Colorado Medicaid
Community Mental Health Services Program

FY 2013–2014 Validation of Performance Measures

for

Access Behavioral Care

April 2014

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

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 300 ◆ Phoenix, AZ 85016

Phone 602.264.6382 ◆ Fax 602.241.0757

CONTENTS

for **Access Behavioral Care**

ACKNOWLEDGMENTS AND COPYRIGHTS

HSAG HEALTH SERVICES ADVISORY GROUP

Validation of Performance Measures

for **Access Behavioral Care**

Validation Overview

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care organizations (MCOs), measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory external quality review (EQR) activities required by the Balanced Budget Act of 1997 (BBA) described at 42 Code of Federal Regulations (CFR) §438.358(b)(2). The purpose of performance measure validation is to ensure that MCOs have sufficient systems and processes in place to provide accurate and complete information for calculating valid performance measure rates according to the specifications required by the state. The state, its agent that is not an MCO, or an external quality review organization (EQRO), can perform this validation. Health Services Advisory Group, Inc. (HSAG), the EQRO for the Colorado Department of Health Care Policy and Financing (the Department), conducted the validation activities as outlined in CMS' publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012.[1]

For fiscal year (FY) 2013–2014, the Department contracted with five behavioral health organizations (BHOs) to provide mental health services to Medicaid-eligible recipients. The Department identified a set of performance measures reported by the BHOs for validation for the measurement period of July 1, 2012 through June 30, 2013 (FY 2012–2013). 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.

In addition, HSAG reviewed the Colorado Office of Behavioral Health's (OBH's) process for administering and calculating the survey results of the Mental Health Statistics Improvement Program (MHSIP), Youth Services Survey for Families (YSS-F), and Youth Services Survey (YSS) consumer surveys in FY 2013–2014. While the MHSIP survey was designed for patients aged 18 years and older, the YSS-F surveys were geared toward the caregivers of children aged 0 to 14 years, and the YSS survey was aimed at capturing data from patients aged 15 to 17 years. All surveys were conducted between October 25, 2013, and November 15, 2013. Because HSAG did not validate the process by which the survey participants were selected or how the surveys were distributed, the MHSIP, YSS-F, and YSS measures were not included in the performance measure validation set and were not assigned a validation finding; however, audit findings and recommendations for the MHSIP, YSS-F, and YSS surveys are included in this report. The survey results are also presented in Appendix E.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

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 Site Visit Location:	10065 E. Harvard Ave., Suite 600, Denver, CO 80231
BHO Contact:	John Kiekhaefer, MSW, LCSW, Operations Manager, Access Behavioral Care
Contact Telephone Number:	720.744.5627
Contact E-Mail Address:	john.kiekhaefer@coaccess.com
Site Visit Date:	January 17, 2014

Performance Measures for Validation

HSAG validated a set of performance measures that were selected by the Department. These measures represented HEDIS®-like measures and measures developed by the Department and BHOs. The measures were calculated on an annual basis. Tables 2 and 3 list the performance measure indicators that HSAG validated and identifies who was responsible for calculating the rates. The indicators 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

Table 2—List of Performance Measure Indicators for Access Behavioral Care		
	Indicator	**Calculated by:**
17	Hospital Average Length of Stay	BHO
18	Emergency Department Utilization	BHO

Table 3—List of MHSIP, YSS-F, and YSS Survey Domains for Access Behavioral Care		
	Indicator	**Calculated by:**
19	MHSIP: Percentage of Medicaid adults ages 18 years and older surveyed who agreed with the indicated domain definition measuring the following domains: ◆ Consumer Perception of Access ◆ Consumer Perception of Appropriateness/Quality ◆ Consumer Perception of Participation in Service/Treatment Planning ◆ Consumer Perception of Outcomes ◆ Consumer Perception of Satisfaction	Department
19	YSS-F: Percentage of parents/guardians surveyed on behalf of Medicaid children ages 0 to 14 years who agreed with the indicated domain definition measuring the following domains: ◆ Consumer Perception of Access ◆ Consumer Perception of Participation in Service/Treatment Planning ◆ Consumer Perception of Cultural Sensitivity ◆ Consumer Perception of the Appropriateness/Quality of Services ◆ Consumer Perception of Outcomes	Department
19	YSS: Percentage of Medicaid adolescents ages 15 to 17 years surveyed who agreed with the indicated domain definition measuring the following domains: ◆ Consumer Perception of Access ◆ Consumer Perception of Participation in Service/Treatment Planning ◆ Consumer Perception of Cultural Sensitivity ◆ Consumer Perception of the Appropriateness/Quality of Services ◆ Consumer Perception of Outcomes	Department

Description of Validation Activities

Preaudit Strategy

HSAG conducted the validation activities as outlined in the CMS Performance Measure Validation Protocol. The Department provided a list of the indicators selected for validation and the indicator definitions (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 2013–2014 reporting purposes.

