Colorado Medicaid
Community Mental Health Services Program

FY 2012-2013 Validation of Performance Measures

for

Access Behavioral Care

April 2013

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

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Validation Overview

The Colorado State Medicaid agency, the Department of Health Care Policy and 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 the measurement period of July 1, 2011, through June 30, 2012 (fiscal year [FY] 2011–2012). The BHOs provide mental health services to Medicaid-eligible recipients.

The Department identified the 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 and enrollment/eligibility data. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation for Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September, 2012 (CMS Performance Measure Validation Protocol). 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**) appears in Table 1.

Table 1—Access Behavioral Care Information

BHO Name:	Access Behavioral Care
BHO Location:	10065 E. Harvard Ave., Suite 600, Denver, CO 80231
BHO Contact:	Robert W. Bremer, MA, PhD, Executive Director, Access Behavioral Care
Contact Telephone Number:	720.744.5240
Contact E-Mail Address:	Robert.bremer@coaccess.com
Site Visit Date:	January 18, 2013

Performance Measures for Validation

HSAG validated a set of performance measure indicators that were selected by the Department. These measures represented HEDIS®-like measures and measures developed by the Department. The performance measures were calculated on an annual basis. Table 2 lists the performance measure indicators that were validated and who calculated the performance indicator. The indicators in Table 2 are numbered as they appear in the scope document.

Table 2—List of Performance Measure Indicators for Access Behavioral Care

	Indicator	Calculated by:
1	Hospital Recidivism	BHO
8–11	Overall Penetration Rates	Department
8–11	Penetration Rates by Service Category	Department
8–11	Penetration Rates by Age Category	Department
8–11	Penetration Rates by Medicaid Eligibility Category	Department
13	Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)	BHO
14	Percent of Members with SMI with a Focal Point of Behavioral Health Care	BHO
15	Improving Physical Healthcare Access	Department
16	Inpatient Utilization	BHO
17	Hospital Average Length of Stay	BHO
18	Emergency Department Utilization	BHO

® HEDIS refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

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 first used for performance measure validation purposes in FY 2007–2008. The Department and BHOs worked on additional improvements of these measures and the specification document in the Department's Behavioral Health Quality Improvement Committee meeting, and a revised specification document was used for FY 2011–2012 performance measure reporting purposes. 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 responded to 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.

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
David Mabb, MS, CHCA *Director, Audits* *Lead Auditor*	Auditing expertise, performance measure knowledge, source code review management, statistics, analysis, and source code programming knowledge.
Judy Yip, Ph.D. *Secondary Auditor*	Auditor in training.
Tammy GianFrancisco *Project Leader*	Health plan and physician organization communications, project coordination, HEDIS and P4P knowledge, scheduling, organization, tracking, and administrative support.

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 2011–2012* 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 an 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-on-site visit activities.

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

Table 4—List of Access Behavioral Care Participants	
Name	**Title**
Robert Bremer	Executive Director
Suzanne Kinney	Behavioral Health Quality Program Manager
Ann Brunker	Senior Business Analyst
Greg Jensen	Director, Decision Support, Colorado Access
Chris Pieron	Director, IT, Colorado Access
Mary Fischer	Senior Manager, Claims/Appeals, Colorado Access
John Kiekhaefer	Operations Manager
Julie McNamara	Director, System Performance, Colorado Access
Julie Salazar	Senior Decision Support Analyst, Colorado Access
Carrie Bandell	Director, Quality Management, Colorado Access
List of Department Observers	
Name	**Title**
Jerry Ware	Quality and Compliance Specialist
List of Department Measures/Survey Calculation Staff	
Name	**Title**
Sarah Campbell	Statistical Analyst
Michael Sajovetz	Statistical Analyst
Taylor Larsen	Statistical Analyst
James Bloom	Statistical Analyst

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 acted on the recommendations made by HSAG during the previous year's audit. **ABC** indicated that it is ready for the ICD-10 conversion which will become effective July 2013. **ABC**'s performance measure reporting and process flow document is very detailed and is a valuable resource. The **ABC** performance measure team has retained its core team members for the past several years, adding to the reliability of processes in place.

Areas for Improvement

ABC should continue to work with the Department and other BHOs to address and resolve issues identified in the scope document, such as clarifying the type of mental health practitioners required and required diagnoses for select measures.

ABC should implement a rate validation process to ensure accurate rates. This process should include checking the source data using various data sorts to ensure that proper date ranges and codes are used, as well as ensuring all data for the review period have been included.

It was identified during the site visit that one individual was responsible for the performance measure rate calculation process. **ABC** should implement a process to have other staff serve as backup should the primary person be unavailable to perform his or her duties.

As **ABC** begins the transition to a new transactional system, the process should be thoroughly documented, including any issues encountered along the way and how those issues were resolved.

Eligibility Data System Findings

HSAG found no issues with the processing of eligibility files from the State. Files were loaded into **ABC**'s eligibility transactional system (PowerSTEPP) after being downloaded daily from the State's portal. Enrollment files were reviewed, and errors were worked prior to disseminating to the mental health center and providers. **ABC** did not experience any data delays from the State portal during the past year.

