COLORADO
Department of Health Care Policy & Financing

2017–2018 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)

November 2018

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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Assessment of Compliance With Medicaid Managed Care Regulations

In fiscal year (FY) 2017–2018, Health Services Advisory Group, Inc. (HSAG) reviewed four standards as directed by Colorado's Department of Health Care Policy and Financing (the Department) (see Section 2—Methodology). For the two managed care organizations (MCOs) providing physical healthcare, the health plans experienced mixed results in complying with managed care regulations for the four standards reviewed in FY 2017–2018 (depicted in bold in Table 1-1). One plan consistently performed from slightly to significantly higher than the other plan in each standard reviewed; however, the average of the two MCOs is presented. The MCO average was below 90 percent in each standard reviewed in FY 2017–2018, largely related to revisions to the Medicaid managed care regulations released in May 2016 and effective for the Medicaid MCOs July 1, 2017. No common trends existed in relation to the subcontracts and delegation standard; one plan performed at 100 percent compliance and one plan performed at 0 percent compliance.

Table 1-1 displays the statewide average compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 1-1—Compliance Monitoring Statewide Trended Performance for MCOs

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	88%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	85%	96%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	77%	96%
Standard IV—Member Rights and Protections (2012–2013, 2016)	90%	90%
Standard V—Member Information (2014–2015, 2017–2018)*	**87%**	**85%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)*	**77%**	**87%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)*	**97%**	**86%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	97%	99%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)*	**100%**	**50%**

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	81%	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)***	NA	77%

**Bold text indicates standards that HSAG reviewed during FY 2017–2018.*

***The review conducted in FY 2017–2018 reflects revision of requirements per Code of Federal Regulations. Title 42, Volume 81, May 6, 2016, and may not be comparable to any previous review of standards. For all standards, the health plans' contracts with the State may have changed since the previous review year and may have contributed to the appearance of performance changes.*

****FY 2016–2017 was the initial year of review for Standard XI.*

Colorado's Medicaid MCO average demonstrated improved performance in the most recent year of review for six of ten standards as compared to the previous year the standard was reviewed. In one standard (Standard IV—Member Rights and Protections), the statewide average remained stable at 90 percent across review cycles. Statewide performance declined in three standards (Standard V—Member Information, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation) in FY 2017–2018 when compared to the previous year the standards were reviewed. HSAG cautions that many federal healthcare regulation revisions are found in these three standards. No comparative results were available for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

For individual health plan scores and findings for the Medicaid MCOs, see Section 3 of this report. For the health plan comparison of scores for FY 2017–2018 standards, see Section 5, Table 5-1.

Validation of Performance Measures

IS Standards Review

HSAG evaluated the health plans' information system (IS) capabilities for accurate HEDIS reporting. For the current reporting period, Rocky Mountain Health Plans Medicaid Prime (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, RMHP Prime's HEDIS auditor identified no notable issues with negative impact on HEDIS reporting. Denver Health Medicaid Choice (DHMC) was fully compliant with four of the IS standards and partially compliant with two of the IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. DHMC's HEDIS auditor found that the health plan was partially compliant with IS standards 1 and 7, which related to the *Childhood Immunization Status* measure; however, none of these concerns materially impacted DHMC's ability to report performance measure data for this measure. Therefore, HSAG determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology; and the rates and audit results are valid, reliable, and accurate.

Performance Measure Results

Table 1-2 and Table 1-3 display the Medicaid statewide weighted averages for HEDIS 2016 through HEDIS 2018, along with the percentile ranking for each HEDIS 2018 rate for the high- and low-performing measure rates. Statewide performance measure results for HEDIS 2018 were compared to Quality Compass national Medicaid percentiles for HEDIS 2017 when available. Additionally, rates for HEDIS 2018 shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates for HEDIS 2018 shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.[1-1] Additional Medicaid statewide weighted average measure rates can be found in Section 5.

Table 1-2—Colorado Medicaid Statewide Weighted Averages—HEDIS 2018 High Performers

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	81.12%	87.50%	83.67%	75th–89th
Appropriate Treatment for Children With Upper Respiratory Infection[1]				
Appropriate Treatment for Children With Upper Respiratory Infection	96.85%	96.98%	97.55%	≥90th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.66%	0.23%	0.34%	≥90th
Living With Illness				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[1]				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	43.16%	44.38%	45.60%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 rates to prior years.

The HEDIS 2018 rates within the Pediatric Care domain that are high performing are mainly representative of DHMC's performance as RMHP Prime's rates were too small to report (i.e., denominator less than 30). Of note, DHMC's measure rate for *Appropriate Treatment for Children With Upper Respiratory Infection* increased from 2017 to 2018 to exceed the national Medicaid 90th percentile, demonstrating the appropriate antibiotic treatment for emergency department (ED) and outpatient visits related to respiratory infections.

[1-1] Performance comparisons are based on the Chi-square test of statistical significance with a p value <0.05. Therefore, results reporting the percentages of measures that changed significantly from HEDIS 2017 rates may be understated or overstated.

For the statewide high-performing measure within the Preventive Screening domain, DHMC demonstrated strength, while this area represents an opportunity for improvement for RMHP Prime. For *Non-Recommended Cervical Cancer Screening in Adolescents,* DHMC performed above the national Medicaid 90th percentile while RMHP Prime performed below the national Medicaid 50th percentile, indicating that RMHP Prime should focus improvement efforts on ensuring that young women do not inappropriately receive non-recommended screenings for cervical cancer.

DHMC and RMHP Prime had similar results for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* measure in the Living With Illness domain, demonstrating a strength for both health plans regarding antibiotic use for acute respiratory conditions.

Table 1-3—Colorado Medicaid Statewide Weighted Averages—HEDIS 2018 Low Performers

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	75.92%	72.43%	**68.25%^^**	10th–24th
Combination 3	75.40%	71.48%	**65.92%^^**	25th–49th
Combination 4	74.99%	71.36%	**64.21%^^**	25th–49th
Well-Child Visits in the First 15 Months of Life[1]				
*Zero Visits**	7.69%	6.01%	9.12%	<10th
Six or More Visits	3.36%	14.01%	**4.39%^^**	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.87%	59.69%	60.89%	10th–24th
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	38.27%	37.83%	**34.29%^^**	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	78.83%	27.4%	**16.52%^^**	<10th
Counseling for Nutrition—Total	77.37%	23.42%	**6.14%^^**	<10th
Counseling for Physical Activity—Total	63.26%	22.88%	**1.35%^^**	<10th
Access to Care				
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	63.05%	**43.75%^^**	<10th
Postpartum Care	—	37.45%	38.18%	<10th
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	89.30%	89.47%	86.85%	<10th
Ages 25 Months to 6 Years	73.74%	73.09%	72.27%	<10th
Ages 7 to 11 Years	78.33%	77.19%	75.68%	<10th
Ages 12 to 19 Years	79.12%	77.70%	75.68%	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Adults' Access to Preventive/Ambulatory Health Services				
Total	68.91%	67.55%	**62.88%^^**	<10th
Preventive Screening				
Cervical Cancer Screening[1]				
Cervical Cancer Screening	56.93%	44.89%	43.12%	<10th
Adult BMI Assessment[1]				
Adult BMI Assessment	84.43%	56.21%	**47.08%^^**	<10th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Continuation Phase Treatment	43.14%	38.31%	**34.05%^^**	25th–49th
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	31.97%	33.78%	37.59%	10th–24th
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	21.95%	<10th
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	75.00%	76.00%	66.18%	<10th
Comprehensive Diabetes Care[1]				
Hemoglobin A1c (HbA1c) Testing	89.78%	85.56%	83.03%	10th–24th
*HbA1c Poor Control (>9.0%)**	36.74%	54.64%	56.53%	10th–24th
HbA1c Control (<8.0%)	48.66%	36.27%	35.51%	10th–24th
Eye Exam (Retinal) Performed	55.96%	45.89%	**27.40%^^**	<10th
Medical Attention for Nephropathy	89.29%	87.12%	**82.72%^^**	<10th
Blood Pressure Control (<140/90 mm Hg)	73.72%	38.12%	**32.61%^^**	<10th
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	—	55.97%	**49.60%^^**	<10th
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	84.92%	87.87%	84.90%	10th–24th
Diuretics	84.65%	87.80%	**84.75%^^**	10th–24th
Pharmacotherapy Management of COPD Exacerbation[2]				
Systemic Corticosteroid	58.22%	60.52%	**50.53%^^**	10th–24th
Bronchodilator	66.04%	75.52%	**61.10%^^**	<10th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017.
[2] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 rates to prior years.
— Indicates that the measure was not required in previous technical reports.
Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.

DHMC and RMHP Prime demonstrated low performance for most measure rates within the Pediatric Care domain for HEDIS 2018, indicating that improvement efforts should be focused on ensuring that children and adolescents receive necessary well-care visits and documenting these services within administrative data sources.

Within the Access to Care domain, DHMC fell below the national Medicaid 10th percentile for the *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services* measure rates, demonstrating an area of concern regarding access to care for child and adult members. Although RMHP Prime's rates exceeded DHMC's rates by more than 12 percentage points for all *Adults' Access to Preventive/Ambulatory Health Services* rates, opportunities for improvement still exist for RMHP Prime with adults' access to care. Of note, RMHP Prime's rate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* indicator still fell below the national Medicaid 25th percentile.

For the Preventive Screening domain, both DHMC and RMHP Prime should work with providers to ensure that screenings for BMI and cervical cancer are documented within administrative data sources.

The three low-performing statewide measure rates within the Mental/Behavioral Health domain are related to appropriate medications for members with behavioral health conditions. This indicates that both health plans should focus on improving medication management for the behavioral health population.

For measures within the Living With Illness domain related to medication management, low performance was demonstrated by both DHMC and RMHP Prime, indicating that improvement efforts should focus on ensuring that members receive their medications and that providers appropriately monitor these members. The remaining measure, *Comprehensive Diabetes Care*, requires health plans to work with providers to improve documentation of these services within administrative data sources so as to improve the quality of care being provided to members.

Validation of Performance Improvement Projects

Table 1-4 summarizes trends in performance improvement project (PIP) performance among the MCOs from FY 2015–2016 to FY 2017–2018. Each MCO conducted a PIP focusing on a topic related to transitions of care during this three-year period. During the first year listed, FY 2015–2016, neither MCO had progressed to reporting study indicator remeasurement results; therefore, the PIP validation status was based on performance in the Design and Implementation stages of the PIP. In FY 2016–2017, RMHP progressed to reporting remeasurement results and being evaluated for demonstrating improvement in the Outcomes stage; however, DHMC began a new PIP topic in FY 2016–2017 and therefore did not progress to the Outcomes stage. In the FY 2017–2018 validation cycle both MCOs reported remeasurement results and were evaluated for demonstrating improvement of outcomes. In the Outcomes stage, HSAG evaluated the PIPs on demonstrating statistically significant improvement from baseline to the most recent remeasurement period. Demonstrating statistically significant improvement is evaluated for a critical evaluation element in HSAG's PIP validation tool; therefore, once a PIP progresses to the Outcomes stage, the PIP must demonstrate statistically significant improvement over baseline across all study indicators to receive an overall *Met* validation status.

Table 1-4—Performance Improvement Project Results for MCOs

MCO	PIP Topic	FY 2015–2016 Validation Status	FY 2016–2017 Validation Status	FY 2017–2018 Validation Status	Statistically Significant Improvement Achieved?
Denver Health Medicaid Choice (DHMC)	*Transition to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit*	*Met**	*Met*	*Not Met*	No
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	*Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*	*Met*	*Not Met*	*Not Met*	No

**DHMC submitted a different PIP topic, Improving Follow-Up Communications Between Referring Providers and Pediatric Obesity Specialty Clinics, for the FY 2015–2016 validation cycle. Upon review of the FY 2015–2016 baseline results, HSAG recommended that the health plan select a new topic because of a small eligible population and a baseline rate of 100 percent, offering no room for improvement. The DHMC topic listed in the table was validated for the second two years of the three-year cycle only.*

Over the three-year period, the two MCOs each received a *Met* overall validation status during the validation cycles when the PIPs were evaluated only for the Design and Implementation stages of the PIPs. When the two MCOs progressed to reporting study indicator outcomes for the PIPs, the results did not demonstrate statistically significant improvement over baseline. A detailed discussion of validation and study indicator results for each PIP is provided in Section 3—Evaluation of Colorado's Managed Care Organizations.

Consumer Assessment of Healthcare Providers and Systems

This section will contain the high-level summary of the statewide average results for the two MCOs based on CAHPS results for FY 2015–2016 through FY 2017–2018. Table 1-5 shows the adult statewide results for FY 2015–2016, FY 2016–2017, and FY 2017–2018.[1-2]

Table 1-5—Adult Statewide Results for MCOs

Measure	FY 2015–2016 Statewide Aggregate	FY 2016–2017 Statewide Aggregate	FY 2017–2018 Statewide Aggregate
Getting Needed Care	81.5%	81.1%	79.6%
Getting Care Quickly	75.8%	80.1%	81.2%
How Well Doctors Communicate	91.9%	90.8%	92.3%
Customer Service	83.4%	87.4%	87.1%
Shared Decision Making	78.2%	83.0%	79.9%
Rating of Personal Doctor	69.6%	64.3%	70.0%
Rating of Specialist Seen Most Often	67.0%	65.4%	62.7%
Rating of All Health Care	49.5%	55.4%	56.0%
Rating of Health Plan	55.5%	54.7%	58.0%

Adult Statewide Results: Strengths

Overall, member satisfaction rates for the MCOs' adult population have fluctuated, either increasing or decreasing slightly through the years; however, an upward trend (i.e., higher rates) appears to be occurring for the *Getting Care Quickly* and *Rating of All Health Care* measure rates. Conversely, a downward trend (i.e., lower rates) relating to the *Getting Needed Care* and *Rating of Specialist Seen Most Often* measures rates appears to be transpiring for the MCOs' adult population.

Table 1-6—Child Statewide Results for MCOs

Measure	FY 2015–2016 Statewide Aggregate	FY 2016–2017 Statewide Aggregate	FY 2017–2018 Statewide Aggregate
Getting Needed Care	80.6%	79.6%	84.8%
Getting Care Quickly	85.9%	84.1%	86.2%
How Well Doctors Communicate	93.6%	94.0%	94.7%
Customer Service	88.2%	85.5%	91.2%

[1-2] Due to the State of Colorado's decision not to renew the Access Kaiser Permanente (Access KP) contract for Medicaid members, the program ended on June 30, 2017; therefore, HSAG removed Access KP's results from the FY 2016–2017 statewide aggregate results for comparison purposes.

Measure	FY 2015–2016 Statewide Aggregate	FY 2016–2017 Statewide Aggregate	FY 2017–2018 Statewide Aggregate
Shared Decision Making	76.0%	74.5% +	78.2% +
Rating of Personal Doctor	80.7%	79.2%	86.1%
Rating of Specialist Seen Most Often	74.9%	66.6% +	75.0% +
Rating of All Health Care	66.8%	70.1%	76.7%
Rating of Health Plan	73.2%	68.1%	76.9%

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.

For the MCOs' child population, an upward trend (i.e., higher rates) appears to be occurring for the *How Well Doctors Communicate* and *Rating of All Health Care* measure rates. Member satisfaction rates for the remaining measures have fluctuated, either increasing or decreasing slightly through the years.

Behavioral Health Organizations

Assessment of Compliance With Medicaid Managed Care Regulations

For the four standards reviewed in FY 2017–2018, Colorado's five behavioral health organizations (BHOs) demonstrated wide variation in compliance with managed care regulations, as evidenced by a range of nearly 20 percentage points seen in the Member Information standard and a range of nearly 40 percentage points in the Grievance and Appeal System standard. However, performance in the provider participation and program integrity standard varied by a maximum of 7 percentage points, and only one BHO performed at less than 100 percent in the subcontracts and delegation standard. HSAG observed the following similarities in findings:

Standard V—Member Information:

- All BHOs required improvement in their websites and PDF documents for ready accessibility per Section 508 guidelines.
- All BHOs had insufficient information in their provider directories to address new requirements—e.g., access for members with disabilities, cultural competency training, provider website addresses.
- Four of five BHOs required taglines in 18-point font in member documents.
- Four of five BHOs had member documents—e.g., grievance and appeal letters—written in language difficult for the member to understand.
- Three of five BHOs failed to include on their website notification that information was available in paper form.

Standard VI—Grievance and Appeal System

- All BHOs required update of documents to address new time frames or other revised requirements for processing grievances or appeals.
- All BHOs included an inaccurate criterion for how long benefits would continue during an appeal or SFH, and three of five BHOs exhibited additional areas of confusion in documents addressing continued benefits.
- All BHOs required updates in the provider manual or other provider communications to accurately inform providers of grievance and appeal procedures.
- Three of five BHOs included inaccurate or inappropriate information in appeal resolution letters.
- Three of five BHOs demonstrated inadequate processes for handling grievances.

Standard VII—Provider Participation and Program Integrity

- Three of five BHOs had no written processes to address requirements for reporting compliance issues or overpayments to the Department and/or mechanisms for providers to report overpayments to the BHO.

Standard IX—Subcontracts and Delegation

The BHOs experienced no trends in performance related to subcontracts and delegation; four of five BHOs demonstrated 100 percent compliance.

Table 1-7 displays the statewide average compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 1-7—Compliance Monitoring Statewide Trended Performance for BHOs

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review**
Standard I—Coverage and Authorization of Services (2013–2014***, 2016–2017)	95%	88%
Standard II—Access and Availability (2013–2014***, 2016–2017)	99%	100%
Standard III—Coordination and Continuity of Care (2012–2013***, 2015–2016)	100%	84%
Standard IV—Member Rights and Protections (2012–2013***, 2015–2016)	100%	93%
Standard V—Member Information (2014–2015, 2017–2018)*	**95%**	**67%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)*	**81%**	**71%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)*	**97%**	**88%**
Standard VIII—Credentialing and Recredentialing (2012–2013***, 2015–2016)	98%	92%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)*	**100%**	**90%**
Standard X—Quality Assessment and Performance Improvement (2012–2013***, 2015–2016)	99%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)	NA	NA

**Bold text indicates standards that HSAG reviewed during FY 2017–2018.*
***The 2017–2018 review reflects revision of requirements per Code of Federal Regulations. Title 42, Volume 81, May 6, 2016, and may not be comparable to previous review. For all standards, the health plans' contracts with the State may have changed since the previous review year and may have contributed to the appearance of performance changes.*
****The statewide average for previous reviews 2012–2013 and 2013–2014 included results of one BHO contractor replaced by a different BHO contractor in subsequent years.*
FY 2016–2017 was the initial year of review for Standard XI. BHO requirements were not scored in 2016–2017.

Colorado's statewide BHO average demonstrated relatively stable performance—a score change from 99 percent to 100 percent—in the most recent year of review for two of ten standards (Standard II—Access and Availability and Standard X—Quality Assessment and Performance Improvement) as compared to the previous year the standard was reviewed. Statewide performance declined in the other eight standards in the most recent year of review compared to the previous year the standards were

reviewed. HSAG cautions that many federal healthcare regulation revisions are found in the four standards reviewed in FY 2017–2018 and may have impacted the FY 2017–2018 scores. For the remaining standards that experienced a performance decline, changes in the BHO contract with the State or differences in compliance monitoring tools or processes may have contributed to the appearance of performance declines.

For individual health plan scores and findings for the Medicaid MCOs, see Section 4 of this report. For the health plan comparison of scores for FY 2017–2018 standards, see Section 5, Table 5-3.

Validation of Performance Measures

IS Standards Review

HSAG evaluated the health plans' accuracy of performance measure reporting and determined the extent to which the reported rates followed the State specifications and reporting requirements. For the current reporting period, HSAG determined that the data collected and reported for the Department-selected measures by all five BHOs followed the State specifications and reporting requirements; and the rates were valid, reliable, and accurate.

Performance Measure Results

Table 1-8 shows the measurement year (MY) 2016–2017 performance measure results for the statewide average and the corresponding incentive performance targets for the BHOs. As this was the first year of reporting these measures for the BHOs, historical rates are not available.

Table 1-8—Statewide Averages for BHOs

Performance Measure	MY 2016–2017 Rate[1]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)		
Mental Health Engagement (All Members Excluding Foster Care)	41.76%	48.48%
Mental Health Engagement (Only Foster Care)		
Mental Health Engagement (Only Foster Care)	53.92%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment		
Engagement of Alcohol and Other Drug Dependence Treatment	25.24%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	40.85%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	59.67%	72.94%

Performance Measure	MY 2016–2017 Rate[1]	Performance Target
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*		
Emergency Department Utilization for Mental Health Condition	16.475	7.722
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*		
Emergency Department Utilization for Substance Use Condition	23.41	19.71

** For this indicator, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).

In the first year of reporting, no measure rates for the BHO statewide average met or exceeded the incentive performance target, indicating opportunities to increase contact with members to improve care and reduce unnecessary utilization of services.

Validation of Performance Improvement Projects

Table 1-9 summarizes trends in PIP performance among the BHOs from FY 2015–2016 to FY 2017–2018. Each BHO conducted a PIP focusing on a topic related to transitions of care during this three-year period. During the first year listed, FY 2015–2016, the BHOs had not progressed to reporting study indicator remeasurement results; therefore, the PIP validation status was based on performance in the Design and Implementation stages of the PIP. In FY 2016–2017, four of the five BHOs progressed to reporting remeasurement results and were evaluated for demonstrating improvement in the Outcomes stage. One BHO, Access Behavioral Care—Northeast, was unable to report remeasurement results for FY 2016–2017 and therefore did not progress to the Outcomes stage until the following validation cycle. For the FY 2017–2018 validation cycle, all five BHOs reported remeasurement results and were evaluated for demonstrating statistically significant improvement in study indicator outcomes. In the Outcomes stage, HSAG evaluated the PIPs on demonstrating statistically significant improvement from baseline to the most recent remeasurement period. Demonstrating statistically significant improvement is evaluated for a critical evaluation element in HSAG's PIP validation tool; therefore, once a PIP progresses to the Outcomes stage, the PIP must demonstrate statistically significant improvement over baseline across all study indicators to receive an overall *Met* validation status.

Table 1-9—Performance Improvement Project Results for BHOs

BHO	PIP Topic	FY 2015–2016 Validation Status	FY 2016–2017 Validation Status	FY 2017–2018 Validation Status	Statistically Significant Improvement Achieved?
Access Behavioral Care—Denver (ABC-D)	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	*Met*	*Not Met*	*Not Met*	No
Access Behavioral Care—Northeast (ABC-NE)	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	*Met*	*Met*	*Not Met*	No
Behavioral Healthcare, Inc. (BHI)	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	*Met*	*Not Met*	*Met*	Yes
Colorado Health Partnerships, LLC (CHP)	*Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release*	*Met*	*Not Met*	*Not Met*	No
Foothills Behavioral Health Partners, LLC (FBHP)	*Improving Transition From Jail to Community- Based Behavioral Health Treatment*	*Met*	*Not Met*	*Not Met*	No

Across the three-year period, the BHOs received a *Met* overall validation status during the validation cycles when the PIPs were evaluated only for the Design and Implementation stages of the PIPs. When the BHOs progressed to reporting study indicator remeasurement results for the PIPs, only one BHO, BHI, reported statistically significant improvement over baseline. For the *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP, BHI reported statistically significant improvement from baseline to the second remeasurement. The remaining four BHOs reported study indicator results that did not demonstrate statistically significant improvement over baseline during the three-year period. A detailed discussion of validation and study indicator results for each PIP is provided in Section 4—Evaluation of Colorado's Behavioral Health Organizations.

Experience of Care and Health Outcomes Surveys

This section will contain the high-level summary of the statewide comparison findings for the five BHOs based on ECHO results conducted FY 2015–2016 through FY 2017–2018. Table 1-10 shows the adult ECHO statewide results for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 1-10—Adult ECHO Statewide Results for BHOs

Measure	FY 2015–2016 Statewide Aggregate	FY 2016–2017 Statewide Aggregate	FY 2017–2018 Statewide Aggregate
Rating of All Counseling or Treatment	42.3%	46.9%	46.3%
Getting Treatment Quickly	64.6%	66.3%	67.3%
How Well Clinicians Communicate	86.9%	88.3%	86.3%
Perceived Improvement	55.4%	60.9%	60.0%
Information About Treatment Options	59.8%	60.3%	58.7%
Office Wait	78.5%	83.1%	80.0%
Told About Medication Side Effects	76.2%	76.9%	77.4%
Including Family	42.5%	45.1%	43.8%
Information to Manage Condition	73.1%	75.7%	74.2%
Patient Rights Information	86.6%	86.1%	87.0%
Patient Feels He or She Could Refuse Treatment	83.1%	81.4%	86.5%
Privacy	93.5%	94.2%	93.2%
Cultural Competency	69.0%+	65.9%+	56.5%+
Amount Helped	83.0%	81.4%	79.9%
Improved Functioning	50.1%	54.8%	51.4%
Social Connectedness	62.9%	65.2%	62.7%

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.

Overall, member satisfaction rates for the adult ECHO statewide Medicaid population have fluctuated, either increasing or decreasing slightly through the years; however, an upward trend (i.e., higher rates) appears to be occurring for the *Getting Treatment Quickly* and *Told About Medication Side Effects* measure rates. Conversely, a downward trend (i.e., lower rates) relating to the *Cultural Competency* and *Amount Helped* measure rates appears to be transpiring for the adult ECHO statewide Medicaid population.

Table 1-11 shows the child ECHO statewide results for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 1-11—Child ECHO Statewide Results for the BHOs

Measure	FY 2015–2016 Statewide Aggregate	FY 2016–2017 Statewide Aggregate	FY 2017–2018 Statewide Aggregate
Rating of All Counseling or Treatment	42.2%	43.5%	43.2%
Getting Treatment Quickly	70.1%	67.8%	68.0%
How Well Clinicians Communicate	87.3%	87.0%	86.7%
Perceived Improvement	70.1%	69.8%	69.9%
Information About Treatment Options	71.9%	71.3%	71.5%
Office Wait	86.1%	83.2%	86.4%
Told About Medication Side Effects	88.3%	86.0%	85.3%
Information to Manage Condition	70.2%	69.3%	70.2%
Patient Rights Information	90.3%	89.5%	89.6%
Patient Feels He or She Could Refuse Treatment	85.8%	87.2%	88.6%
Privacy	94.7%	97.4%	96.5%
Cultural Competency	61.3%+	76.3%+	60.6%+
Amount Helped	76.7%	76.4%	76.9%
Improved Functioning	63.2%	61.6%	59.6%
Social Connectedness	84.5%	84.8%	85.9%

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.

Member satisfaction rates for the child ECHO statewide Medicaid population have fluctuated, either increasing or decreasing slightly, across the years. An upward trend (i.e., higher rates) appears to be occurring for the *Patient Feels He or She Could Refuse Treatment* and *Social Connectedness* measure rates. Conversely, a downward trend (i.e., lower rates) relating to the *How Well Clinicians Communicate*, *Told About Medication Side Effects*, and *Improved Functioning* measure rates appears to be transpiring for the child ECHO statewide Medicaid population.

Statewide Recommendations

Assessment of Compliance With Medicaid Managed Care Regulations

For three of the four managed care compliance standards reviewed in 2017–2018, the statewide average performance of Medicaid managed care plans declined compared to the previous year the standards were reviewed. HSAG cautions, however, that changes in federal healthcare regulations or State contract requirements over the three-year cycle may impact the comparability of statewide averages from one review cycle to the next. Given that the federal healthcare regulation revisions released in May 2016 were effective July 2017 for the Medicaid MCOs and BHOs and that on-site reviews were performed shortly thereafter, performance declines may be related. This conclusion is particularly applicable to the Member Information and the Grievance and Appeal System standards, in which many of the revisions are found. HSAG found that noncompliance in the following specific new requirements may have largely driven the lower performance in these standards:

- The Member Information standard included revised requirements for ready accessibility per Section 508 guidelines for health plan websites and electronic documents as well as revisions in requirements for information in the provider directory.
- The Grievance and Appeal System standard included revisions in time frames and other requirements for processing grievances and appeals. In addition, most managed care plans experienced issues with using easy-to-understand language in member grievance and appeal notices.
- For the Provider Participation and Program Integrity standard, the most common opportunities for improvement among the managed care plans related to requirements for reporting compliance or overpayment issues to the State.

In spring 2011, Colorado developed its Accountable Care Collaborative (ACC) Program. The next iteration of the program, ACC Phase II, seeks to leverage the proven successes of the ACC to enhance Colorado's Medicaid member and provider experiences. In November 2017, the Department announced the awards for the seven regional accountable entities (RAEs). In July 2018, the RAEs began managing networks of fee-for-service (FFS) primary care providers and capitated behavioral healthcare providers to ensure access to care for Medicaid members. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and for assuming the responsibilities previously contracted to both the Regional Care Collaborative Organizations (RCCOs) and BHOs in each region. In two regions, Region 1 and Region 5 (RMHP Prime and DHMC), the RAE is also responsible for a limited managed care initiative. Therefore, HSAG recommends that the RAEs consider the results of the 2017–2018 compliance monitoring findings for BHOs and the Medicaid physical health MCOs to ensure that any findings are incorporated, as applicable, into their own organizations' policies and processes. HSAG also recommends that the Department consider working with the RAEs to clearly outline the State's expectations, responsibilities, and processes for reporting overpayments or compliance issues (e.g., provider exclusions from participation in federal programs) to the Department.

Validation of Performance Measures

At the statewide level, three of the four high performing measures are related to appropriate antibiotic use for ED and outpatient visits for respiratory conditions, indicating a strength in antibiotic stewardship. With statewide performance consistently falling below the national Medicaid 25th percentile, improvement efforts could be focused on ensuring that members receive the appropriate medications to manage health conditions and that members receive the appropriate follow-up care when using medications long term. Additionally, an opportunity exists to improve adults' and children's access to care as statewide performance fell below the national Medicaid 10th percentile.

The BHOs demonstrated room for improvement across all measures as only one BHO met the performance target for one measure. Additionally, most BHO performance measure rates had a relative difference greater than 10 percent from the performance target, indicating that the Department should consider adjusting the performance targets to be more attainable.

Performance Improvement Projects

During the three-year period from FY 2015–2016 to FY 2017–2018, the two MCOs and five BHOs progressed to the PIP Outcomes stage and reported study indicator remeasurement results. In the Outcomes stage, HSAG evaluates whether a PIP has demonstrated real improvement in outcomes by achieving statistically significant improvement in study indicator results. After progressing to the Outcomes stage, one PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*, conducted by BHI, one of the BHOs, demonstrated statistically significant improvement in study indicator outcomes. The PIPs conducted by the two MCOs and the remaining four BHOs did not demonstrate statistically significant improvement in study indicator outcomes during the three-year period. Following the FY 2017–2018 PIP validation cycle, the Department instructed the MCOs and BHOs to close out the current PIPs in preparation for the initiation of new PIP topics. As part of the PIP closeout process, HSAG recommended that the MCOs and BHOs synthesize knowledge gained and lessons learned through the duration of the PIPs and identify opportunities for applying PIP results in ongoing improvement efforts. For example, the MCOs and BHOs should consider how remaining barriers can be addressed, how successful improvement strategies can be spread, and how any improvement achieved through the PIP can be sustained for the long term.