HSAG prepared a documentation request, which included the Information Systems Capabilities Assessment Tool (ISCAT), Appendix V of the CMS Performance Measure Validation Protocol. In collaboration with the Department, HSAG customized the ISCAT to collect the necessary data consistent with Colorado's mental health service delivery model. The ISCAT was forwarded to the BHOs with a timetable for completion and instructions for submission. When requested, HSAG fielded ISCAT-related questions directly from the BHOs during the pre-on-site phase.

HSAG prepared an agenda for each BHO, describing all on-site visit activities and indicating the type of staff needed for each session. The agendas were then forwarded to the respective BHOs prior to the on-site visit. When requested, HSAG conducted pre-on-site conference calls with the BHOs to discuss any outstanding ISCAT questions and on-site visit activities.

Validation Team

The HSAG performance measure validation (PMV) team was assembled based on the full complement of skills required for the validation and requirements of the particular BHO. Some team members, including the lead auditor, participated in the on-site meetings; others conducted their work at HSAG offices. Table 4 describes each team member's role and expertise.

Table 4—Validation Team

Name and Role	Skills and Expertise
David Mabb, MS, CHCA *Director, Audits; Lead Auditor*	Certified HEDIS compliance auditor with extensive experience in leading HEDIS audits and PMV activities in multiple states. Additional experience in statistics, data analysis and management, state Medicaid programs, and source code programming knowledge.
Timea Jonas *Audit Specialist; Secondary Auditor*	Auditor-in-training; claims processing and auditing experience, health care fraud analysis experience.
Derrick Mendel, BS, MBA *Audit Specialist; Secondary Auditor*	Auditor-in-training; 10+ years of health care industry experience, expertise in both quality assurance program development and regulatory auditing.
Tammy GianFrancisco *Project Leader*	Project coordination and communication.

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. The list below provides information on how HSAG conducted an analysis of these data:

- *Information Systems Capabilities Assessment Tools (ISCATs)* were requested and received from the BHOs and the Department. Upon receipt by HSAG, the ISCATs underwent a cursory review to ensure each section was complete and all applicable attachments were present. HSAG then thoroughly reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- *Source code (programming language) for performance measures* was requested and was submitted by the Department and the BHOs. HSAG completed line-by-line review of the supplied source code to ensure compliance with the State-defined performance indicator specifications. HSAG identified areas of deviation from the specifications, evaluating the impact to the indicator and assessing the degree of bias (if any).
- *Performance measure reports for FY 2012–2013* were reviewed by the validation team. The team also reviewed previous reports to assess trending patterns and rate reasonability.

- *Supporting documentation* included any documentation that provided additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, with issues or clarifications flagged for follow-up.

On-Site Activities

HSAG conducted on-site visits with the Department and the BHOs. HSAG collected information using several methods 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 as follows.

- **Opening session**—included introductions of the validation team and key BHO and Department staff involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—included a review of the information systems, focusing on the processing of claims, encounter, consumer, and provider data. HSAG performed primary source verification on a random sample of consumers, 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 BHO 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, a review of how all data sources were combined, and how the analytic file used for reporting the performance indicators was generated. HSAG performed primary source verification to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration. This session addressed data control and security procedures as well.
- **Closing conference**—provided a summary of preliminary findings based on the review of the ISCAT and the on-site visit, and reviewed the documentation requirements for any post-on-site visit activities.

HSAG conducted several interviews with key **ABC** and Department staff members involved with any aspect of performance indicator reporting. Table 5 displays a list of **ABC** key interviewees.

Table 5—List of Access Behavioral Care Participants	
Name	**Title**
Robert Bremer	Executive Director
Suzanne Kinney	Behavioral Health Quality Program Manager
Mary Fischer	Senior Manager, Claims/Appeals, Colorado Access
Jeni Sargent	Senior Manager, Eligibility/Enrollment
Ann Brunker	Senior Business Analyst
Greg Jensen	Director, Decision Support, Colorado Access
Becky Rowles	Business Analyst
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

Data Integration, Data Control, and Performance Measure Documentation

Several aspects involved in the calculation of performance indicators are crucial to the validation process. These include data integration, data control, and documentation of performance measure calculations. Each of the sections 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, HSAG determined that the data integration processes used by the Department and the BHO were:

☒ 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, HSAG determined that the data control processes in place at **ABC** were:

☒ 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, HSAG determined that the documentation of performance measure data collection and calculations by **ABC** and the Department was:

☒ Acceptable

☐ Not acceptable

Validation Results

HSAG identified overall strengths and areas for improvement for **ABC**. In addition, HSAG evaluated **ABC**'s data systems for the processing of each type of data used for reporting the performance indicators. General findings are indicated below.