Claims/Encounter Data System Findings

HSAG identified no issues with the processing of claims and encounter data. **ABC** demonstrated evidence of a good working relationship with, and appropriate oversight of, its claims processing vendor, DST. Based on contract, DST internally audited 2 percent of manually adjudicated claims and auto-adjudicated claims daily and sent results to **ABC** daily. Summaries of findings were sent monthly and quarterly. **ABC** performed two types of audits on DST. First, a 7-percent sample of the audits performed by DST was reviewed to ensure the quality of the internal audit conducted by DST. Second, internal auditors at Colorado Access audited 3 to 5 percent of claims processed daily.

Actions Taken as a Result of the Previous Year's Recommendations

During the previous year's audit, HSAG recommended that **ABC** continue to collaborate with the Department and other BHOs regarding the scope document, addressing the challenges with continuous enrollment and proper numbering of the indicators. Through a review of the scope document, it was evident that this had occurred.

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

Report (R)	Measure was compliant with Department specifications.
Not Reported (NR)	This designation is assigned to measures for which: (1) the BHO rate was materially biased or (2) the BHO was not required to report.
No Benefit (NB)	Measure was not reported because the BHO did not offer the benefit required by the measure.

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 compliant. Consequently, it is possible that an error for a single audit element may result in a designation of NR because the impact of the error biased the reported performance measure by more than five 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 R.

Table 6 through Table 16 below display the review findings and key recommendations for **ABC** for each validated performance measure. For more detailed information, please see Appendix D.

Table 6—Key Review Findings for Access Behavioral Care Performance Indicator 1: Hospital Recidivism
Findings
ABC calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no issues. **ABC** documented the process of validating data entry. HSAG performed primary source verification for this measure on-site and identified no discrepancies.
Key Recommendations
◆ **ABC** should continue to closely monitor the data used to calculate this measure to determine the reasonableness of the data.

Table 7—Key Review Findings for Access Behavioral Care Performance Indicators 8–11: Overall Penetration Rates
Findings
The Department calculated penetration rates based on encounter data received quarterly from **ABC**. The encounter data used to calculate these rates were submitted in a flat file format. HSAG auditors conducted interviews with key staff members from the Department and **ABC** and determined that the processes used to collect data from claims and encounters met standards. Both prior to the site visit and while on-site with **ABC**, HSAG reviewed the programming code and the member month figures used by the Department to calculate penetration rates; and no issues or concerns were identified. HSAG noted that specific types of mental health practitioners were not specified in the scope document for Intensive Outpatient and Partial Hospitalization and Outpatient and ED services. This issue was communicated to the Department as a potential recommendation.
Key Recommendations
◆ **ABC** should continue to inspect for accuracy and completeness the encounter data received from the community mental health centers (CMHCs) and providers. ◆ The Department should provide clarifications on what provider type(s) should be considered as a mental health practitioner in the scope document for this measure.

Table 8—Key Review Findings for Access Behavioral Care Performance Indicators 8–11: Penetration Rates by Service Category
Findings
The Department calculated penetration rates based on encounter data received quarterly from **ABC**. The encounter data used to calculate these rates were submitted in a flat file format. HSAG auditors conducted interviews with key staff members from the Department and **ABC**, and determined that the processes used to collect data from claims and encounters met standards. Both prior to the site visit and while on-site with **ABC**, HSAG reviewed the programming code and the member month figures used by the Department to calculate penetration rates; and no issues or concerns were identified. HSAG noted that specific types of mental health practitioners were not specified in the scope document for Intensive Outpatient and Partial Hospitalization and Outpatient and ED services. This issue was communicated to the Department as a potential recommendation.
Key Recommendations
◆ **ABC** should continue to inspect for accuracy and completeness the encounter data received from the CMHCs and providers. ◆ The Department should provide clarifications on what provider type(s) should be considered as a mental health practitioner in the scope document for this measure.

Table 9—Key Review Findings for Access Behavioral Care Performance Indicators 8–11: Penetration Rates by Age Category
Findings
The Department calculated penetration rates based on encounter data received quarterly from **ABC**. The encounter data used to calculate these rates were submitted in a flat file format. HSAG auditors conducted interviews with key staff members from the Department and **ABC**, and determined that the processes used to collect data from claims and encounters met standards. Both prior to the site visit and while on-site with **ABC**, HSAG reviewed the programming code and the member month figures used by the Department to calculate penetration rates; and no issues or concerns were identified. HSAG noted that specific types of mental health practitioners were not specified in the scope document for Intensive Outpatient and Partial Hospitalization and Outpatient and ED services. This issue was communicated to the Department as a potential recommendation.
Key Recommendations
◆ **ABC** should continue to inspect for accuracy and completeness the encounter data received from the CMHCs and providers. ◆ The Department should provide clarifications on what provider type(s) should be considered as a mental health practitioner in the scope document for this measure.

