the data needed for study indicator calculations and intervention evaluation. In some cases, this step delayed the baseline study indicator measurement and initiation of improvement strategies. The state-wide Transitions of Care topic also challenged the health plans to facilitate partnerships and communication between separate departments or systems. For example, PIPs that dealt with the transition from physical healthcare to behavioral healthcare encountered unique challenges in tracking and communicating related services received in the two settings. For some PIPs, substantial groundwork was required to establish the relationships and communication necessary to deploy interventions and foster improvement in outcomes.

The PIPs will be assessed for demonstrating statistically significant improvement again during the next validation cycle. To move toward demonstrating real improvement in the Transitions of Care PIP outcomes, the health plans should address issues identified in Activity VIII (Improvement Strategies) related to identification of barriers, employing active and appropriate interventions, and evaluating interventions for effectiveness. The health plans designed methodologically sound PIPs; however, many were not able to demonstrate real improvement in outcomes at the first remeasurement. The health plans should review HSAG's feedback in the PIP validation tool and should revisit the PIP's causal/barrier analysis to determine if additional barriers can be identified. After revisiting and updating the causal/barrier analyses, the health plans should prioritize the barriers and develop active interventions that are logically linked to high-priority barriers and are likely to positively impact PIP outcomes.

As the PIPs progress, HSAG recommends that the MCOs and BHOs:

- Incorporate interventions that directly address identified barriers, actively engage members and/or providers, and are likely to impact the PIP outcomes.
- Ensure that the PIP primarily incorporates interventions that actively engage members and/or providers and which are likely to impact the PIP outcomes.
- Explore resources for developing innovative interventions that have the potential to result in fundamental change and sustainable improvement. HSAG is available to provide resources that may assist in generating new ideas for interventions of greater impact.
- Evaluate the effectiveness of each implemented intervention. Obtaining evaluation results for each intervention will allow the health plan 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 quality improvement science techniques 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.
- Conduct 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.

Consumer Assessment of Healthcare Providers and Systems Surveys

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. HSAG presented the 2017 adult Medicaid CAHPS top-box rates for Access KP, DHMC, RMHP Prime, and the statewide average. Additionally, the 2017 child Medicaid CAHPS top-box rates for DHMC, RMHP Prime, and the statewide average are presented in the tables on the following pages.[5-1]

Table 5-9 shows the adult Medicaid results achieved by the three MCOs and the statewide average for FY 2016–2017.[5-2]

Table 5-9—2017 Adult Statewide Results for MCOs

Measure	Access KP	DHMC	RMHP Prime	Statewide Average
Getting Needed Care	82.3%	76.1%	86.7%	81.2%
Getting Care Quickly	78.2%	76.1%	84.6%	79.8%
How Well Doctors Communicate	89.3%	92.6%	88.8%	90.6%
Customer Service	87.8%	86.6% +	88.2% +	87.4%
Shared Decision Making	77.2%	82.6% +	83.4%	82.2%
Rating of Personal Doctor	58.6%	71.8%	55.6%	63.4%
Rating of Specialist Seen Most Often	68.9%	69.0% +	61.4%	65.9%
Rating of All Health Care	52.1%	61.7%	48.2%	54.9%
Rating of Health Plan	57.7%	57.4%	51.6%	55.1%

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.

[5-1] HSAG received no child Medicaid CAHPS Survey data for Access KP.

[5-2] The Colorado adult and statewide average Medicaid scores are derived from a weighted average of the three adult Colorado Medicaid plans: Access KP, DHMC, and RMHP Prime.

Table 5-10 shows the child Medicaid results achieved by DHMC and RMHP Prime and the statewide average for FY 2016–2017.[5-3]

Table 5-10—2017 Child Statewide Results for MCOs

Measure	DHMC	RMHP Prime	Statewide Average
Getting Needed Care	79.5%	88.5% +	79.6%
Getting Care Quickly	84.0%	95.5% +	84.1%
How Well Doctors Communicate	93.9%	97.0% +	94.0%
Customer Service	85.5% +	84.1% +	85.5%
Shared Decision Making	74.3% +	91.7% +	74.5% +
Rating of Personal Doctor	79.2%	80.3% +	79.2%
Rating of Specialist Seen Most Often	66.7% +	57.5% +	66.6% +
Rating of All Health Care	70.2%	56.1% +	70.1%
Rating of Health Plan	68.1%	64.7% +	68.1%

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.