Consumer Assessment of Healthcare Providers and Systems

Adult Statewide: Summary Assessment of Opportunities for Improvement and Recommendations

For the adult statewide Medicaid population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018 or between FY 2015–2016 and FY 2017–2018. However, the following four measure rates showed slight decreases between FY 2016–2017 and FY 2017–2018: *Getting Needed Care*, *Customer Service*, *Shared Decision Making*, and *Rating of Specialist Seen Most Often*. HSAG recommends that the Department prioritize improving those measures that demonstrated decreases in rates.

Child Statewide: Summary Assessment of Opportunities for Improvement and Recommendations

For the child statewide Medicaid population, no measure rates decreased substantially or slightly between FY 2016–2017 and FY 2017–2018 or between FY 2015–2016 and FY 2017–2018. HSAG recommends that the Department continue to monitor the measures to ensure that no significant decreases in rates occur.

Experience of Care and Health Outcomes Surveys

Adult ECHO Statewide: Summary Assessment of Opportunities for Improvement and Recommendations

For the adult ECHO statewide Medicaid population, one measure rate decreased substantially between FY 2016–2017 and FY 2017–2018 and FY 2015–2016 and FY 2017–2018: *Cultural Competency* (9.4 and 12.5 percentage points, respectively). Additionally, the following 11 measure rates showed slight decreases between FY 2016–2017 and FY 2017–2018: *Rating of All Counseling or Treatment*, *How Well Clinicians Communicate*, *Perceived Improvement*, *Information About Treatment Options*, *Office Wait*, *Including Family*, *Information to Manage Condition*, *Privacy*, *Amount Helped*, *Improved Functioning*, and *Social Connectedness*. HSAG recommends that the Department prioritize improving those measures that demonstrated decreases in rates. HSAG recommends that the preceding measures be assessed to determine if a significant improvement or decrease in member satisfaction exists over time, which could be related to the transition of behavioral healthcare to the RAEs. For example, performance measures or other quality improvement (QI) initiatives could be developed to assist the RAEs with monitoring the targeted measures.

Child ECHO Statewide: Summary Assessment of Opportunities for Improvement and Recommendations

For the child ECHO statewide Medicaid population, one measure rate, *Cultural Competency*, decreased substantially (by 15.7 percentage points) between FY 2016–2017 and FY 2017–2018. Additionally, the following five measure rates showed slight decreases between FY 2016–2017 and FY 2017–2018: *Rating of All Counseling or Treatment*, *How Well Clinicians Communicate*, *Told About Medication Side Effects*, *Privacy*, and *Improved Functioning*. HSAG recommends that the preceding measures be assessed to determine if a significant improvement or decrease in member satisfaction exists over time, which could be related to the transition of behavioral healthcare to the RAEs. For example, performance measures or other QI initiatives could be developed to assist the RAEs with monitoring the targeted measures.

2. Introduction to the Report

Report Purpose and Overview

States with Medicaid program delivery systems that include managed care entities (MCEs), referred to in this report collectively as health plans, are required to annually provide an assessment of each MCE's 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 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 Medicaid health plans that deliver services in Colorado are listed in Table 2-1 and Table 2-2.

Table 2-1—Colorado Medicaid MCOs

Medicaid MCOs	Services Provided
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 2-2—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.

How This Report Is Organized

Section 1 includes a high-level, statewide summary of results and statewide average information derived from conducting mandatory and optional EQRO activities. This section also includes a summary description of relevant trends over a three-year period for each EQRO activity as applicable, with references to the section where the health plan specific data are found. In addition, Section 1 includes any conclusions drawn and recommendations made for statewide performance improvement, if applicable.

Section 2 provides a brief overview of Colorado's Medicaid healthcare delivery system and its managed care entities and describes the purpose and overview of this EQR annual technical report, the authority under which it must be provided, and the EQR activities conducted during the FY under review. This section also provides an overview of the methodology for each EQR activity performed and how HSAG used data and results obtained to draw conclusions.

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

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

Section 5 includes statewide comparative results organized by EQR activity. Three-year trend tables (when applicable) include summary results for each health plan (MCO and BHO) and statewide averages. This section also identifies, through presentation of results for each EQR activity, trends and commonalities used to derive statewide conclusions and recommendations.

Section 6 provides, by 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 activities.

Section 7 provides, by 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 activities.

Scope of EQR Activities—Physical Health MCOs

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).** 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 four standard areas developed based on federal managed care regulations and contract requirements.
- **Validation of performance measures.** To assess the accuracy of the performance measures reported by or on behalf of the MCOs, each MCO's licensed HEDIS auditor validated each performance measure selected by the Department for review. The validation also determined the extent to which performance measures calculated by the MCOs followed specifications required 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 was designed to determine the BHOs' compliance with their contracts with the State and with State and federal managed care regulations. HSAG determined compliance through review of four standard areas developed based on federal managed care regulations and contract requirements.
- **Validation of performance measures.** To evaluate accuracy of the performance measures reported by the BHOs, HSAG validated each performance measure selected by the Department for validation. The validation determined the extent to which performance measures reported by the BHOs were calculated following 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 BHOs' 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 BHO 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."[2-1]

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."[2-2] 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.

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 the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[2-3]

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[2-2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.
[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

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 2017–2018 site review process, the Department requested a review of four areas of performance. The standard areas chosen were Standard V—Member Information, Standard VI—Grievance and Appeal System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. HSAG developed a strategy and monitoring tools to review compliance with federal managed care regulations and managed care contract requirements related to each standard. HSAG also reviewed the health plans' administrative records to evaluate compliance with federal healthcare regulations related to processing and documenting grievances and appeals.

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' 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 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 interventions recommended or corrective actions required to improve the quality of, timeliness of, or access to care as applicable to the standard areas reviewed.

Technical Methods of Data Collection

For the health plans, 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.[2-4] Table 2-3 describes the five protocol activities and the specific tasks that HSAG performed to complete each of these protocol activities.

Table 2-3—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.
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. • Prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for pre-on-site review documents via email. The document request included instructions for organizing and preparing the documents related to review of the four standards and on-site review of records. Thirty days prior to each scheduled on-site review, the health plans provided documents for the pre-on-site review. • Documents submitted for the pre-on-site 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 also submitted lists of all of the health plan's grievances and appeals that occurred between July 1, 2017, and December 31, 2017, to the extent possible, based on each health plan's on-site review date. HSAG used a random sampling technique to select records for review during the on-site visit.

[2-4] 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: July 17, 2018.

For this step,	HSAG completed the following activities:
	• 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 review.
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete understanding of the health plan's level of compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's organizational performance. • HSAG reviewed a sample of administrative records to evaluate compliance with federal managed care regulations related to grievances and appeals for Medicaid members. • Also while on-site, HSAG collected and reviewed additional documents, as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents that were confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the site review, HSAG met with health plan staff members and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved site review report template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined 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 and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plan 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 training attendance
- Applicable correspondence or template communications
- Records or files related to administrative tasks (processing of grievances and appeals)
- Interviews with key health plan 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 and BHOs, 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 within each standard. Table 2-4 depicts assignment of the standards to the domains.

Table 2-4—Assignment of Compliance Standards to the Quality, Timeliness, and Access to Care Domains

Compliance Review Standards	Quality	Timeliness	Access
V—Member Information	X		X
VI—Grievance and Appeal System		X	X
VII—Provider Participation and Program Integrity	X		X
IX—Subcontracts and Delegation	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.
- Determine the extent to which the specific performance measures calculated by the health plan (or on behalf of the health plan) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

Managed Care Organizations—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 MCOs to use their existing HEDIS auditors. The NCQA HEDIS Compliance Audit followed NCQA audit methodology and encompassed a more in-depth examination of the MCO's processes than do the requirements for validating performance measures as set forth by CMS. Therefore, using the HEDIS audit methodology complied with both NCQA and CMS specifications, allowing for a complete and reliable evaluation of the MCOs.

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*.[2-5]

- Teleconference calls with the health plan's personnel and vendor representatives, as necessary.
- Detailed review of the health plan's completed responses to the Record of Administration, Data Management and Processes (Roadmap) and any updated information communicated by NCQA to the audit team directly.
- On-site meetings at the health plan's offices, including:
  - Interviews with individuals whose job functions or responsibilities played a role in the production of HEDIS data.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.

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

  - 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 2018 rates as presented within the NCQA-published Interactive Data Submission System (IDSS) completed by the health plan and/or its contractor.

The MCOs were responsible for obtaining and submitting their respective HEDIS Final Audit Reports (FARs) to HSAG. The HEDIS auditor's responsibility was to express an opinion on each MCO'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 MCOs, it did review the audit reports produced by the licensed audit organizations. All licensed organizations followed NCQA's methodology in conducting their HEDIS Compliance Audits.

Behavioral Health Organizations—The Department selected the performance measures for calculation. 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 data sources, including claims/encounter data and enrollment/eligibility data.

HSAG conducted performance measure validation for each of the BHOs' measure rates. The Department required that the measurement year (MY) 2017 (i.e., July 1, 2016–June 30, 2017) performance measures be validated during FY 2017–2018 based on the specifications outlined in the *BHO-HCPF Annual Performance Measures Scope Document*, which was written collaboratively by the BHOs and the Department.[2-6] 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 2017, several measures were HEDIS-like measures, and several other measures were developed by the Department and the BHOs.

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).[2-7] HSAG followed the same process for performance measure validation for each BHO. The process included the following steps.

[2-6] Colorado Department of Health Care Policy and Financing. *BHO-HCPF Annual Performance Measures Scope Document: Fiscal Year 2018* (FY18).

[2-7] 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,

- **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 of 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.
  - Reviewed 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, encounters, and 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.

September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2018.

- 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 reporting 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

Managed Care Organizations—As identified in the HEDIS audit methodology, the following key types of data were obtained and reviewed for FY 2017–2018 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 Organizations—As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data for MY 2017 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

IS Standards Review

Managed Care Organizations—Health plans must be able to demonstrate compliance with information system (IS) standards. Health plans' compliance with IS standards is linked to the validity and reliability of reported performance measure data. HSAG reviewed and evaluated all data sources to determine MCO compliance with the HEDIS Compliance Audit Standards. The IS standards are listed as follows:

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry
- IS 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, HEDIS 2017, and HEDIS 2018 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, HEDIS 2017, and HEDIS 2018, 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.

Performance Measure Results

The MCOs' 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 statistically significant improvement in performance in reporting year (RY) 2018 from the previous RY. Rates shaded red with two carets (^^) indicate statistically significant declines in performance from the previous year. Performance comparisons are based on the Chi-square test of proportions with results deemed statistically significant 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. To limit the impact of this, a change will not be considered statistically significant unless the change was at least 3 percentage points. Note that

statistical testing could not be performed on the utilization-based measures within the Use of Services domain given that variances were not available in the IDSS for HSAG to use for statistical testing.

The statewide average presented in this report is a weighted average of the rates for each health plan, weighted by the eligible population for each plan. This results in a statewide average similar to an actual statewide rate because, rather than counting each health plan equally, the size of each plan is taken into consideration when determining the average. The formula for calculating the statewide average is as follows:

$$Statewide\ Average = \frac{P_1R_1 + P_2R_2}{P_1 + P_2}$$

Where P_1 = the eligible population for Health Plan 1
R_1 = the rate for Health Plan 1
P_2 = the eligible population for Health Plan 2
R_2 = the rate for Health Plan 2

Measure results for HEDIS 2018 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2017, when available. Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure indicator were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2017 since this indicator is not published in Quality Compass. The percentile rankings denoted in the measure results tables are defined in Table 2-5.

Table 2-5—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 2018 measure rate was not reportable or because the measure did not have an applicable benchmark. Additionally, the following logic determined the high- and low-performing measure rates discussed within the results:

- High performers are measures for which the statewide average is high compared to national benchmarks and performance is trending positively. These measures are those:
  - Ranked at or above the national Medicaid 75th percentile without a statistically significant decline in performance from HEDIS 2017.
  - Ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017.
- Low performers are measures for which statewide performance is low compared to national percentiles or performance is toward the middle but declining over time. These measures are those:
  - Below the national Medicaid 25th percentile.
  - Ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017.

According to the Department's guidance, all measure rates presented in this report for the health plans are based on administrative data only. The Department required that all HEDIS 2017 and 2018 measures be reported using the administrative methodology only. However, RMHP Prime still reported certain measures to NCQA using the hybrid methodology. The hybrid measures' results are found in Table A-1 in Appendix A. When reviewing HEDIS measure results, the following items should be considered:

- Health plans capable of obtaining supplemental data or capturing more complete data will generally report higher rates when using only the administrative methodology. As a result, the HEDIS measure rates presented in this report for measures with a hybrid option 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 or to prior years' results that were established using administrative and/or medical record review data as results likely underestimate actual performance. Table 2-6 presents the measures in this report that could be reported using the hybrid methodology.

Table 2-6—HEDIS Measures That Can Be Reported Using the Hybrid Methodology

HEDIS Measures
Pediatric Care 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
Access to Care Measure
Prenatal and Postpartum Care

HEDIS Measures
Preventive Screening Measures
Cervical Cancer Screening
Adult BMI Assessment
Living With Illness Measure
Comprehensive Diabetes Care

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 2-7.

Table 2-7—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for Physical Health Plans

Performance Measures	Quality	Timeliness	Access
Pediatric Care Measures			
Adolescent Well-Care Visits	✓		
Appropriate Testing for Children With Pharyngitis	✓		
Appropriate Testing for Children With Upper Respiratory Infection	✓		
Childhood Immunization Status	✓		
Immunizations for Adolescents	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 15 Months of Life	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Access to Care Measures			
Adults' Access to Preventive/Ambulatory Health Services			✓
Children and Adolescents' Access to Primary Care Practitioners			✓
Prenatal and Postpartum Care	✓	✓	✓
Preventive Screening Measures			
Adult BMI Assessment	✓		
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening in Adolescent Females	✓		

Performance Measures	Quality	Timeliness	Access
Mental/Behavioral Health Measures			
Antidepressant Medication Management	✓		
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics	✓		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	✓		
Living With Illness Measures			
Annual Monitoring for Patients on Persistent Medications	✓		
Asthma Medication Ratio	✓		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	✓		
Comprehensive Diabetes Care	✓		
Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	✓		
Medication Management for People With Asthma	✓		
Persistence of Beta-Blocker Treatment After a Heart Attack	✓		
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	✓	✓	
Statin Therapy for Patients With Cardiovascular Disease	✓		
Statin Therapy for Patients With Diabetes	✓		
Use of Imaging Studies for Low Back Pain	✓		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	✓		
Use of Service Measures			
Ambulatory Care (Per 1,000 Member Months [MM])	NA	NA	NA
Antibiotic Utilization	NA	NA	NA
Frequency of Selected Procedures (Procedures per 1,000 MM)	NA	NA	NA
Inpatient Utilization—General Hospital/Acute Care	NA	NA	NA
Plan All-Cause Readmissions	✓		
Use of Opioids at High Dosage	✓		
Use of Opioids From Multiple Providers	✓		

Behavioral Health Organization—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*.

Measure results for 2018 were compared to the Department's established performance targets and are denoted in Table 2-8.

Table 2-8—Performance Targets

Performance Measures	Performance Targets
Mental Health Engagement (All Members Excluding Foster Care)	48.48%
Mental Health Engagement (Only Foster Care)	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	72.94%
Emergency Department Utilization for Mental Health Condition	7.722
Emergency Department Utilization for Substance Use Condition	19.71

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 2-9.

Table 2-9—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains for Behavioral Health Organizations

Performance Measures	Quality	Timeliness	Access
Mental Health Engagement (All Members Excluding Foster Care)	✓	✓	✓
Mental Health Engagement (Only Foster Care)	✓	✓	✓
Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	✓
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	✓	✓	✓
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	✓	✓	✓
Emergency Department Utilization for Mental Health Condition	NA	NA	NA
Emergency Department Utilization for Substance Use Condition	NA	NA	NA

Validation of Performance Improvement Projects

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each health plan's compliance with requirements set forth in 42 CFR 438.240(b) (1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in 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.[2-8] Using this protocol, HSAG, in collaboration with the Department, developed the PIP Summary Form, which each health plan completed and submitted to HSAG for review and validation. The PIP Summary Forms standardized the process for submitting information regarding PIPs and ensured that all CMS protocol requirements were addressed.

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

- Activity I. Select the Study Topic(s)
- Activity II. Define the Study Question(s)
- Activity III. Use a Representative and Generalizable Study Population

[2-8] 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: July 17, 2018.

[2-8] 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: July 17, 2018.

- 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' 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 2-10.

Table 2-10—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 and gain understanding about patients' experience with healthcare.

Technical Methods of Data Collection

DHMC and RMHP Prime were required to arrange for conducting CAHPS surveys for Medicaid members enrolled in their specific organizations. The technical method of data collection for the 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.

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

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to, services provided by the 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 2-11.

Table 2-11—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 objectives of administering the ECHO surveys were to effectively and efficiently obtain information and to gain understanding about patients' experiences with behavioral healthcare and services provided by Colorado's managed behavioral healthcare organizations.

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 through 2018 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 Colorado's 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."[2-9] 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

[2-9] For the individual item measure, "Privacy," a positive response is defined as "No."

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 components reviewed for the ECHO surveys to one or more of these three domains. This assignment to domains is depicted in Table 2-12.

Table 2-12—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	✓		

ECHO Topics	Quality	Timeliness	Access
Privacy	✓		
Cultural Competency	✓		
Amount Helped	✓		
Improved Functioning	✓		✓
Social Connectedness	✓		

Aggregating and Analyzing Statewide Data

For each MCO and BHO (collectively health plans), HSAG analyzed the results obtained from each EQR mandatory activity. For the Medicaid physical health MCOs, HSAG also analyzed the CAHPS survey results; and for the BHOs, HSAG also analyzed the ECHO survey results. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about quality of, timeliness of, or access to care and services for each health plan independently as well as related to statewide improvement.

3. Evaluation of Colorado's Managed Care Organizations

Denver Health Medicaid Choice

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 3-1 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 2017–2018.

Table 3-1—Summary of DHMC Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
V—Member Information	25	13	9	4	0	12	69%
VI—Grievance and Appeal System	35	35	30	2	3	0	86%
VII—Provider Participation and Program Integrity	16	15	12	1	2	1	80%
IX—Subcontracts and Delegation	4	4	0	2	2	0	0%
Totals	**80**	**67**	**51**	**9**	**7**	**13**	**76%***

**The overall compliance 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 record review score for FY 2017–2018.

Table 3-2—Summary of DHMC Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	42	29	29	0	13	100%
Appeals	24	24	20	4	0	83%
Totals	**66**	**53**	**49**	**4**	**13**	**92%***

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

DHMC: Strengths

DHMC provided member materials upon enrollment to inform members of the benefits and requirements of the plan, including procedures for choosing a provider, obtaining referrals and out-of-network services, member rights, processes for filing grievances and appeals, how to obtain emergency and after-hours services, and other required information. Policies, procedures, and materials clearly stated that information is available in Spanish, that interpreter services and auxiliary aids are available, and that member information must be written at the sixth grade reading level. DHMC posted the Medicaid formulary and provider directory on its website and notified members that printed copies were available.

DHMC policies and procedures addressed federal Medicaid managed care regulations and State contract requirements pertaining to member grievance, appeal, and State fair hearing processes, and were compliant with requirements and time frames for receiving, acknowledging, resolving, and providing member notices regarding grievances and appeals. DHMC demonstrated effective electronic processes for documenting and tracking grievance and appeal information. On-site record reviews confirmed that DHMC's processes for addressing member grievances were compliant with managed care regulations and State contract requirements and that DHMC reviewed and resolved appeals timely.

DHMC demonstrated detailed policies and procedures to support healthcare selection and retention of healthcare providers, including a documented process for complying with the State's credentialing and recredentialing requirements. DHMC also had a robust monitoring system to ensure that no employees, providers, consultants, subcontractors, board of director members, or other applicable individuals and entities were excluded from participation in federal healthcare programs. DHMC's corporate compliance program was detailed and addressed all required components of an effective compliance program. The compliance program documented processes and procedures for detecting, investigating, and reporting suspected fraud, waste, and abuse (FWA), including auditing and monitoring activities. Staff training documents and other communications demonstrated that staff were adequately informed of FWA policies and other compliance-related activities.

DHMC's policies and documents related to subcontracting administrative services addressed the processes for pre-delegation assessment of all potential subcontractors, provided for ongoing review and annual reassessment of subcontractor performance under the contract, provided for a prompt response to identified deficiencies, and for reporting results to DHMC's Compliance Committee.

DHMC: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard V—Member information

While the member materials policy correctly stated the requirements for font size, tag lines, and alternative formats related to member materials, HSAG found that some critical materials—e.g., appeal and grievance process letters and forms—failed to include large-print tag lines. In addition, HSAG tested materials provided electronically as well as DHMC's website and identified several issues

regarding ready accessibility for members with disabilities. The provider directory failed to include provider cultural competency training or locations with access to accommodations for members with physical disabilities. The member handbook included inaccurate time frames for filing grievances and appeals and incorrectly stated that members may request State fair hearings before completing the health plan appeals process. DHMC was required to:

- Ensure that all critical written member communications include the large-print tag line informing members of how to request auxiliary aids and services.
- Ensure that all information available on its website is readily accessible (i.e., complies with Section 508 guidelines).
- Revise its provider directory to designate which providers have completed cultural competency training, and identify office locations with accommodations for members with physical disabilities.
- Revise its member handbook to include accurate time frames and information related to filing grievances and appeals and for requesting a State fair hearing.

Standard VI—Grievance and Appeal System

HSAG noted several concerns with DHMC's grievance and appeals policies, procedures, and organizational processes. Areas of concern included that:

- Documents described a DHMC second-level appeal process (in conflict with federal healthcare regulations).
- Attachments were out of compliance with current requirements and time frames.
- Documents did not accurately identify the difference between a grievance and an appeal, causing failure to process appropriately.
- The content of appeal resolution letters lacked clarity and included inaccurate information concerning the State fair hearing process.
- DHMC provided no documentation to support that it implemented a process to inform providers about the grievance and appeal system requirements and time frames or how to request a State fair hearing.

DHMC was required to:

- Update its grievance and appeal system policies and procedures, including all appendices and attachments, with information in compliance with the federal Medicaid regulations and associated State contract requirements.
- Ensure that all staff are aware of and have mechanisms in place for appropriately managing appeals and grievances in compliance with current federal regulation and State contract changes.
- Ensure that written notices of appeal resolutions are in formats and language that may be easily understood by members.

- Ensure that appeal resolution letters as well as policies and procedures related to appeal resolution contain accurate information about when a member or a designated representative may request a State fair hearing.
- Implement mechanisms to ensure that all providers and subcontractors are provided with information about the grievance and appeal system and the State fair hearing processes upon entering into contracts or employment with DHMC.

Standard VII—Provider Participation and Program Integrity

While DHMC staff members verbally described that processes were in place for: identifying and recovering overpayments to providers; conducting screening of all claims for potential fraud, waste, or abuse; and notifying the Department of a network provider's termination or circumstances that could affect the provider's eligibility to participate in the managed care program, DMHC was unable to demonstrate that it had processes for reporting to the Department these types of issues. Additionally, DHMC was unable to demonstrate evidence of providing the Department with written disclosures of any prohibited affiliations, written disclosure of ownership and control, identification of any capitation or other payments received in excess of the amounts specified in the contract, or that providers were aware of their obligations to report the same to DHMC. Similarly, no evidence was presented to support that providers were aware of the requirement to report overpayments to DHMC or that the Department was notified annually of any recoveries of overpayments. DHMC was required to:

- Have mechanisms in place for promptly reporting all overpayments identified or recovered due to potential fraud; screen all provider claims for potential fraud, waste, or abuse; and notify the Department about changes in a network provider's circumstances that could affect the provider's eligibility to participate in the Medicaid managed care program.
- Have documented procedures for notifying the Department of the following: written disclosure of any prohibited affiliation, written disclosure of ownership and control, and identification within 60 calendar days of any capitation payments or other payments made for amounts greater than those specified in the contract.
- Have mechanisms in place for ensuring that network providers report to DHMC when they have received an overpayment, return the overpayment to DHMC within 60 calendar days of its identification as such, and notify DHMC in writing of the reason for the overpayment. DHMC must also report annually to the Department recoveries of overpayments.

Standard IX—Subcontracts and Delegation

While DHMC provided evidence of written procedures for pre-delegation review, ongoing monitoring, and having determined corrective actions to address subcontractor performance when issues were found, staff members were unable to demonstrate that these processes had been implemented. Staff were also unable to demonstrate that DHMC held written agreements with all subcontractors. DHMC was required to:

- Implement processes to perform pre-delegation assessment, ongoing monitoring, and correction of any identified deficiencies for every subcontractor—in accordance with its policies.

- Ensure having a signed written agreement with each subcontractor that includes delegated activities and related reporting responsibilities; remedies—including revocation—for instances in which the subcontractor fails to perform delegated responsibilities; required compliance with all applicable Medicaid laws and regulations; and the right of the State, CMS, the U.S. Department of Health and Human Services (HHS) Inspector General, Comptroller General, or designees to audit, evaluate, and inspect records, as delineated in 42 CFR 438.230(c)(3).

DHMC: Trended Performance for Compliance Monitoring

Table 3-3 displays DHMC's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for the same standard.

Table 3-3—Compliance Monitoring Trended Performance for DHMC

Standard and Applicable Review Years	DHMC Previous Review	DHMC Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	91%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	80%	92%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	93%	92%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	100%	100%
Standard V—Member Information (2014–2015, 2017–2018)	**93%**	**69%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	**65%**	**86%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	**100%**	**80%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	94%	98%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	**100%**	**0%**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	85%	88%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)	NA	62%

Bold text indicates standards that HSAG reviewed during FY 2017–2018.
FY 2017–2018 review reflects revised requirements per Code of Federal Regulations Title 42, Volume 81, May 6, 2016, and may not be comparable to previous review.
For all standards, the health plan's contract with the State may have changed since the previous review year and may have contributed to performance changes.
FY 2016–2017 was the initial year of review for Standard XI.

DHMC demonstrated improved performance when compared to the previous year's review for five of 10 standards with the most significantly increased performance observed in the Grievance and Appeal System standard. DHMC demonstrated a significant decline in performance in three standards, with the Subcontracts and Delegation standard experiencing a decline from 100 percent to 0 percent compliance between review cycles. HSAG cautions, however, that over the three-year cycle between review periods

several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of the compliance monitoring tool—may have impacted comparability of the compliance results. No previous review results were available for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2018 HEDIS Compliance Audit Report, DHMC was fully compliant with four of the IS standards and partially compliant with two of the IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. DHMC's HEDIS auditor found that the health plan was partially compliant with IS standards 1 and 7, which related to the *Childhood Immunization Status* measure; however, no concerns materially impacted DHMC's ability to report performance measure data for this measure.

DHMC: Performance Measure Results

Table 3-4 shows the performance measure results for DHMC for HEDIS 2016 through HEDIS 2018, along with the percentile ranking for each HEDIS 2018 rate.

Table 3-4—Performance Measure Results for DHMC

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	75.92%	72.57%	**68.27%^^**	10th–24th
Combination 3	75.40%	71.58%	**65.94%^^**	25th–49th
Combination 4	74.99%	71.42%	**64.23%^^**	25th–49th
Combination 5	64.68%	59.46%	58.09%	25th–49th
Combination 6	52.87%	53.76%	**43.39%^^**	50th–74th
Combination 7	64.42%	59.35%	56.77%	25th–49th
Combination 8	52.67%	53.76%	**42.53%^^**	50th–74th
Combination 9	47.02%	46.50%	**39.50%^^**	50th–74th
Combination 10	46.87%	46.50%	**38.80%^^**	50th–74th
Immunizations for Adolescents[1]				
Combination 1 (Meningococcal, Tdap)	76.72%	75.37%	75.69%	25th–49th
Well-Child Visits in the First 15 Months of Life[1]				
*Zero Visits**	7.69%	7.03%	9.12%	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Six or More Visits	3.36%	3.52%	4.39%	<10th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.87%	58.59%	60.91%	10th–24th
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	38.27%	34.68%	36.33%	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	78.83%	7.68%	16.75%^	<10th
Counseling for Nutrition—Total	77.37%	1.08%	5.97%^	<10th
Counseling for Physical Activity—Total	63.26%	0.55%	1.36%	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	76.34%	80.52%	83.93%	75th–89th
Appropriate Treatment for Children With Upper Respiratory Infection[2]				
Appropriate Treatment for Children With Upper Respiratory Infection	97.48%	96.04%	97.70%	≥90th
Access to Care				
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	74.04%	**64.59%^^**	<10th
Postpartum Care	—	44.42%	49.06%^	<10th
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	89.33%	88.32%	86.84%	<10th
Ages 25 Months to 6 Years	73.66%	71.74%	72.12%	<10th
Ages 7 to 11 Years	78.22%	76.19%	75.53%	<10th
Ages 12 to 19 Years	79.00%	76.40%	75.43%	<10th
Adults' Access to Preventive/Ambulatory Health Services				
Total	65.78%	59.87%	**55.19%^^**	<10th
Preventive Screening				
Chlamydia Screening in Women				
Total	69.33%	68.73%	66.68%	75th–89th
Cervical Cancer Screening[1]				
Cervical Cancer Screening	56.93%	45.77%	43.03%	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17%	0.06%	0.14%	≥90th
Adult BMI Assessment[1]				
Adult BMI Assessment	84.43%	81.03%	83.25%	25th–49th
Mental/Behavioral Health				
Antidepressant Medication Management[3]				
Effective Acute Phase Treatment	46.35%	49.05%	54.88%^	50th–74th
Effective Continuation Phase Treatment	31.41%	31.02%	33.52%	25th–49th
Follow-Up Care for Children Prescribed ADHD Medication[3]				
Initiation Phase	29.41%	26.88%	37.40%	10th–24th
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	NB	—
Use of Multiple Concurrent Antipsychotics in Children and Adolescents**,[3]				
Total	4.55%	0.00%	0.00%	≥90th
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	69.77%	10th–24th
Comprehensive Diabetes Care[1]				
Hemoglobin A1c (HbA1c) Testing	89.78%	82.60%	82.16%	10th–24th
*HbA1c Poor Control (>9.0%)**	36.74%	44.02%	42.92%	25th–49th
HbA1c Control (<8.0%)	48.66%	44.33%	45.45%	25th–49th
Eye Exam (Retinal) Performed	55.96%	45.70%	46.59%	10th–24th
Medical Attention for Nephropathy	89.29%	87.35%	**82.47%^^**	<10th
Blood Pressure Control (<140/90 mm Hg)	73.72%	57.41%	64.01%^	50th–74th
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	57.92%	59.83%	**54.64%^^**	10th–24th
Statin Adherence 80%	59.43%	54.71%	59.47%	25th–49th
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	62.18%	72.18%	75.00%	25th–49th
Statin Adherence 80%—Total	63.92%	54.17%	58.33%	25th–49th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	85.22%	85.93%	85.24%	10th–24th
Diuretics	85.05%	84.95%	83.78%	<10th
Use of Imaging Studies for Low Back Pain[3]				
Use of Imaging Studies for Low Back Pain	81.26%	65.53%	69.33%	25th–49th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[2]				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	45.54%	65.57%	59.29%	≥90th
Pharmacotherapy Management of COPD Exacerbation[2]				
Systemic Corticosteroid	61.54%	64.16%	**55.69%^^**	10th–24th
Bronchodilator	73.08%	81.82%	**67.06%^^**	<10th
Medication Management for People With Asthma				
Medication Compliance 50%—Total	39.76%	47.83%	54.19%^	25th–49th
Medication Compliance 75%—Total	16.87%	22.64%	27.75%	25th–49th
Asthma Medication Ratio				
Total	32.39%	42.41%	63.77%^	50th–74th
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%	27.44%	25th–49th
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis				
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	83.33%	86.49%	**73.56%^^**	50th–74th
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total—Total**	43.97	42.22	41.79	≥90th
Outpatient Visits—Total—Total	207.09	193.35	183.12	<10th
Inpatient Utilization—General Hospital/Acute Care—Total				
Discharges per 1,000 Member Months (Total Inpatient)—Total	5.48	4.85	4.58	<10th
Average Length of Stay (Total Inpatient)—Total	4.55	4.41	4.73	75th–89th
Discharges per 1,000 Member Months (Medicine)—Total	3.06	2.63	2.55	25th–49th
Average Length of Stay (Medicine)—Total	4.41	3.94	4.25	50th–74th
Discharges per 1,000 Member Months (Surgery)—Total	0.81	0.81	0.78	<10th
Average Length of Stay (Surgery)—Total	8.77	8.79	9.40	≥90th
Discharges per 1,000 Member Months (Maternity)—Total	2.61	2.07	1.75	10th–24th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Average Length of Stay (Maternity)—Total	2.69	2.79	2.77	50th–74th
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics—Total	0.34	0.31	0.31	≥90th
Average Days Supplied per Antibiotic Script—Total	9.33	9.28	9.27	25th–49th
Average Scripts PMPY for Antibiotics of Concern—Total	0.10	0.09	0.09	≥90th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	28.12%	27.79%	27.52%	≥90th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017.
[2] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 rates to prior years.
[3] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.
— indicates that the rate is not presented in this report as the measure was not required previously. This symbol may also indicate that a percentile ranking is not appropriate (e.g., rate was too small to report).
† 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 poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.
Performance comparisons are based on the Chi-square test of statistical significance, with a p value 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.
NB (No Benefit) indicates that the health plan did not offer the health benefit required by the measure.

