Colorado Medicaid
Community Mental Health Services Program

FY 2008–2009 Validation of Performance Measures

for

Access Behavioral Care

March 2009

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

HSAG HEALTH SERVICES ADVISORY GROUP

1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020
Phone 602.264.6382 • Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

for **Access Behavioral Care**

HSAG HEALTH SERVICES ADVISORY GROUP

Validation of Performance Measures

for Access Behavioral Care

Validation Overview

The Colorado State Medicaid agency, the Department of Health Care Policy & Financing (the Department) requires external quality review (EQR) activities as per the Balanced Budget Act of 1997 (BBA), 42 Code of Federal Regulations (CFR) §438.358. One of these activities is the validation of performance measures. The Department has contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to conduct the validation of performance measures for five Colorado behavioral health organizations (BHOs) for fiscal year (FY) 2008–2009. The BHOs provide mental health services to Medicaid-eligible recipients.

The Department identified a number of performance measures for validation. Some of these measures were calculated by the Department using data submitted by the BHOs; other measures were calculated by the BHOs. The measures came from a number of sources, including claims/encounter data and Mental Health Statistics Improvement Program (MHSIP) consumer surveys. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol). This report uses three sources—the BHO and Department versions of the Information Systems Capabilities Assessment Tool (ISCAT), site reviews, and source code—to tabulate findings for each BHO.

Access Behavioral Care Information

Information about **Access Behavioral Care** (**ABC**), a BHO in the Southeast Metro Denver region of Colorado, appears in Table 1.

Table 1—Access Behavioral Care Information

BHO Name:	Access Behavioral Care
BHO Location:	10065 E. Harvard Avenue, Suite 600, Denver, CO 80231
BHO Contact:	Robert W. Bremer, MA, PhD, Deputy Director, Access Behavioral Care
Contact Telephone Number:	720-744-5240
Contact E-Mail Address:	Robert.bremer@coaccess.com
Site Visit Date:	December 10, 2008

Performance Measures for Validation

HSAG validated a set of performance measures developed by the Department and BHOs and selected by the Department, as shown in Table 2. These measures represented five HEDIS-like measures, three measures developed by the Department, and six survey-based measures. The performance measures were calculated on an annual basis.

Table 2—List of Performance Measures for Access Behavioral Care	
1.	Inpatient Utilization
2.	Hospital Average Length of Stay
3.	Follow-up After Hospitalization for Mental Illness (7 and 30-day follow-up)
4.	Emergency Department Utilization
5.	Hospital Recidivism
6.	Overall Penetration Rates
7.	Penetration Rates by Service Category
8.	Penetration Rates by Age Category
9.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of access (Consumer Perception of Access). Source: MHSIP survey.
10.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of quality/appropriateness (Consumer Perception of Quality/Appropriateness). Source: MHSIP survey.
11.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of outcome/positive change (Consumer Perception of Outcome). Source: MHSIP survey.
12.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of general satisfaction (Consumer Perception of Satisfaction). Source: MHSIP survey.
13.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring participation in treatment planning (Consumer Perception of Participation). Source: MHSIP survey.
14.	Percentage of Medicaid adults surveyed who reported seeing a doctor or nurse face to face other than in the emergency room (Doctor Contacts Outside of the Emergency Room). Source: MHSIP survey.

Description of Validation Activities

Preaudit Strategy

HSAG conducted the validation activities outlined in the CMS Performance Measure Validation Protocol. The Department provided the performance measure definitions for review by the HSAG validation team (Appendix A). The Department and BHOs worked together to develop this document, which was in test mode for FY 2006–2007. For FY 2007–2008, the performance measures listed on this document were moved out of test mode and were primary performance measures for the BHOs. The Department and BHOs worked on additional improvements of these measures in the Department's Behavioral Health Quality Improvement Committee meeting. Based on the measure definitions and reporting guidelines, HSAG developed the following:

a. Measure-specific worksheets based on Attachment I of the CMS Performance Measure Validation Protocol.

b. A documentation request, which consisted of the ISCAT or Appendix Z of the CMS Performance Measure Validation Protocol.

c. A customized ISCAT to collect the necessary data consistent with Colorado's mental health service delivery model. The ISCAT was forwarded to **ABC** with a timetable for completion and instructions for submission. HSAG fielded ISCAT-related questions directly from **ABC** during the pre-on-site phase. HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff needed for each session. The agendas were forwarded to **ABC** approximately one month prior to the on-site visit. HSAG also conducted pre-on-site conference calls with **ABC** to discuss any outstanding ISCAT questions and on-site visit activities.

Validation Team

The HSAG performance measure validation team was assembled based on the full complement of skills required for the validation and requirements of this particular BHO. The team consisted of a lead auditor and validation team members, as described in Table 3.

Table 3—HSAG Validation Team

Name	Team Position	Skills and Expertise
Terry Wilkens, RN, CHCA	Lead Auditor	Auditing expertise, clinical experience, tool development, record review supervision, performance measure validation, encounter data validation
Patience Hoag, RHIT, CHCA, CCS, CCS-P	Secondary Auditor	Coding expertise, performance measure validation, encounter data validation
Raj Shrestha, MPH, MBA, CHCA	Executive Director, Audits	Auditing expertise, computer programming, compliance with performance measure specifications
Tammy GianFrancisco	Administrative Assistant III	Communications

The HSAG lead auditor and secondary auditor participated in the on-site review at the BHO. The remaining team members conducted their work at their respective HSAG offices.

Technical Methods of Data Collection and Analysis

The CMS Performance Measure Validation Protocol identifies key types of data that should be reviewed as part of the validation process. Below is a list of the types of data collected and how HSAG conducted an analysis of this data:

- *Information Systems Capabilities Assessment Tools (ISCATs)* were requested and received from each BHO and the Department. Upon receipt by HSAG, the ISCATs were reviewed to ensure that all sections were completed. The ISCATs were then forwarded to the validation team for review. The review identified issues or items that needed further follow-up.
- *Source code (programming language) for performance measures* was requested and was submitted by the Department and the BHOs. The validation team completed query review and observation of program logic flow to ensure compliance with performance measure definitions during the site visit. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- *Performance measure reports for FY 2007–2008* were reviewed by the validation team. The team also reviewed previous reports for trends and rate reasonability.
- *Supportive documentation* included any documentation that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. All supportive documentation was reviewed by the validation team, with issues or clarifications flagged for further follow-up.