Statewide Conclusions and Recommendations for CAHPS

Providing statewide recommendations based on averages for a limited number of plans (three Medicaid plans) may not be the most valuable strategy for health plans. Therefore, HSAG identified several possible interventions that could be applied by the health plans as appropriate to the plans' populations and organizational structures for *Rating of Specialist Seen Most Often* and *Rating of Health Plan* measures for the adult population and for the *Rating of All Health Care* measure for the child population, based on consistently low rates across health plans.

To impact member perception related to specialty providers and the health plan and to ensure provider knowledge of the Medicaid benefit plan processes that impact members, HSAG recommends that the two health plans build upon provider communications designed for training and informing providers of health plan procedures and ongoing changes The health plans may also want to investigate physician communication skills and cultural competency skills and consider implementing interactive workshops for providers and staff to further improve dissemination of information about appointment availability standards and communication skills.

To impact member perceptions related to overall healthcare, HSAG recommends that the health plans develop or expand upon member advisory committee or groups and consider expanding member

[5-3] The Colorado child and statewide average Medicaid scores are derived from a weighted average of DHMC and RMHP Prime rates.

participation or investigate how member participants can positively communicate with the health plans' membership to reach additional members and assist them in understanding the Medicaid program and the health plans' processes. The health plans may also want to consider developing performance measures related to customer service activities and providing health plan staff training programs that will impact outcomes related to these measures.

Experience of Care and Health Outcomes Surveys

The technical method of data collection was through the administration of a modified version of the *Adult ECHO Survey, Managed Behavioral Healthcare Organization (MBHO), Version 3.0* (adult ECHO survey), which incorporates items from the Mental Health Statistics Improvement Program (MHSIP) survey, and a modified version of the *Child/Parent ECHO Survey, MBHO, Version 3.0* (child/parent ECHO survey), which incorporates items from the Youth Services Survey for Families (YSS-F) and the YSS. HSAG presented the 2017 adult and child ECHO top-box rates for ABC-D, ABC-NE, BHI, CHP, FBHP, and the statewide average in the tables below.

Table 5-11 shows the adult ECHO survey results achieved by the five BHOs and the statewide average for FY 2016–2017.

Table 5-11—2017 Adult Statewide Results for ECHO

Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Rating of All Counseling or Treatment	51.3%	55.6%	47.3%	40.0%	49.4%	46.9%
Getting Treatment Quickly	62.3%	69.8%	61.1%	69.6%	67.3%	66.3%
How Well Clinicians Communicate	87.8%	88.9%	86.0%	89.4%	89.2%	88.3%
Perceived Improvement	56.9%	63.4%	65.6%	58.9%	60.3%	60.9%
Information About Treatment Options	59.4%	54.1%	63.4%	60.8%	60.6%	60.3%
Office Wait	77.0%	83.1%	82.5%	83.8%	88.0%	83.1%
Told About Medication Side Effects	82.1%	73.2%	73.9%	77.6%	77.9%	76.9%
Including Family	42.0%	49.7%	47.4%	45.5%	40.8%	45.1%
Information to Manage Condition	80.7%	78.8%	74.3%	71.5%	79.0%	75.7%
Patient Rights Information	86.0%	85.6%	90.1%	83.1%	87.4%	86.1%
Patient Feels He or She Could Refuse	78.9%	78.6%	82.0%	81.1%	85.8%	81.4%
Privacy	90.0%	94.5%	93.3%	95.1%	97.2%	94.2%
Cultural Competency	N/A	N/A	N/A	N/A	N/A	65.9%+
Amount Helped	82.8%	84.2%	80.6%	80.0%	81.8%	81.4%

Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Improved Functioning	52.6%	57.9%	56.6%	53.3%	54.9%	54.8%
Social Connectedness	68.9%	64.7%	65.8%	65.7%	60.6%	65.2%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Table 5-12 shows the child ECHO Survey results achieved by the five BHOs and the statewide average for FY 2016–2017.