Table 10—Key Review Findings for Access Behavioral Care Performance Indicators 8–11: Penetration Rates by Medicaid Eligibility Category
Findings
The Department calculated penetration rates based on encounter data received quarterly from **ABC**. The encounter data used to calculate these rates were submitted in a flat file format. HSAG auditors conducted interviews with key staff members from the Department and **ABC**, and determined that the processes used to collect data from claims and encounters met standards. Both prior to the site visit and while on-site with **ABC**, HSAG reviewed the programming code and the member month figures used by the Department to calculate penetration rates; and no issues or concerns were identified. HSAG noted that specific types of mental health practitioners were not specified in the scope document for Intensive Outpatient and Partial Hospitalization and Outpatient and ED services. This issue was communicated to the Department as a potential recommendation.
Key Recommendations
◆ **ABC** should continue to inspect for accuracy and completeness the encounter data received from the CMHCs and providers. ◆ The Department should provide clarifications on what provider type(s) should be considered as a mental health practitioner in the scope document for this measure.

Table 11—Key Review Findings for Access Behavioral Care Performance Indicator 13: Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)
Findings
ABC calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no issues. HSAG found that certain diagnoses not included in the covered diagnoses were listed as qualifying diagnoses for this measure in the scope document. Since claims submitted with these diagnoses were not paid by **ABC**, to avoid confusion when developing the programming codes, these non-covered diagnosis codes should be removed from the measure. While reviewing the programming code, HSAG found that **ABC** did not include the non-covered diagnoses listed for this measure in its source code. **ABC** was able to accurately identify the number of members who received at least one service during the measurement period based on paid claims in the BHO transaction system, and the number of consumers with at least one discharge from a hospital episode for treatment of a covered mental health disorder, also based on paid claims in the BHO transaction system. **ABC** documented the process of validating data entry. HSAG performed primary source verification for this measure on-site and identified no discrepancies. During the on-site visit, HSAG identified that **ABC** may not be identifying the follow-up visits based on the specific types of mental health practitioners according to the HEDIS specifications. However, since the scope document does not provide specific guidelines, this issue was communicated to the Department as a potential recommendation. To ensure that claims/encounters associated with the non-covered diagnoses would not significantly impact the rate, HSAG requested a frequency distribution of claims/encounters with diagnosis code "299" from **ABC**.
Key Recommendations
◆ **ABC** should continue to closely monitor the data used to calculate this measure to determine the reasonableness of the data. ◆ The Department should remove the non-covered diagnoses listed on the measure pages within the scope document. ◆ The Department should provide clarifications on what provider type(s) should be considered as a mental health practitioner in the scope document for this measure.

Table 12—Key Review Findings for Access Behavioral Care Performance Indicator 14: Percent of Members with SMI with a Focal Point of Behavioral Health Care
Findings
ABC calculated this rate. HSAG reviewed the programming code used for calculation of this rate and found that **ABC** included only the first three of the eight available diagnosis fields from its transaction system when identifying the denominator. Additional frequency distributions for the other five diagnosis fields was requested and reviewed. Since it is highly unlikely that members in the denominator were identified only from these five fields, the omission is not likely to have a significant impact on the rate. No re-run of the data was requested by HSAG. HSAG did not identify any other issues. **ABC** was able to accurately identify the numerator for this measure based on claims in the BHO transaction system. **ABC** documented the process of validating data entry. HSAG performed primary source verification for this measure on-site and identified no discrepancies.
Key Recommendations
◆ **ABC** should update its source code to include all eight available diagnosis fields for this measure. ◆ **ABC** should continue to closely monitor the data used to calculate this measure to determine the reasonableness of the data.

Table 13—Key Review Findings for Access Behavioral Care Performance Indicator 15: Improving Physical Healthcare Access
Findings
The Department calculated this rate. HSAG reviewed the programming code used for calculation of this rate and revealed no issues of concern. The data used to calculate the **ABC** rate for this measure were based on claims/encounters submitted annually by Denver Health for rate setting purposes. Prior to the site visit, HSAG reviewed the programming code used by the Department to calculate this measure for **ABC**; and no issues or concerns were identified. HSAG auditors conducted interviews with key staff members from the Department and **ABC** and determined that the processes used to collect data from claims and encounters met standards. HSAG reviewed the rate and found that it was slightly lower than the rates for other BHOs. The Department also indicated that for the measurement year, all BHOs had experienced a decline in their rates. In discussing with the Department, HSAG found that this could be related to the claims/encounter submission cycle by Denver Health and other physical managed care organizations. The Department indicated that it will be implementing a process in spring 2013 to allow Denver Health to submit its claims/encounters into Medicaid Management Information Systems just like the other BHOs. HSAG performed primary source verification for this measure on-site and identified no discrepancies.
Key Recommendations
◆ **ABC** should continue to inspect for accuracy and completeness the encounter data received from the CMHCs and providers to ensure data used for the denominator are complete. ◆ The Department should monitor any significant changes in claims/encounter volume when Denver Health begins to submit its data to the MMIS starting in spring 2013. The Department should continue to receive the annual submission from Denver Health and use the data to verify Denver Health's weekly submission.

Table 14—Key Review Findings for Access Behavioral Care Performance Indicator 16: Inpatient Utilization
Findings
ABC calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no issues. **ABC** was able to determine 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 who were seen on an outpatient basis as a follow-up within the time frames of 7 days and 30 days. **ABC** was able to accurately identify those members who met the criteria to be included in both the numerator and denominator for both Non-state Hospitals and All Hospitals categories. HSAG performed primary source verification for this measure on-site and identified no discrepancies.
Key Recommendations
◆ **ABC** should continue to closely monitor the data used to calculate this measure to determine the reasonableness of the data.