On-Site Activities

HSAG conducted a one-day on-site visit with both the Department and **ABC**. HSAG used several methods to collect information, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described below.

- **Opening meeting**—included introductions of the validation team and key **ABC** and Department staff involved in the performance measure activities. The review purpose, required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Evaluation of system compliance**—included a review of the information systems assessment, focusing on the processing of claims, encounter, member, and provider data. Reviewers 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 systems. Additionally, the review evaluated the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
- **Review of ISCAT and supportive documentation**—included a review of the processes used to collect, store, validate, and report performance measure data. This session was designed to be interactive with key **ABC** and Department staff. The goal of this session was to obtain a complete picture of the degree of compliance with written documentation. HSAG used 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.
- **Overview of data integration and control procedures**—included discussion and observation of source code logic and a review of how all data sources were combined. The data file used to report the selected performance measures was produced. 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.
- **Closing conference**—provided a summary of preliminary findings based on the review of the ISCAT and the on-site visit, and a review of the documentation requirements for any post-visit activities.

HSAG conducted several interviews with key **ABC** and Department staff members involved with performance measure reporting. Table 4 lists these key interviewees from **ABC**.

Table 4—List of Access Behavioral Care Participants	
Name	**Title**
Robert Bremer	Deputy Director, Access Behavioral Care
Mike McKitterick	Vice President, Clinical Services
Julie Salazar	Manager, Decision Support
Ann Brunker	Senior Business Analyst, Production Control Manager
Carrie Bandell	Director, Quality Management
Guinevere Blodgett	Behavioral Health Quality Coordinator
Robbie Snyder	Senior Analyst, Decision Support
Lenore Ralston	Executive Director, Access Behavioral Care
Jeni Sargent	Manager, Enrollment and Eligibility
Julie McNamara	Director, Business Process and System Operations

Data Integration, Data Control, and Performance Measure Documentation

The calculation of performance measures includes several crucial aspects: data integration, data control, and documentation of performance measure calculations. Each section below describes the validation processes used and the validation findings. For more detailed information, please see Appendix B.

Data Integration

Accurate data integration is essential to calculating valid performance measures. The steps used to combine various data sources, including encounter data and eligibility data, must be carefully controlled and validated. HSAG validated the data integration process used by the Department and the BHO. This validation included a comparison of source data to warehouse files and a review of file consolidations or extracts, data integration documentation, source code, production activity logs, and linking mechanisms. By evaluating linking mechanisms, HSAG was able to determine how different data sources (i.e., claims data and membership data) interacted with one another and how certain elements were consolidated readily and used efficiently. Overall, the data integration processes used by the Department and the BHO were determined by the audit team to be:

☒ Acceptable

☐ Not acceptable

Data Control

The organizational infrastructure of **ABC** must support all necessary information systems. Each quality assurance practice and backup procedure must be sound to ensure timely and accurate processing of data, as well as provide data protection in the event of a disaster. HSAG validated the data control processes used by **ABC**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, the data control processes in place at **ABC** were determined by the audit team to be:

☒ Acceptable

☐ Not acceptable

Performance Measure Documentation

Complete and sufficient documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by **ABC** and the Department. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, computer programming code, output files, work flow diagrams, narrative descriptions of performance measure calculations, and other related documentation. Overall, the documentation of performance measure data collection and calculations by **ABC** and the Department was determined by the audit team to be:

☒ Acceptable

☐ Not acceptable

Validation Findings

Through the validation process, the review team identified overall strengths and areas for improvement for **ABC**. In addition, the team evaluated **ABC**'s data systems for the processing of each type of data used for reporting the performance measures. General findings are indicated below.

Strengths

ABC had an encounter work group that met biweekly and helps to ensure that the BHO's encounter data were complete and accurate on an ongoing basis. In addition, **ABC** had a tool called SharePoint that was still in development, which will facilitate communication, training, and data retrieval within the organization. **ABC** used MedStat, NCQA-certified software, to calculate the HEDIS-like measures. This software ensured that these measures were pulled in a consistent way. There was a well-documented quality assurance process in place at **ABC** on the data extracts to MedStat. Core reports were readily available through "Decision Analyst," MedStat's Web-based application.

Last year the HSAG auditors encouraged **ABC** to continue its oversight of all delegated functions since additional processes (such as adjudication) were being delegated to DST Healthcare Solutions. This year the auditors noted that **ABC**'s transition to DST for adjudication was successfully accomplished and the oversight processes in place at **ABC** met standards.

Areas for Improvement

HSAG recommends that the BHO work with the Department to reformat the Attachment A document, including a title page and modification date/version number to ensure that everyone is working with the same document. The Attachment B document could also be modified. The diagnosis codes within this document did not match those covered by State contract. The BHO should direct any questions or concerns related to the scope document to the Department.

The auditors recommend that **ABC** increase formal oversight of Mental Health Center of Denver (MHCD). Although the BHO has a longstanding relationship with MHCD, the BHO remains ultimately responsible for this entity's data. MHCD may only need formal oversight annually, but the oversight should still occur.

Eligibility Data System Findings

HSAG had no concerns with the processing of membership data. The BHO processed the State eligibility files in a standardized fashion, and the provider network had multiple means to check member eligibility at the time of service.

Claims/Encounter Data System Findings

HSAG had no concerns with the processing of claims and encounters other than what is noted above. The auditors noted that, in previous years, the BHO conducted an internal 411 audit, comparing encounter data to medical record documentation, on an annual basis. For the current year, this activity was being conducted by HSAG, so the BHO suspended the internal audit activity. The auditors suggested that the BHO continue its own internal audits, which do not need to involve large numbers such as those used in the 411 audit, as a means to ensure that claims and encounter data are complete and accurate.

Performance Measure Specific Findings and Recommendations

Based on all validation activities, the HSAG team determined results for each performance measure. The CMS Performance Measure Validation Protocol identifies four separate validation results for each performance measure, which are defined in Table 5.

Table 5—Validation Results Definitions

Fully Compliant (FC)	Indicates that the performance measure was fully compliant with Department specifications.
Substantially Compliant (SC)	Indicates that the performance measure was substantially compliant with Department specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid (NV)	Indicates that the performance measure deviated from Department specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
Not Applicable (NA)	Indicates that the performance measure was not reported because the BHO did not have any Medicaid consumers who qualified for that denominator.

According to the protocol, the validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be *Not Met*. Consequently, it is possible that an error for a single audit element may result in a designation of NV because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, and the measure could be given a designation of SC.