Table 5-12—2017 Child Statewide Results for ECHO

Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Rating of All Counseling or Treatment	51.5%+	41.5%	44.1%	41.7%	42.2%	43.5%
Getting Treatment Quickly	75.5%	66.3%	64.8%	68.1%	68.6%	67.8%
How Well Clinicians Communicate	90.0%	85.5%	87.1%	85.5%	88.8%	87.0%
Perceived Improvement	74.8%	74.9%	65.3%	65.4%	76.8%	69.8%
Information About Treatment Options	75.0%	74.4%	68.7%	68.2%	75.6%	71.3%
Office Wait	77.4%	80.2%	84.7%	83.9%	86.3%	83.2%
Told About Medication Side Effects	91.1%+	80.8%+	83.9%+	88.3%+	86.6%+	86.0%
Information to Manage Condition	70.4%+	69.7%	68.8%	68.4%	70.4%	69.3%
Patient Rights Information	92.9%+	87.9%	87.6%	88.7%	93.5%	89.5%
Patient Feels He or She Could Refuse	82.8%+	87.9%	84.1%	88.0%	92.8%	87.2%
Privacy	98.0%	98.4%	96.3%	96.8%	98.7%	97.4%
Cultural Competency	N/A	N/A	N/A	N/A	N/A	76.3%+
Amount Helped	80.5%	78.3%	72.6%	79.2%	73.4%	76.4%
Improved Functioning	66.0%	65.5%	59.0%	58.0%	65.6%	61.6%
Social Connectedness	91.9%	89.2%	84.1%	78.7%	88.3%	84.8%

ECHO scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for an ECHO measure, caution should be exercised when interpreting results.
"Not Applicable" indicates fewer than 30 responses; therefore, results were suppressed.

Statewide Conclusions and Recommendations for ECHO

Conclusions Related to Quality, Timeliness, and Access for ECHO

All measures within the adult and child ECHO survey addressed quality. In addition, *Information About Treatment Options*, *Information to Manage Condition*, and *Improved Functioning* addressed access; *Getting Treatment Quickly* addressed timeliness; and *Office Wait* addressed both access and timeliness.

A substantial increase is noted when a BHO's measure rate was 5 percentage points or more above the statewide average. A substantial decrease is noted when a BHO's measure rate was 5 percentage points or more below the statewide average. The adult and child statewide averages are calculated as weighted averages, with each BHO's eligible population acting as the weight.

Adult BHOs

For the adult Medicaid population, ABC-D had no measure rates substantially higher than the statewide averages. Five of ABC-D's measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Told About Medication Side Effects*
- *Information to Manage Condition*
- *Amount Helped*
- *Social Connectedness*

One of ABC-D's adult Medicaid population measure rates was substantially lower than the statewide average:

- *Office Wait* (6.1 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining nine measure rates were lower than the statewide averages.

For the adult Medicaid population, ABC-NE had one measure rate that was substantially higher than the statewide average:

- *Rating of All Counseling or Treatment* (8.7 percentage points)

Eight of ABC-NE's measure rates were higher than the statewide averages:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Perceived Improvement*
- *Including Family*
- *Information to Manage Condition*

- *Privacy*
- *Amount Helped*
- *Improved Functioning*

In addition, one measure for ABC-NE had the same rate as the statewide average.

- *Office Wait*

One of ABC-NE's adult Medicaid population measure rates was substantially lower than the statewide average:

- *Information About Treatment Options* (6.2 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining four measure rates were slightly lower than the statewide averages.

For the adult Medicaid population, BHI did not have any measure rates that were substantially higher than the statewide averages. Eight of BHI's measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Perceived Improvement*
- *Information About Treatment Options*
- *Including Family*
- *Patient Rights Information*
- *Patient Feels He or She Could Refuse Treatment*
- *Improved Functioning*
- *Social Connectedness*

One of BHI's adult Medicaid population measure rates was substantially lower than the statewide average:

- *Getting Treatment Quickly* (5.2 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining six measure rates were slightly lower than the statewide averages.