Table 15—Key Review Findings for Access Behavioral Care Performance Indicator 17: Hospital Average Length of Stay
Findings
ABC calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no issues. **ABC** was able to determine the average length of stay in a hospital for BHO members accurately by identifying the number of members discharged from a hospital episode and the total days for all hospital episodes resulting in a discharge. **ABC** validated data entry prior to submitting rates to the State. HSAG performed primary source verification for this measure on-site and identified no discrepancies.
Key Recommendations
◆ **ABC** should continue to closely monitor the data used to calculate this measure to determine the reasonableness of the data.

Table 16—Key Review Findings for Access Behavioral Care Performance Indicator 18: Emergency Department Utilization
Findings
ABC calculated this rate. HSAG reviewed the programming code used for calculation and identified no issues. **ABC** documented the process of validating data entry. HSAG performed primary source verification on-site and did not have any concerns with **ABC**'s calculation of this measure.
Key Recommendations
◆ **ABC** should continue to closely monitor the data used to calculate this measure to determine the reasonableness of the data.

Table 17 lists the validation result for each validated performance measure indicator for **ABC**.

Table 17—Summary of Results		
Performance Indicator		**Validation Result**
1	Hospital Recidivism	**Report**
8–11	Overall Penetration Rates	**Report**
8–11	Penetration Rates by Service Category	**Report**
8–11	Penetration Rates by Age Category	**Report**
8–11	Penetration Rates by Medicaid Eligibility Category	**Report**
13	Follow-up After Hospitalization for Mental Illness (7- and 30-day follow-up)	**Report**
14	Percent of Members with SMI with a Focal Point of Behavioral Health Care	**Report**
15	Improving Physical Healthcare Access	**Report**
16	Inpatient Utilization	**Report**
17	Hospital Average Length of Stay	**Report**
18	Emergency Department Utilization	**Report**

Indicators

- Hospital Recidivism (Indicator 1)
- Overall Penetration Rates* (Indicators 8–11)
- Penetration Rates by Service Category* (Indicators 8–11)
- Penetration Rates by Age Category* (Indicators 8–11)
- Penetration Rates by Medicaid Eligibility Category* (Indicators 8–11)
- Follow-Up After Hospitalization for Mental Illness: 7- and 30-day follow-up (Indicator 13)
- Percent of Members with SMI with a Focal Point of Behavioral Health Care (Indicator 14)
- Improving Physical Healthcare Access* (Indicator 15)
- Inpatient Utilization (Indicator 16)
- Hospital Average Length of Stay (Indicator 17)
- Emergency Department Utilization (Indicator 18)

*Calculated by the Department

The Department collaborated with the BHOs to create a scope document that serves as the specifications for the performance measures being validated. The following pages were taken from the *FY 2012 BHO-HCPF Annual Performance Measures Scope Document, Version 5, Created: January 13, 2011, Last Updated: August 9, 2012.* Please note that the complete scope document is not listed in this appendix. The Table of Contents, Introduction, and Definitions pages and corresponding page numbers have been modified for use in this report; however, the verbiage for the measures validated under the scope of the review is reproduced in its entirety.

FY 2012

BHO-HCPF Annual Performance Measures Scope Document

Version 5
Created: January 13, 2011
Last updated: August 9, 2012

Table of Contents

(Listed According to BHO Contract)

Introduction

This document includes the details for calculations of the BHO-HCPF Annual Performance Measures for the five Colorado Behavioral Health Organizations (BHOs). Some of these measures are calculated by HCPF using eligibility data and encounter data submitted by the BHOs, other measures are calculated by the BHOs. With the exception of Penetration Rates, all measures are calculated using paid claims/encounters data. Penetration Rates are calculated using paid and denied claims/encounters data.

Performance Measures Indexed by Agency Responsible for Calculation

Calculated by the BHO:

Calculated by HCPF:

Update process:

1. Moved Indicator 15, “Improving physical healthcare access” from Calculated by BHO to Calculated by HCPF.
2. Indicator 13: Added specific diagnoses codes to be included. Age category in Table 10 changed.
3. Indicator 14: Defined SMI, better described Numerator and Denominator. Changed POS codes in Table 11.
4. Indicator 15: Clarified that the denominator will be the numerator from the Service Category Penetration Rates measures excluding ED services.

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.

Covered Mental Health Disorder: The BHO Colorado Medicaid Community Mental Health Services Program contract specifies that certain mental health diagnoses are covered. These specific diagnoses can be found below or in the BHO Medicaid BHO contract Exhibit D. Only those services that cover mental health, with the exception of services related to Assessment, Prevention, and Crisis procedure coding as a diagnosis may have yet to be ascribed, will be included in the calculations of performance measures; however, penetration rates will be calculated using both paid and denied claims/encounters, regardless of the mental health diagnoses.

- **295.00-298.99**
- **300.00-301.99**
- **307.00-309.99**
- **311.00-314.99**

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 and penetration rates. For inpatient hospitalization, age category determination will be based upon the client's age on the date of discharge. For penetration rates, age category determination will be based upon the age of the client on the last day of the fiscal year.