Table 6 below displays the review findings, validation results, and key recommendations for **ABC** for each performance measure. For more detailed information, please see Appendix C.

Table 6—Key Review Findings for Access Behavioral Care

Performance Measures		Findings	Validation Results	Key Recommendations
1.	Inpatient Utilization	The BHO calculated this rate. The auditors reviewed the scope (specification) document and Attachment A and B related to the calculation of the measure. Discussion with BHO staff revealed that the scope document and attachments had undergone multiple updates. In addition, during interviews, it became evident that certain elements were not explicitly defined within these documents. The recommendation section contains examples of missing/incomplete information. Primary source verification performed on-site did not identify any concerns with the BHO's calculation of the rate. Because the scope document was a work in progress, and the BHO complied with the specifications to the best of its ability, the auditors determined that the BHO was fully compliant with specifications.	Fully Compliant	HSAG encourages the BHO to work with the Department to reformat the Attachment A document, including a title page or header and modification date/version number in the footer to ensure that everyone is working with the same document. Any unnecessary tables and codes within tables in Attachment A should be deleted to avoid confusion, and tables should be labeled according to the relevant measure. HSAG also encourages the BHO to work with the Department to modify the Attachment B document. For example, the diagnosis codes within this document did not match those covered by State contract. Other modifications may be necessary to meet the criteria in the scope document, such as deletion of certain codes not used in measure calculation (e.g., DRG). An alternative solution might be to incorporate the revised information from Attachments A and B into the scope document and eliminate Attachments A and B altogether. HSAG encourages the BHO to work with the Department to establish eligibility criteria for each performance measure, which should be spelled out explicitly in the scope document. In addition, the covered mental health diagnoses should be specified within the document or referenced specifically as an attachment to the scope document.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
2.	Hospital Average Length of Stay	The BHO calculated this rate. The auditors reviewed the scope (specification) document and Attachment A and B related to the calculation of the measure. Discussion with BHO staff revealed that the scope document and attachments had undergone multiple updates. In addition, during interviews, it became evident that certain elements were not explicitly defined within these documents. The recommendation section contains examples of missing/incomplete information. Primary source verification performed on-site did not identify any concerns with the BHO's calculation of the rate. Because the scope document was a work in progress, and the BHO complied with the specifications to the best of its ability, the auditors determined that the BHO was fully compliant with specifications.	Fully Compliant	HSAG encourages the BHO to work with the Department to reformat the Attachment A document, including a title page or header and modification date/version number in the footer to ensure that everyone is working with the same document. Any unnecessary tables and codes within tables in Attachment A should be deleted to avoid confusion, and tables should be labeled according to the relevant measure. HSAG also encourages the BHO to work with the Department to modify the Attachment B document. For example, the diagnosis codes within this document did not match those covered by State contract. Other modifications may be necessary to meet the criteria in the scope document, such as deletion of certain codes not used in measure calculation (e.g., DRG). An alternative solution might be to incorporate the revised information from Attachments A and B into the scope document and eliminate Attachments A and B altogether. HSAG encourages the BHO to work with the Department to establish eligibility criteria for each performance measure, which should be spelled out explicitly in the scope document. In addition, the covered mental health diagnoses should be specified within the document or referenced specifically as an attachment to the scope document.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
3.	Follow-up After Hospitalization for Mental Illness (7 and 30-day follow-up)	The BHO calculated this rate. The auditors reviewed the scope (specification) document and Attachment A and B related to the calculation of the measure. Discussion with BHO staff revealed that the scope document and attachments had undergone multiple updates. In addition, during interviews, it became evident that certain elements were not explicitly defined within these documents. The recommendation section contains examples of missing/incomplete information. Primary source verification performed on-site did not identify any concerns with the BHO's calculation of the rate. Because the scope document was a work in progress, and the BHO complied with the specifications to the best of its ability, the auditors determined that the BHO was fully compliant with specifications.	Fully Compliant	HSAG encourages the BHO to work with the Department to reformat the Attachment A document, including a title page or header and modification date/version number in the footer to ensure that everyone is working with the same document. Any unnecessary tables and codes within tables in Attachment A should be deleted to avoid confusion, and tables should be labeled according to the relevant measure. HSAG also encourages the BHO to work with the Department to modify the Attachment B document. For example, the diagnosis codes within this document did not match those covered by State contract. Other modifications may be necessary to meet the criteria in the scope document, such as deletion of certain codes not used in measure calculation (e.g., DRG). An alternative solution might be to incorporate the revised information from Attachments A and B into the scope document and eliminate Attachments A and B altogether. HSAG encourages the BHO to work with the Department to establish eligibility criteria for each performance measure, which should be spelled out explicitly in the scope document. In addition, the covered mental health diagnoses should be specified within the document or referenced specifically as an attachment to the scope document.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
4.	Emergency Department Utilization	The BHO calculated this rate. The auditors reviewed the scope (specification) document and Attachment A and B related to the calculation of the measure. Discussion with BHO staff revealed that the scope document and attachments had undergone multiple updates. In addition, during interviews it became evident that certain elements were not explicitly defined within these documents. The recommendation section contains examples of missing/incomplete information. Primary source verification performed on-site did not identify any concerns with the BHO's calculation of the rate. Because the scope document was a work in progress, and the BHO complied with the specifications to the best of its ability, the auditors determined that the BHO was fully compliant with specifications.	Fully Compliant	HSAG encourages the BHO to work with the Department to reformat the Attachment A document, including a title page or header and modification date/version number in the footer to ensure that everyone is working with the same document. Any unnecessary tables and codes within tables in Attachment A should be deleted to avoid confusion, and tables should be labeled according to the relevant measure. HSAG also encourages the BHO to work with the Department to modify the Attachment B document. For example, the diagnosis codes within this document did not match those covered by State contract. Other modifications may be necessary to meet the criteria in the scope document, such as deletion of certain codes not used in measure calculation (e.g., DRG). An alternative solution might be to incorporate the revised information from Attachments A and B into the scope document and eliminate Attachments A and B altogether. HSAG encourages the BHO to work with the Department to establish eligibility criteria for each performance measure, which should be spelled out explicitly in the scope document. In addition, the covered mental health diagnoses should be specified within the document or referenced specifically as an attachment to the scope document.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
5.	Hospital Recidivism	The BHO calculated this rate. The auditors reviewed the scope (specification) document and Attachment A and B related to the calculation of the measure. Discussion with BHO staff revealed that the scope document and attachments had undergone multiple updates over the past several years. In addition, during interviews, it became evident that certain elements were not explicitly defined within these documents. The recommendation section contains examples of missing/incomplete information. Primary source verification performed on-site did not identify any concerns with the BHO's calculation of the rate. Because the scope document was a work in progress, and the BHO complied with the specifications to the best of its ability, the auditors determined that the BHO was fully compliant with specifications.	Fully Compliant	HSAG encourages the BHO to work with the Department to reformat the Attachment A document, including a title page or header and modification date/version number in the footer to ensure that everyone is working with the same document. Any unnecessary tables and codes within tables in Attachment A should be deleted to avoid confusion, and tables should be labeled according to the relevant measure. HSAG also encourages the BHO to work with the Department to modify the Attachment B document. For example, the diagnosis codes within this document did not match those covered by State contract. Other modifications may be necessary to meet the criteria in the scope document, such as deletion of certain codes not used in measure calculation (e.g., DRG). An alternative solution might be to incorporate the revised information from Attachments A and B into the scope document and eliminate Attachments A and B altogether. HSAG encourages the BHO to work with the Department to establish eligibility criteria for each performance measure, which should be spelled out explicitly in the scope document. In addition, the covered mental health diagnoses should be specified within the document or referenced specifically as an attachment to the scope document.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