DHMC: Strengths

The following HEDIS 2018 measure rates were determined to be high performers for DHMC (i.e., ranked at or above the national Medicaid 75th percentiles without a statistically significant decline in performance from HEDIS 2017; or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017):

- *Appropriate Testing for Children With Pharyngitis*
- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Chlamydia Screening in Women—Total*
- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Asthma Medication Ratio—Total*

DHMC: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers for DHMC (i.e., fell below the national Medicaid 25th percentiles or ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017):

- *Childhood Immunization Status—Combinations 2*, *3*, and *4*
- *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*
- *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*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Persistence of Beta-Blocker Treatment After a Heart Attack*
- *Comprehensive Diabetes Care—HbA1c Testing*, *Eye Exam (Retinal) Performed*, and *Medical Attention for Nephropathy*
- *Statin Therapy for Patients With Diabetes—Received Statin Therapy*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*

DHMC's performance for HEDIS 2018 suggests that adult and child members may face challenges accessing services to receive appropriate care, as evidenced by the measure rates for *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services* falling below the national Medicaid 10th percentiles. Of note, DHMC's low rates for *Ambulatory Care* and *Inpatient Utilization—General Hospital/Acute Care* suggest that members are not utilizing available healthcare services in any capacity; these measures evaluate the volume of inpatient, outpatient, and emergency department visits for DHMC's population. The access issues may also have an impact on the quality of care received, as evidenced by low performance related to *Prenatal and Postpartum Care* and *Comprehensive Diabetes Care—HbA1c Testing* and *Medical Attention for Nephropathy* measures, which fell below the national Medicaid 25th percentiles. DHMC should evaluate access issues and implement procedures to ensure that adequate care is provided and develop mechanisms to ensure that care provided is appropriately documented within administrative data

systems. This may also result in improvement of the quality of care provided. Additionally, DHMC has opportunities to improve in areas related to medication management, as evidenced by the following measures performing below the national Medicaid 25th percentile: *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*; *Persistence of Beta-Blocker Treatment After a Heart Attack*; *Annual Monitoring for Patients on Persistent Medications*; and *Pharmacotherapy Management of COPD Exacerbation*. DHMC should work to ensure that members receive medications necessary to treat their conditions and that providers appropriately monitor members receiving long-term medications.

Conversely, DHMC demonstrated strengths for antibiotic stewardship. Compared to national trends, DHMC has low overall antibiotic utilization rates and ranks above the national Medicaid 75th percentiles for the following measures related to antibiotic use for acute respiratory conditions: *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*; *Appropriate Testing for Children With Pharyngitis*; and *Appropriate Treatment for Children With Upper Respiratory Infection*. Additionally, DHMC performed above the national Medicaid 75th percentile for *Chlamydia Screening in Women—Total* and *Non-Recommended Cervical Cancer Screening in Adolescent Females*, indicating that younger women are receiving appropriate screenings.

Validation of Performance Improvement Projects

Table 3-5 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 2017–2018. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the projects. Each protocol activity is composed of individual evaluation elements scored *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 3-5 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 second year of validation for this PIP because DHMC's 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 the DHMC would implement a new topic, which was submitted in 2016. For this second year of validation for the current PIP, HSAG validated Activities I through IX.

Table 3-5—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	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)**	**0% (0/21)**

Overall, 90 percent of all applicable evaluation elements validated received scores of *Met.* For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII through VIII), and Activity IX in the Outcomes stage were validated.

Table 3-6 displays baseline and Remeasurement 1 data for DHMC's *Transition to Primary Care After Asthma-Related Emergency, Urgent Care, or Inpatient Visit* 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 3-6—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.	62.7%	61.8%	*Not Applicable*	*Not Assessed*

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 62.7 percent. The health plan 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 the denominator remains at 67. This calculation sets the Remeasurement 1 goal at 80.6 percent to achieve projected statistically significant improvement.

For Remeasurement 1, the rate declined to 61.8 percent. This decline was not statistically significant, as evidenced by a *p* value of 1.0000. DHMC reported that this decline in performance was unexpected and had there not been such an increase in its population (i.e., the denominator size had stayed relatively the same as the baseline), the study indicator performance would have yielded statistically significant improvement.

DHMC: Strengths

DHMC designed a methodologically sound project. The sound study design allowed the MCO to progress to data collection. DHMC accurately reported and summarized the Remeasurement 1 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

For the *Transitions to Primary Care After Asthma-Related Emergency Department, Urgent Care, or Inpatient Visit* PIP, DHMC identified the following barriers to address:

- Lack of consistent post-discharge follow-up by patient-centered medical homes (PCMHs).
- Lack of emergency department, urgent care, and inpatient facility encounter data for Children's Hospital Colorado.

To address these barriers, DHMC implemented the following interventions:

- Created a weekly list for asthma-related concerns and admissions to DHMC's patient navigators. The list represents all members presenting to the emergency department, urgent care, or inpatient facility at Children's Hospital Colorado. The quality improvement intervention manager then filters for asthma-related diagnoses and sends the list to the Ambulatory Care Services Patient Navigation staff members for outreach.
- An outreach call is conducted to the member by the Department of Ambulatory Care Service's patient navigators within 48 hours of a member's discharge. The patient navigators assist the member with scheduling the follow-up visit with the primary care provider within 30 days of the discharge from the emergency department, urgent care, or inpatient facility.

DHMC: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the MCOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. At the conclusion of DHMC's PIP, HSAG recommended the following:

- Consider using other quality improvement tools such as a process map or failure modes effects analysis (FMEA) to isolate barriers or gaps within processes that may not have been previously identified.
- Continue to conduct ongoing evaluations of each intervention and make data-driven decisions regarding revising, continuing, or discontinuing interventions.
- For improvement strategies deemed successful, develop a plan for sustaining and spreading the success beyond the life of the PIP.

Consumer Assessment of Healthcare Providers and Systems

Table 3-10 shows the adult Medicaid results achieved by DHMC for FY 2015–2016 through FY 2017–2018.

Table 3-7—Adult Medicaid Question Summary Rates and Global Proportions for DHMC

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	78.1%	76.1%	77.5%
Getting Care Quickly	69.7%	76.1%	78.0%
How Well Doctors Communicate	89.5%	92.6%	92.5%
Customer Service	84.5%	86.6% +	85.7%
Shared Decision Making	79.3%	82.6% +	77.8%
Rating of Personal Doctor	71.5%	71.8%	70.9%
Rating of Specialist Seen Most Often	67.2%	69.0% +	61.4% +
Rating of All Health Care	50.2%	61.7%	52.2%
Rating of Health Plan	56.0%	57.4%	59.1%

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

Table 3-11 shows the child Medicaid results achieved by DHMC for FY 2015–2016 through FY 2017–2018.

Table 3-8—Child Medicaid Question Summary Rates and Global Proportions for DHMC

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	80.6%	79.5%	84.8%
Getting Care Quickly	85.8%	84.0%	86.1%
How Well Doctors Communicate	93.6%	93.9%	94.7%
Customer Service	88.2%	85.5% +	91.2%
Shared Decision Making	75.8% +	74.3% +	78.0% +
Rating of Personal Doctor	80.7%	79.2%	86.0%
Rating of Specialist Seen Most Often	75.0% +	66.7% +	75.0% +
Rating of All Health Care	66.9%	70.2%	76.9%
Rating of Health Plan	73.3%	68.1%	77.0%

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.

DHMC: Adult Medicaid Strengths

For DHMC's adult Medicaid population, no measure rates increased substantially between FY 2016–2017 and FY 2017–2018.

For DHMC's adult Medicaid population, one measure rate increased substantially between FY 2015–2016 and FY 2017–2018:

- *Getting Care Quickly* (8.3 percentage points)

Three measure rates were higher than the 2017 national averages:

- *How Well Doctors Communicate*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

Of these three, none were considered substantially higher than the 2017 national averages.

DHMC: Child Medicaid Strengths

For DHMC's child Medicaid population, six measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Getting Needed Care* (5.3 percentage points)
- *Customer Service* (5.7 percentage points)
- *Rating of Personal Doctor* (6.8 percentage points)
- *Rating of Specialist Seen Most Often* (8.3 percentage points)
- *Rating of All Health Care* (6.7 percentage points)
- *Rating of Health Plan* (8.9 percentage points)

For DHMC's child Medicaid population, two measure rates increased substantially between FY 2017–2018 and FY 2015–2016:

- *Rating of Personal Doctor* (5.3 percentage points)
- *Rating of All Health Care* (10.0 percentage points)

Seven measures were higher than the 2017 national averages:

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

Of these seven, three measure rates were considered substantially higher, each being more than 5 percentage points greater than the 2017 national average:

- *Rating of Personal Doctor* (9.9 percentage points)
- *Rating of All Health Care* (7.6 percentage points)
- *Rating of Health Plan* (6.2 percentage points)

DHMC: Adult Medicaid Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For DHMC's adult Medicaid population, two measure rates decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Rating of Specialist Seen Most Often* (7.6 percentage points)
- *Rating of All Health Care* (9.5 percentage points)

For DHMC's adult Medicaid population, one measure rate decreased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of Specialist Seen Most Often* (5.8 percentage points)

Six measures were lower than the 2017 national averages:

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

Of these six, one measure rate was considered substantially lower, being more than 5 percentage points below the 2017 national average:

- *Rating of Specialist Seen Most Often* (5.7 percentage points)

DHMC experienced substantial rate decreases for two measures in the 2017–2018 measurement year when compared to the previous measurement year. In addition, four measure rates showed slight decreases when compared to the previous year. HSAG recommends that DHMC prioritize improving those measures that demonstrated substantial decreases in rates. However, to improve member perception for all measures showing a decline, HSAG offers the following recommendations that DHMC could consider based on population needs and MCO resources.

The *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of All Health Care* measures could be impacted by many variables, including a member's willingness to engage, the provider's cultural

competency, a clinician's communication regarding treatment recommendations or medication, or whether a member receives the perceived help needed and is treated with courtesy and respect by customer service staff. DHMC could consider the following specific recommendations:

- Conducting evaluations to assess staff members' and providers' customer service skills and developing training programs designed to address issues found related to both staff and providers.
- Developing an ongoing tracking mechanism that captures why members called customer service and identifies the most common questions and concerns expressed by members. With this information, DHMC should develop training directed at those findings to ensure that customer service representatives, call center staff, and clinic-based reception area staff have the information and resources needed to address the most common concerns.
- Querying members regarding their communication preferences and using the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increasing follow-up contacts (e.g., phone or electronic) and outreach efforts to members to assess and ensure understanding of health and treatment information.
- Evaluating the timeliness of access to specialists. Additionally, to more specifically determine network needs, DHMC should evaluate the adequacy of its specialist provider network and the most common provider-to-specialist referral patterns.
- Coordinating with community organizations to enhance disease management programs; and offering to children, youth, and families health education and support related to chronic conditions such as asthma, diabetes, and weight management.

For the *Rating of Specialist Seen Most Often* and *Rating of All Health Care* rates that experienced a substantial decrease (more than 5 percentage points) compared to the previous measurement year, HSAG recommends that the MCO implement a barrier analysis to determine the key driver(s) of performance on these measures and whether or not specific quality improvement initiatives are needed to improve member experiences.

DHMC: Child Medicaid Summary Assessment of Opportunities for Improvement and Recommendations Related to CAHPS

For DHMC's child Medicaid population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018 or between FY 2015–2016 and FY 2017–2018.

Two measure rates were lower than the 2017 national averages:

- *Getting Care Quickly*
- *Shared Decision Making*

Of these two, neither was considered substantially lower than the 2017 national averages.

DHMC experienced neither substantial nor slight rate decreases in the 2017–2018 measurement year when compared to the previous year. HSAG encourages DHMC to continue initiatives that appear to be positively impacting rates in many child-related measures. For recommendations related to the measures based on rates that were lower than the 2017 national average, please refer to Section 5.

Rocky Mountain Health Plans Medicaid Prime

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 2017–2018.

Table 3-9—Summary of RMHP Prime Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
V—Member Information	25	14	14	0	0	11	100%
VI—Grievance and Appeal System	35	35	31	0	4	0	89%
VII—Provider Participation and Program Integrity	16	14	13	1	0	2	93%
IX—Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**80**	**67**	**62**	**1**	**4**	**13**	**93%**

**The overall compliance 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 record review score for FY 2017–2018.

Table 3-10—Summary of RMHP Prime Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	60	35	33	2	25	94%
Appeals	60	59	52	7	1	88%
Totals	**120**	**94**	**85**	**9**	**26**	**90%**

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

RMHP Prime: Strengths

RMHP Prime mailed member handbooks and welcome letters to all new members and conducted a welcome call to inform members of specific requirements and benefits of the plan. Member informational materials were written using easy-to-understand language and format, included required tag lines, and reminded members to contact customer service representatives with any questions. The member handbooks, provider directory, and formulary drug list included all required content and were available in both English and Spanish as well as on RMHP Prime's website. RMHP Prime demonstrated commitment to serving members with physical disabilities and those who are deaf or hard of hearing through partnerships with several Western Slope coalitions and councils.

RMHP Prime's policies and procedures addressed federal regulations and State contract requirements and time frames pertaining to member grievance and appeal processes and how to request a State fair hearing. RMHP Prime provided grievance and appeal system information to all contracted providers and subcontractors through provider contracts and the provider manual. RMHP Prime had an effective electronic system for documenting and tracking information related to the grievance and appeal system and demonstrated mechanisms for ensuring appeal and grievance timeliness. On-site record review demonstrated that RMHP Prime staff who make decisions on appeals and grievances have the appropriate clinical expertise and consider all documentation submitted by the member. Grievance and appeal resolution letters were member-centric and easy to understand.

RMHP Prime demonstrated effective mechanisms to support the appropriate selection and retention of healthcare providers, including detailed policies and procedures and a documented process for complying with the State's credentialing and recredentialing requirements. RMHP Prime had a monitoring and tracking system for ensuring that no employees, providers, consultants, subcontractors, board of director members, or other applicable individuals or entities were excluded from participation in federal healthcare programs. RMHP Prime's compliance program included written policies and procedures, a compliance committee, staff to conduct internal audits and fraud and abuse investigation, effective lines of communication for reporting compliance-related issues, provisions for taking action when noncompliance or suspected fraud is identified, and annual audit and risk-assessment plans.

RMHP Prime's policies and procedures described the processes for evaluating a prospective subcontractor's ability to perform activities to be delegated, for monitoring subcontractors' performance ongoing and annually, and for requiring corrective actions for any identified deficiencies or identified areas needing improvement. RMHP Prime's written agreements with its subcontractors included all required content, including delegated activities and reporting requirements, provisions for sanctions or revocation, agreement to comply with applicable laws, and the right to audit by State or federal designees. RMHP Prime provided evidence of ongoing monitoring and formal annual reviews of subcontractors.

RMHP Prime: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard VI—Grievance and Appeal System

While grievance and appeal policies and procedures required that RMHP Prime mail members written acknowledgement of grievances and appeals, on-site file review demonstrated that RMHP Prime did not consistently mail written acknowledgement of grievances or appeals within two days. Similarly, the appeals policy accurately addressed the requirements for content of notices of appeal resolution, yet on-site record reviews identified that several resolution letters contained inaccurate time frame requirements for requesting a State fair hearing—30 days instead of 120 days—and/or the notice did not include the date that the resolution process was completed. RMHP Prime was required to:

- Have mechanisms in place to ensure that written acknowledgement of each grievance and each appeal is sent to the member within two working days of receipt of the grievance or the appeal.
- Include in the written notice of appeal resolution the date that the resolution process was completed. For appeals not resolved wholly in favor of the member, include in the resolution notice the right to request a State fair hearing within 120 days from the date of the notice of appeal resolution.

Standard VII—Provider Participation and Program Integrity

RMHP Prime was unable to demonstrate an existing process to regularly verify that services billed by network providers were actually received by members. RMHP Prime was required to implement a method to regularly verify, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.

RMHP Prime: Trended Performance for Compliance Monitoring

Table 3-11 displays RMHP Prime's compliance results for the most recent year that each standard area was reviewed as compared to the previous review year's results for that standard.

Table 3-11—Compliance Monitoring Trended Performance for RMHP Prime

Standard and Applicable Review Years	RMHP Prime Previous Review	RMHP Prime Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	85%	94%
Standard II—Access and Availability (2013–2014, 2016–2017)	90%	100%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	60%	100%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	80%	80%
Standard V—Member Information (2014–2015, 2017–2018)	**80%**	**100%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	**88%**	**89%**
Standard VII—Provider Participation and Program Integrity	**93%**	**93%**

Standard and Applicable Review Years	RMHP Prime Previous Review	RMHP Prime Most Recent Review
(2014–2015, 2017–2018)		
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	100%	100%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	**100%**	**100%**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	77%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)	NA	92%

Bold text indicates standards that HSAG reviewed during FY 2017–2018.
FY 2017–2018 review reflects revised requirements per Code of Federal Regulations Title 42, Volume 81, May 6, 2016, and may not be comparable to previous review.
For all standards, the health plan's contract with the State may have changed since the previous review year and may have contributed to performance changes.
FY 2016–2017 was the initial year of review for Standard XI.

RMHP Prime's most recent year of review for four of 10 standards demonstrated significant performance improvement (10 percentage points or more). RMHP Prime improved most significantly—by 40 percentage points—in the Coordination and Continuity of Care standard. RMHP Prime's performance improved slightly in two additional standards and remained unchanged in four standards, with two of those standards remaining stable at 100 percent. HSAG cautions, however, that over the three-year cycle between review periods several factors—e.g., changes in federal regulations, changes in State contract requirements, and design of the compliance monitoring tool—may have impacted comparability of the compliance results. No previous review results were available for Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Validation of Performance Measures

Compliance With Information Systems (IS) Standards

According to the 2018 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 identified no issues that impacted RMHP Prime's HEDIS performance measure reporting.

RMHP Prime: Performance Measure Results

Table 3-12 shows the performance measure results for RMHP Prime for HEDIS 2016 through HEDIS 2018, along with the percentile ranking for each HEDIS 2018 rate.

Table 3-12—Performance Measure Results for RMHP Prime

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status[1]				
Combination 2	BR	NA	NA	—
Combination 3	BR	NA	NA	—
Combination 4	BR	NA	NA	—
Combination 5	BR	NA	NA	—
Combination 6	BR	NA	NA	—
Combination 7	BR	NA	NA	—
Combination 8	BR	NA	NA	—
Combination 9	BR	NA	NA	—
Combination 10	BR	NA	NA	—
Immunizations for Adolescents[1]				
Combination 1 (Meningococcal, Tdap)	BR	NA	NA	—
Well-Child Visits in the First 15 Months of Life[1]				
*Zero Visits**	NA	NA	NA	—
Six or More Visits	NA	NA	NA	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[1]				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	BR	67.35%	58.21%	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Adolescent Well-Care Visits[1]				
Adolescent Well-Care Visits	BR	15.57%	15.68%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[1]				
BMI Percentile Documentation—Total	BR	2.40%	3.18%	<10th
Counseling for Nutrition—Total	BR	14.00%	15.55%	<10th
Counseling for Physical Activity—Total	BR	0.80%	0.71%	<10th
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	89.14%	NA	NA	—
Appropriate Treatment for Children With Upper Respiratory Infection[2]				
Appropriate Treatment for Children With Upper Respiratory Infection	94.98%	94.74%	NA	—
Access to Care				
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	51.22%	**22.65%^^**	<10th
Postpartum Care	—	28.22%	27.15%	<10th
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12 to 24 Months	NA	NA	NA	—
Ages 25 Months to 6 Years	84.93%	90.57%	87.84%	25th–49th
Ages 7 to 11 Years	91.67%	90.11%	90.36%	25th–49th
Ages 12 to 19 Years	89.60%	86.06%	91.12%	50th–74th
Adults' Access to Preventive/Ambulatory Health Services				
Total	71.69%	72.23%	70.93%	10th–24th
Preventive Screening				
Chlamydia Screening in Women				
Total	46.27%	45.23%	49.26%^	10th–24th
Cervical Cancer Screening[1]				
Cervical Cancer Screening	BR	40.88%	43.21%	<10th
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	4.04%	3.07%	2.12%	25th–49th
Adult BMI Assessment[1]				
Adult BMI Assessment	BR	16.21%	17.25%	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Mental/Behavioral Health				
Antidepressant Medication Management[3]				
Effective Acute Phase Treatment	69.92%	56.03%	52.34%	50th–74th
Effective Continuation Phase Treatment	57.47%	36.21%	34.46%	25th–49th
Follow-Up Care for Children Prescribed ADHD Medication[3]				
Initiation Phase	35.19%	NA	NA	—
Continuation and Maintenance Phase	NA	NA	NA	—
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	—	—	21.95%	<10th
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[3]				
Total	0.00%	NA	2.70%	25th–49th
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NA	—
Comprehensive Diabetes Care[1]				
Hemoglobin A1c (HbA1c) Testing	BR	86.05%	83.94%	10th–24th
*HbA1c Poor Control (>9.0%)**	BR	74.00%	70.68%^	<10th
HbA1c Control (<8.0%)	BR	21.71%	25.19%^	<10th
Eye Exam (Retinal) Performed	BR	38.23%	**7.47%^^**	<10th
Medical Attention for Nephropathy	BR	83.54%	82.98%	<10th
Blood Pressure Control (<140/90 mm Hg)	BR	0.00%	0.00%	<10th
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	33.44%	43.48%	43.37%	<10th
Statin Adherence 80%	64.81%	62.75%	57.33%	25th–49th
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	41.79%	71.08%	71.96%	25th–49th
Statin Adherence 80%—Total	NA	66.10%	68.38%	75th–89th
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	84.54%	84.67%	84.52%	10th–24th
Diuretics	84.17%	85.51%	85.80%	25th–49th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Use of Imaging Studies for Low Back Pain[3]				
Use of Imaging Studies for Low Back Pain	78.35%	74.17%	72.70%	50th–74th
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis[2]				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	42.11%	37.87%	40.89%	≥90th
Pharmacotherapy Management of COPD Exacerbation[2]				
Systemic Corticosteroid	53.99%	53.09%	44.50%	<10th
Bronchodilator	57.06%	62.89%	54.13%	<10th
Medication Management for People With Asthma				
Medication Compliance 50%—Total	65.91%	63.41%	63.25%	50th–74th
Medication Compliance 75%—Total	45.45%	34.63%	38.89%	50th–74th
Asthma Medication Ratio				
Total	58.26%	56.35%	52.07%	10th–24th
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%	34.87%	50th–74th
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis				
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	65.00%	75.25%	74.77%	50th–74th
Use of Services†				
Ambulatory Care (Per 1,000 Member Months)				
*Emergency Department Visits—Total—Total**	71.40	66.27	62.98	25th–49th
Outpatient Visits—Total—Total	306.76	320.65	317.25	25th–49th
Inpatient Utilization—General Hospital/Acute Care—Total				
Discharges per 1,000 Member Months (Total Inpatient)—Total	9.35	9.66	9.01	75th–89th
Average Length of Stay (Total Inpatient)—Total	3.50	3.66	3.62	10th–24th
Discharges per 1,000 Member Months (Medicine)—Total	0.65	4.47	4.20	75th–89th
Average Length of Stay (Medicine)—Total	3.90	3.66	3.70	25th–49th
Discharges per 1,000 Member Months (Surgery)—Total	6.37	2.36	2.12	75th–89th
Average Length of Stay (Surgery)—Total	3.93	5.39	5.39	10th–24th
Discharges per 1,000 Member Months (Maternity)—Total	2.42	2.96	2.83	25th–49th
Average Length of Stay (Maternity)—Total	2.21	2.20	2.10	<10th

Performance Measures	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	Percentile Ranking
Antibiotic Utilization*				
Average Scripts PMPY for Antibiotics—Total	1.02	0.75	0.70	75th–89th
Average Days Supplied per Antibiotic Script—Total	9.30	9.27	9.32	25th–49th
Average Scripts PMPY for Antibiotics of Concern—Total	0.44	0.32	0.28	75th–89th
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	43.15%	42.10%	39.55%	50th–74th

** For this indicator, a lower rate indicates better performance.*
[1] Changes in the rates from HEDIS 2016 to HEDIS 2017 and HEDIS 2018 should be interpreted with caution due to a change in the Department's reporting requirement from hybrid in HEDIS 2016 to administrative in HEDIS 2017. This measure rate presented in this table is based on administrative data only. To see the hybrid rate reported by the MCO to NCQA, please see table A-1 in Appendix A.
[2] Due to changes in the technical specifications for this measure for HEDIS 2017, exercise caution when trending HEDIS 2017 rates to prior years.
[3] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.
— indicates that the rate is not presented in this report as the measure was not required previously. This symbol may also indicate that a percentile ranking is not appropriate (e.g., rate was too small to report).
† 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 poorer performance. Rates are not risk adjusted; therefore, the percentile ranking should be interpreted with caution and may not accurately reflect high or low performance.
Rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year.
Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year.
Performance comparisons are based on the Chi-square test of statistical significance, with a p value 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.
BR (Biased Rate) indicates that the reported rate was invalid; therefore, the rate is not presented.

RMHP Prime: Strengths

The following HEDIS 2018 measure rates were determined to be high performers for RMHP Prime (i.e., ranked at or above the national Medicaid 75th percentiles without a statistically significant decline in performance from HEDIS 2017; or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017):

- *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

RMHP Prime: Summary Assessment of Opportunities for Improvement and Recommendations Related to Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers for RMHP Prime (i.e., fell below the national Medicaid 25th percentiles or ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017):

- *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*
- *Adults' Access to Preventive/Ambulatory Health Services—Total*
- *Chlamydia Screening in Women—Total*
- *Cervical Cancer Screening*
- *Adult BMI Assessment*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*
- *Statin Therapy for Patients With Diabetes—Received Statin Therapy*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*
- *Asthma Medication Ratio—Total*

For HEDIS 2018, RMHP Prime demonstrated consistently low performance on measures related to medication management, with the following measure rates all ranking below the national Medicaid 25th percentiles: *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*; *Statin Therapy for Patients With Diabetes—Received Statin Therapy*; *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*; and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*. RMHP Prime's performance on measures related to medication management suggests that the health plan should ensure that members receive necessary medications and that providers appropriately monitor members on medications. Additionally, RMHP Prime's performance for *Adults' Access to Preventive/Ambulatory Health Services—Total* ranked below the national Medicaid 25th percentile, indicating that barriers may exist for adults attempting to access preventive care. RMHP Prime should work to ensure that adult members have access to preventive and ambulatory care.

Conversely, the rate for *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* ranked above the national Medicaid 90th percentile, demonstrating that providers in emergency department and outpatient settings are not unnecessarily prescribing antibiotics when patients present with acute bronchitis. Additionally, although the percentage of members with cardiovascular disease who received statin therapy fell below the national Medicaid 50th percentile, RMHP Prime demonstrated a strength in ensuring that members with cardiovascular disease remained on statins; the *Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total* measure ranked above the national Medicaid 75th percentile.

Validation of Performance Improvement Projects

Findings

Table 3-13 displays the validation results for the RMHP Prime PIP, *Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*, validated during FY 2017–2018. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each protocol 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 3-13 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 fourth validation year for this PIP, with HSAG validating Activities I through IX.

Table 3-13—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)**
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)**

			Percentage of Applicable Elements		
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% (18/20)**	**0% (0/20)**	**10% (2/20)**

Overall, 90 percent of all applicable evaluation elements validated received scores of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII through VIII), and Activity IX in the Outcomes stage were validated.

Table 3-14 displays baseline, Remeasurement 1, and Remeasurement 2 data for RMHP Prime's *Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility* PIP. RMHP Prime's goal is to increase the percentage of paroled members who have a visit with a primary care provider within 90 days of enrollment into RMHP Medicaid Prime.

Table 3-14—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%	13.9%	*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 Remeasurement 1 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 was 35 percent. RMHP Prime indicated in its analysis of findings that it believes 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 feels that this project has been successful in connecting recently released parolees with primary care visits.

For Remeasurement 2, the rate fell to 13.9 percent. This decline over baseline was not statistically significant, as evidenced by the *p* value of 0.2993. The health plan indicated having revised its goal to 15 percent based on newer published research on continuity of care for individuals released from incarceration as well as on current issues with data collection and enrollment timing. RMHP Prime indicated that factors existed which may have impacted the study indicator performance and reliability of the data reported. These factors include:

- The Department moving to a new Medicaid Management Information System (MMIS) vendor starting in March 2017. This change was approximately nine months into the data collection period for Remeasurement 2. Most issues that may have impacted the PIP were related to enrollment anomalies that took place between March 1, 2017, through June 30, 2017. Following the change in vendor, the Department identified issues of inaccurate eligibility data for some members.
- Change in Medicaid enrollment policy so that eligibility for incarcerated individuals was suspended instead of terminated. Due to this policy change, RMHP Prime identified that some members either remained eligible while incarcerated or became eligible during incarceration. This had an impact on the data collection process and data reporting because the study indicator methodology required a primary care visit within 90 days of enrollment into RMHP Prime, using the enrollment into Prime as the anchor date. The member may have spent 90 days from initial enrollment still incarcerated and therefore would not have counted in the numerator or denominator even though the intervention took place.

RMHP Prime: Strengths

RMHP Prime designed a methodologically sound project and performed well in the Design and Implementation stages. RMHP Prime accurately reported and summarized the study indicator results and used appropriate quality improvement methods and processes to identify, prioritize, and reprioritize barriers. The interventions implemented were logically linked to the barriers and had a positive impact on the number of members who had primary care visits following release from prison. This conclusion is based on the additional analysis conducted by RMHP Prime, from which members were not excluded because of the statewide policy and information changes; this impacted the eligible population for the PIP. The actual number of members receiving coordination of care and navigation to primary care was significantly larger than what could be reported for the study indicator results. The additional analysis performed by RMHP Prime supported the health plan's conclusion that quality improvement efforts and interventions were successful despite the decline illustrated in the PIP.