For the adult Medicaid population, CHP did not have any measure rates that were substantially higher than the statewide averages. Eight of CHP's measure rates were slightly higher than the statewide average:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Information About Treatment Options*
- *Office Wait*

- *Told About Medication Side Effects*
- *Including Family*
- *Privacy*
- *Social Connectedness*

One of CHP's adult Medicaid population measure rates was substantially lower than the statewide average:

- *Rating of All Counseling or Treatment* (6.9 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining six measure rates were slightly lower than the statewide averages.

For the adult Medicaid population, FBHP had no measure rates substantially higher than the statewide average. Twelve of FBHP's measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Information About Treatment Options*
- *Office Wait*
- *Told About Medication Side Effects*
- *Information to Manage Condition*
- *Patient Rights Information*
- *Patient Feels He or She Could Refuse Treatment*
- *Privacy*
- *Amount Helped*
- *Improved Functioning*

Furthermore, no FBHP adult Medicaid population measure rates were substantially lower than the statewide averages. One measure had fewer than 30 responses; therefore, results were suppressed. The remaining three measure rates were lower than the statewide averages.

Child BHOs

For ABC-D's child Medicaid population, five measure rates were substantially higher than the statewide averages:

- *Rating of All Counseling or Treatment* (8.0 percentage points)
- *Getting Treatment Quickly* (7.7 percentage points)
- *Perceived Improvement* (5.0 percentage points)

- *Told About Medication Side Effects* (5.1 percentage points)
- *Social Connectedness* (7.1 percentage points)

Seven of ABC-D's measure rates were higher than the statewide averages:

- *How Well Clinicians Communicate*
- *Information About Treatment Options*
- *Information to Manage Condition*
- *Patient Rights Information*
- *Privacy*
- *Amount Helped*
- *Improved Functioning*

One of ABC-D's child Medicaid population measure rates was substantially lower than the statewide average:

- *Office Wait* (5.8 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining measure rate was lower than the statewide average.

For ABC-NE's child Medicaid population, one measure rate was substantially higher than the statewide average:

- *Perceived Improvement* (5.1 percentage points)

Seven of ABC-NE's measure rates were higher than the statewide average:

- *Information About Treatment Options*
- *Information to Manage Condition*
- *Patient Feels He or She Could Refuse Treatment*
- *Privacy*
- *Amount Helped*
- *Improved Functioning*
- *Social Connectedness*

One of ABC-NE's child Medicaid population measure rates was substantially lower than the statewide average:

- *Told About Medication Side Effects* (5.2 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining five measure rates were slightly lower than the statewide averages.

For the child Medicaid population, BHI had no measure rates substantially higher than the statewide average. Three of BHI's measure rates were slightly higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *How Well Clinicians Communicate*
- *Office Wait*

No BHI child Medicaid population measure rates were substantially lower than the statewide average. One measure had fewer than 30 responses; therefore, results were suppressed. The remaining eleven measure rates were lower than the statewide averages.

For the child Medicaid population, CHP had no measure rates substantially higher than the statewide averages. Five CHP measure rates were slightly higher than the statewide averages:

- *Getting Treatment Quickly*
- *Office Wait*
- *Told About Medication Side Effects*
- *Patient Feels He or She Could Refuse Treatment*
- *Amount Helped*

One of CHP's child Medicaid population measure rates was substantially lower than the statewide average:

- *Social Connectedness* (6.1 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining eight measure rates were lower than the statewide averages.

For FBHP's child Medicaid population, two measure rates were substantially higher than the statewide averages:

- *Perceived Improvement* (7.0 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (5.6 percentage points)

Ten of FBHP's measure rates were higher than the statewide averages:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Information About Treatment Options*
- *Office Wait*
- *Told About Medication Side Effects*
- *Information to Manage Condition*
- *Patient Rights Information*

- *Privacy*
- *Improved Functioning*
- *Social Connectedness*

No FBHP child Medicaid population measure rates were substantially lower than the statewide average. One measure had fewer than 30 responses; therefore, results were suppressed. The remaining two measure rates were lower than the statewide averages.

Recommendations

One measure demonstrated a statewide rate below 50 percent for both the child and adult populations—*Rating of All Counseling or Treatment*. For the adult population, one additional measure demonstrated a statewide rate below 50 percent—*Including Family*. HSAG identified possible interventions that could be applied by the BHOs as appropriate to each population and organizational structure.