6.	Overall Penetration Rates	HSAG interviewed key BHO staff members and reviewed the ISCAT. The processes in place to receive and collect claims/encounter data met standards. At the Department level, interviews with key staff members revealed that a code editor/scrubber (to ensure valid diagnosis/service codes) was not in place for penetration rate calculations. There was an editor/scrubber in place for rate-setting activities. The reviewers determined that this would not significantly bias any penetration rates due to edit-checks performed during backend processing. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	HSAG recommends that the BHO continue to oversee and monitor the receipt of encounter data from the community mental health center (CMHC) as well as submissions of encounter data to the Department. HSAG recommends that at the Department level, a code editor/ scrubber (to validate diagnosis/ service codes) be added to the process for determining the penetration rate.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		**Findings**	**Validation Results**	**Key Recommendations**
7.	Penetration Rates by Service Category	HSAG interviewed key BHO staff members and reviewed the ISCAT. The processes in place to receive and collect claims/encounter data met standards. At the Department level, interviews with key staff members revealed that a code editor/scrubber (to ensure valid diagnosis/service codes) was not in place for penetration rate calculations. There was an editor/scrubber in place for rate-setting activities. The reviewers determined that this would not significantly bias any penetration rates due to edit-checks performed during backend processing. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	HSAG recommends that the BHO continue to oversee and monitor the receipt of encounter data from the community mental health center (CMHC) as well as submissions of encounter data to the Department. HSAG recommends that at the Department level, a code editor/ scrubber (to validate diagnosis/ service codes) be added to the process for determining the penetration rate.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		**Findings**	**Validation Results**	**Key Recommendations**
8.	Penetration Rates by Age Category	HSAG interviewed key BHO staff members and reviewed the ISCAT. The processes in place to receive and collect claims/encounter data met standards. At the Department level, interviews with key staff members revealed that a code editor/scrubber (to ensure valid diagnosis/service codes) was not in place for penetration rate calculations. There was an editor/scrubber in place for rate-setting activities. The reviewers determined that this would not significantly bias any penetration rates due to edit-checks performed during backend processing. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	HSAG recommends that the BHO continue to oversee and monitor the receipt of encounter data from the community mental health center (CMHC) as well as submissions of encounter data to the Department. HSAG recommends that at the Department level, a code editor/ scrubber (to validate diagnosis/ service codes) be added to the process for determining the penetration rate.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
9.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of access.	The Department of Behavioral Health (DBH) administered the MHSIP survey according to standard administration protocols. However, similar to previous years' findings, HSAG discovered during interviews with DBH staff members that the current survey administration could allow a consumer to complete more than one survey. In addition, the survey included a question that asked whether or not a consumer was eligible for Medicaid. The use of this question to determine actual eligibility should be reevaluated since the response could be incorrect. The reviewers determined that these issues would not significantly bias any MHSIP survey rates as standard MHSIP survey protocol was followed. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	DBH should consider creating a survey methodology that would allow a consumer to complete only one (MHSIP) survey. Additionally, the Department and DBH should reevaluate the use of the response to a survey question as a means to determine actual eligibility since responses to the question could be incorrect.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		**Findings**	**Validation Results**	**Key Recommendations**
10.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of quality/ appropriateness.	DBH administered the MHSIP survey according to standard administration protocols. However, similar to previous years' findings, HSAG discovered during interviews with DBH staff members that the current survey administration could allow a consumer to complete more than one survey. In addition, the survey included a question that asked whether or not a consumer was eligible for Medicaid. The use of this question to determine actual eligibility should be reevaluated since the response could be incorrect. The reviewers determined that these issues would not significantly bias any MHSIP survey rates, as standard MHSIP survey protocol was followed. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	DBH should consider creating a survey methodology that would allow a consumer to complete only one (MHSIP) survey. Additionally, the Department and DBH should reevaluate the use of the response to a survey question as a means to determine actual eligibility since responses to the question could be incorrect.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
11.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of outcome/ positive change.	DBH administered the MHSIP survey according to standard administration protocols. However, similar to previous years' findings, HSAG discovered during interviews with DBH staff members that the current survey administration could allow a consumer to complete more than one survey. In addition, the survey included a question that asked whether or not a consumer was eligible for Medicaid. The use of this question to determine actual eligibility should be reevaluated since the response could be incorrect. The reviewers determined that these issues would not significantly bias any MHSIP survey rates, as standard MHSIP survey protocol was followed. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	DBH should consider creating a survey methodology that would allow a consumer to complete only one (MHSIP) survey. Additionally, the Department and DBH should reevaluate the use of the response to a survey question as a means to determine actual eligibility since responses to the question could be incorrect.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
12.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring consumer perceptions of general satisfaction.	DBH administered the MHSIP survey according to standard administration protocols. However, similar to previous years' findings, HSAG discovered during interviews with DBH staff members that the current survey administration could allow a consumer to complete more than one survey. In addition, the survey included a question that asked whether or not a consumer was eligible for Medicaid. The use of this question to determine actual eligibility should be reevaluated since the response could be incorrect. The reviewers determined that these issues would not significantly bias any MHSIP survey rates, as standard MHSIP survey protocol was followed. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	DBH should consider creating a survey methodology that would allow a consumer to complete only one (MHSIP) survey. Additionally, the Department and DBH should reevaluate the use of the response to a survey question as a means to determine actual eligibility since responses to the question could be incorrect.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
13.	Percentage of Medicaid adults surveyed who agreed with the domain score measuring participation in treatment planning.	DBH administered the MHSIP survey according to standard administration protocols. However, similar to previous years' findings, HSAG discovered during interviews with DBH staff members that the current survey administration could allow a consumer to complete more than one survey. In addition, the survey included a question that asked whether or not a consumer was eligible for Medicaid. The use of this question to determine actual eligibility should be reevaluated since the response could be incorrect. The reviewers determined that these issues would not significantly bias any MHSIP survey rates, as standard MHSIP survey protocol was followed. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	DBH should consider creating a survey methodology that would allow a consumer to complete only one (MHSIP) survey. Additionally, the Department and DBH should reevaluate the use of the response to a survey question as a means to determine actual eligibility since responses to the question could be incorrect.