Barriers/Interventions

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

- Parolees have urgent or emergent medical or behavioral health needs and lack ability to navigate the system independently.
- Parolees are unable to identify a primary care medical provider (PCMP) with which to schedule a visit.
- Parolees lack reliable forms of communication—either no communication or limited telephonic communication.
- Parolees do not prioritize healthcare as an immediate need.
- Many individuals are released to parole in Mesa County from facilities across the state, not just local facilities. Current re-entry programs in areas outside Region 1 provide limited or no information or resources on Health First Colorado (HFC) benefits and access to a care coordinator.
- Challenges with tracking and documenting parole interventions.

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 to help coordinate care and services.
- Parole officer or parole office behavioral health specialist contacts the MCO with the parolee present and provides a warm handoff referral to the care coordinator.
- Assigned a care coordinator to each parolee to assess for health needs and to help coordinate primary care, schedule the initial appointment, and ensure that the parolee attends the appointment.
- Developed a health literacy module for the required parolee orientation after release from prison.

RMHP Prime: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Improvement Projects.

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the CHP+ MCOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. At the conclusion of RMHP Prime's PIP, HSAG recommended the following:

- Evaluate the effectiveness of each individual intervention and make changes as necessary.
- Develop a plan to sustain the improvement achieved through the PIP process.

Consumer Assessment of Healthcare Providers and Systems

Table 3-15 shows the adult Medicaid results achieved by RMHP Prime for FY 2015–2016 through FY 2017–2018.

Table 3-15—Adult Medicaid Question Summary Rates and Global Proportions for RMHP Prime

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	84.8%	86.7%	82.5%
Getting Care Quickly	81.9%	84.6%	85.8%
How Well Doctors Communicate	94.4%	88.8%	92.2%
Customer Service	82.2% +	88.2% +	88.9% +
Shared Decision Making	77.0% +	83.4%	82.7%
Rating of Personal Doctor	67.8%	55.6%	68.7%
Rating of Specialist Seen Most Often	66.7% +	61.4%	64.5%
Rating of All Health Care	48.8%	48.2%	61.4%
Rating of Health Plan	55.0%	51.6%	56.5%

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 3-16 shows the child Medicaid results achieved by RMHP Prime for FY 2015–2016 through FY 2017–2018.

Table 3-16—Child Medicaid Question Summary Rates and Global Proportions for RMHP Prime

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Getting Needed Care	84.9% +	88.5% +	89.8% +
Getting Care Quickly	90.8% +	95.5% +	95.3% +
How Well Doctors Communicate	93.7% +	97.0% +	96.9% +
Customer Service	87.4% +	84.1% +	89.3% +
Shared Decision Making	94.6% +	91.7% +	92.1% +
Rating of Personal Doctor	72.5% +	80.3% +	87.5% +
Rating of Specialist Seen Most Often	65.1% +	57.5% +	74.1% +
Rating of All Health Care	55.7% +	56.1% +	63.0% +
Rating of Health Plan	61.9% +	64.7% +	68.5% +

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.

RMHP Prime: Adult Medicaid Strengths

For RMHP Prime's adult Medicaid population, two measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Rating of Personal Doctor* (13.1 percentage points)
- *Rating of All Health Care* (13.2 percentage points)

For RMHP Prime's adult Medicaid population, three measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Customer Service* (6.7 percentage points)
- *Shared Decision Making* (5.7 percentage points)
- *Rating of All Health Care* (12.6 percentage points)

Rates for seven measures were higher than the 2017 national averages:

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

Of these seven, one measure rate was considered substantially higher, being more than 5 percentage points above the 2017 national average:

- *Rating of All Health Care* (6.7 percentage points)

RMHP Prime: Child Medicaid Strengths

For RMHP Prime's child Medicaid population, four measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Customer Service* (5.2 percentage points)
- *Rating of Personal Doctor* (7.2 percentage points)
- *Rating of Specialist Seen Most Often* (16.6 percentage points)
- *Rating of All Health Care* (6.9 percentage points)

For RMHP Prime's child Medicaid population, four measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of Personal Doctor* (15.0 percentage points)
- *Rating of Specialist Seen Most Often* (9.0 percentage points)
- *Rating of All Health Care* (7.3 percentage points)
- *Rating of Health Plan* (6.6 percentage points)

Rates for seven measures were higher than the 2017 national averages:

- *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*

Of these seven, four measure rates were considered substantially higher, each being more than 5 percentage points greater than the 2017 national average:

- *Getting Needed Care* (5.3 percentage points)
- *Getting Care Quickly* (6.5 percentage points)
- *Shared Decision Making* (13.4 percentage points)
- *Rating of Personal Doctor* (11.4 percentage points)

RMHP Prime: Adult Summary Assessment of Opportunities for Improvement and Recommendations for CAHPS

For RMHP Prime's adult Medicaid population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018 or between FY 2015–2016 and FY 2017–2018.

Two measure rates were lower than the 2017 national averages:

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

Of these two, neither was considered substantially lower than the 2017 national average.

RMHP Prime experienced no substantial rate decreases in the 2017–2018 measurement year compared to the previous year. However, two measure rates showed slight decreases compared to the previous year. HSAG offers the following recommendations for RMHP Prime to consider based on population

needs and MCO resources. To improve members' perception of *Getting Needed Care*, HSAG recommends that RMHP Prime consider:

- Developing a focus study or PIP to obtain data about appointment scheduling patterns, provider hours offered, and frequency of no-show appointments to determine if interventions may be appropriate.
- Offering provider incentives for expanding the availability of evening and weekend hours, developing open-access scheduling, and adopting alternative schedules such as early morning or late evening hours.
- Encouraging the use of electronic communication between providers and members when appropriate to provide care when face-to-face appointments may not be needed.
- Developing and implementing a system to provide ongoing communication to inform both members and providers of timeliness access standards and where to access after-hours care.

To improve members' perception on the *Shared Decision Making* measure, HSAG recommends that RMHP Prime consider:

- Exploring creative mechanisms such as expanding member advisory committees, developing community-based member committees, and offering member mentorship programs for member engagement.
- Coordinating with community organizations to enhance disease management programs; and offering health education and support related to chronic conditions such as asthma, diabetes, and weight management to children, youth, and families.

RMHP Prime: Child Summary Assessment of Opportunities for Improvement and Recommendations for CAHPS

For RMHP Prime's child Medicaid population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018 or between FY 2015–2016 and FY 2017–2018.

Two measures were lower than the 2017 national averages:

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

Of these two, one measure rate was considered substantially lower, being more than 5 percentage points below the 2017 national average:

- *Rating of All Health Care* (6.3 percentage points)

RMHP Prime experienced no substantial rate decreases in the 2017–2018 measurement year compared to the previous year. However, two measure rates showed slight decreases compared to the previous year. HSAG offers the following recommendations for RMHP Prime to consider based on population needs and MCO resources. To improve members' perception of the *Getting Care Quickly* and *How Well Doctors Communicate* measures, HSAG recommends that RMHP Prime consider:

- Evaluating scheduling mechanisms related to timely access to appointment standards by perhaps including assessment and training of schedulers to assess the urgency of an appointment request and providing schedulers with specific information to direct members to alternative sources of service when appropriate. RMHP Prime could also consider further expanding use of walk-in clinics and services and providing members and families with ongoing reminders of where to access after-hours or walk-in care.
- Developing provider training forums or developing procedures that encourage providers to verify or ensure that members understand communications.
- Querying members regarding their communication preferences and using the results to determine the most effective member-specific forms of communication (e.g., verbal, written, phone, electronic, telehealth) and increasing follow-up contacts (e.g., phone or electronic).

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 2017–2018.

Table 4-1—Summary of ABC-D Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
V—Member Information	12	11	6	5	0	1	55%
VI—Grievance and Appeal System	27	27	24	3	0	0	89%
VII—Provider Participation and Program Integrity	13	13	12	1	0	0	92%
IX—Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**56**	**55**	**46**	**9**	**0**	**1**	**84%**

**The overall compliance 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 2017–2018.

Table 4-2—Summary of ABC-D Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	12	8	8	0	4	100%
Appeals	30	27	27	0	3	100%
Totals	**42**	**35**	**35**	**0**	**7**	**100%**

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

ABC-D: Strengths

ABC-D's policies and procedures regarding member materials met member information requirements and were sufficient to ensure that member communications were easily understood. All written member materials were available in English and in Spanish, and ABC's website included a translation function which made the website viewable in over 50 languages. ABC provided member materials in a variety of alternative formats to ensure that members had access to information regarding rights and processes for obtaining healthcare. Member materials, both printed and electronic, used simple, easy-to-understand language. ABC-D's website provided a wealth of information to members.

ABC-D's grievance and appeal policies and procedures were updated to incorporate the revised Medicaid managed care regulations effective July 1, 2017, and associated State contract requirements. ABC-D record reviews demonstrated 100 percent compliance with requirements for processing both grievances and appeals. ABC-D efficiently processed all grievances and appeals, rarely extending the time frame required to make resolution decisions. In addition to communicating with members in writing, ABC-D's appeals manager contacted all members orally to acknowledge receipt of appeals, answer member questions, and guide the member through the appeals process. ABC-D maintains records of grievances and appeals in the Altruista Health care management system.

ABC-D's policies and procedures for selection and retention of providers clearly described methods used to identify a specific area of need and then to recruit providers to fill the gap. ABC-D provided evidence of initial and ongoing screening of providers, employees, board members, consultants, and other entities to ensure that is has no relationships with individuals or entities excluded from participation in federal healthcare programs. If any individual or entity was determined to be excluded from participation in federal programs, ABC-D had processes in place to terminate the contract and notify the Department. ABC-D had a robust compliance program that consisted of an organizational structure to support compliance activities; initial and annual training of staff regarding compliance requirements; and processes for monitoring for and reporting fraud, waste, and abuse (FWA).

ABC-D's subcontracts and delegation policies, procedures, and agreements were applicable to all Colorado Access lines of business. Policies described the delegation program, pre-delegation assessment of the subcontractor, ongoing oversight and monitoring of delegated functions, and corrective actions when necessary. All existing subcontractor agreements had been updated to address all regulatory requirements, including a detailed description of delegated activities and related reporting requirements. Colorado Access had designated internal "business owners" for oversight of each subcontractor, responsible for ongoing monitoring and management of corrective actions when applicable. ABC-D provided sample documentation of such monitoring.

ABC-D: Summary Assessment of Opportunities for Improvement and Required Actions for Compliance Monitoring

Standard V—Member Information

Taglines describing how to request auxiliary aids and services, including written translation and oral interpretation, were not printed in 18-point font on both paper and in electronic member materials. HSAG noted that the ABC-D member handbook available on its website contained information that conflicts with the Health First Colorado member handbook or was inaccurate, which could be confusing to members. HSAG was unable to locate notification on the ABC website informing members that electronic information is available in paper form upon request. HSAG's accessibility check identified several accessibility errors on ABC-D's website and within electronic PDF documents. ABC-D's provider directory did not designate which provider locations have specific accommodations for members with disabilities—e.g. accessible offices, exam rooms, and equipment. ABC-D was required to:

- Ensure that all member materials include taglines in 18-point font describing how to request auxiliary aids and services, including written translation and oral interpretation.
- Remove its Member and Family Handbook from its website to ensure that members are not receiving conflicting or inaccurate member information.
- Inform members in a prominent location on its website that information found on the website is available in paper form upon request, without charge, and will be provided within five business days.
- Develop a process to ensure that all information on its website is readily accessible per Section 508 guidelines.
- Update its printable provider directory and the online "Find A Provider" feature to better clarify what it defines as "disability access."

Standard VI—Grievance and Appeal System

While the Member Grievance Process policy had been updated to indicate that a member may file a grievance at any time, the related Quality of Care Concern (QOCC) Investigations policy inaccurately stated that a member must file a QOCC within 30 days of the incident. The Member Appeal Process policy described one inaccurate criterion for how long benefits would continue during an appeal or State Fair Hearing (SFH). Neither the provider manual nor the website links referenced in the provider manual contained detailed information to inform providers about the grievance and appeal system and how to request an SFH. In addition, the provider manual did not include information on the appeals process available under the Child Mental Health Treatment Act (CMHTA). ABC-D was required to:

- Ensure that the QOCC policy is updated to reflect that a quality of care grievance may be filed by a member at any time.
- Remove from the member appeals policy and related communications "until the time period or service limits of the previously authorized service has been met" as a criterion for how long benefits would continue during an appeal or SFH if requested by the member.

- Develop mechanisms to inform providers and subcontractors about the grievance and appeal system and how to request an SFH in sufficient detail to address all federal regulations and State contract requirements.

Standard VII—Provider Participation and Program Integrity

While ABC-D's policies included a process for ensuring that laboratory-testing sites have a Clinical Laboratory Improvement Amendments (CLIA) waiver or certification, staff members confirmed that checking for CLIA certification for hospital laboratories was not part of the credentialing process. ABC-D was required to:

- Develop and adhere to a documented process for confirming that all laboratory-testing sites providing services to ABC-D members have either a CLIA Certificate of Waiver or a certificate of registration.

ABC-D: Trended Performance for Compliance Monitoring

Table 4-3—Compliance Monitoring Trended Performance for ABC-D

Standard and Applicable Review Years	ABC-D Previous Review	ABC-D Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	97%	87%
Standard II—Access and Availability (2013–2014, 2016–2017)	93%	100%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	100%	70%
Standard IV—Member Rights and Protections (2013–2014, 2016–2017)	100%	83%
Standard V—Member Information (2014–2015, 2017–2018)	**90%**	**55%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	**88%**	**89%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	**100%**	**92%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	98%	93%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	**100%**	**100%**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	100%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)	NA	NA

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.
Most recent 2017–2018 review reflects revision of requirements per Code of Federal Regulations. Title 42, Volume 81, May 6, 2016, and may not be comparable to previous review.
For all standards, the health plan's contract with the State may have changed since the previous review year and may have contributed to performance changes.
FY 2016–2017 was the initial year of review for Standard XI. BHOs were evaluated but not scored for compliance with these requirements.

ABC-D's most recent year of review for one standard demonstrated slightly improved performance when compared to the previous year that the standard was reviewed. ABC-D's performance remained relatively unchanged in an additional three standards, with two of these standards (Subcontracts and Delegation and Quality Assessment and Performance Improvement) remaining stable at 100 percent compliance. ABC-D demonstrated significant declines in performance (10 or more percentage points each) in four standards and a slight decline in performance in two additional standards, with the most significant decline in performance—45 percentage points—in the Member Information standard. HSAG cautions, however, that over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, or design of the compliance monitoring tool—may have impacted comparability of the compliance results

Validation of Performance Measures

Compliance With Information System (IS) Standards

HSAG identified no concerns with how ABC-D received and processed enrollment data. Prior to March 1, 2017, ABC-D received both monthly eligibility full files and daily change files from the Department through a secure file transfer protocol (FTP) site in a flat-file format. On March 1, 2017, ABC-D began receiving 834 monthly eligibility full files and daily change files from DXC Technology (DXC). ABC-D experienced no challenges with the transition to the new DXC system for receiving eligibility data. Both the 834 and flat files were mapped into tables and loaded in to Oracle, the BHO's database management system. Oracle validated the files and performed electronic checks for changes, additions, and terminations prior to loading the files into QNXT™, the BHO's transactional system. QNXT processed the files and loaded them back in Oracle and the enterprise data warehouse (EDW). Eligibility files were submitted to ABC-D providers and affiliated Community Mental Health Centers (CMHCs) daily. Providers continued to have the ability to log in to the Colorado Access portal or the Department portal to obtain eligibility information for members. Each member received a unique identification (ID) number. ABC-D did experience limited instances in which members were issued more than one Medicaid ID number; these included members who had changed their names and a few foster care members. In these instances, ABC-D linked both ID numbers and kept the assigned QNXT number within the system. In addition, the Medicaid ID numbers were linked to the corresponding enrollment periods.

HSAG identified no issues or concerns with how ABC-D received, processed, or reported claims and encounter data. Claims and encounters were received and processed in the same way; data were received in an 837 file through a secure FTP site or clearinghouse. The files were loaded into QNXT via a Cognizant FTP site that performed checks using BizTalk, a Microsoft software program, to identify accurate formatting and complete data. A 999-response file was generated in addition to a 277 acceptance or rejection report. Paper claims were sorted, batched, scanned, and uploaded to Cognizant's FTP site within three days, then converted into an 837-format using optical character recognition (OCR) software before being loaded into QNXT. CMHCs submitted encounter data through a secure FTP site. The files were loaded into QNXT through Cognizant. Nightly, Cognizant staff members audited 2.5 percent of auto-adjudicated claims and 5 percent of manually adjudicated claims. As an additional

quality check, ABC-D conducted daily audits on 7 percent of claims previously verified by Cognizant. ABC-D and Cognizant performed audits on 100 percent of facility claims exceeding a $10,000 threshold and professional claims exceeding a $5,000 threshold. State hospital data were received from the Department quarterly via a secure email in an Excel format. The data included member name, Medicaid ID number, admit and discharge dates, and the total number of inpatient days; this information was saved on a shared drive in an Excel format.

ABC-D submitted 837 and flat files to the Department through a secure FTP site monthly. On March 1, 2017, the Department began a new process for BHOs to submit encounters to the Department interchange using DXC. ABC-D experienced several challenges with this transition, including formatting discrepancies and incorrect data fields, and at the time of the site visit had not successfully submitted encounters using this method. ABC-D continued to test the new data submission process. The BHOs and the Department conducted monthly meetings to address this ongoing issue. ABC-D also engaged in weekly calls with other BHOs to work through these challenges.

ABC-D had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy. All cases included in performance measure reporting were identified properly based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. HSAG found that ABC-D had several verification processes in place to ensure data completeness and data accuracy. Claims and encounters were extracted from QNXT and loaded into EDW for rate calculation. ABC-D generated a query in EDW to generate both denominator- and numerator-compliant member data for each indicator. Once the data were queried, they were extracted and loaded into an Oracle system in which tables were created. The State hospital data were loaded in Oracle, and a query was run to load the State hospital data with the data contained in the Oracle tables in the EDW. The Business Intelligence department generated the indicator rates and submitted them to the Quality department. The Quality department conducted primary source verification (PSV) on 5 to 10 members per indicator to ensure accuracy before the data were submitted to the Department.

ABC-D: Performance Measure Results

Table 4-4 shows the measurement year (MY) 2016–2017 measure results for ABC-D and the corresponding performance targets. As this was the first year of reporting these measures for the BHOs, trending to historical rates was not conducted.

Table 4-4—Measure Results for ABC-D

Performance Measures	MY 2016–2017 Rate[1]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)		
Mental Health Engagement (All Members Excluding Foster Care)	35.56%	48.48%
Mental Health Engagement (Only Foster Care)		
Mental Health Engagement (Only Foster Care)	55.84%	62.36%

Performance Measures	MY 2016–2017 Rate[1]	Performance Target
Engagement of Alcohol and Other Drug Dependence Treatment		
Engagement of Alcohol and Other Drug Dependence Treatment	19.32%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	36.58%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	53.48%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*		
Emergency Department Utilization for Mental Health Condition	23.257	7.722
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*		
Emergency Department Utilization for Substance Use Condition	42.51	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).

ABC-D: Strengths

During the first year of reporting these measure rates, ABC-D did not meet the performance target for any incentive measures. Of note, no measure rates were within a 10 percent relative difference from the performance target, and nearly all the performance measure rates (approximately 86 percent) had relative differences greater than 35 percent from their respective performance targets.

ABC-D: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Measures

ABC-D did not meet any performance targets for the MY 2016–2017 measure rates; therefore, ABC-D has opportunities to improve performance for all measure rates.

Validation of Performance Improvement Projects

Table 4-5 displays the validation results for the ABC-D PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider,* validated during FY 2017–2018. This table illustrates the BHO's overall application of the PIP process and achieved success in implementing the studies. Each protocol 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 4-5 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 fourth validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-5—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	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	67% (4/6)	33% (2/6)	0% (0/6)
Implementation Total			**67% (6/9)**	**33% (3/9)**	**0% (0/9)**
Outcomes	IX.	Real Improvement Achieved	67% (2/3)	0% (0/3)	33% (1/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**67% (2/3)**	**0% (0/3)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**81% (17/21)**	**14% (3/21)**	**5% (1/21)**

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

Overall, 81 percent of all applicable evaluation elements validated received scores of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII through VIII), and Activity IX in the Outcomes stage were validated.

Table 4-6 displays baseline, Remeasurement 1, and Remeasurement 2 data for ABC-D's *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* 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 4-6—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%	21.2%	*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 Remeasurement 1, 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 ($p = 1.000$).

At Remeasurement 2, 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 21.2 percent. The Remeasurement 2 rate was an increase of 21.2 percentage points over the baseline rate; however, the increase was not statistically significant ($p = 0.5679$). The Remeasurement 2 rate exceeded the Remeasurement 2 goal of 15.0 percent.

ABC-D: Strengths

ABC-D designed a methodologically sound project. The sound PIP study design allowed the BHO to measure and evaluate study indicator outcomes. The BHO accurately reported study indicator results, completed a causal/barrier analysis, and set goals for each remeasurement. For the causal/barrier analysis process, the BHO involved internal and external stakeholders in identifying and prioritizing barriers to improvement—using interdisciplinary brainstorming, analysis of survey data, and a key driver diagram to illustrate the anticipated impact of interventions.

Barriers/Interventions

For the *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP, ABC-D identified the same barriers during the Remeasurement 2 period as were identified for the Remeasurement 1 period. The health plan identified the following barriers to a successful transition of care:

- Incorrect coding and billing practices for depression screening by behavioral health and primary care providers.
- Provider challenges in navigating the behavioral health system.
- Lack of an established workflow process following a positive depression screen.
- Reduced likelihood of receiving claims for transition of care services from an increasing number of co-located medical and behavioral providers.

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

- For primary care providers and practice managers in Regional Care Collaborative Organization (RCCO) regions 3 and 5, established a provider training on proper billing and coding for depression screening. A "how to" flyer for providers was distributed as part of the training.
- Distributed 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.
- Established a provider and community forum providing organizations and stakeholders with information on Colorado Medicaid behavioral health systems as well as best practices and current efforts to integrate care, and conducted a behavioral health panel discussion.

ABC-D: Summary Assessment of Opportunities for Improvement and Recommendations for Validation of PIPs

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the BHOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. At the conclusion of ABC-D's PIP, HSAG recommended the following:

- Document a thorough and complete interpretation of study indicator results for each measurement period to monitor and communicate progress toward meeting outcome-related goals.
- Consider using a different approach to causal/barrier analysis, such as process mapping, to uncover previously unidentified barriers that may be inhibiting the improvement of outcomes.
- Continue to evaluate each intervention for effectiveness, and use intervention-specific evaluation results to guide decisions about future improvement strategies.

Experience of Care and Health Outcomes Surveys

Table 4-7 shows the adult ECHO survey results achieved by ABC-D for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

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

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	45.9%	51.3%	50.4%
Getting Treatment Quickly	73.5%	62.3%	72.0%+
How Well Clinicians Communicate	88.7%	87.8%	90.3%
Perceived Improvement	56.0%	56.9%	61.9%
Information About Treatment Options	60.7%	59.4%	56.2%
Office Wait	77.2%	77.0%	82.1%
Told About Medication Side Effects	75.3%	82.1%	84.9%+
Including Family	41.3%	42.0%	33.6%
Information to Manage Condition	79.6%	80.7%	77.3%
Patient Rights Information	85.6%	86.0%	84.7%
Patient Feels He or She Could Refuse Treatment	82.4%	78.9%	84.0%
Privacy	94.5%	90.0%	92.4%
Cultural Competency	N/A	N/A	N/A
Amount Helped	85.6%	82.8%	87.6%
Improved Functioning	54.4%	52.6%	54.2%
Social Connectedness	59.9%	68.9%	58.5%

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.
Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

Table 4-8 shows the child ECHO survey results achieved by ABC-D for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-8—Child ECHO Question Summary Rates and Global Proportions for ABC-D

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	46.9%	51.5%+	53.4%
Getting Treatment Quickly	73.8%	75.5%	72.3%
How Well Clinicians Communicate	92.1%	90.0%	92.0%
Perceived Improvement	72.7%	74.8%	77.1%
Information About Treatment Options	75.4%	75.0%	76.8%
Office Wait	81.8%	77.4%	86.6%
Told About Medication Side Effects	91.9%+	91.1%+	86.7%+
Information to Manage Condition	79.6%	70.4%+	74.1%
Patient Rights Information	89.9%	92.9%+	89.7%
Patient Feels He or She Could Refuse Treatment	82.6%	82.8%+	87.1%
Privacy	95.1%	98.0%	97.8%
Cultural Competency	N/A	N/A	N/A
Amount Helped	74.3%	80.5%	81.7%
Improved Functioning	68.0%	66.0%	72.4%
Social Connectedness	84.7%	91.9%	84.7%

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.
Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

ABC-D: Strengths

For ABC-D's adult Medicaid population, four measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Getting Treatment Quickly* (9.7 percentage points)
- *Perceived Improvement* (5.0 percentage points)
- *Office Wait* (5.1 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (5.1 percentage points)

For ABC-D's adult Medicaid population, two measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Perceived Improvement* (5.9 percentage points)
- *Told About Medication Side Effects* (9.6 percentage points)

For ABC-D's child Medicaid population, two measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Office Wait* (9.2 percentage points)
- *Improved Functioning* (6.4 percentage points)

For ABC-D's child Medicaid population, two measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of All Counseling or Treatment* (6.5 percentage points)
- *Amount Helped* (7.4 percentage points)

ABC-D: Summary Assessment of Opportunities for Improvement and Recommendations Related to ECHO

For ABC-D's adult Medicaid population, two measure rates decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Including Family* (8.4 percentage points)
- *Social Connectedness* (10.4 percentage points)

For ABC-D's adult Medicaid population, one measure rate decreased substantially between FY 2015–2016 and FY 2017–2018:

- *Including Family* (7.7 percentage points)

For ABC-D's child Medicaid population, one measure rate decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Social Connectedness* (7.2 percentage points)

For ABC-D's child Medicaid population, two measure rates decreased substantially between FY 2015–2016 and FY 2017–2018:

- *Told About Medication Side Effects* (5.2 percentage points)
- *Information to Manage Condition* (5.5 percentage points)

Access Behavioral Care—Northeast

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-9 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 2017–2018.

Table 4-9—Summary of ABC-NE Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Compliance Score (% of Met Elements)
V—Member Information	12	11	7	4	0	1	64%
VI—Grievance and Appeal System	27	27	23	4	0	0	85%
VII—Provider Participation and Program Integrity	13	13	12	1	0	0	92%
IX—Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**56**	**55**	**46**	**9**	**0**	**1**	**84%**

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

Table 4-10 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 2017–2018.

Table 4-10—Summary of ABC-NE Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Record Review Score (% of Met Elements)
Grievances	42	29	29	0	13	100%
Appeals	24	21	20	1	3	95%
Totals	**66**	**50**	**49**	**1**	**16**	**98%**

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

ABC-NE: Strengths

Most policies and procedures, processes, and materials applicable to ABC-D were also applicable to ABC-NE. ABC-NE's policies and procedures regarding member materials met member information requirements and were sufficient to ensure that member communications were accessible. All written member materials were available in English and in Spanish, and ABC-NE's website included a translation function which made the website viewable in over 50 languages. ABC-NE provided member materials in a variety of alternative formats to ensure that members had access to information regarding rights and processes for obtaining healthcare. Member materials, both printed and electronic, used, easy-to-understand language. ABC-NE's website provided a wealth of information to members.

ABC-NE's grievance and appeal policies and procedures were updated to incorporate the revised federal regulations effective July 1, 2017, and State contract requirements. ABC-NE record reviews demonstrated 100 percent compliance with requirements for processing grievances and compliance with requirements for processing appeals in all but one record. ABC-NE efficiently processed all grievances and appeals, rarely extending the time frame required to make resolution decisions. In addition to communicating with members in writing, ABC-NE's appeals manager contacted all members to orally acknowledge receipt of appeals, answer member questions, and guide members through the appeals process. ABC-NE maintained records of grievances and appeals in the Altruista Health care management system.

ABC-NE's policies and procedures for selection and retention of providers clearly described methods used to identify a specific area of need and to recruit providers to fill any gap. ABC-NE provided evidence of initial and ongoing screening of providers, employees, board members, consultants, and other entities to determine exclusion from participation in federal healthcare programs. If any individual or entity was determined to be excluded from participation in federal programs, ABC-NE terminated the contract and notified the Department. ABC-NE had a robust compliance program that consisted of an organizational structure to support compliance activities, initial and annual training of staff regarding compliance requirements, and processes for monitoring for and reporting FWA.

ABC-NE's subcontracts and delegation policies, procedures, and agreements were applicable to all Colorado Access lines of business. Policies described the delegation program, pre-delegation assessment of the subcontractor, ongoing oversight and monitoring of delegated functions, and corrective actions when necessary. All existing subcontractor agreements had been updated to address all regulatory requirements, including a detailed description of delegated activities and related reporting requirements. Colorado Access had designated internal "business owners" for oversight of each subcontractor responsible for ongoing monitoring and management of corrective actions, if applicable. ABC-NE provided documentation of such monitoring.

ABC-NE: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard V—Member Information

Taglines describing how to request auxiliary aids and services, including written translation and oral interpretation, were not printed in 18-point font on both paper and in electronic member materials. HSAG was unable to locate notification on the ABC-NE website informing members that electronic information is available in paper form upon request. HSAG's accessibility check identified several accessibility errors on ABC-NE's website and within electronic PDF documents. ABC-NE's provider directory did not designate which provider locations have specific accommodations for members with disabilities—e.g. accessible offices, exam rooms, and equipment—at each provider location. ABC-NE was required to:

- Ensure that all member materials include taglines in 18-point font describing how to request auxiliary aids and services, including written translation and oral interpretation.
- Inform members in a prominent location on its website that information on the website is available in paper form upon request, without charge, and will be provided within five business days.
- Develop a process to ensure that all information available electronically and on its website is readily accessible per Section 508 guidelines.
- Update its printable provider directory and the online "Find A Provider" feature to better clarify what it defines as "disability access."

Standard VI—Grievance and Appeal System

While the Member Grievance Process policy had been updated to indicate that a member may file a grievance at any time, the related QOCC Investigations policy inaccurately stated that a member must file a QOCC within 30 days of the incident. In one ABC-NE appeal record, the BHO failed to send an acknowledgement letter within two days of receipt of the appeal request. The Member Appeal Processes policy described one inappropriate criterion for how long benefits would continue during an appeal or SFH. Neither the provider manual nor the website links referenced in the provider manual contained detailed information to inform providers about the grievance, appeal, and SFH system. In addition, the provider manual included no information on the appeals process available under the CMHTA. ABC-NE was required to:

- Ensure that the QOCC policy is updated to reflect that a quality of care grievance may be filed by a member at any time.
- Ensure that written acknowledgement of a standard appeal request is sent to the member or designated representative within two days of receipt of the appeal request.
- Remove from the member appeals policy and related communications "until the time period or service limits of the previously authorized service has been met" as a criterion for how long benefits would continue during an appeal or SFH when requested by the member.

- Develop mechanisms to inform providers and subcontractors about the grievance and appeal system and how to request an SFH in sufficient detail to address all federal regulations and State contract requirements.