The *Rating of All Counseling or Treatment* and *Including Family* measures may indicate the need for quality improvement initiatives by a provider based on members' perspectives in areas such as access, communications, and perceived treatment outcomes.

HSAG recommends that the BHOs work with providers to investigate key factors contributing to the outcomes of these measures. BHOs should discuss with members the reasons for diminished satisfaction with the counseling or treatment received and identify any detailed patterns for improvement. Possible areas to investigate may be providers' and provider staff members' communication skills, cultural competency, or customer service skills. In addition, member advisory committees or focus groups may provide more detailed information regarding their experiences, from the member perspective.

6. Assessment of MCO Follow-Up on Prior Recommendations

The Department requested that each Medicaid MCO address recommendations and required actions following EQR activities conducted in FY 2015–2016. Therefore, this section of the report outlines the recommendations provided to the MCOs in FY 2015–2016 for compliance monitoring, PIP validation, and CAHPS based on 2015–2016 EQR activities performed; and for performance measure validation, based on the MY 2014–2015 performance measure rates. This section also describes any improvement activities reported by the MCOs intended to address performance in these areas and presents an assessment of how the MCOs responded to recommendations provided during the 2015–2016 EQR activities and/or an assessment of performance improvement noted during FY 2016–2017.

Access Kaiser Permanente

As this was the first year for Access KP, no prior year's recommendations existed for this health plan. Therefore, this section of the report is not applicable for Access KP.

Denver Health Medicaid Choice

Assessment of Compliance With Medicaid Managed Care Regulations

As a result of the FY 2015–2016 site review, DHMC was required to address one *Partially Met* element in the Coordination and Continuity of Care standard, one *Partially Met* element in the Credentialing and Recredentialing standard, and two *Partially Met* elements in the Quality Assessment and Performance Improvement standard. DHMC submitted its proposal to HSAG and the Department in April 2016. HSAG and the Department required DHMC to revise one element in its initial plan before submitting documents that demonstrated compliance. In August 2016, DHMC submitted to HSAG and the Department revised policies and procedures, provider communications, staff training, and tracking tools—all as evidence of having completed proposed actions. HSAG and the Department participated in telephone calls and one on-site consultation with DHMC staff members to provide additional assistance and clarification, as needed.

Also in August 2016, HSAG and the Department determined that DHMC had addressed all but one required action. In December 2016, HSAG and the Department determined that the one outstanding QAPI action item—related to EPSDT—was included with additional EPSDT-related requirements in the new EPSDT standard as part of the FY 2016–2017 compliance monitoring tool (see Standard XI, Element 9, in Appendix A). For this reason, HSAG and the Department deferred additional review and approval of the FY 2015–2016 corrective action for the EPSDT requirement to the FY 2016–2017 compliance audit.

Validation of Performance Measures

For FY 2015–2016, HSAG recommended that DHMC focus efforts on improving HEDIS rates for well-child and well-care visits, access to care, care for members on antidepressant or asthma medications, and care for children on ADHD medication. At the time that this report was written, DHMC had not provided information regarding quality initiatives addressing these performance areas. Similar to the prior year, based on the HEDIS 2017 rates, the same measurement areas were identified as opportunities for improvement. As a result, HSAG recommends that DHMC continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these HEDIS rates in future years.

Validation of Performance Improvement Projects

The FY 2016–2017 validation cycle was the first year of validation for the DHMC PIP, *Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*. The previous PIP's eligible population was very small, and the baseline rate for Study Indicator 1 was 100 percent; therefore, for Study Indicator 2, the denominator was zero. During a technical assistance call with DHMC and the Department, it was decided that DHMC would implement a new topic, which was submitted in 2016. This was the first year of validation for the PIP; therefore, follow-up on prior recommendations did not apply.

Consumer Assessment of Healthcare Providers and Systems

DHMC reported implementing 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 offering Saturday availability for appointments.