Table 6—Key Review Findings for Access Behavioral Care				
Performance Measures		Findings	Validation Results	Key Recommendations
14.	Percentage of Medicaid adults surveyed who reported seeing a doctor or nurse face to face, other than in the emergency room.	DBH administered the MHSIP survey according to standard administration protocols. However, similar to previous years' findings, HSAG discovered during interviews with DBH staff members that the current survey administration could allow a consumer to complete more than one survey. In addition, the survey included a question that asked whether or not a consumer was eligible for Medicaid. The use of this question to determine actual eligibility should be reevaluated since the response could be incorrect. The reviewers determined that these issues would not significantly bias any MHSIP survey rates, as standard MHSIP survey protocol was followed. This finding was at the Department level; therefore, the reviewers determined that **ABC** was fully compliant for this measure.	Fully Compliant	DBH should consider creating a survey methodology that would allow a consumer to complete only one (MHSIP) survey. Additionally, the Department and DBH should reevaluate the use of the response to a survey question as a means to determine actual eligibility since responses to the question could be incorrect.

Table 7—Overall Results	
Validation Results	**Number of Performance Measures**
Fully Compliant	14
Substantially Compliant	0
Not Valid	0
Not Applicable	0

Indicators

- Inpatient Utilization
- Hospital Length of Stay
- Overall Penetration Rates*
- Penetration Rates by Service Category*
- Penetration Rates by Age Category*
- Hospital Recidivism
- Emergency Department Utilization
- Follow-Up after Hospitalization for Mental Illness
- Consumer Perception of Access**
- Consumer Perception of Outcomes**
- Consumer Perception of Quality**
- Consumer Satisfaction with Services **
- Consumer Participation in Service Planning **
- Consumers Linked to Primary Care **

***Calculated by the Department**

****MHSIP Survey Results**

The Department collaborated with the BHOs to create a scope document that serves as the specifications for measures being validated. The following verbiage from the scope document is reproduced in its entirety through page A-9.

Definitions

Members: Individuals eligible for Medicaid assigned to a specific BHO. Membership is calculated by the number of member months during a 12-month period divided by 12, which gives equivalent members or the average health plan enrollment during the 12-month reporting period.

Per 1000 members: A measure based on total eligible members per 1000.

Fiscal Year: Based on the State fiscal year July to June

Quarter: Based on fiscal year quarters (Jul–Sep, Oct–Dec, Jan–Mar, Apr–Jun)

Age Category: Based on HEDIS age categories: 0–12 (Child), 13–17 (Adolescent), 18–64 (Adult), and 65+ (Older Adult). Age category determination will be based upon the client's age on the date of service for all performance indicators except for inpatient hospitalization. For inpatient hospitalization, age category determination will be based upon the client's age on the date of discharge.

24-Hour Treatment Facility: A residential facility that has 24-hr professional staffing and a program of treatment services. Includes PRTF and TRCCFs. Does not include Nursing Facilities or ACFs (defined as an assisted living residence licensed by the State to provide alternative care services and protective oversight to Medicaid clients).

Hospital discharge: A discharge from a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis that does not result in a re-hospitalization within 24 hrs (transfer). There can be multiple discharges during the specified fiscal year period. The discharge must result in a paid claim for the hospital episode, except where the discharge is from a State Hospital for ages 21–64.

Hospital admit: An admit to a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis. There can be multiple admits during the specified fiscal year period. The admit must result in a paid claim for the hospital episode, except where the admit is from a State Hospital for ages 21–64.

Indicators

1. Inpatient Utilization

Description: The total number of BHO member discharges from a hospital episode for treatment of a covered mental health disorder per 1000 members, by age group (see above for age categories) and total population. The discharge must occur in the period of measurement. Two indicators are provided: 1) Number of member discharges from a non-State hospital and 2) Number of member discharges from all hospitals (non-State and State hospitals). Age for this indicator is determined at hospital discharge. Please note: For members transferred from one hospital to another within 24 hours, only one discharge should be counted and it should be attributed to the hospital with the final discharge.

Denominator: Total number of members during the specified fiscal year (12–month period).

Numerator: All discharges from a hospital episode for treatment of a covered mental health disorder

Non-State Hospitals: All discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30.

All Hospitals: All discharges from a hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30.

Data Source(s): Denominator: Members by BHO provided by HCPF. Numerator: Discharge dates from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Discharge dates from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: who: BHO; Calculation: Numerator (non-state hospital)/Denominator x 1000; Numerator (all hospital)/Denominator x 1000

Benchmark: HEDIS for all hospital and Overall BHOs for all hospital and non-State

2. Hospital Length of Stay

Description: The average length of stay (in days) for BHO members discharged from a hospital episode for treatment of a covered mental health disorder, by age group and total population. Two indicators are provided: 1) Average length of stay for members discharged from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) Average length of stay for members discharged from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 though June 30. Age for this indicator is determined at hospital discharge. Please note: For members transferred from one hospital to another within 24 hours, total length of stay for both hospitals should be attributed to the hospital with the final discharge. For State hospitalization, all days in the hospital episode will be included if the member was Medicaid eligible at the time of admission.

Denominators: Number of Members discharged from a hospital episode. The discharge day must occur within the specified fiscal year, July 1 through June 30.

Non-State Hospital: Total number of Members discharged from a non-State hospital during the specified fiscal year

All Hospitals: Total number of Members discharged from all hospitals during the specified fiscal year.

Numerators: Total days for all hospital episodes resulting in a discharge. Discharge day is not counted. The discharge day must occur within the specified fiscal year, July 1 through June 30. If the admit date and the discharge date are the same then the number of days for the episode is one.