Strengths

ABC had an outstanding readiness process in place for the 2014 October rollout of the ICD-10 implementation, including system analysis to ensure that ABC's system is capable of supporting ICD-10. **ABC**'s performance measure reporting and process flow document is very detailed and serves as a valuable resource. **ABC**'s performance measure team has retained its core team members for the past several years, adding to the reliability of existing processes.

Areas for Improvement

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

Eligibility Data System Findings

HSAG had no concerns or issues with the way **ABC** received and processed eligibility data. Data files were downloaded daily from the Department's portal and were loaded into the transactional system. Monthly files containing new consumer profiles, terminations, and changes for the month were downloaded. Eligibility files were received in an 834 file format. A reconciliation process for comparing the 834 eligibility file to the 820 capitation file was in place to ensure data accuracy.

Claims/Encounter Data System Findings

HSAG identified no issues or concerns regarding policies/procedures for receiving, processing, and reporting claims and encounter data. Electronic claim files were submitted to a file transfer protocol (FTP) site and were subject to two automated quality check sweeps prior to loading electronic data interchange (EDI) claims into the PowerSTEPP transactional system. Paper claims were scanned via optical character recognition (OCR) software, batched, and converted into an 837 file format and were adjudicated by the contracted claims processing vendor, DST. **ABC** had a good process in place for oversight of its claims processing vendor. A daily system check, quality meetings, weekly claims review reports, and monthly reconciliation processes were in place to ensure claims data accuracy. **ABC** also had excellent processes in place for monitoring capitated providers' data submission, including the use of a monthly volume report. Prior to submitting the encounters to the Department, all 837 files underwent an internal review process including a code validity check to determine if these files were acceptable for submission.

Survey Data Results

The Division of Behavioral Health (DBH) administered the Mental Health Statistics Improvement Program (MHSIP) survey. Each of the surveys (MHSIP, YSS-F, and YSS) was available in both English and Spanish versions. HSAG found that the Department had sufficient data collection and calculation processes in place. The Department also had appropriate oversight of its survey vendor, Integrated Document Services (IDS), which was responsible for printing and distributing the survey questionnaire to all community mental health centers (CMHCs). This oversight included manual verification of the survey records including record count check, and consumer gender and name check.

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

HSAG found that **ABC** took action as a result of last year's recommendation and continued to work with the Department and other BHOs to address issues identified in the scope document. **ABC** also had adequate validation processes in place to ensure that proper date ranges and codes were being used, as well as to ensure that all data were included for the reporting period. **ABC** had appropriate processes and documentation in place to support its transition to the new claims system for the next reporting period.

Performance Indicator Specific Findings and Recommendations

Based on all validation activities, HSAG determined results for each performance indicator. The CMS Performance Measure Validation Protocol identifies three possible validation finding designations for performance indicators, which are defined in Table 6.

Table 6—Designation Categories for Performance Indicators

Report (R)	Indicator was compliant with the Department's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to indicators for which (1) the BHO rate was materially biased or (2) the BHO was not required to report.
No Benefit (NB)	Indicator was not reported because the BHO did not offer the benefit required by the indicator.

According to the protocol, the validation finding for each indicator 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 based on the review findings. Consequently, an error for a single audit element may result in a designation of NR because the impact of the error biased the reported performance indicator 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 R.

Table 7 through Table 17 below display the review findings and key recommendations for **ABC** for each validated performance measure. For more detailed information, please see Appendix D.

Table 7—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 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 8—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 HSAG determined that the processes used to collect data from claims and encounters met standards. Prior to the site visit, 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.
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 as to what provider type(s) should be considered as mental health practitioner(s) in the scope document for this measure.

Table 9—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 HSAG determined that the processes used to collect data from claims and encounters met standards. Prior to the site visit, 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.
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 as to what provider type(s) should be considered as mental health practitioner(s) in the scope document for this measure.

Table 10—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 HSAG determined that the processes used to collect data from claims and encounters met standards. Prior to the site visit, 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.
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 as to what provider type(s) should be considered as mental health practitioner(s) in the scope document for this measure.

Table 11—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 HSAG determined that the processes used to collect data from claims and encounters met standards. Prior to the site visit, 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.
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 as to what provider type(s) should be considered as mental health practitioner(s) in the scope document for this measure.

Table 12—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 performed primary source verification 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. ◆ The Department should provide clarifications as to what provider type(s) should be considered as mental health practitioner(s) in the scope document for this measure.

Table 13—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 identified no issues. **ABC** documented the process of validating data entry. HSAG performed primary source verification 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 14—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 no concerns were identified. HSAG auditors conducted interviews with key staff members from the Department and **ABC**, and HSAG determined that the processes used to collect data from claims and encounters met standards. HSAG performed primary source verification 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.