As a result, between FY 2015–2016 and FY 2016–2017, DHMC demonstrated rate increases for eight of the nine adult measures, and two of these increases were substantial: *Getting Care Quickly* (6.4 percentage points) and *Rating of All Health Care* (11.5 percentage points). The remaining six measures demonstrated slight increases (fewer than 5 percentage points each): *How Well Doctors Communicate, Customer Service, Shared Decision Making, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Rating of Health Plan*. In addition, only one measure, *Getting Needed Care*, showed a slight rate decrease.

Between FY 2015–2016 and FY 2016–2017, DHMC demonstrated rate increases for two child measures, *How Well Doctors Communicate* and *Rating of All Health Care*; however, these increases were not substantial (increases fewer than 5 percentage points each). DHMC demonstrated decreases in rates for seven measures, two of which decreased substantially: *Rating of Specialist Seen Most Often* and *Rating of Health Plan*.

Rocky Mountain Health Plans Medicaid Prime

Assessment of Compliance With Medicaid Managed Care Regulations

Based on the FY 2015–2016 site review, RMHP Prime was required to revise its policies to allow members to receive family planning services from any duly licensed provider, in or out of RMHP Prime's network. This was the only required action for the review. RMHP Prime submitted documents to demonstrate that it updated its policies to allow female members to obtain family planning services from any duly licensed provider, in or out of RMHP Prime's network, and additional documents to demonstrate implementation of revised policies and procedures. HSAG and the Department reviewed the revised documents and determined that RMHP Prime had completed the required corrective action.

Validation of Performance Measures

HSAG's FY 2015–2016 recommendations for RMHP Prime related to improving access to care; chlamydia screenings for women; breast cancer screenings; care for children on ADHD medication; monitoring for members on ACEs, ARBs, or diuretics; and care for members with COPD. At the time that this report was written, RMHP Prime had not provided information regarding quality initiatives addressing these performance areas. Similar to the prior year, based on the HEDIS 2017 rates, the same measurement areas were identified as opportunities for improved performance. Only care for children prescribed ADHD medication was not included due to a small denominator for this measure. As a result, HSAG recommends that RMHP Prime continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these HEDIS rates in future years.

Validation of Performance Improvement Projects

RMHP Prime received a *Met* score for 100 percent of applicable evaluation elements during the FY 2015–2016 validation cycle; therefore, no prior PIP recommendations existed for follow-up during the FY 2016–2017 validation cycle.

Consumer Assessment of Healthcare Providers and Systems

Between FY 2015–2016 and FY 2016–2017, RMHP Prime demonstrated rate increases for four adult measures, and two of these increases were substantial: *Customer Service* (6.0 percentage points) and *Shared Decision Making* (6.4 percentage points). The remaining two measures demonstrated slight increases (fewer than 5 percentage points each): *Getting Needed Care* and *Getting Care Quickly*. These increases may indicate that RMHP Prime followed up on HSAG's recommendations. RMHP Prime demonstrated rate decreases for five adult measures. Three of these decreases were substantial: *How Well Doctors Communicate, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often.*

Between FY 2015–2016 and FY 2016–2017, RMHP Prime demonstrated rate increases for six child measures; and one of these increases was substantial: *Rating of Personal Doctor* (7.8 percentage points).

The remaining five measures demonstrated slight increases (fewer than 5 percentage points each): *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Health Plan.* These increases may indicate that RMHP Prime followed up on HSAG's recommendations. RMHP Prime demonstrated decreases in rates for three child measures, and one of these decreases was substantial: *Rating of Specialist Seen Most Often.*

7. Assessment of BHO Follow-Up on Prior Recommendations

The Department requested that each BHO address recommendations and required actions following EQR activities conducted in FY 2015–2016. Therefore, this section of the report outlines the recommendations that were provided to the BHOs in FY 2015–2016 for compliance monitoring and PIP validation, based on 2015–2016 EQR activities; and for performance measure validation, based on the MY 2014–2015 performance measure rates. This section also describes any improvement activities reported by the BHOs to address performance in these areas and presents an assessment of how the BHOs responded to recommendations provided during the 2015–2016 EQR activities and/or an assessment of performance improvement noted during FY 2016–2017. Of note, ABC-NE's performance measure rates were evaluated for the first time during FY 2015–2016. As such, the MY 2014–2015 rates were provided for information purposes; therefore, recommendations pertaining to performance measure rates were not provided to ABC-NE the prior year, and this BHO is not discussed in this section. For the ECHO survey activity, this is the first year that these results have been presented in the technical report; therefore, no follow-up information is presented in this section.