Non-State Hospitals: Total days= Discharge date from the non-State hospital-Admit date

All Hospitals: Total days=Discharge date from all hospitals-Admit date

Data Source(s): Denominator: Number of Members discharged, from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the state hospital data file. Numerator: Hospital days (discharge date – admit date) from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Hospital days (discharge date – admit date) from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-State hospital)/Denominator (non-State hospital); Numerator (all hospital)/Denominator (all hospital)

Benchmark: HEDIS for all hospital, BHO for all hospital and non-State hospital

3. Overall Penetration Rates

Description: Percent BHO Members with one contact in a specified fiscal year (12-month period) by eligibility category, age, cultural/ethnic group (race).

- Age is determined by the member's age on the last day of the fiscal year.
- Medicaid eligibility category is the eligibility category on the member's most recent Medicaid eligibility span during the fiscal year.
- Cultural/ethnic group (race) is the race category on the member's most recent Medicaid eligibility span during the fiscal year.

Table 1—Medicaid Eligibility Categories	
Eligibility Type Code	**Description**
001	OAP-A
002	OAP-B-SSI
003	AND/AB-SSI
004	AFDC/CWP ADULTS
005	AFDC/CWP CHILDREN
006	FOSTER CARE
007	BC WOMEN
008	BC CHILDREN
013	OAP STATE ONLY
020	BCCP-WOMEN BREAST & CERVICAL CAN
999	UNSPECIFIED

Table 2—Medicaid Race Categories	
Race Code	**Description**
1	SPANISH AMERICAN
2	OTHER – WHITE
3	BLACK
4	AMERICAN INDIAN
5	ORIENTAL
6	OTHER
7	UNKNOWN
8	NATV HAWAIIAN OTH PACIFIC ISL

Denominator: Total BHO membership for the specified fiscal year (12-month period)

Numerator: Members with one contact in the specified fiscal year (12-month period) in each eligibility category, age group, and cultural/ethnic group

Data Source(s): BHO encounter/claim file

Calculation of Measure: HCPF (by Overall, HEDIS age, eligibility category, cultural/ethnic [% total missing])

Benchmark: Overall BHO

4. Penetration Rates by Service Category

Description: Percent BHO Members with any MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. Initially, the ambulatory care rate will be calculated twice; the first rate will be calculated using HEDIS specifications only, and the second rate will be calculated using HEDIS specifications plus additional place of service and service codes specified by the BHOs that are used to encounter services not included in the original HEDIS specifications. See Appendix A for HEDIS specs and additional POS and service codes. Place of Service category 53 will be excluded for the intensive outpatient and partial hospitalization service category.

Denominator: Total BHO membership for the specified fiscal year (12-month period)

Numerator: Members with any MH service, grouped as inpatient, intensive outpatient/partial hospitalization, and ambulatory care in a 12-month period (see Appendix A).

Data Source(s): Denominator: HCPF; Numerator: Encounter/Claims

Calculation of Measure: HCPF; Calculation: Numerator (inpatient)/Denominator; Numerator (intensive outpatient/partial hospitalization)/Denominator; Numerator (ambulatory care)/Denominator

Benchmark: HEDIS and Overall BHO

Problems/Issues/Questions: For ambulatory penetration rate see Description above and Appendix A for specifications for calculating the HEDIS and non-HEDIS rates.

5. Hospital Recidivism

Description: Proportion of BHO Member discharges from a hospital episode for treatment of a covered mental health disorder and readmitted for another hospital episode for treatment of a covered diagnosis within 7, 30, 90 days by age group and overall (recidivism rates). Two indicators are provided: 1) **Non-State:** Recidivism rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Recidivism rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 though June 30. Age for this indicator is determined at first hospital discharge.

Denominator: Total number of BHO member discharges during the reporting period. The eligible population is based on discharges (e.g., one member can have multiple discharges).

Non-State Hospital: Total number of Member discharges from a non-State hospital during the specified fiscal year

All Hospitals: Total number of Member discharges from all hospitals during the specified fiscal year

Numerator: Number of BHO member discharges with an admission within 7, 30, and 90 days of the discharge, reported cumulatively.

Non-State Hospital: Total number of Member discharges from a non-State hospital, during the specified fiscal year, July 1 through June 30, and then admitted to any hospital (non-state or state) 7, 30, and 90 days after the discharge.

All Hospitals: Total number of Member discharges from all hospitals, during the specified fiscal year, July 1 through June 30, and then admitted to all hospitals 7, 30, and 90 days after the discharge.

Data Source(s): Denominator: Number of Member discharges, from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by TBD. Numerator: Admissions from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Admissions from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation (6 ratios): Numerator (7 days, non-state hospital)/Denominator (non-State hospital); Numerator (30 days, non-state hospital)/Denominator (non state hospital), Numerator (90 days, non state hospital)/Denominator (non state hospital); etc

Benchmark: Overall BHOs.

6. Emergency Department Utilization

Description: Number of BHO Member emergency room visits for a covered diagnosis per 1,000 Members by age group and overall for the specified fiscal year 12-month period. For this measure include only paid encounters. Age for this indicator is determined on date of service.

Denominator: Total number of Members during the specified fiscal year (12-month period).

Numerator: ED visits that don't result in an inpatient admission within 24 hrs of the day of the ED visit. ED visit codes include: CPT 99281–99285 and 99291–99292; and revenue code 450.

Data Source(s): Denominator: HCPF; Numerator: BHO encounter claim file.

Calculation of Measure: BHO; Calculation: Numerator/Denominator x 1,000

Benchmark: Overall BHO

7. Follow-up after hospitalization for mental illness

Description: The percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health disorder to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider by age group and overall within 7 or 30 days (follow-up rates). Two indicators are provided: 1) **Non-State:** Follow-up rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Follow-up rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 though June 30. Age group is defined as 6 years and older as of the date of discharge.

Numerators: Total number of discharges with an outpatient service (see Attachment B) within 7 and 30 days (the 30 days includes the 7 day number also). For each denominator event (discharge), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure. See CPT, UB-92, HCPCS codes in HEDIS Table (FUH-B) for follow-up visit codes allowed.

Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year with an outpatient service within 7 and 30 days.

All Hospitals: All discharges from any inpatient facility for a specified fiscal year with an outpatient service within 7 and 30 days.

Denominators: the eligible population based on discharges during the specified fiscal year July 1 through June 30(can have multiple discharges for the same individual). Discharges for the whole fiscal year are calculated because the use of 90 day run out data provides the time to collect 30 day follow-up information.

Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year.

All Hospitals: All discharges from any inpatient facility for the specified fiscal year.

Exclusions:

- Exclude those individuals who were readmitted within 30 days to an inpatient setting for all calculations
- Exclude discharges to any 24 hr**.** treatment facility within 24-hr of discharge (see definition). Compare using residential treatment per diem code.

Data Source(s): Denominator: Number of Member discharges, from non-State hospitals, all ages, and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the State. Numerator: Follow-up provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO; Calculation: Includes 4 ratios: Numerator (7 days, non-state hospital)/Denominator (non-State hospital); Numerator (30 days, non-state hospital)/Denominator (non state hospital), Numerator (7 days, all hospital)/Denominator (all hospital), Numerator (30 days, all hospital)/Denominator (all hospital)

Benchmark: HEDIS and all BHOS

Consumer Perception of Services

Population: Medicaid adults and older adults responding to the MHSIP Consumer Survey

Source: MHSIP Consumer Survey

Measures (6): Percent of persons surveyed agreeing with each of the five domain scores measuring consumer perceptions of access, quality/appropriateness, outcome, participation, and general satisfaction. An additional performance measure reflects the percentage of adults surveyed who reported seeing a doctor or nurse face-to-face other than in the emergency room.

The MHSIP Consumer Survey Measures consumers' Perceptions with these Items:

Access

1. The location of services was convenient.
2. Staff were willing to see me as often as I felt it was necessary.
3. Staff returned my calls within 24 hours.
4. Services were available at times that were good for me.

Quality/Appropriateness

1. Staff believed I could grow, change and recover.
2. I felt free to complain.
3. Staff told me what side effects to watch for.
4. Staff respected my wishes about who is and is not to be given information about my treatment.
5. Staff were sensitive to my cultural/ethnic background.
6. Staff helped me obtain the information I needed so I could take charge of managing my illness.

Participation in Service/Treatment Planning

1. I, not staff, decided my treatment goals.
2. I felt comfortable asking questions about my treatment and medication.

Outcome (Positive Change)

1. I am dealing more effectively with my daily problems.
2. I am better able to control my life.
3. I am better able to deal with crisis.
4. I am getting along better with my family.
5. I do better in social situations.
6. I do better in school and/or work.
7. My symptoms are not bothering me as much.

General Satisfaction

1. I liked the services that I received here.
2. If I had other choices, I would still get services from this agency.
3. I would recommend this agency to a friend or family member.

Numerator: The total number of respondents agreeing with the items (scale score less than 2.5)

Denominator: Total number of respondents with scores in each of the five domains

Consumers Linked to Primary Care

Population: Medicaid Adult and Older Adult clients

Source: MHSIP Consumer Survey

The MHSIP Consumer Survey Measures consumers' Perceptions with this Item:

Consumers Linked to Physical Health

In the last year, other than going to a hospital emergency room, did you see a doctor or nurse for a health check-up, physical exam, or because you were sick?

Measure: The proportion of persons completing the MHSIP Consumer Survey who report seeing a doctor or nurse (face-to-face), other than in an emergency room, in the last year.

Numerator: Number of persons surveyed who report seeing a doctor or nurse (face-to-face), other than in an emergency room, in the last year.

Denominator: Number of respondents to the questions.

Documentation Worksheet

BHO Name:	Access Behavioral Care
On-Site Visit Date:	December 10, 2008
Reviewer:	Terry Wilkens and Patience Hoag

Data Integration and Control Element	*Met*	*Not Met*	*N/A*	Comments
Accuracy of data transfers to assigned performance measure data repository.				
◆ The Department and the BHO accurately and completely process transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	☒	☐	☐	
◆ Samples of data from the repository are complete and accurate.	☒	☐	☐	
Accuracy of file consolidations, extracts, and derivations.				
◆ The Department and the BHO's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	☒	☐	☐	
◆ Actual results of file consolidations or extracts are consistent with results expected from documented algorithms or specifications.	☒	☐	☐	
◆ Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	☒	☐	☐	
◆ Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	N/A	Comments
If the Department and the BHO use a performance measure data repository, the structure and format facilitate any required programming necessary to calculate and report required performance measures.				
◆ The repository's design, program flow charts, and source codes enable analyses and reports.	☒	☐	☐	
◆ Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	
Assurance of effective management of report production and reporting software.				
◆ Documentation governing the production process, including Department and BHO production activity logs and staff review of report runs, is adequate.	☒	☐	☐	
◆ Prescribed data cutoff dates are followed.	☒	☐	☐	
◆ The Department and the BHO retain copies of files or databases used for performance measure reporting in the event that results need to be reproduced.	☒	☐	☐	
◆ The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	☒	☐	☐	
◆ The Department and the BHO's processes and documentation comply with standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Reviewer Worksheets

BHO Name:	Access Behavioral Care
On-Site Visit Date:	December 10, 2008
Reviewer:	Terry Wilkens and Patience Hoag

Denominator Elements for Access Behavioral Care				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
◆ For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.
◆ Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.
◆ The Department and the BHO have correctly calculated member months and years, if applicable to the performance measure.	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.

Denominator Elements for Access Behavioral Care				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
◆ The Department and the BHO have properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.
◆ Parameters required by the specifications of each performance measure are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.
◆ Exclusion criteria included in the performance measure specifications have been followed.	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.
◆ Systems or methods used by the Department and the BHO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	Population estimates were not necessary for reporting current performance measures.

Numerator Elements for Access Behavioral Care				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
◆ The Department and the BHO have used appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.
◆ Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.
◆ The Department and the BHO have avoided or eliminated all duplication of counted members or numerator events.	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.
◆ Any nonstandard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program.	☐	☐	☒	The BHO did not use or report nonstandard codes for the current performance measures.
◆ Parameters required by the specifications of the performance measure are adhered to (e.g., the measured event occurred during the time period specified or defined in the performance measure).	☒	☐	☐	The BHO adhered to the common understanding of the specification language within the scope document. HSAG recommends that the BHO work with the Department to further clarify verbiage in the specifications/ scope and related documents.

Encounter Data

Penetration Rates

The penetration rate is a calculation of the percentage of consumers served by the respective BHO out of all Medicaid-eligible individuals within the BHO service area.