24 Hour Treatment Facility – A residential facility that has 24-hr professional staffing and a program of treatment services and 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. Adult members on the list of discharges from the State hospital who are not eligible at the time of hospital admission should be dropped from the hospital discharge list. Adult members who lose eligibility during the hospital stay may remain on the hospital discharge list.

Hospital Admit – An admission 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 admission must result in a paid claim for the hospital episode, except where the admission is from a State Hospital for ages 21-64.

HCPF—The Department of Health Care Policy and Financing for the State of Colorado.

HEDIS—Healthcare Effectiveness Data and Information Set

Indicator 1: Hospital readmissions within 7, 30, 90 days post-discharge

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 mental health 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 through June 30. Age for this indicator is determined at first hospital discharge.

Denominator: Total number of BHO member discharges during the reporting period. The 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 HCPF. 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.

Indicators 8-11: Penetration rates (including breakouts by HEDIS age groups, Medicaid eligibility category, race, and service category)

Description: Percent BHO Members with one contact (paid or denied) in a specified fiscal year (12-month period) by HEDIS age group, Medicaid eligibility category **(refer to Table 7 for eligibility categories)**, race **(refer to Table 7 for race/ethnicity categories)**, and service category **(refer to Table 8 for HEDIS specs and additional place of service (POS) and service codes.)**

- HEDIS age group 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.
- Race/ethnic group is the race category on the member's most recent Medicaid eligibility span during the fiscal year.
- Service category is defined any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. POS category 53 will be excluded for the intensive outpatient and partial hospitalization service category.
- Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are analyzed.
- All enrollment spans identified as: enrollment begin date <= the last date of the fiscal year (6/30) AND enrollment end date >= the first date of the fiscal year (7/1).
- Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.
- BHO - Behavioral Health Organization
- FY - fiscal year
- FTE - full time equivalent
- MM - member months
- NOTE: The Data Analysis Section tailors data to specific internal and external customer needs that are not met through existing reporting. Thus, calculations may differ from existing published figures due to several factors that may include, but are not limited to: the specificity of the request, retroactivity in eligibility determination, claims processing and dollar allocation differences between MMIS and COFRS.

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

Numerator: Members with any MH service in the specified fiscal year (12-month period) in each age group, Medicaid eligibility category, race/ethnic group, and by service category grouped as inpatient, intensive outpatient/partial hospitalization, and ambulatory care.

Data Source(s): BHO claims/encounter file (both paid and denied claims/encounters will be used).

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

Benchmark: Overall BHO

TABLE 7

Medicaid Eligibility and Race/Ethnicity Categories

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
020	BCCP-WOMEN BREAST&CERVICAL CAN

Medicaid Race Categories:

Race Code	Description
1	SPANISH AMERICAN
2	OTHER – WHITE
3	BLACK
4	AMERICAN INDIAN
5	ORIENTAL
6	OTHER
7	UNKNOWN

TABLE 8

Penetration Rates by Service Category

For calculating the penetration rates by service category performance measure

Description

The number and percentage of members receiving the following mental health services during July 1 and June 30 of the fiscal year.

- Any services
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Calculations

Count members who received inpatient, intensive outpatient, partial hospitalization, and outpatient and ED mental health services in each column. Count members only once in each column, regardless of number of visits. Count members in the *Any Services* column for any service during the measurement year.

For members who have had more than one encounter, count in each column only once and report the member in the respective age category as of the last date of the fiscal year (6/30).

Member months Report all member months during the measurement year for members with the benefit. Refer to *Specific Instructions for Use of Services Tables*. Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. The denominator in the *Any* column should include all members with any mental health benefit.

Inpatient Include inpatient care at either a hospital or treatment facility with a covered mental health disorder as the principal diagnosis: 290.xx, 293-302.xx, 306-316.xx.

Use one of the following criteria to identify inpatient services.

An Inpatient Facility code in conjunction with a covered mental health diagnosis. Include discharges associated with residential care and rehabilitation.

Codes to Identify Inpatient Service

Inpatient Facility codes : 100, 101, 110, 114, 124, 134, 144, 154, 204
Sub-acute codes : 0919
ATU codes : 190, H2013, H0018AT
RTC codes : H2013, 0191, 0192, 0193, H0018, H0019, S5135

MS—DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Codes to Identify Intensive Outpatient and Partial Hospitalization Services:

HCPCS	UB Revenue		
Visits identified by the following HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).			
G0410, G0411, H0035, H2001, H2012, S0201, S9480	0905, 0907, 0912, 0913,		
CPT			**POS**
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876		*WITH*	52
Visits identified by the following CPT/POS codes must be with a mental health practitioner.			
99221-99223, 99231-99233, 99238, 99239, 99251-99255,		*WITH*	52

Codes to Identify Outpatient and ED Services: Additional BHO codes & POS

CPT	HCPCS	UB Revenue	
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).			
90804-90815, 96101-3, 96105, 96110, 96111, 96116, 96118-20, 96125	G0155, G0176, G0177, G0409, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485, T1005, T1016, T1017, H0033, H0038, H0043, H0046, H2012, H2021, H2022, H2023, H2024, H2025, H2026, H2030, H2031, H2032, S0220, S0221, S9449, S9451, S9452, S9453, S9454, S9470	0513, 0900-0904, 0911, 0914-0919, 0762, 0769, 045x	
CPT			**POS**
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876		*WITH*	05, 07, 11, 12, 15, 20, 22, 23, 49, 50, 53*, 71, 72, 19, 26, 32, 34, 41, 99
CPT		**UB Revenue**	
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.			
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99510, 90772, 97535, 97537		045x, 0510, 0515-0517, 0519,-0523, 0526-0529, 0762, 0981-0983	

* POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization elects to use POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

- Note: The specifications presented here for the Penetration Rates by Service Category performance indicator are closely based upon HEDIS 2011 specifications.