Access Behavioral Care—Denver

Compliance With Medicaid Managed Care Regulations

As a result of the FY 2015–2016 site review, ABC-D was required to address three *Partially Met* elements in the Coordination and Continuity of Care standard, one *Not Met* element in the Member Rights and Protections standard, and three *Partially Met* elements in the Credentialing and Recredentialing standard. ABC-D submitted its proposal to HSAG and the Department in April 2016. HSAG and the Department required ABC-D to revise its initial plan before submitting documents that demonstrated compliance. ABC-D began submitting evidence of having completed proposed actions to HSAG and the Department in June. HSAG and the Department participated in telephone calls with ABC-D staff members to provide additional assistance and clarification, as needed.

In December 2016, HSAG and the Department determined that ABC-D had addressed all but one required action related to EPSDT regulations. The outstanding action item was then included with additional EPSDT-related requirements in the new EPSDT standard as part of the FY 2016–2017 compliance monitoring tool (see Standard XI, Element 9, in Appendix A). For this reason, HSAG and the Department deferred additional review and approval of the FY 2015–2016 corrective action for the EPSDT requirement to the findings in the FY 2016–2017 compliance audit. Any unmet required actions have been added to the FY 2016–2017 corrective action plan and will be reviewed in FY 2017–2018.

Validation of Performance Measures

For FY 2015–2016, HSAG recommended that ABC-D improve the number of members in foster care who receive services and decrease the number of hospital readmissions. At the time that this report was written, ABC-D had not provided information regarding quality initiatives addressing these performance

areas. MY 2015–2016 rates indicating the number of members in foster care who received services and hospital readmissions demonstrated no change or minor improvements; therefore, HSAG recommends that ABC-D continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these rates in future years.

Validation of Performance Improvement Projects

ACB-D received a *Met* score for 100 percent of applicable evaluation elements during the FY 2015–2016 validation cycle; therefore, no prior PIP recommendations were made for follow-up during the FY 2016–2017 validation cycle.

Access Behavioral Care—Northeast

Compliance With Medicaid Managed Care Regulations

As a result of the FY 2015–2016 site review, ABC-NE was required to address three *Partially Met* elements in the Coordination and Continuity of Care standard, one *Not Met* element in the Member Rights and Protections standard, and three *Partially Met* elements in the Credentialing and Recredentialing standard. ABC-NE submitted its proposal to HSAG and the Department in April 2016. HSAG and the Department required ABC-NE to revise its initial plan before submitting documents that demonstrated compliance. ABC-NE began submitting evidence of having completed proposed actions to HSAG and the Department in June. HSAG and the Department participated in telephone calls with ABC-NE staff members to provide additional assistance and clarification, as needed.

In December 2016, HSAG and the Department determined that ABC-NE had addressed all but one required action. The outstanding action item was then included with additional EPSDT-related requirements in the new EPSDT standard as part of the FY 2016–2017 compliance monitoring tool (see Standard XI, Element 9, in Appendix A). For this reason, HSAG and the Department deferred additional review and approval of the FY 2015–2016 corrective action for the EPSDT requirement to the findings in the FY 2016–2017 compliance audit. Any unmet required actions have been added to the FY 2016–2017 corrective action plan and will be reviewed in FY 2017–2018.

Validation of Performance Measures

Because FY 2015–2016 was the first year that ABC-NE reported performance measure rates, HSAG had no historical data from which to draw conclusions and make recommendations; therefore, this section is not applicable for ABC-NE for this review year.

Validation of Performance Improvement Projects

ABC-NE received a *Met* score for 100 percent of applicable evaluation elements during the FY 2015–2016 validation cycle; therefore, no prior PIP recommendations were made for follow-up during the FY 2016–2017 validation cycle.

Behavioral Healthcare, Inc.

Compliance With Medicaid Managed Care Regulations

As a result of the FY 2015–2016 site review, BHI was required to address one element in the Coordination and Continuity of Care standard and one element in the Credentialing and Recredentialing standard. BHI submitted its proposed plan to HSAG and the Department in May 2016 and began submitting documents to demonstrate implementation of the plan in June 2016. After requesting that BHI submit additional documentation, HSAG and the Department determined that BHI had successfully addressed all required actions.