Standard VII—Provider Participation and Program Integrity

While ABC-NE's policies included a process for ensuring that laboratory-testing sites have a CLIA waiver or certification, staff members confirmed that checking for CLIA certification for hospital laboratories was not part of the credentialing process. ABC-NE was required to:

- Develop and adhere to a documented process for confirming that all laboratory-testing sites providing services to ABC-NE members have either a CLIA Certificate of Waiver or a certificate of registration.

ABC-NE: Trended Performance for Compliance Monitoring

Table 4-11—Compliance Monitoring Trended Performance for ABC-NE

Standard and Applicable Review Years	ABC-NE Previous Review	ABC-NE Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	NA	84%
Standard II—Access and Availability (2013–2014, 2016–2017)	NA	100%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	NA	70%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	NA	83%
Standard V—Member Information (2014–2015, 2017–2018)	**90%**	**64%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	**88%**	**85%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	**100%**	**92%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	NA	93%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	**100%**	**100%**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	NA	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)	NA	NA

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.
Most recent 2017–2018 review reflects revision of requirements per Code of Federal Regulations. Title 42, Volume 81, May 6, 2016, and may not be comparable to previous review.
For all standards, the health plan's contract with the State may have changed since the previous review year and may have contributed to performance changes.
FY 2016–2017 was the initial year of review for Standard XI. BHOs were evaluated but not scored for compliance with requirements.

ABC-NE did not have the contract to provide BH services at the time of the previous review for six of the eleven standards, resulting in no comparable results between review cycles. For the remaining four standards, compared to the previous review year, ABC-NE's performance significantly declined (26 percentage points) in the Member Information standard, slightly declined in two other standards, and remained stable at 100 percent compliance in one additional standard (Subcontract and Delegation). HSAG cautions, however, that over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, or design of the compliance monitoring tool—may have impacted comparability of the compliance results.

Validation of Performance Measures

Compliance With Information System (IS) Standards

HSAG identified no concerns with how ABC-NE received and processed enrollment data. Prior to March 1, 2017, ABC-NE received both monthly eligibility full files and daily change files from the Department through an FTP site in a flat-file format. On March 1, 2017, ABC-NE began receiving 834 monthly eligibility full files and daily change files from DXC. ABC-NE experienced no challenges with the transition to the new DXC system for receiving eligibility data. Both the 834 and flat files were mapped into tables and loaded in to Oracle, the BHO's database management system. Oracle validated the files and checked for changes, additions, and terminations prior to loading the files into QNXT, the BHO's transactional system. QNXT processed the files and reloaded them in to Oracle and the EDW. Eligibility files were submitted to ABC-NE providers and affiliated CMHCs daily. Providers continued to have the ability to log in to the Colorado Access portal or the Department portal to obtain eligibility information for members. Each member received a unique ID number. ABC-NE did experience limited instances in which members were issued more than one Medicaid ID number; these included members who had changed their names and a few foster care members. In these instances, ABC-NE linked both ID numbers and kept the assigned QNXT number within the system. In addition, the Medicaid ID numbers were linked to the corresponding enrollment periods.

HSAG identified no issues or concerns with how ABC-NE received, processed, or reported claims and encounter data. Claims and encounters were received and processed in the same way; data were received in an 837 file through a secure FTP site or clearinghouse. The files were loaded into QNXT via a Cognizant FTP site that performed checks using BizTalk, a Microsoft software, to identify accurate formatting and complete data. A 999-response file was generated in addition to a 277 acceptance or rejection report. Paper claims were sorted, batched, scanned, and uploaded to Cognizant's FTP site within three days, which converted them into an 837-format using OCR software before loading them into QNXT. CMHCs submitted encounter data through a secure FTP site. The files were loaded into QNXT through Cognizant. Nightly, Cognizant staff members audited 2.5 percent of auto-adjudicated claims and 5 percent of manually adjudicated claims. As an additional quality check, ABC-NE conducted daily audits on 7 percent of claims previously verified by Cognizant. ABC-NE and Cognizant performed audits on 100 percent of facility claims exceeding a $10,000 threshold and professional claims exceeding a $5,000 threshold. State hospital data were received from the Department quarterly via a secure email in an Excel format. ABC-NE submitted 837 and flat files to the Department through a

secure FTP site monthly. On March 1, 2017, the Department began a new process for BHOs to submit encounters to the Department interchange using DXC. ABC-NE experienced several challenges with this transition, including formatting discrepancies and incorrect data fields, and at the time of the site visit had not successfully submitted encounters using this method. ABC-NE continue to test the new data submission process. The BHOs and the Department conducted monthly meetings to address this ongoing issue. ABC-NE also engaged in weekly calls with other BHOs to work through these challenges.

ABC-NE had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy. All cases included in performance measure reporting were identified properly based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. HSAG found several verification processes in place to ensure data completeness and data accuracy. Claims and encounters were extracted from QNXT and loaded into EDW for rate calculation. ABC-NE generated a query in EDW to generate both denominator and numerator compliant members for each indicator. Once the data were queried they were extracted into an Oracle system in which tables were created. The State hospital data were loaded in to Oracle, and a query was run to load the State hospital data with the data contained in the Oracle tables in the EDW. The Business Intelligence department generated the indicator rates and submitted them to ABC's Quality department. The Quality department conducted PSV on 5 to 10 members per indicator to ensure accuracy before the data were submitted to the Department.

ABC-NE: Performance Measure Results

Table 4-12 shows the MY 2016–2017 measure results for ABC-NE and the corresponding performance targets. As this was the first year of reporting these measures for the BHOs, trending to historical rates was not conducted.

Table 4-12—Measure Results for ABC-NE

Performance Measure	MY 2016–2017 Rate[1]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)		
Mental Health Engagement (All Members Excluding Foster Care)	45.83%	48.48%
Mental Health Engagement (Only Foster Care)		
Mental Health Engagement (Only Foster Care)	59.01%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment		
Engagement of Alcohol and Other Drug Dependence Treatment	22.43%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	40.40%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	55.92%	72.94%

Performance Measure	MY 2016–2017 Rate[1]	Performance Target
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*		
Emergency Department Utilization for Mental Health Condition	16.155	7.722
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*		
Emergency Department Utilization for Substance Use Condition	21.74	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).

ABC NE: Strengths

During the first year of reporting these measure rates, ABC-NE did not meet the performance target for any incentive measures. Of note, the *Mental Health Engagement (All Members Excluding Foster Care)*, *Mental Health Engagement (Only Foster Care)*, and *Emergency Department Utilization for Substance Use Condition (per 1,000 Members)* performance measure rates were all within a 10 percent relative difference of the performance targets. All other performance measure rates had relative differences greater than 25 percent from their respective performance targets.

ACB-NE: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Measures

ABC-NE did not meet any performance targets for the MY 2016–2017 measure rates; therefore, ABC-NE has opportunities to improve performance for all measure rates.

Validation of Performance Improvement Projects

Findings

Table 4-13 displays the validation results for the ABC-NE PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*, validated during FY 2017–2018. 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 4-13 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 fourth validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-13—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	33% (1/3)	67% (2/3)	0% (0/3)
	VIII.	Appropriate Improvement Strategies	67% (4/6	33% (2/6)	0% (0/6)
Implementation Total			**56% (5/9)**	**44% (4/9)**	**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*			**71% (15/21)**	**19% (4/21)**	**10% (2/21)**

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

Overall, 71 percent of all applicable evaluation elements validated received scores of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII through VIII), and Activity IX in the Outcomes stage were validated.

Table 4-14 displays Remeasurement 1 data for ABC-NE's *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP. The BHO repeated the baseline measurement period in CY 2015 because it was unable to calculate a baseline rate in 2014.

Table 4-14—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%	0.0%		*Not Assessed*

[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.

The Remeasurement 1 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. No improvement occurred in the study indicator rate from baseline to Remeasurement 1, and the Remeasurement 1 goal of 15.0 percent was not met.

ABC- NE: Strengths

ABC-NE designed a methodologically sound project. The sound PIP study design allowed the BHO to measure and evaluate study indicator outcomes. The BHO accurately reported study indicator results, completed a causal/barrier analysis, and set goals for each remeasurement. For the causal/barrier analysis, the BHO conducted discussions and brainstorming with key stakeholders and used a key driver diagram to summarize relationships between interventions and outcomes.

Barriers/Interventions

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

- Distributed 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.
- Established a provider and community forum providing organizations and stakeholders with information on Colorado Medicaid behavioral health systems as well as best practices and current efforts to integrate care, and conducted a behavioral health panel discussion.

ABC-NE: Summary Assessment of Opportunities for Improvement and Recommendation Related to Validation of PIPs

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the BHOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. At the conclusion of ABC-NE's PIP, HSAG recommended the following:

- Document a thorough and complete interpretation of study indicator results for each measurement period to monitor and communicate progress toward meeting outcome-related goals.
- Consider using a different approach to causal/barrier analysis, such as process mapping, to uncover previously unidentified barriers that may be inhibiting the improvement of study indicator outcomes.
- Continue to evaluate each intervention for effectiveness, and use intervention-specific evaluation results to guide decisions about future improvement strategies.

Experience of Care and Health Outcomes Surveys

Table 4-15 shows the adult ECHO survey results achieved by ABC-NE for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-15—Adult ECHO Question Summary Rates and Global Proportions for ABC-NE

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	49.4%	55.6%	42.9%
Getting Treatment Quickly	68.8%	69.8%	67.5%
How Well Clinicians Communicate	90.2%	88.9%	86.4%
Perceived Improvement	61.5%	63.4%	59.9%
Information About Treatment Options	64.2%	54.1%	58.9%
Office Wait	82.5%	83.1%	85.2%
Told About Medication Side Effects	79.5%	73.2%	71.7%
Including Family	48.2%	49.7%	41.5%
Information to Manage Condition	76.5%	78.8%	78.2%
Patient Rights Information	89.8%	85.6%	86.2%
Patient Feels He or She Could Refuse Treatment	81.9%	78.6%	84.5%
Privacy	92.3%	94.5%	91.5%
Cultural Competency	N/A	N/A	N/A
Amount Helped	84.8%	84.2%	83.1%
Improved Functioning	54.0%	57.9%	54.9%
Social Connectedness	69.0%	64.7%	64.8%

Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

Table 4-16 shows the child ECHO survey results achieved by ABC-NE for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-16—Child ECHO Question Summary Rates and Global Proportions for ABC-NE

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	43.4%	41.5%	42.2%
Getting Treatment Quickly	70.5%	66.3%	72.1%+
How Well Clinicians Communicate	87.2%	85.5%	89.8%
Perceived Improvement	71.6%	74.9%	71.2%
Information About Treatment Options	73.0%	74.4%	74.9%
Office Wait	85.2%	80.2%	90.8%
Told About Medication Side Effects	83.7%+	80.8%+	83.1%+
Information to Manage Condition	71.0%	69.7%	75.5%
Patient Rights Information	93.1%	87.9%	93.5%
Patient Feels He or She Could Refuse Treatment	87.7%	87.9%	94.9%
Privacy	95.9%	98.4%	97.1%
Cultural Competency	N/A	N/A	N/A
Amount Helped	77.5%	78.3%	79.3%
Improved Functioning	63.9%	65.5%	62.8%
Social Connectedness	79.7%	89.2%	87.1%

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.
Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

ABC-NE: Strengths

For ABC-NE's adult Medicaid population, one measure rate increased substantially between FY 2016–2017 and FY 2017–2018:

- *Patient Feels He or She Could Refuse Treatment* (5.9 percentage points)

For ABC-NE's adult Medicaid population, no measure rates increased substantially between FY 2015–2016 and FY 2017–2018.

For ABC-NE's child Medicaid population, five measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Getting Treatment Quickly* (5.8 percentage points)
- *Office Wait* (10.6 percentage points)

- *Information to Manage Condition* (5.8 percentage points)
- *Patient Rights Information* (5.6 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (7.0 percentage points)

For ABC-NE's child Medicaid population, three measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Office Wait* (5.6 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (7.2 percentage points)
- *Social Connectedness* (7.4 percentage points)

ABC-NE: Summary Assessment of Opportunities for Improvement and Recommendation Related to ECHO

For ABC-NE's adult Medicaid population, two measure rates decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Rating of All Counseling or Treatment* (12.7 percentage points)
- *Including Family* (8.2 percentage points)

For ABC-NE's adult Medicaid population, four measure rates decreased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of All Counseling or Treatment* (6.5 percentage points)
- *Information About Treatment Options* (5.3 percentage points)
- *Told About Medication Side Effects* (7.8 percentage points)
- *Including Family* (6.7 percentage points)

For ABC-NE's child Medicaid population, no measure rates decreased substantially between FY 2015–2016 FY and 2017–2018 or FY 2016–2017 and FY 2017–2018.

Behavioral Healthcare, Inc.

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-17 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 2017–2018.

Table 4-17—Summary of BHI Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V—Member Information	12	11	8	3	0	1	73%
VI—Grievance and Appeal System	27	27	19	8	0	0	70%
VII—Provider Participation and Program Integrity	13	13	11	2	0	0	85%
IX—Subcontracts and Delegation	4	4	2	2	0	0	50%
Totals	**56**	**55**	**40**	**15**	**0**	**1**	**73%**

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

Table 4-18 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 2017–2018.

Table 4-18—Summary of BHI Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Grievances	60	54	53	0	6	98%
Appeals	54	45	35	10	9	78%
Totals	**114**	**99**	**88**	**10**	**15**	**89%**

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

BHI: Strengths

BHI's member welcome letter and annual letter to members included instructions for members on several key topics—e.g., how to find a provider—to enable members to better understand and access their Medicaid benefits. BHI's policies and procedures described the processes used to ensure that written member materials use easily understood language, are available in alternative formats and prevalent non-English languages, and include taglines in large print. BHI subcontracted oral interpretation and written translation services to several organizations. BHI's online practitioner search allowed members to search for providers by name, location, clinical specialty, language spoken, ethnicity, office hours, license type, whether or not a provider has completed cultural competency training, and whether or not the location is accessible for persons with physical disabilities.

BHI's grievance and appeals policies thoroughly addressed requirements related to grievances, appeals, and the SFH process, including accurate time frames for filing, processes for providing notices to members, content of resolution notices, provision of assistance to members, and procedures for reviewing grievances and appeals. Record reviews demonstrated that BHI consistently handled both grievances and appeals in accordance with requirements. Staff members demonstrated a commitment to handling member grievances and appeals thoroughly and expeditiously. BHI's grievance and appeals documentation and tracking system was thorough, easy to access, and captured detailed information about each step in the processing of a grievance or an appeal. BHI's provider manual thoroughly informed providers of all required components of the grievance and appeal system and how to request an SFH.

BHI had policies and procedures related to and had implemented processes for selection and retention of providers. These processes included: credentialing and recredentialing using NCQA standards and guidelines, anti-discrimination in credentialing committee decisions, and the right of a provider to appeal the denial of participation in the network. BHI's corporate compliance plan was comprehensive, thoroughly addressing all required components of the program, and was supported by numerous detailed policies and procedures. The compliance program also addressed monitoring for and reporting potential FWA. BHI staff members demonstrated thorough knowledge of compliance requirements and having processes in place for annual training of staff and providers, open lines of communication, processes for reporting per the False Claims Act, and monitoring for and investigation of potential compliance or FWA issues. BHI conducted pre-employment, pre-contracting, and monthly screening of all employees and contracted entities against the federal exclusion databases.

BHI's Sub-Contractual Relationships and Delegation policy and procedure described the process for conducting pre-delegation evaluations, delineated the required contents of the contract consistent with regulations, required ongoing and annual performance reviews, and required that the subcontractor submit corrective action plans to address any identified performance issues. BHI's written contracts included the delegated activities, related reporting responsibilities, and provision for revocation. Three of BHI's four written contracts also included the contractor's agreement to comply with Medicaid laws and the right to audit provisions found at 42 CFR 438.230.

BHI: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard V—Member Information

While BHI's online provider search application included most required components of the provider directory, the PDF version failed to designate which providers have completed cultural competency training and which locations are accessible for persons with physical disabilities. Neither the online nor PDF versions of the provider directory included the provider's website address. HSAG's accessibility checker identified several accessibility errors in both online documents and BHI's website pages. On-site record reviews revealed that appeal resolution letters included some inappropriate or confusing information. BHI was required to:

- Update the print version of its provider manual to identify providers who have completed cultural competency training and to include locations accessible for persons with physical disabilities as well as update both the print version and online provider search to include providers' website addresses (if available).
- Develop a process to ensure that all information available on its website is readily accessible per Section 508 guidelines.
- Ensure that all member information is written using appropriate and easy-to-understand language.

Standard VI—Grievance and Appeal System

HSAG identified several areas requiring improvement in the grievance and appeals policies, processes for handling grievances or appeals, and member communications regarding appeals. BHI had not implemented a mechanism to verify that a provider had the member's written consent to file a grievance or appeal on behalf of that member. The Grievance Procedures policy stated that staff "will request permission from the member to take steps necessary to investigate and work to resolve the grievance." The Appeal Process policy incorrectly addressed several elements related to providing continued benefits during an appeal or SFH. The appeal resolution letter included some information that was inaccurate or potentially confusing for members. The BHI provider manual also included inaccuracies in some grievance and appeal information. BHI was required to:

- Implement a mechanism to ensure that a provider has the member's written permission to file a grievance or appeal on behalf of the member.
- Modify grievance procedures to ensure that all grievances are processed regardless of whether or not remedial action is requested by the member.
- Modify appeals policies and procedures to correctly outline the elements related to provision of continued benefits during an appeal or SFH when requested by the member. These included that the member must request continuation of benefits (rather than filing the appeal at this point) according to the "timely filing" parameters (within 10 calendars days following the advance notice to terminate, suspend, or reduce services—a notice of adverse benefit determination) and file the appeal within 60 calendar days of the notice of adverse benefit determination and removal of the

criterion "the time period or service limits of a previously authorized service have been met" from the definition of how long benefits will continue during an appeal or SFH.

- Modify the appeal resolution letter template to ensure that the information included is written in language that may be easily understood by the member and that the template includes the accurate time frame for requesting an SFH.
- Modify procedures and/or monitoring processes to ensure that written notice of grievance resolution is provided to the member within the required time frame.
- Ensure that continued benefit information is included only in appeal resolution letters that apply to an appeal of termination or reduction of previously authorized services.
- Ensure that all corrections implemented in response to grievance and appeal required actions are similarly reflected in the provider manual.

Standard VII—Provider Participation and Program Integrity

BHI's compliance policies included no requirements for reporting overpayments or program integrity requirements to the Department as specified in federal regulations and the State contract. BHI was required to include policy statements (within an existing applicable policy) stating that BHI will:

- Identify and return to the Department within 60 calendar days any overpayments of capitation amounts received by BHI.
- Report to the Department any prohibited affiliation within five business days of discovery.
- Report to the Department any change in ownership within 35 days after the change.

Standard IX—Subcontracts and Delegation

One of BHI's delegation subcontracts failed to include a provision acknowledging the subcontractor's agreement to comply with applicable Medicaid laws and regulations and failed to include the right to audit provisions. BHI was required to:

- Amend this subcontract to include the subcontractor's agreement to comply with Medicaid laws and the right to audit provisions outlined in 42 CFR 438.230.

BHI: Trended Performance for Compliance Monitoring

Table 4-19—Compliance Monitoring Trended Performance for BHI

Standard and Applicable Review Years	BHI Previous Review	BHI Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	81%	87%
Standard II—Access and Availability (2013–2014, 2016–2017)	100%	100%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	100%	90%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	100%	100%
Standard V—Member Information (2014–2015, 2017–2018)	**95%**	**73%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	**73%**	**70%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	**86%**	**85%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	96%	96%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	**100%**	**50%**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	94%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)	NA	NA

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.
Most recent 2017–2018 review reflects revision of requirements per Code of Federal Regulations. Title 42, Volume 81, May 6, 2016, and may not be comparable to previous review.
For all standards, the health plan's contract with the State may have changed since the previous review year and may have contributed to performance changes.
FY 2016–2017 was the initial year of review for Standard XI. BHOs were evaluated but not scored for compliance with requirements.

BHI's performance as compared to the previous year the standard was reviewed slightly improved in two standards and remained relatively unchanged in an additional four standards, with two standards remaining stable (Access and Availability and Member Rights and Protections) at 100 percent compliance. BHI demonstrated significant decline (10 or more percentage points) in performance in three standards and a slight decline in performance in one additional standard. BHI most significantly decreased performance—50 percentage points—in the Subcontracts and Delegation standard. HSAG cautions, however, that over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, or design of the compliance monitoring tool—may have impacted comparability of the compliance results.

Validation of Performance Measures

Compliance With Information System (IS) Standards

HSAG identified no concerns with how Colorado Access received and processed enrollment data for BHI. Prior to March 1, 2017, Colorado Access (BHI's administrative service organization [ASO]) received both monthly eligibility full files and daily change files from the Department through an FTP site in a flat-file format. On March 1, 2017, Colorado Access began receiving 834 monthly eligibility full files and daily change files from DXC. Colorado Access experienced no challenges with the transition to the new DXC system for receiving eligibility data. Both the 834 and flat files were mapped into tables and loaded in Oracle, Colorado Access' database management system. Oracle validated the files and checked for changes, additions, and terminations prior to loading the files into QNXT, Colorado Access' transactional system. QNXT processed the files and reloaded them in to Oracle and the EDW. Eligibility files were submitted to BHI's providers and affiliated CMHCs daily. Providers continued to have the ability to log in to the Colorado Access portal or the Department portal to obtain eligibility information for members. Each member received an ID number. Colorado Access did experience limited instances in which members were issued more than one Medicaid ID number; these included members who had changed their names and a few foster care members. In these instances, Colorado Access linked both ID numbers and kept the assigned QNXT number within the system. In addition, the Medicaid ID numbers were linked to the corresponding enrollment periods.

HSAG identified no issues or concerns with how Colorado Access received, processed, or reported claims and encounter data. Claims and encounters wee received and processed in the same way; data were received in an 837 file through a secure FTP site or clearinghouse. The files were loaded into QNXT via a Cognizant FTP site that performed checks using BizTalk, a Microsoft software program, to identify accurate formatting and complete data. A 999-response file was generated in addition to a 277 acceptance or rejection report. Paper claims were sorted, batched, scanned, and uploaded to Cognizant's FTP site within three days, then converted into an 837 format using OCR software before being loaded into QNXT. CMHCs submitted encounter data through a secure FTP site. The files were loaded into QNXT through Cognizant. Nightly, Cognizant staff members audited 2.5 percent of auto-adjudicated claims and 5 percent of manually adjudicated claims. As an additional quality check, Colorado Access conducted daily audits on 7 percent of claims previously verified by Cognizant. Colorado Access and Cognizant performed audits on 100 percent of facility claims exceeding a $10,000 threshold and professional claims exceeding a $5,000 threshold. State hospital data were received from the Department quarterly via a secure email in an Excel format. Colorado Access submitted 837 and flat files to the Department through a secure FTP site monthly. On March 1, 2017, the Department began a new process for BHOs to submit encounters to the Department interchange using DXC. Colorado Access experienced several challenges with this transition, including formatting discrepancies and incorrect data fields, and has yet to successfully submit encounters on behalf of BHI using this method. Colorado Access continued to test the new data submission process. The BHOs and the Department conducted monthly meetings to address this ongoing issue. Colorado Access also engaged in weekly calls with other BHOs to work through these challenges.

Colorado Access managed data flow and calculated performance indicator rates on behalf of BHI. All cases included in performance measure reporting were identified properly based on the description provided in the *BHO-HCPF Annual Performance Measure Scope* document. Claims and encounters were extracted from QNXT and loaded into EDW for rate calculation. Colorado Access generated a query in EDW to generate both denominator- and numerator-compliant member data for each indicator. Once the data were queried, they were extracted and loaded into an Oracle system in which tables were created. The State hospital data were loaded in to Oracle and a query was run to load the State hospital data with the data contained in the Oracle tables in the EDW. Colorado Access submitted the rate tables to BHI. BHI staff members conducted reasonability checks on the data; however, a comprehensive validation process was not in place. BHI submitted the indicator rates to the Department through a secure FTP site.

BHI: Performance Measure Results

Table 4-20 shows the MY 2016–2017 measure results for BHI and the corresponding performance targets. As this was the first year of reporting these measures for the BHOs, trending to historical rates was not conducted.

Table 4-20—Measure Results for BHI

Performance Measure	MY 2016–2017 Rate[1]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)		
Mental Health Engagement (All Members Excluding Foster Care)	45.53%	48.48%
Mental Health Engagement (Only Foster Care)		
Mental Health Engagement (Only Foster Care)	46.84%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment		
Engagement of Alcohol and Other Drug Dependence Treatment	21.73%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	38.68%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	57.03%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*		
Emergency Department Utilization for Mental Health Condition	17.095	7.722
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*		
Emergency Department Utilization for Substance Use Condition	20.38	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).

BHI: Strengths

During the first year of reporting these measure rates, BHI did not meet the performance target for any incentive measures. Of note, the measure rates for *Mental Health Engagement (All Members Excluding Foster Care)* and *Emergency Department Utilization for Substance Use Condition (per 1,000 Members)* were within a 10 percent relative difference from the performance target. All other performance measure rates had relative differences greater than 25 percent from their respective performance targets.

BHI: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Measures

Since BHI did not meet any performance targets for the MY 2016–2017 measure rates, BHI has opportunities to improve performance for all measure rates.

Validation of Performance Improvement Projects

Findings

Table 4-21 displays the validation results for the BHI PIP, *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* validated during FY 2017–2018. 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 4-21 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 fourth validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-21—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	100% (3/3)	0% (0/3)	67% (2/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**95% (20/21)**	**5% (1/21)**	**0% (0/21)**

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

Overall, 95 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII through VIII), and Activity IX in the Outcomes stage were validated.

Table 4-22 displays baseline, Remeasurement 1, and Remeasurement 2 data for BHI's *Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider* PIP. BHI's Remeasurement 2 goal was 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 4-22—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%	46.1%	*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 23.7 percent. The BHO set a goal of 28.7 percent for the Remeasurement 1 period.

At Remeasurement 1, 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 Remeasurement 1 goal of 28.7 percent.

At Remeasurement 2, 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 46.1 percent. The Remeasurement 2 rate represented a statistically significant improvement ($p = 0.0081$) of 22.4 percentage points over the baseline rate. The Remeasurement 2 rate exceeded the goal of 28.7 percent.

BHI: Strengths

BHI designed a scientifically sound project supported by key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The BHO reported accurate study indicator results in the Activity VII data table; however, an incorrect *p* value was reported in the narrative interpretation of results. The BHO used appropriate quality improvement tools to conduct its causal/barrier analysis and to prioritize identified barriers. BHI also evaluated interventions for effectiveness, reported evaluation results, and made decisions about continuing or discontinuing interventions based on the evaluation results. In the

Outcomes stage of the PIP, BHI succeeded in demonstrating statistically significant improvement over baseline at Remeasurement 2.

Barriers/Interventions

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 2 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:

- Distributed 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.
- Established a provider and community forum providing organizations and stakeholders with information on Colorado Medicaid behavioral health systems as well as best practices and current efforts to integrate care, and conducted a behavioral health panel discussion.
- Rolled out an e-referral system to allow primary care and medical providers to electronically refer patients for behavioral health services through a secure portal on BHI's website.
- Created a new integrated care coordinator position. The integrated care coordinator conducts on-site provider visits to educate and inform providers about resources to assist with behavioral health system navigation, behavioral health referrals, crisis service resources, and coding and billing for depression screens.

BHI: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of PIPs

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the BHOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. At the conclusion of BHI's PIP, HSAG recommended the following:

- Conduct methodologically sound analyses of study indicator outcomes, and accurately report all results.
- Consider spreading successful interventions, and develop a sustainability plan within the organization and in collaboration with any key partners to ensure that demonstrated improvement is maintained beyond the life of the PIP.

Experience of Care and Health Outcomes Surveys

Table 4-23 shows the adult ECHO survey results achieved by BHI for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-23—Adult ECHO Question Summary Rates and Global Proportions for BHI

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	39.9%	47.3%	46.2%
Getting Treatment Quickly	60.7%	61.1%	62.2%
How Well Clinicians Communicate	86.4%	86.0%	87.4%
Perceived Improvement	53.8%	65.6%	62.6%
Information About Treatment Options	54.6%	63.4%	56.3%
Office Wait	82.2%	82.5%	80.4%
Told About Medication Side Effects	71.9%	73.9%	75.2%
Including Family	45.9%	47.4%	42.2%
Information to Manage Condition	67.6%	74.3%	70.7%
Patient Rights Information	85.4%	90.1%	85.6%
Patient Feels He or She Could Refuse Treatment	83.3%	82.0%	84.0%
Privacy	92.3%	93.3%	93.8%
Cultural Competency	N/A	N/A	N/A
Amount Helped	80.3%	80.6%	76.4%
Improved Functioning	51.4%	56.6%	48.4%
Social Connectedness	67.0%	65.8%	62.3%

Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

Table 4-24 shows the child ECHO survey results achieved by BHI for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-24—Child ECHO Question Summary Rates and Global Proportions for BHI

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	38.1%	44.1%	44.8%
Getting Treatment Quickly	64.7%	64.8%	65.9%
How Well Clinicians Communicate	86.3%	87.1%	84.7%
Perceived Improvement	67.4%	65.3%	69.3%
Information About Treatment Options	67.9%	68.7%	73.0%
Office Wait	86.7%	84.7%	82.2%
Told About Medication Side Effects	89.9%+	83.9%+	89.3%+
Information to Manage Condition	67.9%	68.8%	75.0%
Patient Rights Information	91.5%	87.6%	91.7%
Patient Feels He or She Could Refuse Treatment	89.0%	84.1%	87.2%
Privacy	93.3%	96.3%	95.0%
Cultural Competency	N/A	N/A	N/A
Amount Helped	76.4%	72.6%	75.0%
Improved Functioning	60.5%	59.0%	56.7%
Social Connectedness	86.6%	84.1%	86.5%

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.
Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

BHI: Strengths

For BHI's adult Medicaid population, no measure rates increased substantially between FY 2016–2017 and FY 2017–2018.

For BHI's adult Medicaid population, two measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of All Counseling or Treatment* (6.3 percentage points)
- *Perceived Improvement* (8.8 percentage points)

For BHI's child Medicaid population, two measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Told About Medication Side Effects* (5.4 percentage points)
- *Information to Manage Condition* (6.2 percentage points)

For BHI's child Medicaid population, three measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of All Counseling or Treatment* (6.7 percentage points)
- *Information About Treatment Options* (5.1 percentage points)
- *Information to Manage Condition* (7.1 percentage points)

BHI: Summary Assessment of Opportunities for Improvement and Recommendations Related to ECHO

For BHI's adult Medicaid population, three measure rates decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Information About Treatment Options* (7.1 percentage points)
- *Including Family* (5.2 percentage points)
- *Improved Functioning* (8.2 percentage points)

For BHI's adult Medicaid population, no measure rates decreased substantially between FY 2015–2016 and FY 2017–2018.

For BHI's child Medicaid population, no measure rates decreased substantially between FY 2016–2017 and FY 2017–2018 or FY 2015–2016 and FY 2017–2018.

Colorado Health Partnerships, LLC

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-25 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 2017–2018.

Table 4-25—Summary of CHP Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V—Member Information	12	11	8	3	0	1	73%
VI—Grievance and Appeal System	27	27	17	10	0	0	63%
VII—Provider Participation and Program Integrity	13	13	11	2	0	0	85%
IX—Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**56**	**55**	**40**	**15**	**0**	**1**	**73%**

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

Table 4-26 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 2017–2018.