Indicator 13: Follow-up appointments within seven (7) and thirty (30) days after hospital discharge

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 through June 30. Diagnosis codes to be included are 295-299, 300.3, 300.4, 301, 308, 309, 311-314.

Numerators: Total number of discharges with an outpatient service (**see Table 10)** 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 **Table 10 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 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 followed by admission to any non-acute treatment facility within 30 days of hospital discharge for any mental health disorder. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.
- Refer to HEDIS codes in **Table 10** to identify nonacute care. For residential treatment, compare using residential treatment per diem code. Due to the fact that residential treatment for Foster Care members is paid under fee-for-service, the BHOs cannot easily determine if a Foster Care member was discharged to residential treatment. Therefore, prior to official rate reporting, the HCPF Business Analysis Section will forward each BHO a list of foster care members who were discharged from an inpatient setting to a residential treatment facility, in order to assist the BHOs in removing these members from this measure.

Data Source(s): Denominator: Number of Member discharges, from non-State hospitals, ages 6+, 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: An outpatient visit, intensive outpatient encounter or partial hospitalization 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

TABLE 10

HEDIS Follow-Up After Hospitalization for Mental Illness (FUH)

For calculating Follow-up after hospitalization for mental illness performance measure

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of a covered mental health disorder and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

1. The percentage of members who received follow-up within 30 days of discharge
2. The percentage of members who received follow-up within 7 days of discharge

Eligible Population

Ages	Two age categories are identified, ages 6-20 and 21+.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Event/diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a covered mental health diagnosis during July1 and June 30 of the fiscal year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge during July1 and June 30 of the fiscal year.
Mental health readmission or direct transfer	If the discharge is followed by readmission or direct transfer to an *acute facility* for any covered mental health disorder within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although re-hospitalization might not be for a selected mental health disorder, it is probably for a related condition. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after June 30 of the fiscal year. Exclude discharges followed by readmission or direct transfer to a *nonacute facility* for any covered mental health disorder within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to the following table for codes to identify nonacute care.

Codes to Identify Nonacute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB Revenue or Type of Bill codes for billing (e.g., ICF, SNF)				

Administrative Specification

Denominator	The eligible population.
Numerators	
30-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.
7-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.

Codes to Identify Visits

CPT	HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409, G0410, G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

CPT		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255,	***WITH***	52, 53
UB Revenue		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following Revenue codes must be with a mental health practitioner or in conjunction with any diagnosis code from Table FUH-A.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

- Note: The specification presented here for the Follow up Post Discharge performance indicator are closely based upon HEDIS 2011 specifications.

Indicator 14: Percent of members with SMI with a focal point of behavioral health care

Description: The percent of members with SMI who have a focal point of care identified and established. For the purpose of this indicator, SMI includes the following: Schizophrenia, Schizoaffective, and Bipolar diagnoses. See Table 11.

Denominator: Total number of unduplicated members meeting the following criteria:

- 21 years of age or older on first day of the measurement period (SFY)
- Continuously enrolled 12 out of 12 months in the same BHO during the measurement period (SFY)
- Identifying outpatient service with an SMI diagnosis- at least one paid BHO outpatient service (refer to **Table 11**) in the first 9 months of the measurement period (SFY) for diagnoses in any position (refer to **Table 11 for SMI diagnoses**).

Numerator: Total number of members in the denominator that meet at least one of the following track criteria (using **Table 11**) with the same billing provider during the measurement period (SFY).

- Identifying outpatient service with an SMI diagnosis- at least one paid BHO outpatient service (refer to **Table 11**) in the first 9 months of the measurement period (SFY) for diagnoses in any position (refer to **Table 11 for SMI diagnoses**).
- Treatment/Recovery Track- At least 3 Treatment/Recovery or Case Management or Med Management visits
- Med Management Track- At least 2 Med Management visits

Data Source(s): BHO transaction system.

Calculation of Measure: BHO, Numerator/Denominator

TABLE 11

Codes to Identify BHO Outpatient Services

Service Domain and/or Category	CPT/HCPCS Procedure Code		POS
Assessment	90801-2, H0031		Use POS as indicated in USCS coding manual Page 31. **Exclude POS 21, 51 and 23**
Treatment/Recovery (Psychotherapy, Svc planning, Vocational, Peer support)	90804-19, 90821-9, 90846-7, 90849, 90853, 90857, H0032 H0004, H0036-40, H2014-8, H2023–7, H2030-2	**WITH**	
Case Management	T1016-7		
Med Management	90862, 96372, 99441-3, H0033-4		

Diagnosis Codes

Diagnosis	ICD-9-CM
Schizophrenia	295.10, 295.1, 295.20, 295.2, 295.30, 295.3, 295.60, 295.6, 295.90, 295.9
Schizoaffective disorder	295.70, 295.7
Bipolar disorder	296.0x, 296.40, 296.4, 296.4x, 296.5x, 296.6x, 296.70, 296.7

Indicator 15: Improving physical healthcare access

Description: The total number of Members who received outpatient mental health treatment during the measurement period and also had a qualifying physical healthcare visit during the measurement period

Denominator: Total number of unduplicated members who had at least one BHO outpatient service claim/encounter during the measurement period. Members must be Medicaid eligible and enrolled at least ten months with the same BHO during the 12-month measurement period. (This is the numerator from the Service Category Penetration Rates measures excluding ED services.)