Table D-1—Penetration Rate by HEDIS Age Group: FY 2008–2009 *for* ABC

	Enrollment	Members Served	Rate
Children 12 years of age and younger as of June 30, 2008	35,580	2,092	5.9%
Adolescents between 13 and 17 years of age as of June 30, 2008	7,400	1,337	18.1%
Adults between 18 and 64 years of age as of June 30, 2008	21,997	5,058	23.0%
Adults 65 years of age or older as of June 30, 2008	7,240	653	9.0%
Overall	72,218	9,140	12.7%

Table D-2—Penetration Rate by Service Category: FY 2008–2009 *for* ABC

	Enrollment	Members Served	Rate
Inpatient Care	72,218	802	1.1%
Intensive Outpatient or Partial Hospitalization	72,218	63	0.1%
Ambulatory Care	72,218	8,051	11.1%

Hospital Recidivism

Table D-3—Hospital Recidivism: FY 2008–2009 *for* ABC							
Population	Time Frame	Non-State Hospitals			All Hospitals		
		Denominator (Discharges)	Numerator (Readmissions)	Rate	Denominator (Discharges)	Numerator (Readmissions)	Rate
Child 0–12 Years of Age	7 Days	71	3	4%	129	6	5%
	30 Days	71	9	13%	129	17	13%
	90 Days	71	14	20%	129	31	24%
Adolescent 13–17 Years of Age	7 Days	121	6	5%	184	11	6%
	30 Days	121	19	16%	184	39	21%
	90 Days	121	24	20%	184	50	27%
Adult 18–64 Years of Age	7 Days	358	21	6%	458	32	7%
	30 Days	358	46	13%	458	72	16%
	90 Days	358	78	22%	458	106	23%
Adult 65 Years of Age and Older	7 Days	11	1	9%	13	1	8%
	30 Days	11	1	9%	13	1	8%
	90 Days	11	3	27%	13	3	23%
All Ages	7 Days	561	31	6%	784	50	6%
	30 Days	561	75	13%	784	129	16%
	90 Days	561	119	21%	784	190	24%

Average Length of Stay

Table D-4—Hospital Average Length of Stay (ALOS): FY 2008–2009 *for* ABC						
Population	Non-State Hospitals			All Hospitals		
	Denominator	Numerator	ALOS	Denominator	Numerator	ALOS
Child 0–12 Years of Age	71	703	9.90	129	1,511	11.71
Adolescent 13–17 Years of Age	121	1,165	9.63	184	2,228	12.11
Adult 18–64 Years of Age	358	2,827	7.90	458	7,144	15.60
Adult 65 Years of Age and Older	11	188	17.09	13	223	17.15
All Ages	561	4,883	8.70	784	11,106	14.17

Emergency Room Utilization

Table D-5—Emergency Room Utilization: FY 2008–2009 *for* ABC			
	Denominator	Numerator	Rate per 1,000 Members
Child 0–12 Years of Age	35,580	88	2.47
Adolescent 13–17 Years of Age	7,400	121	16.35
Adult 18–64 Years of Age	21,997	602	27.37
Adult 65 Years of Age and Older	7,240	9	1.24
All Ages	72,217	820	11.35

Inpatient Utilization

Table D-6—Inpatient Utilization: FY 2008–2009 *for* ABC						
Population	Non-State Hospitals			All Hospitals		
	Denominator	Numerator	Rate per 1,000 Members	Denominator	Numerator	Rate per 1,000 Members
Child 0–12 Years of Age	35,580	71	2.00	35,580	129	3.63
Adolescent 13–17 Years of Age	7,400	121	16.35	7,400	184	24.86
Adult 18–64 Years of Age	21,997	358	16.27	21,997	458	20.82
Adult 65 Years of Age and Older	7,240	11	1.52	7,240	13	1.80
All Ages	72,217	561	7.77	72,217	784	10.86

Follow-Up Postdischarge

Table D-7—Follow-Up Postdischarge: FY 2008–2009 *for* ABC			
	Denominator (Discharges)	Numerator (Seen Within Date Criteria)	Follow-Up Rate
7–Day (Non-State Hospital)	561	173	30.84%
30–Day (Non-State Hospital)	561	407	72.55%
7–Day (All Hospitals)	784	247	31.51%
30–Day (All Hospitals)	784	573	73.09%

Mental Health Statistics Improvement Program (MHSIP)

Domain Scores

Based on MHSIP survey data, the scores reflect the percentage of agreement by adults surveyed in each of five domains. The surveys were sent to consumers receiving services between July 1, 2006, and June 30, 2007. MHSIP survey responses were collected using a five-point Likert scale, with 1 equal to strong agreement, and 5 equal to strong disagreement. For the purposes of this report, only agreement results are displayed. Agreement is defined as a mean that is less than 2.5 on a scale of 1 to 5. Disagreement is defined as a mean that is greater than 2.5.

Table D-8 displays the domain name, corresponding definition, and percentage of adults surveyed who agreed with the indicated domain definition.

Table D-8—MHSIP Domain Definitions and Scores: FY 2008–2009
***for* ABC**

Domain	MHSIP Items in Each Domain	Percentage of Adults Who Agreed
Consumer Perception of Access	The location of the services was convenient. Staff was willing to see me as often as I felt it was necessary. Staff returned my calls within 24 hours. Services were available at times that were good for me.	76.6%
Consumer Perception of Quality/Appropriateness	Staff here believes I can grow, change, and recover. I felt free to complain. Staff told me what side effects to watch for. Staff respected my wishes about who is and is not to be given information about my treatment. Staff was sensitive to my cultural/ethnic background. Staff helped me obtain information so that I could take charge of managing my illness.	74.0%
Consumer Perception of Outcome	I deal more effectively with daily problems. I am better able to control my life. I am better able to deal with crises. I am getting along better with my family. I do better in social situations. I do better in school/work. My symptoms are not bothering me as much.	62.2%
Consumer Perception of Satisfaction	I liked the services I received here. If I had other choices, I would still get services from this agency. I would recommend this agency to a friend or family member.	76.3%
Consumer Perception of Participation	I felt comfortable asking questions about my treatment and medication. I, not staff, decided my treatment goals.	70.1%

Doctor Contacts Outside of the Emergency Room

Using MHSIP survey data, this performance measure reflects the percentage of adults surveyed who reported seeing a doctor or nurse face to face other than in the emergency room (ER).

Table D-9—Doctor Contacts Outside of the Emergency Room: FY 2008–2009 *for* ABC

Doctor Visit Outside of ER	No Doctor Visit Outside of ER	Do Not Remember	Percentage With Doctor Visit Outside of ER	Total
64	18	4	74.4%	86