Table 4-26—Summary of CHP Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Grievances	60	44	44	0	16	100%
Appeals	60	59	52	7	1	88%
Totals	**120**	**103**	**96**	**7**	**17**	**93%**

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

CHP: Strengths

CHP delegated all tasks related to member information requirements to its administrative services partner, Beacon Health Options (Beacon). CHP and Beacon policies and procedures described the processes to ensure that all written member materials complied with requirements. CHP made interpretation services available free of charge and educated staff, providers, and members about how to access those services. The CHP website was easy to navigate and included the member handbook, provider directories, rights and responsibilities, advocacy and community resources, and information about benefits and services. Information complied with language requirements and could be downloaded and printed or requested from CHP in paper form. CHP's provider directory included the name, group affiliation, street address, telephone number, areas of specialty, and languages spoken for all providers accepting new patients.

CHP had clearly defined processes for handling grievances and appeals and assisting members with requesting SFHs. Member, provider, and staff training materials indicated that CHP processed grievances and appeals timely. On-site record reviews confirmed that CHP met all timeliness requirements for processing grievances and appeals.

CHP had policies, processes, procedures, a network development plan, and network density report that addressed selection and retention of providers. CHP examined a variety of factors such as analysis of member density; specific practice needs; and provider location, specialty, and license type when considering how to maintain and expand the independent provider network. CHP demonstrated that it uses NCQA standards and guidelines to complete credentialing and recredentialing activities. While CHP's compliance officer was located in Colorado, many of the program integrity audit activities were performed at Beacon's corporate office. CHP's compliance oversight plan and related policies and procedures effectively articulated both CHP's and Beacon's commitment to preventing, reporting, and responding to reports of FWA. CHP's corporate compliance program met all requirements.

CHP delegated grievance processing to its partner CMHCs and numerous operational functions to Beacon. The written agreements described the delegated activities and obligations; reporting responsibilities; specified remedies in instances of unsatisfactory performance; agreement to comply with all federal, State, and Medicaid laws; and the right of the State or designated federal entities to audit, per requirement. CHP demonstrated ongoing and formal monitoring of delegated activities.

CHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard V—Member Information

CHP's provider directory did not include information regarding providers' website URLs (when applicable), cultural competency training, or accommodations for people with physical disabilities. HSAG found that many of CHP's vital member materials—e.g., grievance and appeal template letters and the grievance and appeal guide—scored well above the sixth-grade reading level using the Flesch-Kinkaid readability test. In addition, many of the grievance and appeal resolution letters reviewed as part

of the record reviews were difficult to understand. HSAG identified accessibility errors on various pages of CHP's website and within electronic PDF documents available to members. CHP was required to:

- Update its provider directory to include provider website URL (if available) and to indicate which providers have completed cultural competency training and which locations have accommodations for people with physical disabilities.
- Ensure that all member information is written using easy-to-understand language.
- Develop a process to ensure that all information on its website is readily accessible per Section 508 guidelines.

Standard VI—Grievance and Appeal System

CHP policies excluded "the denial of a member's request to dispute a member financial liability" from the definition of "adverse benefit determination." Information for staff and members differentiated between an expression of dissatisfaction and a "formal grievance." CHP's policies, procedures, and other documents failed to adequately address processes for informing members of the limited time available to provide evidence or testimony in the case of an expedited appeal resolution and included inaccurate and confusing information regarding the time frame for processing an expedited appeal. On-site appeal record reviews included resolution notices that were difficult to understand and included incomplete information about the member's right to request continuation of benefits and services during the SFH. The appeals policy did not address procedures for handling the denial of a request for an expedited resolution of an appeal. CHP's Appeals Process policy and member and staff materials had not been updated to accurately reflect the revision in requirements associated with continuation of services during an appeal or SFH when requested by the member. Inaccuracies and incomplete content contained in CHP's appeal and grievance policies, member communications, and staff materials were similarly reflected in the provider manual. CHP was required to:

- Ensure that grievance and appeal system policies, procedures, and other applicable documents (e.g., member and provider communications) each include a complete and accurate definition of "adverse benefit determination."
- Ensure that member materials, forms, training, job aids, informal direction, and other communications to staff emphasize that all expressions of dissatisfaction (about any matter other than an adverse benefit determination) must be considered grievances and documented and treated as such.
- Ensure that members or representatives requesting expedited resolution of an appeal are informed of the limited time available to present evidence or testimony.
- Revise the appeals policy to reflect accurate time frames and processes for expedited resolution of appeals, and ensure accuracy and consistency across all related documents.
- Revise the appeals policy and other applicable documents to reflect the steps that must be taken if the BHO denies a request for expedited resolution of an appeal, including: transferring the appeal to the standard time frame; giving the member prompt oral notice and written notice within two

calendar days of the denial to expedite the resolution; informing the member in writing of the right to file a grievance if he or she disagrees with that decision.

- Develop a mechanism to ensure that appeal resolution notices meet the format and language requirements of 42 CFR 438.10 to the extent possible.
- Develop a mechanism (e.g., resolution notice template) to ensure that members are informed of the right to request continuation of services (if applicable) during an SFH.
- Revise all applicable documents to accurately reflect the time frames associated with requesting continuation of benefits during an appeal or SFH and remove the provision that continued services may cease "at the end of the benefit limits or service authorization time frame."
- Ensure that policies, procedures, and other applicable documents accurately depict the member's right to request an SFH within 120 days following the adverse appeal resolution notice.
- Revise its provider manual and review other provider materials to ensure that providers are accurately informed of requirements and time frames regarding the grievance and appeal system.

Standard VII—Provider Participation and Program Integrity

CHP was unable to provide adequate documentation of procedures to provide the Department written disclosure of ownership and control or to provide to the Department written disclosure of any prohibited affiliation. While the provider manual did address overpayments, it did not specifically state that providers are required to report to CHP (in writing) overpayments received and the reason for such overpayments. CHP was required to:

- Develop procedures to provide the Department written disclosure of ownership and control within 35 days after any change in ownership of the managed care entity.
- Develop procedures to provide to the Department written disclosure of any prohibited affiliation within five business days of discovery.
- Develop a mechanism to ensure that network providers report to CHP any overpayments received, return such overpayments to CHP within 60 calendar days of identification, and notify CHP in writing of reason for each overpayment.

CHP: Trended Performance for Compliance Monitoring

Table 4-27—Compliance Monitoring Trended Performance for CHP

Standard and Applicable Review Years	CHP Previous Review	CHP Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	100%	93%
Standard II—Access and Availability (2013–2014, 2016–2017)	100%	100%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	100%	90%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	100%	100%
Standard V—Member Information (2014–2015, 2017–2018)	**100%**	**73%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	**77%**	**63%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	**100%**	**85%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	98%	87%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	**100%**	**100%**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	100%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)	NA	NA

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.
Most recent 2017–2018 review reflects revision of requirements per Code of Federal Regulations. Title 42, Volume 81, May 6, 2016, and may not be comparable to previous review.
For all standards, the health plan's contract with the State may have changed since the previous review year and may have contributed to performance changes.
FY 2016–2017 was the initial year of review for Standard XI. BHOs were evaluated but not scored for compliance with requirements.

CHP's performance in the most recent years of review as compared to the previous year the standard was reviewed demonstrated no improvement in any standard, but performance remained unchanged at 100 percent compliance in four standards. CHP demonstrated significant declines in performance (10 or more percentage points each) in five standards and a slight decline in performance in one additional standard. CHP's most significant decline in performance—27 percentage points—occurred in the Member Information standard. HSAG cautions, however, that over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, or design of the compliance monitoring tool—may have impacted comparability of the compliance results.

Validation of Performance Measures

Compliance With Information System (IS) Standards

HSAG had no concerns with how CHP received and processed eligibility data. Prior to March 1, 2017, CHP received both monthly eligibility full files and daily change files from the Department through an FTP site in a flat-file format. On March 1, 2017, CHP began receiving 834 files for both daily change files and monthly full eligibility files from DXC. Both files were downloaded through an automated process from the State's interchange system in the form of a flat file through an FTP site into the Connection Administrative System (CAS), CHP's eligibility system. A file load program within CAS performed validation on the files to ensure that only complete enrollment information was received and loaded in the Oracle data warehouse. CHP did not conduct validation to check for accuracy of the data received. Any inaccuracies that existed were identified when services were rendered and claims or encounters were created. CHP continued to distribute enrollment data to the appropriate CMHCs via FileConnect, a front-end system that connects to CAS. A SQL code generated a flat file out of the data warehouse. CMHCs continued to have the ability to use real-time eligibility verification using the Department's portal. Each member received and maintained an ID number. However, if a member was given a new or different Medicaid ID number by the State, then Beacon's internal ID was modified and synced to the member's history.

HSAG identified no issues or concerns with how CHP received, processed, or reported claims and encounter data. All claims and encounter data were housed and processed in CAS. Claims received electronically were downloaded daily using an automated process through a clearinghouse within FileConnect. Paper claims were received by mail or fax and were scanned using OCR technology. All claims were received in a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 837 format. Affiliated CMHCs submitted encounter data in flat files through FileConnect. The files went through several edits and checks prior to processing. State hospital data were received from the Department quarterly via a secure email in an Excel format. Manual validation was conducted on this file to remove any duplicate records. CHP 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. Prior to March 1, 2017**,** CHP submitted monthly 837 files to the Department using Xerox through an FTP server. A 999-response file was received upon submission, and an error file providing a line item of acceptance or rejection was received within a few days of submission. On March 1, 2017, CHP began submitting monthly 837 files to DXC through the Department interchange and experienced several challenges including: different edit checks from the prior system, acceptable procedure modifiers, additional data fields, and lack of documented requirements. The BHOs and the Department conducted monthly meetings to address this ongoing issue. CHP continues to submit flat files to the Department through a secure portal.

CHP had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy. All cases included in performance measure reporting were identified properly based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. HSAG found that CHP had several verification processes in place to ensure data

completeness and data accuracy. CHP generated data from its corporate data warehouse. All denominator- and numerator-compliant member data were exported into an Excel spreadsheet. Fields included member ID, dates of service, member name, and date of birth. CHP staff members reviewed the data to ensure: that counts matched the member-level detail data, reasonability of lengths of stays, and that inpatient stays matched the total number of discharge counts. A quality manager reviewed the data before submission to the Department to check for reasonability. In addition, spot checks were conducted on 20 to 30 records per measure. CHP submitted data to the Department through a secure FTP site and notified the Department of the submission. CHP only included data that had been submitted to the Department in the calculation of the rates for the performance indicators. While the scope document does not specify if this was permissible, this practice may omit numerator-compliant services from being included if the applicable encounter has not been submitted to the Department.

CHP Performance Measure Results

Table 4-28 shows the MY 2016–2017 measure results for CHP and the corresponding performance targets. As this was the first year of reporting these measures for the BHOs, trending to historical rates was not conducted.

Table 4-28—Measure Results for CHP

Performance Measure	MY 2016–2017 Rate[1]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)		
Mental Health Engagement (All Members Excluding Foster Care)	39.21%	48.48%
Mental Health Engagement (Only Foster Care)		
Mental Health Engagement (Only Foster Care)	56.40%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment		
Engagement of Alcohol and Other Drug Dependence Treatment	31.73%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	42.75%	51.34%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	63.75%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*		
Emergency Department Utilization for Mental Health Condition	12.860	7.722
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*		
Emergency Department Utilization for Substance Use Condition	17.19	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).

CHP: Strengths

During the first year of reporting these measure rates, CHP exceeded the performance target for the *Emergency Department Utilization for Substance Use Condition (per 1,000 Members)* measure, indicating a strength for the BHO. Additionally, the measure rate for *Engagement of Alcohol and Other Drug Dependence Treatment* was within a 10 percent relative difference of the performance target. All other performance measure rates had relative differences greater than 10 percent from their respective performance targets.

CHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Measures

CHP met just one performance target for the MY 2016–2017 measure rates; therefore, CHP has opportunities to improve performance for several measure rates.

Validation of Performance Improvement Projects

Findings

Table 4-29 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 2017–2018. This table illustrates the BHO's overall application of the PIP process and achieved success in implementing the studies. Each protocol 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 4-29 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 fourth validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-29—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	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	67% (2/3)	0% (0/3)	33% (1/3)
	X.	Sustained Improvement Achieved	*Not Assessed*	*Not Assessed*	*Not Assessed*
Outcomes Total			**67% (2/3)**	**0% (0/3)**	**33% (1/3)**
Percentage Score of Applicable Evaluation Elements *Met*			**86% (18/21)**	**10% (2/21)**	**5% (1/21)**

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

Overall, 86 percent of all applicable evaluation elements validated received a score of *Met*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII through VIII), and Activity IX in the Outcomes stage were validated.

Table 4-30 displays baseline, Remeasurement 1, and Remeasurement 2 data for CHP's *Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release* PIP. CHP's goal is to increase the percentage of jail-to-community releases for eligible members with an identified behavioral health issue who are followed by a covered outpatient behavioral health service within 30 days of release.

Table 4-30—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%	22.3%	*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 who 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 who 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.

The Remeasurement 2 rate of jail-to-community releases for eligible members with an identified behavioral health issue who were followed by a covered outpatient behavioral health service within 30 days of release was 22.3 percent. The Remeasurement 2 rate represented a decline of 0.3 percentage point from the baseline rate; however, the goal of 19.2 percent was met.

CHP: Strengths

CHP designed and implemented a methodologically sound project. The BHO reported baseline through Remeasurement 2 study indicator results for this year's validation, completed a causal/barrier analysis, and implemented timely and active interventions. CHP evaluated interventions and used the intervention evaluation results to guide next steps for improvement strategies.

Barriers/Interventions

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.
- Limited jail and CMHC resources to engage members in seeking appropriate behavioral healthcare.
- Lack of knowledge among behavioral health provider staff members 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:

- Provided training and technical assistance to behavioral health facility staff members on the process and tools for obtaining data necessary to identify members being released from jail and in need of follow-up behavioral health services.
- Held monthly PIP task force meetings with behavioral health facility staff members to promote the shared goal of the PIP (identifying newly released members in need of behavioral health services) and to facilitate ongoing monitoring of progress toward meeting the goal for all eligible members.

CHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of PIPs

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the BHOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. At the conclusion of CHP's PIP, HSAG recommended the following:

- Conduct methodologically sound analyses of project outcomes, and accurately report results.
- Consider using a different approach to causal/barrier analysis, such as process mapping, to uncover previously unidentified barriers that may be inhibiting the improvement of study indicator outcomes.
- Continue to evaluate each intervention for effectiveness, and use intervention-specific evaluation results to guide decisions about future improvement strategies.

Experience of Care and Health Outcomes Surveys

Table 4-31 shows the adult ECHO survey results achieved by CHP for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-31—Adult ECHO Question Summary Rates and Global Proportions for CHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	41.4%	40.0%	48.2%
Getting Treatment Quickly	60.0%	69.6%	68.6%
How Well Clinicians Communicate	86.2%	89.4%	84.6%
Perceived Improvement	55.6%	58.9%	57.8%
Information About Treatment Options	59.4%	60.8%	59.9%
Office Wait	74.9%	83.8%	77.6%
Told About Medication Side Effects	80.3%	77.6%	77.5%
Including Family	40.8%	45.5%	48.6%
Information to Manage Condition	74.1%	71.5%	74.6%
Patient Rights Information	88.1%	83.1%	89.4%
Patient Feels He or She Could Refuse Treatment	86.2%	81.1%	87.9%
Privacy	93.6%	95.1%	93.5%
Cultural Competency	N/A	N/A	N/A
Amount Helped	82.2%	80.0%	79.1%
Improved Functioning	48.4%	53.3%	51.2%
Social Connectedness	62.6%	65.7%	63.8%

Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

Table 4-32 shows the child ECHO survey results achieved by CHP for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-32—Child ECHO Question Summary Rates and Global Proportions for CHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	46.6%	41.7%	42.7%
Getting Treatment Quickly	71.4%	68.1%	69.0%
How Well Clinicians Communicate	86.0%	85.5%	85.9%
Perceived Improvement	71.5%	65.4%	68.8%
Information About Treatment Options	72.4%	68.2%	69.9%
Office Wait	86.4%	83.9%	88.1%
Told About Medication Side Effects	86.2%+	88.3%+	80.2%+
Information to Manage Condition	68.6%	68.4%	64.3%
Patient Rights Information	87.9%	88.7%	86.8%
Patient Feels He or She Could Refuse Treatment	82.2%	88.0%	87.9%
Privacy	93.6%	96.8%	97.2%
Cultural Competency	N/A	N/A	N/A
Amount Helped	78.0%	79.2%	74.9%
Improved Functioning	63.1%	58.0%	56.4%
Social Connectedness	85.0%	78.7%	85.5%

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.
Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

CHP: Strengths

For CHP's adult Medicaid population, three measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Rating of All Counseling or Treatment* (8.2 percentage points)
- *Patient Rights Information* (6.3 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (6.8 percentage points)

For CHP's adult Medicaid population, three measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Rating of All Counseling or Treatment* (6.8 percentage points)
- *Getting Treatment Quickly* (8.6 percentage points)
- *Including Family* (7.8 percentage points)

For CHP's child Medicaid population, one measure rate increased substantially between FY 2016–2017 and FY 2017–2018:

- *Social Connectedness* (6.8 percentage points)

For CHP's child Medicaid population, one measure rate increased substantially between FY 2015–2016 and FY 2017–2018:

- *Patient Feels He or She Could Refuse Treatment* (5.7 percentage points)

CHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to ECHO

For CHP's adult Medicaid population, one measure rate decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Office Wait* (6.2 percentage points)

For CHP's adult Medicaid population, no measure rates decreased substantially between FY 2015–2016 and FY 2017–2018.

For CHP's child Medicaid population, one measure rate decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Told About Medication Side Effects* (8.1 percentage points)

For CHP's child Medicaid population, two measure rates decreased substantially between FY 2015–2016 and FY 2017–2018:

- *Told About Medication Side Effects* (6.0 percentage points)
- *Improved Functioning* (6.7 percentage points)

Foothills Behavioral Health Partners, LLC

Monitoring for Compliance With Medicaid Managed Care Regulations

Table 4-33 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 2017–2018.

Table 4-33—Summary of FBHP Scores for the FY 2017–2018 Standards Reviewed

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V—Member Information	12	11	8	3	0	1	73%
VI—Grievance and Appeal System	27	27	13	14	0	0	48%
VII—Provider Participation and Program Integrity	13	13	11	2	0	0	85%
IX—Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**56**	**55**	**36**	**19**	**0**	**1**	**65%**

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

Table 4-34 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 2017–2018.

Table 4-34—Summary of FBHP Scores for the FY 2017–2018 Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Grievances	60	41	32	9	19	78%
Appeals	60	60	52	8	0	87%
Totals	**120**	**101**	**84**	**17**	**19**	**83%**

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

FBHP: Strengths

FBHP's policies and procedures described processes for ensuring that all member materials complied with requirements for readability, including ease of understanding, font size, taglines, alternative formats, and availability of auxiliary aids and translation or oral interpretation. FBHP educated staff, providers, and members about the availability of these services and how to access them. FBHP's website was well-organized and easy to navigate and included a wide range of required member information and other resources targeted to members and their families. HSAG conducted an accessibility check on several FBHP Web pages and found no general accessibility errors.

FBHP discussed the relationship between FBHP and its partner organizations—Beacon, Jefferson Center for Mental Health (JCMH), and Mental Health Partners (MHP)—regarding processing of grievances and appeals. HSAG considered documents from FBHP, JCMH, and MHP in review of compliance with grievance requirements and considered Beacon documents in review of compliance with appeals requirements. Policies and procedures and other documents adequately addressed many grievance and appeal compliance requirements, including recently revised federal requirements. Despite circumstances in which written policies and procedures could be improved, staff members were often able to verbally articulate understanding and implementation of federal and State requirements.

While FBHP was responsible for the overall compliance program for the organization, numerous provider-related responsibilities—network management, credentialing and recredentialing, screening for sanctions, and claims processing activities—were delegated to Beacon. Beacon maintained a network development plan to guide the recruitment and retention of providers as well as a thorough provider credentialing and recredentialing process. The FBHP compliance program description addressed all required components of the organization-wide compliance program. Policies and procedures for monitoring for FWA were comprehensive, and staff members were able to verbalize understanding of FWA requirements. Documents clearly described processes for reporting of suspected FWA, investigation of possible abuses, and disciplinary guidelines for employees and providers. Both FBHP and Beacon conducted initial and monthly screening of all employees, providers, and other individual and entities against federal databases to identify exclusions from participation in federal healthcare programs.

FBHP delegated grievance processing to its partner CMHCs and numerous operational functions to Beacon. FBHP's subcontracts and delegation policy and procedure addressed pre-delegation assessments and required components of delegation agreements. Written agreements included delegated activities and obligations; reporting responsibilities; specified remedies in instances of unsatisfactory performance; agreement to comply with applicable laws and regulations; and the right for the State, federal entities, or designees to audit, per regulations. FBHP demonstrated having ongoing and formal monitoring of delegated activities.

FBHP: Summary Assessment of Opportunities for Improvement and Required Actions Related to Compliance Monitoring

Standard V—Member Information

HSAG found that several member-facing documents related to grievances and appeals were written in language that was difficult to understand and failed to include large-print taglines (18-point font). HSAG also discovered accessibility errors within several PDF documents downloaded from the FBHP website. Additionally, the website did not include a statement informing members that information is available in paper form upon request. FBHP's provider directory failed to include all required information. FBHP was required to:

- Ensure that all member information is written using easy-to-understand language and includes large-print (18-point font) taglines describing how to request auxiliary aids and services.
- Ensure that all information available for download from its website is readily accessible per Section 508 guidelines.
- Add a statement to its website informing members that all information is available in print form and free of charge, and how to request such information.
- Update its provider directory to include providers' website addresses (if available), indicate which providers have completed cultural competency training, and note which locations are accessible for people with physical disabilities.

Standard VI—Grievance and Appeal System

The JCMH grievance guide and MHP grievance policy defined "grievance" using language that could be construed as dissatisfaction with an adverse benefit determination. The MHP grievance policy incorrectly stated that the member may file a grievance within 30 days of an incident. In addition, the MHP grievance policy failed to specify the time frame for extensions and did not include procedures for informing the member of an extension. On-site grievance record reviews identified cases in which the BHO failed to send an acknowledgement letter in the required time frame, failed to notify the member of the grievance resolution within the required time frame, and sent resolution letters that were likely difficult for the member to understand.

HSAG identified several compliance issues in the Beacon Appeal Process policy. On-site appeal record reviews found that most appeal resolution letters included clinical content that HSAG deemed inappropriate to communicate to the member. The Appeal Decision Letter template did not include information on the member's right to request continuation of services during an SFH (when applicable) or the member's potential financial liability for continued services if the SFH upholds the adverse benefit determination. The template letter also included two conflicting statements regarding the time frame for requesting an SFH. A sample FBHP expedited appeal request denial letter failed to include the member's right to file a grievance if he or she disagrees with the decision.

Grievance and appeal information in the provider manual duplicated some inaccuracies found in the details of grievance and appeal procedures.

FBHP was required to:

- Ensure that CMHCs clarify the definition of "grievance" as "dissatisfaction about any matter other than an adverse benefit determination."
- Ensure that MHP corrects its grievance policy and procedures to state that a member may file a grievance *at any time*, and include the 14-day time frame for extensions as well as the procedures for notifying members of extensions.
- Ensure that all members are sent acknowledgement letters within two working days of FBHP's receipt of grievances.
- Ensure that CMHCs send resolution letters within the required 15 working days' time frame.
- Ensure that CMHCs write the grievance resolution notice to the member in a format and language that may be easily understood.
- Ensure that Beacon corrects compliance issues in its Beacon Appeal Process policy and procedures as follows:
  - Include "denial of a member's request to dispute a member's financial liability" in the definition of "adverse benefit determination."
  - Include the procedures for informing members of the limited time available to present evidence in the case of an expedited appeal.
  - Clarify expedited appeals procedures to include providing written resolution notice to the member within 72 hours of receiving the appeal.
  - Address continuation of previously approved services as required content of the appeal resolution letter, when applicable.
  - Address the time frame for notifying the member in writing and giving the member prompt oral notice of a decision to deny a request for an expedited appeal.
  - Include the accurate criteria for requesting continuation of benefits during an appeal or SFH.
  - Remove the criterion, "the time period of the previous authorization of the services expires" from the definition of how long benefits will continue pending outcome of an appeal or SFH.
- Update the Appeal Decision Letter template language to include information regarding the continuation of previously authorized services during an SFH, and inform the member that he or she may request an SFH within 120 calendar days of the notice of appeal resolution.
- Ensure that the clinical description of the appeals disposition includes only information appropriate to communicate to the member.
- Ensure that the expedited appeal request denial letter informs the member of the right to file a grievance if he or she disagrees with the decision.
- Ensure that all corrections implemented in response to required actions are incorporated into the grievance and appeal information in the provider handbook.

Standard VII—Provider Participation and Program Integrity

FBHP was unable to provide clearly defined procedures for reporting to the Department disclosure of ownership and control within 35 days after any change in ownership and disclosure of any prohibited affiliation within five business days of discovery. HSAG identified no clearly defined mechanisms for a provider to report to FBHP or Beacon when it has received an overpayment and to return the overpayment within 60 calendar days. FBHP was required to:

- Strengthen its written policies and procedures to define mechanisms for reporting to the Department any change in ownership or control and report to the Department any discovery of prohibited affiliations within the time frames specified in the requirement.
- Develop and communicate to providers a mechanism for a provider to report to FBHP any overpayments received, return the overpayment to FBHP within 60 calendar days of identifying the overpayment, and notify FBHP in writing of the reason for the overpayment.

FBHP: Trended Performance for Compliance Monitoring

Table 4-35—Compliance Monitoring Trended Performance for FBHP

Standard and Applicable Review Years	FBHP Previous Review	FBHP Most Recent Review
Standard I—Coverage and Authorization of Services (2013–2014, 2016–2017)	100%	89%
Standard II—Access and Availability (2013–2014, 2016–2017)	100%	100%
Standard III—Coordination and Continuity of Care (2012–2013, 2015–2016)	100%	100%
Standard IV—Member Rights and Protections (2012–2013, 2015–2016)	100%	100%
Standard V—Member Information (2014–2015, 2017–2018)	**100%**	**73%**
Standard VI—Grievance and Appeal System (2014–2015, 2017–2018)	**77%**	**48%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	**100%**	**85%**
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	100%	93%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	**100%**	**100%**
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	100%	100%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (2016–2017)	NA	NA

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.
Most recent 2017–2018 review reflects revision of requirements per Code of Federal Regulations. Title 42, Volume 81, May 6, 2016, and may not be comparable to previous review.
For all standards, the health plan's contract with the State may have changed since the previous review year and may have contributed to performance changes.
FY 2016–2017 was the initial year of review for Standard XI. BHOs were evaluated but not scored for compliance with requirements.

FBHP's performance in the most recent year of review demonstrated no improved performance when compared to the previous year the standard was reviewed. Performance remained unchanged at 100 percent compliance in five standards. FBHP demonstrated significant declines in performance (10 or more percentage points each) in four standards and a slight decrease in performance in one additional standard. FBHP's performance most significantly declined in the Member Information and Grievance and Appeal System standards with 27- and 29-percentage-point declines respectively. HSAG cautions, however, that over the three-year cycle between review periods, several factors—e.g., changes in federal regulations, changes in State contract requirements, or design of the compliance monitoring tool—may have impacted comparability of the compliance results.

Validation of Performance Measures

Compliance With Information System (IS) Standards

HSAG had no concerns with how FBHP received and processed eligibility data. FBHP received 834 files for both daily change files and monthly full eligibility files. Both types of files were downloaded through an automated process from the State's interchange system in the form of a flat file through an FTP site into the CAS, FBHP's eligibility system. A file load program within CAS performed validation on the files to ensure that only complete enrollment information was received and loaded in the Oracle data warehouse. FBHP did not conduct validation to check for accuracy of the data received. Any inaccuracies that existed were identified when services were rendered and claims or encounters were created. FBHP continued to distribute enrollment data to the appropriate CMHCs via FileConnect, a front-end system that connected to CAS. A SQL code generated a flat file out of the Oracle data warehouse. CMHCs continued to have the ability to use real-time eligibility verification using the Department's portal. Each member received and maintained an ID. However, if a member was given a new or different Medicaid ID number by the State, then Beacon's internal ID was modified and synced to the member's Medicaid history.

HSAG identified no issues or concerns with how FBHP received, processed, or reported claims and encounter data. All claims and encounter data were housed and processed in CAS. Claims received electronically were downloaded daily using an automated process through a clearinghouse within FileConnect. Paper claims were received by mail or fax and were scanned using OCR technology. All claims were received in a HIPAA-compliant 837 format. Affiliated CMHCs submitted encounter data in flat files through FileConnect. The files went through several edits and validation checks prior to processing. State hospital data were received from the Department quarterly via a secure email in an Excel format. Manual validation was conducted on this Excel file to remove any duplicate records. FBHP continued to use the data report card to monitor the CMHCs' performance. Staff members conducted quality checks, 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. Prior to March 1, 2017, FBHP submitted monthly 837 files to the Department using Xerox through an FTP server. A 999-response file was received upon submission, and an error file providing a line item of acceptance or rejection was received within a few days of submission. On March 1, 2017,

FBHP began submitting monthly 837 files to DXC through the Department interchange and experienced several challenges including: different edit checks from the prior system, acceptable procedure modifiers, additional data fields, and lack of documented requirements. The BHOs and the Department conducted monthly meetings to address this ongoing issue. FBHP continued to submit flat files to the Department through a secure portal.

FBHP had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy. All cases included in performance measure reporting were identified properly based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. HSAG found that FBHP has several verification processes in place to ensure data completeness and data accuracy. FBHP generated data from the corporate data warehouse. All denominator- and numerator-compliant member data were exported into an Excel spreadsheet and included member ID, dates of service, member name, and date of birth. FBHP staff members reviewed the data to ensure: that counts matched the member-level detail data, reasonability of lengths of stays, and that inpatient stays matched the total number of discharge counts. A quality manager reviewed the data before submission to the Department to check for reasonability. In addition, spot checks on 20 to 30 records per measure were conducted. FBHP submitted data to the Department through a secure FTP site and notified the Department of the submission. FBHP only included data that had been submitted to the Department in the calculation of the rates for the performance indicators. While the scope document does not specify if this was permissible, this practice may omit numerator-compliant services from being included if the applicable encounter has not been submitted to the Department.

FBHP Performance Measure Results

Table 4-36 shows the MY 2016–2017 measure results for FBHP and the corresponding performance targets. As this was the first year of reporting these measures for the BHOs, trending to historical rates was not conducted.

Table 4-36—Measure Results for FBHP

Performance Measure	MY 2016–2017 Rate[1]	Performance Target
Mental Health Engagement (All Members Excluding Foster Care)		
Mental Health Engagement (All Members Excluding Foster Care)	46.13%	48.48%
Mental Health Engagement (Only Foster Care)		
Mental Health Engagement (Only Foster Care)	51.00%	62.36%
Engagement of Alcohol and Other Drug Dependence Treatment		
Engagement of Alcohol and Other Drug Dependence Treatment	26.67%	33.55%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	45.21%	51.34%

Performance Measure	MY 2016–2017 Rate[1]	Performance Target
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition		
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	65.71%	72.94%
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*		
Emergency Department Utilization for Mental Health Condition	17.381	7.722
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*		
Emergency Department Utilization for Substance Use Condition	24.76	19.71

** For this measure, a lower rate indicates better performance.*
[1] Indicates that the rates contained within this column represent MY 2016–2017 (i.e., July 1, 2016–June 30, 2017).