Numerator: Total number of members in the denominator with at least one preventive or ambulatory medical visit as defined using the service codes in **Table 12** during the measurement period, excluding those services provided by rendering provider type codes identified in **Table 12**.

Data Source(s): The encounter/claims files (BHO, MCO, Fee for Service) for the fiscal year, including paid claims, provided by HCPF

Calculation of Measure: HCPF

Benchmark: Overall BHO

TABLE 12

Preventive or Ambulatory Medical Visits Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services (HEDIS 2011)

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344		
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Rendering Provider Type Code Exclusions

Rendering Provider Type Code	Rendering Provider Type Description
06	Podiatrist
11	Case Manager
07	Optometrist
27	Speech Therapist
12	Independent Laboratory

Indicator 16: Inpatient utilization (per 1000 members)

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: 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 hospital

Indicator 17: Hospital length of stay (LOS)

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 through 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 final discharges from a State hospital, 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 hospitals, 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: BHO for all hospital and non-State hospital

Indicator 18: Emergency department utilization (per 1000 members)

Description: Number of BHO Member emergency room visits for a covered mental health disorder 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 45x.

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

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

Benchmark: Overall BHO

Documentation Work Sheet

BHO Name:	Access Behavioral Care
On-Site Visit Date:	January 18, 2013
Reviewer:	David Mabb and Judy Yip

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's 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's and the BHO's processes and documentation comply with standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Appendix C. Denominator and Numerator Validation Findings

for **Access Behavioral Care**

Reviewer Work Sheets

BHO Name:	Access Behavioral Care
On-Site Visit Date:	January 18, 2013
Reviewer:	David Mabb and Judy Yip

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.	☒	☐	☐	For Indicator 13 (follow-up appointments within 7 and 30 days after hospital discharge), while **ABC** did not include the non-covered diagnosis codes in its source code in identifying the denominator, these codes listed should be removed from the scope document to avoid confusion.
◆ Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	☒	☐	☐	For Indicator 14 (percent of members with SMI with a focal point of behavioral health care), **ABC** included only the first three of the eight available diagnosis fields in identifying the denominator. Frequency distributions of records for the other five diagnosis fields were reviewed. No additional re-run of data was requested by HSAG. **ABC** should update the source code for future calculation.
◆ The Department and the BHO have correctly calculated member months and years, if applicable to the performance measure.	☒	☐	☐	
◆ 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.	☒	☐	☐	

Denominator Elements for Access Behavioral Care				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
◆ 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.).	☒	☐	☐	
◆ Exclusion criteria included in the performance measure specifications have been followed.	☒	☐	☐	
◆ 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 applicable to the measures under the scope of the audit.

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.	☒	☐	☐	
◆ Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	☒	☐	☐	
◆ The Department and the BHO have avoided or eliminated all duplication of counted members or numerator events.	☒	☐	☐	
◆ 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.	☐	☐	☒	Nonstandard codes were not used to determine numerators for 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).	☒	☐	☐	For indicators 8–11 (penetration rates) and Indicator 13 (follow-up appointments within 7 and 30 days after hospital discharge), clarifications on which provider types for mental health practitioners should be provided in the scope document.

Encounter Data

The measurement period for these performance measures is July 1, 2011, through June 30, 2012 (fiscal year [FY] 2011–2012).

Hospital Recidivism—Indicator 1

Table D-1—Hospital Recidivism *for* Access Behavioral Care

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	76	3	3.95%	76	3	3.95%
	30 Days	76	5	6.58%	76	5	6.58%
	90 Days	76	11	14.47%	76	11	14.47%
Adolescent 13–17 Years of Age	7 Days	117	2	1.71%	129	2	1.55%
	30 Days	117	6	5.13%	129	6	4.65%
	90 Days	117	12	10.26%	129	13	10.08%
Adult 18–64 Years of Age	7 Days	310	17	5.48%	373	20	5.36%
	30 Days	310	48	15.48%	373	56	15.01%
	90 Days	310	71	22.90%	373	87	23.32%
Adult 65 Years of Age and Older	7 Days	9	0	0.00%	9	0	0.00%
	30 Days	9	0	0.00%	9	0	0.00%
	90 Days	9	0	0.00%	9	0	0.00%
All Ages	7 Days	512	22	4.30%	587	25	4.26%
	30 Days	512	59	11.52%	587	67	11.41%
	90 Days	512	94	18.36%	587	111	18.91%

Penetration Rates—Indicators 8–11

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-2—Penetration Rates by Age Category *for* Access Behavioral Care

	Enrollment*	Members Served	Rate
Children 12 years of age and younger as of June 30, 2012	50,463	3,104	6.15%
Adolescents between 13 and 17 years of age as of June 30, 2012	11,013	1,632	14.82%
Adults between 18 and 64 years of age as of June 30, 2012	35,800	6,834	19.09%
Adults 65 years of age or older as of June 30, 2012	7,930	532	6.71%
Overall	105,206	12,102	11.50%

* Expressed as full time equivalent (FTE), rounded to the nearest integer.