Validation of Performance Measures

For FY 2015–2016, HSAG recommended that BHI evaluate decreases in services provided to: members ages 18 to 64, children enrolled in a baby care program and who were modified adjusted gross income-(MAGI-) eligible, adults who were MAGI-eligible, children in foster care, and working adults with disabilities. At the time that this report was written, BHI had not provided information regarding quality initiatives addressing these performance areas. MY 2015–2016 rates remained consistent with the prior year related to services received by the groups stated above. HSAG recommends that BHI continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these rates in future years.

Validation of Performance Improvement Projects

BHI received a *Met* score for 100 percent of applicable evaluation elements during the FY 2015–2016 validation cycle; therefore, no prior PIP recommendations were made for follow-up during the FY 2016–2017 validation cycle.

Colorado Health Partnerships, LLC

Compliance With Medicaid Managed Care Regulations

Based on findings from the site review activities, CHP was required to submit a corrective action plan that addressed one element related to coordination and continuity of care and six elements related to credentialing and recredentialing. Most notable, for coordination and continuity of care, CHP was required to enhance policies and procedures and provider communications to more specifically address referral processes and the BHO's and providers' responsibilities to provide referral assistance to members who need services not covered by the BHO but found necessary as a result of screening and diagnosis. CHP submitted its CAP to HSAG and the Department in May 2016 and began submitting documents that demonstrated implementation of its plan in September 2016. 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 March 2017 that CHP had successfully addressed all required actions.

Validation of Performance Measures

For FY 2015–2016, HSAG recommended that CHP monitor declines in the number of services provided to women enrolled in a breast and cervical cancer program. At the time that this report was written, CHP had not provided information regarding quality initiatives addressing these performance areas. CHP's MY 2015–2016 rates for women enrolled in a breast and cervical cancer program and who received services remained similar to the prior year; therefore, HSAG recommends that CHP continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these rates in future years.

Validation of Performance Improvement Projects

CHP received a *Met* score for 100 percent of applicable evaluation elements during the FY 2015–2016 validation cycle; therefore, no prior PIP recommendations were made for follow-up during the FY 2016–2017 validation cycle.

Foothills Behavioral Health Partners, LLC

Compliance With Medicaid Managed Care Regulations

As a result of the FY 2015–2016 site review, FBHP was required to address three *Partially Met* items in the credentialing and recredentialing standard. FBHP was required to document the process it uses to determine which providers are allowed to submit credentialing applications. FBHP was also required to more strictly adhere to its recredentialing time frames for both individual and organizational providers. FBHP submitted its proposed plan to HSAG and the Department in May 2016. Once HSAG and the Department had reviewed the plan, FBHP submitted documentation that demonstrated implementation. HSAG and the Department reviewed documents in August 2016 and determined that FBHP had completed all required actions.

Validation of Performance Measures

HSAG's FY 2015–2016 recommendations for FBHP related to improving services provided to several age groups and Medicaid eligibility categories: members ages 13 and older, children enrolled in a baby care program and who were MAGI-eligible, children with disabilities, working adults with disabilities, adults ages 65 and older (OAPA–A), and adults MAGI-eligible. Additionally, HSAG recommended that FBHP focus efforts on improving follow-up care for members with a mental health condition. At the time that this report was written, FBHP had not provided information regarding quality initiatives addressing these performance areas. The MY 2015–2016 rate indicating working adults with disabilities who received services increased by 7.74 percentage points from the prior year, suggesting performance improvement. However, the remaining age groups and Medicaid eligibility categories recommended for improved penetration were consistent from MY 2014–2015 to MY 2015–2016. As a result, HSAG recommends that FBHP continue to analyze strategies that can be linked to improvement in these areas. HSAG will continue to monitor these rates in future years.

Validation of Performance Improvement Projects

FBHP received a *Met* score for 100 percent of applicable evaluation elements during the FY 2015–2016 validation cycle; therefore, no prior PIP recommendations were made for follow-up during the FY 2016–2017 validation cycle.