FBHP: Strengths

During the first year of reporting these measure rates, FBHP did not meet the performance target for any incentive measures. Of note, the measure rate for *Mental Health Engagement (All Members Excluding Foster Care)* was within a 10 percent relative difference from the performance target. All other performance measure rates had relative differences greater than 10 percent from their respective performance targets.

FBHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Measures

Since FBHP did not meet any performance targets for the MY 2016–2017 measure rates, FBHP has opportunities to improve performance for all measure rates.

Validation of Performance Improvement Projects

Findings

Table 4-37 displays the validation results for the FBHP PIP, *Improving Transition From Jail to Community-Based Behavioral Health Treatment*, validated during FY 2017–2018. This table illustrates the BHO's overall application of the PIP process, implementation of interventions, and achieved success in improving study indicator outcomes. Each protocol 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 4-37 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 fourth validation year for the PIP, with the BHO completing Activities I through IX.

Table 4-37—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*. For this year's submission, the Design stage (Activities I through VI), the Implementation stage (Activities VII through VIII), and Activity IX of the Outcomes stage were validated.

Table 4-38 displays baseline, Remeasurement 1, and Remeasurement 2 data for FBHP's *Improving Transition From Jail to Community-Based Behavioral Health Treatment* 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 4-38—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%	31.3%	*Not Assessed*

In the Remeasurement 1 PIP submission, the BHO reported an updated baseline rate to reflect that, of eligible members released from jail and with identified behavioral health issues, 32.1 percent received a specified covered behavioral health service within 30 days of release. For the Remeasurement 1 period, the BHO set a goal of statistically significant increase over the baseline rate; the BHO estimated that, based on the baseline denominator for the study indicator, a Remeasurement 1 rate of 35.0 percent would reflect such an increase.

At Remeasurement 1, the BHO reported that, of eligible members released from jail and with identified behavioral health issues, 32.3 percent received specified covered behavioral health services within 30 days of release. 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.

At Remeasurement 2, the BHO reported that, of eligible members released from jail and with an identified behavioral health issue, 31.3 percent received specified covered behavioral health services within 30 days of release. The decrease of 0.8 percentage point from baseline to Remeasurement 2 was not statistically significant ($p = 0.5918$). The Remeasurement 2 rate did not meet the goal of 35.0 percent.

FBHP: Strengths

FBHP designed and implemented a methodologically sound project. The BHO accurately reported and analyzed baseline through Remeasurement 2 study indicator results, completed a causal/barrier analysis, and implemented timely and active interventions during the Remeasurement 2 period. FBHP evaluated interventions and used the intervention evaluation results to guide next steps for improvement strategies. The BHO reported process improvements that have been achieved through the PIP. 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 between 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.

Barriers/Interventions

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

- Lack of a key contact and referral process for substance abuse treatment upon jail release.
- 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.
- Difficulty verifying the jail release date of members eligible for Medicaid enrollment.
- Lack of accurate and timely jail release data to facilitate scheduling of timely post-release appointments at mental health centers.
- 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 not accessible to recently released members.
- Lack of access to transportation for members released from jail who require immediate crisis center appointments.
- Member need for primary care physical and dental health services in addition to behavioral health services.

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.
- Revised the member outreach and follow-up process to incorporate pre-release screening data recorded in the new electronic health record (EHR).
- Jail staff members revised the intake process to include partial completion of Medicaid enrollment application upon booking. Upon release from jail, the member applicant's release date is added to

the Medicaid enrollment application and the completed application is systematically sent to Colorado Department of Human Services for processing.

- Expanded distribution of educational materials about community resources to inmates being released and to those inmates' 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.
- Incorporated into the jail transition planning process a taxi transportation referral for members being released from jail who need immediate access to crisis center services.
- Partnered with a local RCCO to provide outreach caseworkers to jails to explain Medicaid benefits and enrollment process and to provide referrals to primary care medical homes.

FBHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Measures

After the FY 2017–2018 PIP validation cycle, the Colorado Department of Health Care Policy and Financing instructed the BHOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. At the conclusion of FBHP's PIP, HSAG recommended the following:

- Consider using a different approach to causal/barrier analysis, such as process mapping, to uncover previously unidentified barriers that may be inhibiting improvement.
- Continue to evaluate each intervention for effectiveness, and use intervention-specific evaluation results to guide decisions about future improvement strategies.

Experience of Care and Health Outcomes Surveys

Table 4-39 shows the adult ECHO survey results achieved by FBHP for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-39—Adult ECHO Question Summary Rates and Global Proportions for FBHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	37.9%	49.4%	41.9%
Getting Treatment Quickly	65.4%	67.3%	66.7%
How Well Clinicians Communicate	84.5%	89.2%	85.6%
Perceived Improvement	51.4%	60.3%	60.6%
Information About Treatment Options	62.1%	60.6%	60.4%
Office Wait	79.2%	88.0%	79.1%
Told About Medication Side Effects	71.5%	77.9%	78.7%
Including Family	38.9%	40.8%	43.8%
Information to Manage Condition	68.0%	79.0%	71.8%
Patient Rights Information	83.5%	87.4%	85.2%
Patient Feels He or She Could Refuse Treatment	78.9%	85.8%	90.1%
Privacy	94.4%	97.2%	93.8%
Cultural Competency	N/A	N/A	N/A
Amount Helped	83.1%	81.8%	78.1%
Improved Functioning	44.5%	54.9%	50.6%
Social Connectedness	57.5%	60.6%	62.4%

Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

Table 4-40 shows the child ECHO survey results achieved by FBHP for FY 2015–2016, FY 2016–2017, and FY 2017–2018.

Table 4-40—Child ECHO Question Summary Rates and Global Proportions for FBHP

Measure	FY 2015–2016 Rate	FY 2016–2017 Rate	FY 2017–2018 Rate
Rating of All Counseling or Treatment	35.9%	42.2%	37.6%
Getting Treatment Quickly	72.6%	68.6%	63.3%
How Well Clinicians Communicate	87.3%	88.8%	86.3%
Perceived Improvement	68.2%	76.8%	69.2%
Information About Treatment Options	73.1%	75.6%	67.0%
Office Wait	88.8%	86.3%	85.3%
Told About Medication Side Effects	90.9%	86.6%+	91.8%+
Information to Manage Condition	68.6%	70.4%	69.1%
Patient Rights Information	90.7%	93.5%	89.2%
Patient Feels He or She Could Refuse Treatment	88.2%	92.8%	87.5%
Privacy	96.9%	98.7%	96.0%
Cultural Competency	N/A	N/A	N/A
Amount Helped	76.3%	73.4%	80.2%
Improved Functioning	62.9%	65.6%	63.1%
Social Connectedness	84.8%	88.3%	85.0%

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.
Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

FBHP: Strengths

For FBHP's adult Medicaid population, no measure rates increased substantially between FY 2016–2017 and FY 2017–2018.

For FBHP's adult Medicaid population, four measure rates increased substantially between FY 2015–2016 and FY 2017–2018:

- *Perceived Improvement* (9.2 percentage points)
- *Told About Medication Side Effects* (7.2 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (11.2 percentage points)
- *Improved Functioning* (6.1 percentage points)

For FBHP's child Medicaid population, two measure rates increased substantially between FY 2016–2017 and FY 2017–2018:

- *Told About Medication Side Effects* (5.2 percentage points)
- *Amount Helped* (6.8 percentage points)

For FBHP's child Medicaid population, no measure rates increased substantially between FY 2015–2016 and FY 2017–2018.

FBHP: Summary Assessment of Opportunities for Improvement and Recommendations Related to Validation of Performance Measures

For FBHP's adult Medicaid population, three measure rates decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Rating of All Counseling or Treatment* (7.5 percentage points)
- *Office Wait* (8.9 percentage points)
- *Information to Manage Condition* (7.2 percentage points)

For FBHP's adult Medicaid population, one measure rate decreased substantially between FY 2015–2016 and FY 2017–2018:

- *Amount Helped* (5.0 percentage points)

For FBHP's child Medicaid population, four measure rates decreased substantially between FY 2016–2017 and FY 2017–2018:

- *Getting Treatment Quickly* (5.3 percentage points)
- *Perceived Improvement* (7.6 percentage points)
- *Information About Treatment Options* (8.6 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (5.3 percentage points)

For FBHP's child Medicaid population, two measure rates decreased substantially between FY 2017–2018 and FY 2015–2016:

- *Getting Treatment Quickly* (9.3 percentage points)
- *Information About Treatment Options* (6.1 percentage points)

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	DHMC	RMHP Prime	Statewide Average
Standard I—Coverage and Authorization of Services (2016–2017)	94%	94%	94%
Standard II—Access and Availability (2016–2017)	92%	100%	96%
Standard III—Coordination and Continuity of Care (2015–2016)	92%	100%	96%
Standard IV—Member Rights and Protections (2015–2016)	100%	80%	90%
Standard V—Member Information (2017–2018)	**69%**	**100%**	**85%**
Standard VI—Grievance and Appeal System (2017–2018)	**86%**	**89%**	**87%**
Standard VII—Provider Participation and Program Integrity (2017–2018)	**80%**	**93%**	**86%**
Standard VIII—Credentialing and Recredentialing (2015–2016)	98%	100%	99%
Standard IX—Subcontracts and Delegation (2017–2018)	**0%**	**100%**	**50%**
Standard X—Quality Assessment and Performance Improvement (2016)	88%	100%	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (2016–2017 for DHMC and RMHP Prime only)	62%	92%	77%

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.

Table 5-2—Statewide Results for Medicaid Managed Care MCO Record Reviews

Record Reviews	DHMC	RMHP Prime	Statewide Average
Appeals (2017–2018)	**83%**	**88%**	**86%**
Credentialing (2015–2016)	100%	100%	100%
Denials (2016–2017)	87%	90%	88%
Grievances (2017–2018)	**100%**	**94%**	**97%**
Recredentialing (2015–2016)	100%	100%	100%

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.

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 (2017–2018)	**55%**	**64%**	**73%**	**73%**	**73%**	**68%**
Standard VI—Grievance and Appeal System (2017–2018)	**89%**	**85%**	**70%**	**63%**	**48%**	**71%**
Standard VII—Provider Participation and Program Integrity (2017–2018)	**92%**	**92%**	**85%**	**85%**	**85%**	**88%**
Standard VIII—Credentialing and Recredentialing (2016)	93%	93%	96%	87%	93%	92%
Standard IX—Subcontracts and Delegation (2017–2018)	**100%**	**100%**	**50%**	**100%**	**100%**	**90%**
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 standards that HSAG reviewed during FY 2017–2018.

Table 5-4—Statewide Results for Medicaid Managed Care BHO Record Reviews

Record Reviews	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Appeals (2017–2018)	**100%**	**95%**	**78%**	**88%**	**87%**	**88%**
Credentialing (2016)	100%	100%	100%	100%	99%	100%
Denials (2017)	97%	93%	94%	98%	92%	95%
Grievances (2017–2018)	**100%**	**100%**	**98%**	**100%**	**78%**	**94%**
Recredentialing (2016)	100%	100%	97%	95%	96%	97%

Note: Bold text indicates standards that HSAG reviewed during FY 2017–2018.

Statewide Conclusions and Strengths Related to Compliance Monitoring

For the four standards reviewed in 2017–2018, the Medicaid health plans demonstrated continued compliance in many areas, especially in those requirements not revised in federal regulations effective July 2017. These findings indicate that, with sufficient time to implement revisions in regulations, all health plans are capable and committed to doing so. Medicaid health plans statewide—both physical health and BHOs—most consistently demonstrated the following strengths:

- Provided information upon enrollment to inform members of the Medicaid benefits and requirements and how to use the health plan.
- Made member materials available in alternative formats, and the health plans had processes for providing translation and interpretation services.
- Wrote member materials—other than grievance and appeal notices—in easy-to-understand language and format.
- Made provider directories available on the member page of the health plans' websites and included, at a minimum, previously-required information.
- Included numerous resources for member information on member pages on the health plans' websites.
- Had detailed policies and procedures and organizational processes for addressing grievances and appeals.
- Had effective database systems for maintaining records of grievances and appeals.
- Had processes for informing providers of grievance and appeal procedures.
- For health plan compliance programs, met all requirements and included policies, procedures, and training to address fraud, waste, and abuse requirements.
- Had processes for screening all required individuals and entities for exclusion from participation in federal programs.
- Had credentialing programs designed to comply with NCQA Standards and Guidelines.
- Had policies and procedures for assessing and monitoring subcontractors and for ensuring that subcontractor agreements included all required provisions.

Statewide Conclusions and Recommendations Related to Compliance Monitoring

Medicaid health plans statewide—both physical health and BHO's—most consistently were assigned the following required actions. Health plans were required to:

- Update documents to state that members have 120 days from the date of the appeal resolution notice to request an SFH.
- Update member information to include large-print (18-point font) tag lines.
- Develop and implement processes to ensure ready accessibility (i.e. per Section 508 guidelines) of all electronically available member materials and communications as well as the health plans' websites.
- Update the provider directory to comply with all revisions to the federal healthcare regulations (to include provider URLs, to address cultural competency training, and to state whether or not providers have accommodations for members with physical disabilities).
- Clarify the duration of continued benefits during the appeal or SFH.
- Remove any limits on the time frame for filing a grievance, revise the expedited appeal resolution time frame, and clarify and update the content of appeal resolution letters.
- Update provider manuals with accurate information about the grievance and appeal system.
- Develop and implement procedures to report to the Department required compliance or program integrity information—e.g., disclosure of ownership and control, prohibited affiliations, overpayments.

Validation of Performance Measures

Managed Care Organizations

IS Standards Review

HSAG evaluated the health plans' information system (IS) capabilities for accurate HEDIS reporting. For the current reporting period, 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 identified no notable issues with negative impact on HEDIS reporting. DHMC was fully compliant with four of the IS standards and partially compliant with two of the IS standards relevant to the scope of the performance measure validation performed by the health plan's licensed HEDIS auditor. DHMC's HEDIS auditor found that the health plan was partially compliant with IS Standards 1 and 7, which impacted the *Childhood Immunization Status* measure; however, none of these concerns materially impacted DHMC's ability to report performance measure data for this measure. Therefore, HSAG determined that the data collected and reported for the Department-selected measures followed NCQA HEDIS methodology; and the rates and audit results are valid, reliable, and accurate.

Performance Measure Results

In Table 5-5, plan-specific and statewide weighted averages are presented for the Medicaid MCOs. 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. Due to differences in member eligibility for children in RMHP Prime (i.e., the health plan only serves children with disabilities), measure rates related to providing services to children are not comparable to those of DHMC; therefore, these applicable measures have been removed.

Table 5-5—MCO and Statewide Results

Performance Measures	DHMC	RMHP Prime	Statewide Weighted Average
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	64.59%	22.65%	43.75%
Postpartum Care	49.06%	27.15%	38.18%
Adults' Access to Preventive/Ambulatory Health Services			
Total	55.19%	70.93%	62.88%
Preventive Screening			
Chlamydia Screening in Women			
Total	66.68%	49.26%	60.64%
Breast Cancer Screening			
Breast Cancer Screening	50.65%	50.44%	50.53%
Cervical Cancer Screening			
Cervical Cancer Screening	43.03%	43.21%	43.12%
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.14%	2.12%	0.34%
Adult BMI Assessment			
Adult BMI Assessment	83.25%	17.25%	47.08%
Mental/Behavioral Health			
Antidepressant Medication Management			
Effective Acute Phase Treatment	54.88%	52.34%	53.45%
Effective Continuation Phase Treatment	33.52%	34.46%	34.05%
Living With Illness			
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	69.77%	NA	66.18%
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	82.16%	83.94%	83.03%
*HbA1c Poor Control (>9.0%)**	42.92%	70.68%	56.53%
HbA1c Control (<8.0%)	45.45%	25.19%	35.51%
Eye Exam (Retinal) Performed	46.59%	7.47%	27.40%
Medical Attention for Nephropathy	82.47%	82.98%	82.72%
Blood Pressure Control (<140/90 mm Hg)	64.01%	0.00%	32.61%

Performance Measures	DHMC	RMHP Prime	Statewide Weighted Average
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	54.64%	43.37%	49.60%
Statin Adherence 80%	59.47%	57.33%	58.63%
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	75.00%	71.96%	73.19%
Statin Adherence 80%—Total	58.33%	68.38%	64.22%
Annual Monitoring for Patients on Persistent Medications			
ACE Inhibitors or ARBs	85.24%	84.52%	84.90%
Diuretics	83.78%	85.80%	84.75%
Total	84.66%	85.03%	84.84%
Use of Imaging Studies for Low Back Pain			
Use of Imaging Studies for Low Back Pain	69.33%	72.70%	71.09%
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis			
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	59.29%	40.89%	45.60%
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	55.69%	44.50%	50.53%
Bronchodilator	67.06%	54.13%	61.10%
Medication Management for People With Asthma			
Medication Compliance 50%—Total	54.19%	63.25%	57.27%
Medication Compliance 75%—Total	27.75%	38.89%	31.54%
Asthma Medication Ratio			
Total	63.77%	52.07%	59.69%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD			
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	27.44%	34.87%	31.48%
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis			
Disease-Modifying Anti–Rheumatic Drug Therapy for Rheumatoid Arthritis	73.56%	74.77%	74.24%
Use of Services			
Ambulatory Care (Per 1,000 Member Months)			
*Emergency Department Visits—Total—Total**	41.79	62.98	48.02
Outpatient Visits—Total—Total	183.12	317.25	222.58

Performance Measures	DHMC	RMHP Prime	Statewide Weighted Average
Inpatient Utilization—General Hospital/Acute Care—Total			
Discharges per 1,000 Member Months (Total Inpatient)—Total	4.58	9.01	5.88
Average Length of Stay (Total Inpatient)—Total	4.73	3.62	4.23
Discharges per 1,000 Member Months (Medicine)—Total	2.55	4.20	3.04
Average Length of Stay (Medicine)—Total	4.25	3.70	4.02
Discharges per 1,000 Member Months (Surgery)—Total	0.78	2.12	1.18
Average Length of Stay (Surgery)—Total	9.40	5.39	7.27
Discharges per 1,000 Member Months (Maternity)—Total	1.75	2.83	2.14
Average Length of Stay (Maternity)—Total	2.77	2.10	2.45
Antibiotic Utilization*			
Average Scripts PMPY for Antibiotics—Total	0.31	0.70	0.42
Average Days Supplied per Antibiotic Script—Total	9.27	9.32	9.29
Average Scripts PMPY for Antibiotics of Concern—Total	0.09	0.28	0.14
Percentage of Antibiotics of Concern of All Antibiotic Scripts—Total	27.52%	39.55%	33.25%
Plan All-Cause Readmissions*			
Index Total Stays—Observed Readmissions—Total	16.03%	9.33%	12.58%
Index Total Stays—O/E Ratio—Total	0.72	0.56	0.65
Use of Opioids at High Dosage (Per 1,000 Members)*			
Use of Opioids at High Dosage	29.05	41.26	35.74
Use of Opioids From Multiple Providers (Per 1,000 Members)*			
Multiple Prescribers	206.94	338.13	282.14
Multiple Pharmacies	119.39	91.83	103.59
Multiple Prescribers and Multiple Pharmacies	71.06	62.63	66.23

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

Statewide Conclusions and Strengths Related to MCO Performance Measure Results

The following HEDIS 2018 measure rates were determined to be high performers for the Medicaid statewide weighted average (i.e., ranked at or above the national Medicaid 75th percentiles without a statistically significant decline in performance from HEDIS 2017; or ranked between the national Medicaid 50th and 74th percentiles with statistically significant increases from HEDIS 2017):

- *Appropriate Testing for Children With Pharyngitis*
- *Appropriate Treatment for Children With Upper Respiratory Infection*

- *Non-Recommended Cervical Cancer Screening in Adolescent Females*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

Statewide Opportunities for Improvement and Recommendations Related to MCO Performance Measure Results

The following HEDIS 2018 measure rates were determined to be low performers for the Medicaid statewide weighted average (i.e., fell below the national Medicaid 25th percentiles or ranked between the national Medicaid 25th and 49th percentiles with statistically significant decreases from HEDIS 2017):

- *Childhood Immunization Status—Combinations 2, 3*, and *4*
- *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*
- *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*
- *Antidepressant Medication Management—Effective Continuation Phase Treatment*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total*
- *Persistence of Beta-Blocker Treatment After a Heart Attack*
- *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control <140/90 mm Hg)*
- *Statin Therapy for Patients With Diabetes—Received Statin Therapy*
- *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics*
- *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator*

At the statewide level, three of the four high performing measures are related to appropriate antibiotic use for emergency department and outpatient visits for respiratory conditions, indicating an overall

strength in antibiotic stewardship. With statewide performance consistently falling below the national Medicaid 25th percentiles, improvement efforts could be focused on ensuring that members receive appropriate medications to manage health conditions and that members receive the appropriate follow-up care when using medications long term. Additionally, an opportunity exists to improve adults' and children's access to care, as statewide performance falls below the national Medicaid 10th percentiles.

Behavioral Health Organizations

IS Standards Review

HSAG evaluated the health plans' accuracy of performance measure reporting and determined the extent to which the reported rates followed State specifications and reporting requirements. For the current reporting period, HSAG determined that the data collected and reported by all five BHOs for the Department-selected measures followed State specifications and reporting requirements; and the rates were valid, reliable, and accurate.

Performance Measure Results

In Table 5-6, plan-specific and statewide weighted averages are presented for the Medicaid BHOs.

Table 5-6—BHO and Statewide Results

Performance Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Mental Health Engagement (All Members Excluding Foster Care)						
Mental Health Engagement (All Members Excluding Foster Care)	35.56%	45.83%	45.53%	39.21%	46.13%	41.76%
Mental Health Engagement (Only Foster Care)						
Mental Health Engagement (Only Foster Care)	55.84%	59.01%	46.84%	56.40%	51.00%	53.92%
Engagement of Alcohol and Other Drug Dependence Treatment						
Engagement of Alcohol and Other Drug Dependence Treatment	19.32%	22.43%	21.73%	31.73%	26.67%	25.24%
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition						
Follow-Up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition	36.58%	40.40%	38.68%	42.75%	45.21%	40.85%
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition						
Follow-Up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition	53.48%	55.92%	57.03%	63.75%	65.71%	59.67%

Performance Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Emergency Department Utilization for Mental Health Condition (per 1,000 Members)*						
Emergency Department Utilization for Mental Health Condition	23.257	16.155	17.095	12.860	17.381	16.475
Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*						
Emergency Department Utilization for Substance Use Condition	42.51	21.74	20.38	17.19	24.76	23.41

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

Statewide Conclusions and Strengths Related to BHO Performance Measure Results

During the first year of reporting these measure rates for the BHOs, CHP demonstrated strength, exceeding the performance target for *Emergency Department Utilization for Substance Use Condition (per 1,000 Members)*. No other performance targets were met by any of the BHOs.

Statewide Conclusions and Recommendations Related to BHO Performance Measure Results

The BHOs demonstrated opportunities for improvement across all measures as only one BHO met the performance target for one measure. Additionally, most BHO performance measure rates had relative differences greater than 10 percent from the performance targets, indicating that the Department should consider adjusting performance targets to be more attainable.

Validation of Performance Improvement Projects

Statewide Results for Validation of MCO PIPs

Table 5-7—FY 2017–2018 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*	90%	82%	*Not Met*
RMHP Prime	*Improving Transitions of Care for Individuals Recently Discharged From a Corrections Facility*	90%	82%	*Not Met*

The two MCOs received the same validation scores and validation status for the FY 2017–2018 PIP validation. The PIPs submitted by DHMC and RMHP Prime, though receiving *Met* scores for 90 percent of all evaluation elements, each received a *Not Met* validation status related to scores for critical elements.

Statewide Results for Validation of BHO PIPs

Table 5-8—FY 2017–2018 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%	82%	*Not Met*
ABC-NE	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	71%	64%	*Not Met*
BHI	*Adolescent Depression Screening and Transition of Care to a Behavioral Health Provider*	95%	100%	*Met*
CHP	*Improving the Rate of Completed Behavioral Health Services Within 30 Days After Jail Release*	86%	82%	*Not Met*
FBHP	*Improving Transition From Jail to Community-Based Behavioral Health Treatment*	90%	82%	*Not Met*

Of the five BHOs that each submitted a PIP for validation in FY 2017–2018, one BHO (BHI) received a *Met* validation status and the other four BHOs each received a *Not Met* validation status. The percentage of all evaluation elements receiving a *Met* score ranged from 71 percent to 95 percent across the five PIPs submitted by the BHOs.

Statewide Conclusions and Recommendations Related to PIPs

For the FY 2017–2018 validation, all PIPs had progressed to the Outcomes stage and were evaluated for demonstrating statistically significant improvement in study indicator outcomes. The validation status received for each PIP was driven by whether statistically significant improvement over baseline was demonstrated by study indicator results. Demonstrating statistically significant improvement over baseline is a critical evaluation element in HSAG's PIP validation process; therefore, a *Partially Met* or *Not Met* score for this evaluation element determined the overall PIP validation status. Among the MCOs and BHOs, only one BHO, BHI, received a *Met* validation status. BHI reported study indicator outcomes that demonstrated statistically significant improvement over baseline at Remeasurement 2. The other four BHOs and two MCOs each received a *Not Met* validation status for each PIP because the study indicator outcomes did not demonstrate statistically significant improvement over baseline.

After the FY 2017–2018 PIP validation, the Colorado Department of Health Care Policy and Financing instructed the MCOs and BHOs to close out the current PIPs in preparation for the transition to new PIP topics in the following validation cycle. Considering the closeout plans, HSAG recommended the following for the MCOs and BHOs:

- At the conclusion of the PIP, synthesize the study indicator results and lessons learned throughout the project to provide a springboard for sustaining improvement achieved and attaining new improvements.
- If statistically significant improvement in study indicator outcomes was achieved, develop a plan to continue monitoring outcomes and facilitate sustained improvement beyond the end of the formal PIP.
- Identify successful improvement strategies that had the greatest impact on improving outcomes, and develop a plan for ongoing implementation of those strategies.
- Explore opportunities to spread successful interventions beyond the scope of the PIP.

Consumer Assessment of Healthcare Providers and Systems Surveys

Statewide Results for CAHPS

DHMC and RMHP Prime were required to arrange for administration of the *CAHPS 5.0H Adult Medicaid Health Plan Survey* and the *CAHPS 5.0H Child Medicaid Health Plan Survey* and to submit results to HSAG. HSAG presents the 2018 adult and child Medicaid CAHPS top-box rates for DHMC and RMHP Prime in the following tables.[5-1]

Table 5-9 shows the adult Medicaid results achieved by DHMC and RMHP Prime for FY 2017–2018.

Table 5-9—2018 Adult Results for MCOs

Measure	DHMC	RMHP Prime
Getting Needed Care	77.5%	82.5%
Getting Care Quickly	78.0%	85.8%
How Well Doctors Communicate	92.5%	92.2%
Customer Service	85.7%	88.9% +
Shared Decision Making	77.8%	82.7%
Rating of Personal Doctor	70.9%	68.7%
Rating of Specialist Seen Most Often	61.4% +	64.5%
Rating of All Health Care	52.2%	61.4%
Rating of Health Plan	59.1%	56.5%

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 did not combine DHMC's and RMHP Prime's CAHPS results into a statewide average due to the differences between the plans' Medicaid populations. Therefore, a statewide average is not presented in the table.

Table 5-10 shows the child Medicaid results achieved by DHMC and RMHP Prime for FY 2017–2018.[5-2]

Table 5-10—2018 Child Results for MCOs

Measure	DHMC	RMHP Prime
Getting Needed Care	84.8%	89.8% +
Getting Care Quickly	86.1%	95.3% +
How Well Doctors Communicate	94.7%	96.9% +
Customer Service	91.2%	89.3% +
Shared Decision Making	78.0% +	92.1% +
Rating of Personal Doctor	86.0%	87.5% +
Rating of Specialist Seen Most Often	75.0% +	74.1% +
Rating of All Health Care	76.9%	63.0% +
Rating of Health Plan	77.0%	68.5% +

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

HSAG identified several possible interventions that could be applied by the health plans as appropriate to the plans' populations and organizational structures for the following measures, based on rates that were lower than the 2017 national averages for both the adult and child populations across health plans:

- *Getting Care Quickly*
- *Shared Decision Making*
- *Rating of Health Plan*

To impact member perception related to getting care quickly, HSAG recommends that the two health plans consider offering provider incentives for further expanding the availability of evening and weekend hours; developing open-access scheduling; or adopting alternative schedules, such as early morning and late evening hours and alternating days.

To impact member perceptions related to shared decision making, HSAG recommends that the health plans explore creative mechanisms for member engagement. Examples include expanding member advisory committees, developing community-based member committees, offering member mentorship

[5-2] HSAG did not combine DHMC's and RMHP Prime's CAHPS results into a statewide average due to the differences between the plans' Medicaid populations. Therefore, a statewide average is not presented in the table.

programs, and developing mechanisms to ensure that providers discuss all treatment options with members and families.

To impact member perception related to the health plan and to ensure provider knowledge of the Medicaid benefit plan that impacts members, HSAG recommends that the two health plans build upon provider communications designed for training and inform providers of Medicaid-specific health plan procedures and ongoing changes.

Experience of Care and Health Outcomes Surveys

Statewide Results for ECHO

The technical method of data collection was through HSAG's administration of a modified version of the *Adult ECHO Survey, Managed Behavioral Healthcare Organization (MBHO), Version 3.0* (adult ECHO survey), which incorporated 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 incorporated items from the Youth Services Survey for Families (YSS-F) and the YSS. HSAG presented the 2018 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 2017–2018.

Table 5-11—2018 Adult Statewide Results for ECHO

Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Rating of All Counseling or Treatment	50.4%	42.9%	46.2%	48.2%	41.9%	46.3%
Getting Treatment Quickly	72.0%+	67.5%	62.2%	68.6%	66.7%	67.3%
How Well Clinicians Communicate	90.3%	86.4%	87.4%	84.6%	85.6%	86.3%
Perceived Improvement	61.9%	59.9%	62.6%	57.8%	60.6%	60.0%
Information About Treatment Options	56.2%	58.9%	56.3%	59.9%	60.4%	58.7%
Office Wait	82.1%	85.2%	80.4%	77.6%	79.1%	80.0%
Told About Medication Side Effects	84.9%+	71.7%	75.2%	77.5%	78.7%	77.4%
Including Family	33.6%	41.5%	42.2%	48.6%	43.8%	43.8%
Information to Manage Condition	77.3%	78.2%	70.7%	74.6%	71.8%	74.2%
Patient Rights Information	84.7%	86.2%	85.6%	89.4%	85.2%	87.0%
Patient Feels He or She Could Refuse Treatment	84.0%	84.5%	84.0%	87.9%	90.1%	86.5%
Privacy	92.4%	91.5%	93.8%	93.5%	93.8%	93.2%
Cultural Competency	N/A	N/A	N/A	N/A	N/A	56.5%+
Amount Helped	87.6%	83.1%	76.4%	79.1%	78.1%	79.9%
Improved Functioning	54.2%	54.9%	48.4%	51.2%	50.6%	51.4%
Social Connectedness	58.5%	64.8%	62.3%	63.8%	62.4%	62.7%

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.
Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

Table 5-12 shows the child ECHO Survey results achieved by the five BHOs and the statewide average for FY 2017–2018.