Table D-3—Penetration Rates by Service Category *for* Access Behavioral Care

	Enrollment*	Members Served	Rate
Inpatient Care	105,206	345	0.33%
Intensive Outpatient or Partial Hospitalization	105,206	48	0.05%
Ambulatory Care (Outpatient/ER)	105,206	10,686	10.16%

* Expressed as full time equivalent (FTE), rounded to the nearest integer.

Table D-4—Penetration Rates by Medicaid Eligibility Category *for* Access Behavioral Care

	Enrollment*	Members Served	Rate
AFDC/CWP Adults	21,662	2,359	10.89%
AFDC/CWP Children	52,692	3,234	6.14%
AND/AB-SSI	10,855	3,661	33.73%
BC Children	7,096	437	6.16%
BC Women	692	93	13.43%**
BCCP-Women Breast & Cervical Cancer	103	17	16.43%**
Foster Care	2,400	1,038	43.24%**
OAP-A	7,853	517	6.58%
OAP-B-SSI	1,853	448	24.18%

* Expressed as full time equivalent (FTE), rounded to the nearest integer.

** Values from the Enrollment and Rate columns are copied directly from the spreadsheets provided by the Department. Since the values in the Enrollment column were rounded to the nearest integer, the percentages listed in the Rate column may not equal actual percentages calculated using the Enrollment and Members Served values.

Follow-up After Hospitalization for Mental Illness—Indicator 13

Table D-5—Follow-up After Hospitalization for Mental Illness *for* Access Behavioral Care							
Population	Time Frame	Non-State Hospitals			All Hospitals		
		Denominator (Discharges)	Numerator (Seen Within Date Criteria)	Rate	Denominator (Discharges)	Numerator (Seen Within Date Criteria)	Rate
6–20 Years of Age	7 Days	174	74	42.53%	184	77	41.85%
	30 Days	174	106	60.92%	184	112	60.87%
21+ Years of Age	7 Days	190	81	42.63%	207	89	43.00%
	30 Days	190	120	63.16%	207	131	63.29%
Combined Ages	7 Days	364	155	42.58%	391	166	42.46%
	30 Days	364	226	62.09%	391	243	62.15%

Percent of Members with SMI with a Focal Point of Behavioral Health Care—Indicator 14

Table D-6—Percent of Members with SMI with a Focal Point of Behavioral Health Care *for* Access Behavioral Care		
Denominator (# SMI Members)	Numerator (# SMI Members with a Focal Point of Care)	% SMI Members with a Focal Point of Care
1,520	1,461	96.12%

Improving Physical Healthcare Access—Indicator 15

Table D-7—Percent of Members with Physical Health Care Visit *for* Access Behavioral Care		
Denominator (# of Members with 1 or More Mental Health OP Visits)	Numerator (# of Members in Denominator with at least 1 or More Physical Health Visits)	% Mental Health Members with Physical Health Visit
7,549	4,459	59.07%

Inpatient Utilization—Indicator 16

Table D-8—Inpatient Utilization *for* Access Behavioral Care						
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	50,463	76	1.51	50,463	76	1.51
Adolescent 13–17 Years of Age	11,013	117	10.62	11,013	129	11.71
Adult 18–64 Years of Age	35,800	310	8.66	35,800	373	10.42
Adult 65 Years of Age and Older	7,930	9	1.13	7,930	9	1.13
All Ages	105,206	512	4.87	105,206	587	5.58

* Expressed as full time equivalent (FTE), rounded to the nearest integer.

Hospital Average Length of Stay—Indicator 17

Table D-9—Hospital Average Length of Stay (ALOS) *for* Access Behavioral Care						
Population	Non-State Hospitals			All Hospitals		
	Denominator	Numerator	ALOS	Denominator	Numerator	ALOS
Child 0–12 Years of Age	76	752	9.89	76	752	9.89
Adolescent 13–17 Years of Age	117	874	7.47	129	966	7.49
Adult 18–64 Years of Age	310	2,857	9.22	373	7,891	21.16
Adult 65 Years of Age and Older	9	308	34.22	9	308	34.22
All Ages	512	4,791	9.36	587	9,917	16.89

Emergency Department Utilization—Indicator 18

Table D-10—Emergency Department Utilization *for* Access Behavioral Care			
	Denominator*	**Numerator**	**Rate per 1,000 Members**
Child 0–12 Years of Age	**50,463**	**141**	**2.79**
Adolescent 13–17 Years of Age	**11,013**	**189**	**17.16**
Adult 18–64 Years of Age	**35,800**	**841**	**23.49**
Adult 65 Years of Age and Older	**7,930**	**11**	**1.39**
All Ages	**105,206**	**1,182**	**11.24**

* Expressed as full time equivalent (FTE), rounded to the nearest integer.