Table 5-12—2018 Child Statewide Results for ECHO

Measure	ABC-D	ABC-NE	BHI	CHP	FBHP	Statewide Average
Rating of All Counseling or Treatment	53.4%	42.2%	44.8%	42.7%	37.6%	43.2%
Getting Treatment Quickly	72.3%	72.1%+	65.9%	69.0%	63.3%	68.0%
How Well Clinicians Communicate	92.0%	89.8%	84.7%	85.9%	86.3%	86.7%
Perceived Improvement	77.1%	71.2%	69.3%	68.8%	69.2%	69.9%
Information About Treatment Options	76.8%	74.9%	73.0%	69.9%	67.0%	71.5%
Office Wait	86.6%	90.8%	82.2%	88.1%	85.3%	86.4%
Told About Medication Side Effects	86.7%+	83.1%+	89.3%+	80.2%+	91.8%+	85.3%
Information to Manage Condition	74.1%	75.5%	75.0%	64.3%	69.1%	70.2%
Patient Rights Information	89.7%	93.5%	91.7%	86.8%	89.2%	89.6%
Patient Feels He or She Could Refuse Treatment	87.1%	94.9%	87.2%	87.9%	87.5%	88.6%
Privacy	97.8%	97.1%	95.0%	97.2%	96.0%	96.5%
Cultural Competency	N/A	N/A	N/A	N/A	N/A	60.6%+
Amount Helped	81.7%	79.3%	75.0%	74.9%	80.2%	76.9%
Improved Functioning	72.4%	62.8%	56.7%	56.4%	63.1%	59.6%
Social Connectedness	84.7%	87.1%	86.5%	85.5%	85.0%	85.9%

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.

Results based on fewer than 30 respondents were suppressed and are noted as "N/A" (Not Applicable).

Statewide Conclusions and Recommendations 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.

BHO Adult Survey

Access Behavioral Care—Denver

For the adult Medicaid population, ABC-D had two measure rates that were substantially higher than the statewide averages:

- *Told About Medication Side Effects* (7.5 percentage points)
- *Amount Helped* (7.7 percentage points)

Seven of ABC-D's measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Perceived Improvement*
- *Office Wait*
- *Information to Manage Condition*
- *Improved Functioning*

One of ABC-D's adult Medicaid population measure rates was substantially lower than the statewide average:

- *Including Family* (10.2 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining five measure rates were lower than the statewide averages.

Access Behavioral Care—Northeast

For the adult Medicaid population, ABC-NE had one measure rate that was substantially higher than the statewide average:

- *Office Wait* (5.2 percentage points)

Seven of ABC-NE's measure rates were higher than the statewide averages:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Information About Treatment Options*
- *Information to Manage Condition*
- *Amount Helped*
- *Improved Functioning*
- *Social Connectedness*

One of ABC-NE's adult Medicaid population measure rates was substantially lower than the statewide average:

- *Told About Medication Side Effects* (5.7 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining six measure rates were lower than the statewide averages.

Behavioral Healthcare, Inc.

For the adult Medicaid population, BHI had no measure rates that were substantially higher than the statewide averages. Four of BHI's measure rates were slightly higher than the statewide averages:

- *How Well Clinicians Communicate*
- *Perceived Improvement*
- *Office Wait*
- *Privacy*

One of BHI's adult Medicaid population measure rates was substantially lower than the statewide average:

- *Getting Treatment Quickly* (5.1 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining 10 measure rates were lower than the statewide averages.

Colorado Health Partnerships

For the adult Medicaid population, CHP had no measure rates that were substantially higher than the statewide averages. Ten of CHP's measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Getting Treatment Quickly*
- *Information About Treatment Options*

- *Told About Medication Side Effects*
- *Including Family*
- *Information to Manage Condition*
- *Patient Rights Information*
- *Patient Feels He or She Could Refuse Treatment*
- *Privacy*
- *Social Connectedness*

For the adult Medicaid population, CHP had no measure rates that were substantially lower than the statewide averages.

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining five measure rates were slightly lower than the statewide averages.

Foothills Behavioral Health Partners

For the adult Medicaid population, FBHP had no measure rates that were substantially higher than the statewide averages. Five of FBHP's measure rates were slightly higher than the statewide averages:

- *Perceived Improvement*
- *Information About Treatment Options*
- *Told About Medication Side Effects*
- *Patient Feels He or She Could Refuse Treatment*
- *Privacy*

In addition, one measure for FBHP had the same rate as the statewide average:

- *Including Family*

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 nine measure rates were lower than the statewide averages.

BHO Child Survey

Access Behavioral Care—Denver

For ABC-D's child Medicaid population, five measure rates were substantially higher than the statewide averages:

- *Rating of All Counseling or Treatment* (10.2 percentage points)
- *How Well Clinicians Communicate* (5.3 percentage points)
- *Perceived Improvement* (7.2 percentage points)

- *Information About Treatment Options* (5.3 percentage points)
- *Improved Functioning* (12.8 percentage points)

Seven of ABC-D's measure rates were higher than the statewide averages:

- *Getting Treatment Quickly*
- *Office Wait*
- *Told About Medication Side Effects*
- *Information to Manage Condition*
- *Patient Rights Information*
- *Privacy*
- *Amount Helped*

For the child Medicaid population, ABC-D had no measure rates that were substantially lower than the statewide averages.

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining two measure rates were slightly lower than the statewide averages.

Access Behavioral Care—Northeast

For ABC-NE's child Medicaid population, two measure rates were substantially higher than the statewide average:

- *Information to Manage Condition* (5.3 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (6.3 percentage points)

Ten of ABC-NE's measure rates were higher than the statewide average:

- *Getting Treatment Quickly*
- *How Well Clinicians Communicate*
- *Perceived Improvement*
- *Information About Treatment Options*
- *Office Wait*
- *Patient Rights Information*
- *Privacy*
- *Amount Helped*
- *Improved Functioning*
- *Social Connectedness*

For the child Medicaid population, ABC-NE had no measure rates that were substantially lower than the statewide averages.

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining two measure rates were slightly lower than the statewide averages.

Behavioral Healthcare, Inc.

For the child Medicaid population, BHI had no measure rates that were substantially higher than the statewide averages. Six of BHI's measure rates were higher than the statewide averages:

- *Rating of All Counseling or Treatment*
- *Information About Treatment Options*
- *Told About Medication Side Effects*
- *Information to Manage Condition*
- *Patient Rights Information*
- *Social Connectedness*

No BHI child Medicaid population measure rates were substantially lower than the statewide averages.

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining eight measure rates were lower than the statewide averages.

Colorado Health Partnerships

For the child Medicaid population, CHP had no measure rates that were substantially higher than the statewide averages. Three of CHP's measure rates were slightly higher than the statewide averages:

- *Getting Treatment Quickly*
- *Office Wait*
- *Privacy*

Two of CHP's child Medicaid population measure rates were substantially lower than the statewide averages:

- *Told About Medication Side Effects* (5.1 percentage points)
- *Information to Manage Condition* (5.9 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining nine measure rates were slightly lower than the statewide averages.

Foothills Behavioral Health Partners

For FBHP's child Medicaid population, one measure rate was substantially higher than the statewide average:

- *Told About Medication Side Effects* (6.5 percentage points)

Two of FBHP's measure rates were higher than the statewide averages:

- *Amount Helped*
- *Improved Functioning*

One of FBHP's child Medicaid population measure rates was substantially lower than the statewide average:

- *Rating of All Counseling or Treatment* (5.6 percentage points)

One measure had fewer than 30 responses; therefore, results were suppressed. The remaining 10 measure rates were lower than the statewide averages.

6. Assessment of MCO Follow-Up on FY 2016–2017 Recommendations

The Department requested that each Medicaid MCO address recommendations and required actions following EQR activities conducted in FY 2016–2017. Therefore, this section of the report outlines the recommendations provided to the MCOs in FY 2016–2017 for compliance monitoring, PIP validation, and CAHPS—based on 2016–2017 EQR activities performed; and for performance measure validation, based on the reporting year (RY) 2017 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 2016–2017 EQR activities and/or an assessment of performance improvement or decline noted during FY 2017–2018.

Denver Health Medicaid Choice

Assessment of Compliance With Medicaid Managed Care Regulations

For the three 2016–2017 standards—Coverage and Authorization of Services; Access and Availability; and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), DHMC had two required actions to improve its authorization process and written notice of action. DHMC had one required action to continue to expand its provider network to ensure sufficient access to services. DHMC had five required actions to enhance policies and procedures, provider communications, and definition of "medical necessity" to properly operationalize EPSDT requirements. DHMC submitted its initial corrective action plan (CAP) proposal on May 30, 2017; and, following Department approval completed implementation of all planned interventions on February 21, 2018.

Validation of Performance Measures

Last year for the Pediatric Care Measures, HSAG recommended that DHMC focus improvement efforts on improving rates for several measures related to well-care visits for children and adolescents; improvement in documentation of BMI, nutrition counseling, and physical activity counseling for children and adolescents; and 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. In addition, HSAG recommended that DHMC conduct barrier analysis and identify key drivers for rates that fell below the Medicaid 25th percentile. At the time of writing this report, DHMC had not provided information regarding any specific quality improvement initiatives that may have been developed resultant of HSAG's 2016–2017 recommendations. However, HSAG noted statistically significant improvement in the following measures related to rates with 2016–2017 recommendations: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total* and *Counseling for Nutrition—Total,* and *Prenatal and Postpartum Care—Postpartum Care.* In addition, HSAG noted slight increases in *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling*

for Physical Activity—Total; *Well-Child Visits in the First 15 Months of Life—Six or More Visits*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescents Well-Care Visits*. These increases may or may not indicate the development of improvement activities to positively impact these rates, and HSAG cautions that meaningful differences in HEDIS measure rates resulting from performance improvement activities may take multiple measurement periods to observe.

Validation of Performance Improvement Projects

DHMC received a *Met* score for 100 percent of applicable evaluation elements during the FY 2016–2017 validation cycle; therefore, no prior PIP recommendations for follow-up existed during the FY 2017–2018 validation cycle.

Consumer Assessment of Healthcare Providers and Systems

In FY 2017–2018, DHMC did not report specific interventions designed to address CAHPS measure results or recommendations made based on 2016–2017 CAHPS surveys. However, HSAG notes that interventions reported in the previous FY (regularly monitoring customer service calls, implementing provider communication tips, and expanding appointment availability) may continue to positively impact measure rates in subsequent measure years.

Between FY 2016–2017 and FY 2017–2018, DHMC demonstrated slight increases (fewer than 5 percentage points each) for three adult measures:

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

DHMC demonstrated decreases in rates for six adult measures, two of which decreased substantially:

- *Rating of Specialist Seen Most Often* (7.6 percentage points)
- *Rating of All Health Care* (9.5 percentage points)

The remaining four adult measures demonstrated slight decreases (fewer than 5 percentage points each):

- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*

Between FY 2016–2017 and FY 2017–2018, DHMC demonstrated increases for all child measures, six of which increased substantially:

- *Getting Needed Care* (5.3 percentage points)
- *Customer Service* (5.7 percentage points)
- *Rating of Personal Doctor* (6.8 percentage points)
- *Rating of Specialist Seen Most Often* (8.3 percentage points)
- *Rating of All Health Care* (6.7 percentage points)
- *Rating of Health Plan* (8.9 percentage points)

The remaining three measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*

DHMC did not demonstrate decreases in rates for any of the child measures.

Rocky Mountain Health Plans Medicaid Prime

Assessment of Compliance With Medicaid Managed Care Regulations

For the three 2016–2017 standards—Coverage and Authorization of Services; Access and Availability; and EPSDT, RMHP Prime had two required actions to improve member notices of action. RMHP Prime had one required action to enhance mechanisms for systematic communication with providers regarding EPSDT requirements. RMHP Prime had no required actions related to access and availability. RMHP Prime submitted its initial CAP proposal on June 28, 2017; and, following Department approval, completed implementation of all planned interventions on February 7, 2018.

Validation of Performance Measures

Last year, HSAG recommended that RMHP Prime focus improvement efforts on improving rates for the following measures: *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment; Use of Spirometry Testing in the Assessment and Diagnosis of COPD;* and *Medication Management for People With Asthma—Medication Compliance 75%—Total.* In addition, HSAG recommended that RMHP Prime conduct barrier analysis and identify key drivers for rates that fell below the Medicaid 25th percentile. At the time of writing this report, RMHP Prime had not provided information regarding any specific quality improvement initiatives that may have been developed resultant of HSAG's 2016–2017 recommendations. However, HSAG noted statistically significant improvement in the following measures related to rates with 2016–2017 recommendations: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* and *Chlamydia Screening in Women—Total.* In addition, HSAG noted a slight increase in the *Medication Management for People With Asthma—Medication Compliance 75%—Total* and the *Adult BMI Assessment* measure rates. These increases may or may not indicate the development of improvement activities to positively impact these rates, and HSAG cautions that meaningful differences in HEDIS measure rates resulting from performance improvement activities may take multiple measurement periods to observe.

Validation of Performance Improvement Projects

For the FY 2016–2017 PIP validation cycle, RMHP Prime received a *Not Met* score for two evaluation elements in Activity IX (Real Improvement) of the PIP validation tool. The reported study indicator results demonstrated an improvement from baseline to Remeasurement 1; but the improvement was not statistically significant, and the Remeasurement 1 results did not meet the goal. Resultant of the *Not Met* scores, HSAG provided feedback recommending that the health plan revisit its causal/barrier analysis and quality improvement processes to reevaluate barriers and deploy active interventions to facilitate significant improvement during the next remeasurement period. For the FY 2017–2018 PIP validation cycle, the health plan documented an updated causal/barrier analysis and interventions logically linked to identified barriers; however, the study indicator did not demonstrate statistically significant

improvement over baseline or meet the goal at Remeasurement 2. Therefore, the two evaluation elements in Activity IX again received a *Not Met* score.

Consumer Assessment of Healthcare Providers and Systems

Between FY 2016–2017 and FY 2017–2018, RMHP Prime demonstrated rate increases for seven adult measures, two of which increased substantially:

- *Rating of Personal Doctor* (13.1 percentage points)
- *Rating of All Health Care* (13.2 percentage points)

The remaining five adult measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

The increases for all seven listed measures may indicate that RMHP Prime followed up on HSAG's recommendations.

RMHP Prime demonstrated slight decreases for two adult measures:

- *Getting Needed Care*
- *Shared Decision Making*

Between FY 2016–2017 and FY 2017–2018, RMHP Prime demonstrated rate increases for seven child measures, four of which increased substantially:

- *Customer Service* (5.2 percentage points)
- *Rating of Personal Doctor* (7.2 percentage points)
- *Rating of Specialist Seen Most Often* (16.6 percentage points)
- *Rating of All Health Care* (6.9 percentage points)

The remaining three child measures demonstrated slight increases (fewer than 5 percentage points each):

- *Getting Needed Care*
- *Shared Decision Making*
- *Rating of Health Plan*

These increases may indicate that RMHP Prime followed up on HSAG's recommendations.

RMHP Prime demonstrated slight decreases in rates for two child measures:

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

7. Assessment of BHO Follow-Up on FY 2016–2017 Recommendations

The Department requested that each BHO address recommendations and required actions following EQR activities conducted in FY 2016–2017. This section presents an assessment of how the BHOs responded to recommendations provided during the 2016–2017 EQR activities and/or an assessment of performance improvement noted during FY 2017–2018.

Access Behavioral Care—Denver

Compliance With Medicaid Managed Care Regulations

For the three 2016–2017 standards—Coverage and Authorization of Services; Access and Availability; and EPSDT, ABC-D had one required action to improve member notices of action and two required actions to ensure that internal procedures related to financial responsibility for payment of post-stabilization services were properly operationalized. ABC-D had no required actions related to access and availability. BHO EPSDT requirements were evaluated but not scored in 2016–2017. ABC-D submitted its initial CAP proposal on May 31, 2017; and, following Department approval, completed implementation of all planned interventions on April 23, 2018.

Validation of Performance Measures

Following the FY 2016–2017 performance measure validation activities, HSAG recommended that ABC-D improve its data monitoring process to ensure accuracy for the next measurement year. HSAG also recommended that ABC-D continue to inspect the accuracy and completeness of the encounter and claims data received from the CMHCs and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation. ABC-D should work closely with the Department to ensure having a clear understanding of the scope document and the data elements required for submission.

During the FY 2017–2018 performance measure validation activities, HSAG determined that the BHO continued to demonstrate that the same areas required improvement; therefore, in FY 2018–2019, HSAG will continue to monitor ABC-D's accuracy and completeness of data and the BHO's understanding of the scope document.

Validation of Performance Improvement Projects

For the FY 2016–2017 PIP validation cycle, ABC-D received a *Partially Met* score for two evaluation elements in Activity VII (Analyze Data and Interpret Study Results) and a *Not Met* score for two evaluation elements in Activity IX (Real Improvement) of the PIP validation tool. In FY 2017–2018, ABC-D addressed some but not all recommendations that HSAG provided to address the elements receiving *Partially Met* and *Not Met* scores in FY 2016–2017.

In Activity VII, ABC-D addressed HSAG's recommendations to ensure that the study indicator goal and results were accurately reported but did not address recommendations to ensure that the narrative interpretation of results was complete. Therefore, in FY 2017–2018, one of the two evaluation elements in Activity VII received a *Met* score and the other evaluation element again received a *Partially Met* score.

In Activity IX, ABC-D documented an updated causal/barrier analysis and interventions logically linked to identified barriers to address HSAG's feedback recommending that the health plan revisit its causal/barrier analysis and quality improvement processes to reevaluate barriers and deploy active interventions to facilitate significant improvement during the next remeasurement period. For the FY 2017–2018 PIP validation cycle, the study indicator results met the plan-selected goal at Remeasurement 2 but did not demonstrate statistically significant improvement over baseline. Therefore, in FY 2017–2018, one of the two evaluation elements in Activity IX received a *Met* score and the other evaluation element received a *Not Met* score.

Experience of Care and Health Outcomes Surveys

For ABC-D's adult Medicaid population, four measure rates increased substantially between FY 2017–2018 and FY 2016–2017:

- *Getting Treatment Quickly* (9.7 percentage points)
- *Perceived Improvement* (5.0 percentage points)
- *Office Wait* (5.1 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (5.1 percentage points)

For ABC-D's adult Medicaid population, two measure rates decreased substantially between FY 2017–2018 and FY 2016–2017:

- *Including Family* (8.4 percentage points)
- *Social Connectedness* (10.4 percentage points)

For ABC-D's child Medicaid population, two measure rates increased substantially between FY 2017–2018 and FY 2016–2017:

- *Office Wait* (9.2 percentage points)
- *Improved Functioning* (6.4 percentage points)

For ABC-D's child Medicaid population, one measure rate decreased substantially between FY 2017–2018 and FY 2016–2017:

- *Social Connectedness* (7.2 percentage points)

Access Behavioral Care—Northeast

Compliance With Medicaid Managed Care Regulations

For the three 2016–2017 standards—Coverage and Authorization of Services; Access and Availability; and EPSDT, ABC-NE had two required actions to improve member notices of action and two required actions to ensure that internal procedures related to the financial responsibility for payment of post-stabilization services were properly operationalized. ABC-NE had no required actions related to access and availability. BHO EPSDT requirements were evaluated but not scored in 2016–2017. ABC-NE submitted its initial CAP proposal on May 31, 2017; and, following Department approval, completed implementation of all planned interventions on April 23, 2018.

Validation of Performance Measures

Following the FY 2016–2017 performance measure validation activities, HSAG recommended that ABC-NE improve its data monitoring process to ensure accuracy for the next measurement year. HSAG also recommended that ABC-NE continue to inspect the accuracy and completeness of the encounter and claims data received from the CMHCs and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation. ABC-NE should work closely with the Department to ensure having a clear understanding of the scope document and the data elements required for submission.

During the FY 2017–2018 performance measure validation activities, HSAG determined that the BHO continued to demonstrate that the same areas required improvement; therefore, in FY 2018–2019 HSAG will continue to monitor ABC-NE's accuracy and completeness of data and the BHO's understanding of the scope document.

Validation of Performance Improvement Projects

ABC-NE received a *Met* score for 100 percent of applicable evaluation elements during the FY 2016–2017 validation cycle; therefore, no prior PIP recommendations existed for follow-up during the FY 2017–2018 validation cycle.

Experience of Care and Health Outcomes Surveys

For ABC-NE's adult Medicaid population, one measure rate increased substantially between FY 2017–2018 and FY 2016–2017:

- *Patient Feels He or She Could Refuse Treatment* (5.9 percentage points)

For ABC-NE's adult Medicaid population, two measure rates decreased substantially between FY 2017–2018 and FY 2016–2017:

- *Rating of All Counseling or Treatment* (12.7 percentage points)

- *Including Family* (8.2 percentage points)

For ABC-NE's child Medicaid population, five measure rates increased substantially between FY 2017–2018 and FY 2016–2017:

- *Getting Treatment Quickly* (5.8 percentage points)
- *Office Wait* (10.6 percentage points)
- *Information to Manage Condition* (5.8 percentage points)
- *Patient Rights Information* (5.6 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (7.0 percentage points)

For ABC-NE's child Medicaid population, no measure rates decreased substantially between FY 2017–2018 and FY 2016–2017.

Behavioral Healthcare, Inc.

Compliance With Medicaid Managed Care Regulations

For the three 2016–2017 standards—Coverage and Authorization of Services; Access and Availability; and EPSDT, BHI had four required actions to improve utilization management (UM) policies and procedures, improve member notices of action, and ensure mailing of member notices in compliance with requirements. BHI had no required actions related to access and availability. BHO EPSDT requirements were evaluated but not scored in 2016–2017. BHI submitted its initial CAP proposal on May 9, 2017; and, following Department approval, completed implementation of all planned interventions on November 24, 2017.

Validation of Performance Measures

Following the FY 2016–2017 performance measure validation activities, HSAG recommended that BHI improve its data monitoring process to ensure accuracy for the next measurement year. HSAG also recommended that BHI continue to inspect the accuracy and completeness of the encounter and claims data received from the CMHCs and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation. BHI should work closely with the Department to ensure having a clear understanding of the scope document and the data elements required for submission.

During the FY 2017–2018 performance measure validation activities, HSAG determined that the BHO continued to demonstrate that the same areas required improvement; therefore, in FY 2018–2019 HSAG will continue to monitor BHI's accuracy and completeness of data and the BHO's understanding of the scope document.

Validation of Performance Improvement Projects

For the FY 2016–2017 PIP validation cycle, BHI received a *Partially Met* score for one evaluation element in Activity VII (Analyze Data and Interpret Study Results) and a *Not Met* score for two evaluation elements in Activity IX (Real Improvement) of the PIP validation tool. In FY 2017–2018, BHI addressed some but not all recommendations that HSAG provided to address the elements receiving *Partially Met* and *Not Met* scores in FY 2016–2017. In Activity VII, BHI addressed HSAG's recommendations to ensure that the study indicator goal and results were accurately reported. Therefore, in FY 2017–2018, the evaluation element in Activity VII received a *Met* score.

In Activity IX, BHI documented an updated causal/barrier analysis and interventions that were logically linked to identified barriers to address HSAG's feedback. To address the *Not Met* scores in Activity IX, HSAG recommended that the health plan revisit its causal/barrier analysis, reevaluate barriers, and deploy active interventions to facilitate significant improvement during the next remeasurement period. Despite addressing those recommendations, the study indicator results at Remeasurement 2 did not meet the plan-selected goal and did not demonstrate statistically significant improvement over baseline. Therefore, in FY 2017–2018, the two evaluation elements in Activity IX again received *Not Met* scores.

Experience of Care and Health Outcomes Surveys

For BHI's adult Medicaid population, no measure rates increased substantially between FY 2017–2018 and FY 2016–2017.

For BHI's adult Medicaid population, three measure rates decreased substantially between FY 2017–2018 and FY 2016–2017:

- *Information About Treatment Options* (7.1 percentage points)
- *Including Family* (5.2 percentage points)
- *Improved Functioning* (8.2 percentage points)

For BHI's child Medicaid population, two measure rates increased substantially between FY 2017–2018 and FY 2016–2017:

- *Told About Medication Side Effects* (5.4 percentage points)
- *Information to Manage Condition* (6.2 percentage points)

For BHI's child Medicaid population, no measure rates decreased substantially between FY 2017–2018 and FY 2016–2017.

Colorado Health Partnerships, LLC

Compliance With Medicaid Managed Care Regulations

For the three 2016–2017 standards—Coverage and Authorization of Services; Access and Availability; and EPSDT, CHP had two required actions to improve authorization policies and procedures and to ensure timely member notification of denial of claims payments. CHP had no required actions related to access and availability. BHO EPSDT requirements were evaluated but not scored in 2016–2017. CHP submitted its initial CAP proposal on May 30, 2017; and, following Department approval, completed implementation of all planned interventions on September 28, 2017.

Validation of Performance Measures

Following the FY 2016–2017 performance measure validation activities, HSAG recommended that CHP improve its data monitoring process to ensure accuracy for the next measurement year. HSAG also recommended that CHP continue to inspect the accuracy and completeness of the encounter and claims data received from the CMHCs and providers, to ensure that only accurate and complete data are submitted to the Department for measure calculation.

During the FY 2017–2018 performance measure validation activities, HSAG determined that the BHO continued to demonstrate that the same areas required improvement; therefore, in FY 2018–2019 HSAG will continue to monitor CHP's accuracy and completeness of data and the BHO's understanding of the scope document.

Validation of Performance Improvement Projects

For the FY 2016–2017 PIP validation cycle, CHP received a *Not Met* score for two evaluation elements in Activity IX (Real Improvement) of the PIP validation tool. The reported study indicator results did not demonstrate statistically significant improvement from baseline to Remeasurement 1, and the Remeasurement 1 results did not meet the goal. Resultant of the *Not Met* scores, HSAG provided feedback recommending that the health plan revisit its causal/barrier analysis and quality improvement processes to reevaluate barriers and deploy active interventions to facilitate significant improvement during the next remeasurement period. For the FY 2017–2018 PIP validation cycle, the health plan documented an updated causal/barrier analysis and interventions logically linked to identified barriers. The Remeasurement 2 study indicator results met the plan-selected goal but did not demonstrate statistically significant improvement over baseline. Therefore, in FY 2017–2018, one of the two evaluation elements in Activity IX received a *Met* score and the other evaluation element received a *Not Met* score.

Experience of Care and Health Outcomes Surveys

For CHP's adult Medicaid population, three measure rates increased substantially between FY 2017–2018 and FY 2016–2017:

- *Rating of All Counseling or Treatment* (8.2 percentage points)
- *Patient Rights Information* (6.3 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (6.8 percentage points)

For CHP's adult Medicaid population, one measure rate decreased substantially between FY 2017–2018 and FY 2016–2017:

- *Office Wait* (6.2 percentage points)

For CHP's child Medicaid population, one measure rate increased substantially between FY 2017–2018 and FY 2016–2017:

- *Social Connectedness* (6.8 percentage points)

For CHP's child Medicaid population, one measure rate decreased substantially between FY 2017–2018 and FY 2016–2017:

- *Told About Medication Side Effects* (8.1 percentage points)

Foothills Behavioral Health Partners, LLC

Compliance With Medicaid Managed Care Regulations

For the three 2016–2017 standards—Coverage and Authorization of Services; Access and Availability; and EPSDT—FBHP had three required actions: to improve authorization policies and procedures, to ensure accuracy of information in the member notice of action, and to ensure timely member notification of denial of claims payments. FBHP had no required actions related to Access and Availability. BHO EPSDT requirements were evaluated but not scored in 2016–2017. FBHP submitted its initial CAP proposal on May 12, 2017; and, following Department approval, completed implementation of all planned interventions on September 20, 2017.

Validation of Performance Measures

Following the FY 2016–2017 performance measure validation activities, HSAG recommended that FBHP improve its data monitoring process to ensure accuracy for the next measurement year. HSAG also recommended that FBHP continue to inspect accuracy and completeness of encounter and claims data received from the CMHCs and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

During the FY 2017–2018 performance measure validation activities, HSAG determined that the BHO continued to demonstrate that the same areas required improvement; therefore, HSAG will continue to monitor FBHP's accuracy and completeness of data and the BHO's understanding of the scope document in FY 2018–2019.

Validation of Performance Improvement Projects

For the FY 2016–2017 PIP validation cycle, FBHP received a *Not Met* score for two evaluation elements in Activity IX (Real Improvement) of the PIP validation tool. The reported study indicator results did not demonstrate statistically significant improvement from baseline to Remeasurement 1, and the Remeasurement 1 results did not meet the goal. Resultant of the *Not Met* scores, HSAG provided feedback recommending that the health plan revisit its causal/barrier analysis and quality improvement processes to reevaluate barriers and deploy active interventions to facilitate significant improvement during the next remeasurement period. For the FY 2017–2018 PIP validation cycle, the health plan documented an updated causal/barrier analysis and interventions logically linked to identified barriers. Despite addressing those recommendations, the Remeasurement 2 study indicator results did not demonstrate statistically significant improvement over baseline and did not meet the goal. Therefore, in FY 2017–2018, the two evaluation elements in Activity IX again received a *Not Met* score.

Experience of Care and Health Outcomes Surveys

For FBHP's adult Medicaid population, no measure rates increased substantially between FY 2017–2018 and FY 2016–2017.

For FBHP's adult Medicaid population, three measure rates decreased substantially between FY 2017–2018 and FY 2016–2017:

- *Rating of All Counseling or Treatment* (7.5 percentage points)
- *Office Wait* (8.9 percentage points)
- *Information to Manage Condition* (7.2 percentage points)

For FBHP's child Medicaid population, two measure rates increased substantially between FY 2017–2018 and FY 2016–2017:

- *Told About Medication Side Effects* (5.2 percentage points)
- *Amount Helped* (6.8 percentage points)

For FBHP's child Medicaid population, four measure rates decreased substantially between FY 2017–2018 and FY 2016–2017:

- *Getting Treatment Quickly* (5.3 percentage points)
- *Perceived Improvement* (7.6 percentage points)
- *Information About Treatment Options* (8.6 percentage points)
- *Patient Feels He or She Could Refuse Treatment* (5.3 percentage points)

Appendix A. RMHP Prime Administrative and Hybrid Rates

Table A-1—Administrative and Hybrid Performance Measure Results for RMHP Prime

Performance Measures	Administrative Rate	Hybrid Rate	Percentile Ranking
Pediatric Care			
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	58.21%	83.58%	≥90th
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	15.68%	29.44%	<10th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	3.18%	87.23%	75th–89th
Counseling for Nutrition—Total	15.55%	81.91%	75th–89th
Counseling for Physical Activity—Total	0.71%	79.79%	≥90th
Access to Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	22.65%	84.97%	50th–74th
Postpartum Care	27.15%	64.21%	25th–49th
Cervical Cancer Screening			
Cervical Cancer Screening	43.21%	58.52%	50th–74th
Adult BMI Assessment			
Adult BMI Assessment	17.25%	97.50%	≥90th
Living With Illness			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	83.94%	91.97%	75th–89th
*HbA1c Poor Control (>9.0%)**	70.68%	27.92%	≥90th
HbA1c Control (<8.0%)	25.19%	61.68%	≥90th
Eye Exam (Retinal) Performed	7.47%	60.04%	50th–74th
Medical Attention for Nephropathy	82.98%	90.69%	50th–74th
Blood Pressure Control (<140/90 mm Hg)	0.00%	73.54%	75th–89th

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