Table 15—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. HSAG performed primary source verification 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 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** validated data entry prior to submitting rates to the Department. HSAG performed primary source verification 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 17—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 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 18 lists the validation result for each performance measure indicator for **ABC**.

Table 18—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)
- MHSIP Satisfaction Surveys (Indicator 19)**
- YSS-F Satisfaction Surveys (Indicator 19)**
- YSS Satisfaction Surveys (Indicator 19)**

*Calculated by the Department

**Survey Results

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 2013 BHO-HCPF Annual Performance Measures Scope Document, Version 9, Created: January 11, 2013, Last Updated: October 18, 2013.* 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 2013

BHO-HCPF Annual Performance Measures Scope Document

Version 9
Created: January 11, 2013
Last updated: October 18, 2013

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.

Performance Measures Indexed by Agency Responsible for Calculation

Calculated by the BHO:

Calculated by HCPF:

Update Process

1. For all indicators, each BHO will be responsible for updating code changes after July 1, 2013.
2. Indicator #2: Name changed to include "atypical." Barb Smith (FBHP) and Scott Marmulstein will provide list of atypical antipsychotics for addition to the scope document by August 1st, 2013 from First Data Bank (Value Options has subscription to database). Breaks in Fiscal Year were updated to reflect most current fiscal year.
3. Indicators #4, #5, #21, and #22 information was removed from scope document and can be found in earlier scope documents if needed. Indicator #4 has been replaced with the Behavioral Health Engagement Measure and will be added to the scope document after the August BQuIC meeting.
4. Indicator #12 is new and adapted from HEDIS measure. Indicator #12 was moved from calculated by BHO to calculated by HCPF.
5. Indicator #13 the last sentence of the description paragraph was deleted as it conflicted with covered diagnoses.
6. Indicator #14 in the numerator description the first bullet was deleted to add clarity to the measurement. Also updated Table 11 under "POS" to only list excluded places of service.
7. Indicator #15 updated Table 12 to reflect both adult and child codes. CPT codes added are 99381-99384, 99391-99394. HCPCS codes added are G0402, G0438, and G0439. ICD-9-CM Diagnosis code V20.2 was added.
8. Indicators #8-11: Definition of denominator was changed at the request of group. Also, added more information to Table 8 about the numerator and denominator. Table 7 was changed to reflect new eligibility types and race categories. Codes were updated by HCPF to include new codes. PEI service codes were added.
9. Indicator #3 and #20 were updated to reflect the most recent HEDIS changes. A list of changes are noted in the respective Tables.
10. Indicator #1 ratios were updated to reflect all ratios that are calculated.
11. Indicator #13 ratios were clarified to reflect the specific ratios calculated
12. Codes highlighted and in blue lettering are codes that were added to reflect the most current USCS Manual. Codes highlighted and in black lettering reflect either HEDIS changes are changes made by the Performance Measure workgroup. Codes underlined will be deleted for ***next year's*** calculations.
13. Added Behavioral Health Engagement measure
14. Added verbage to Hospital discharge criteria
15. Added allowable gap in enrollment to Indicator 13: Follow up after hospital discharge.

Definitions

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).

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.

Covered Mental Health Diagnoses: 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.

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

Fiscal Year (FY) or State Fiscal Year (SFY): Based on the state fiscal year July 1-June 30 of the measurement year

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

HEDIS—Healthcare Effectiveness Data and Information Set

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.

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 included in the measure if eligibility is discontinued 1 day before the admission date. Adult members on the list of discharges from the State hospital who are eligible at the time of hospital admission, but who lose eligibility during the hospital stay should also remain on the hospital discharge list.

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.

Member Months: 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.

Penetration Rate is the number of members who received at least one service (paid or denied claim) divided by the number of FTE enrolled in the Medicaid mental health managed care program.

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

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

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 diagnosis 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 HCPF.

Calculation of Measure: BHO, with some data provided by HCPF

Ratios: Child 7 day readmit/Non-state Child discharges; Child 30 day readmit/Non-state Child discharges; Child 90 day readmit/Non-state Child discharges; Child 7 day readmit/All Hospital Child discharges; Child 30 day readmit/All Hospital Child Discharges; Child 90 day readmit/All Hospital Child discharges; Adolescent 7 day readmit/Non-state Adolescent discharges; Adolescent 30 day readmit/Non-state Adolescent discharges; Adolescent 90 day readmit/Non-state Adolescent discharges; Adolescent 7 day readmit/All Hospital Adolescent discharges; Adolescent 30 day readmit/All Hospital Adolescent Discharges; Adolescent 90 day readmit/All Hospital Adolescent discharges; Adult 7 day readmit/Non-state Adult discharges; Adult 30 day readmit/Non-state Adult discharges; Adult 90 day readmit/Non-state Adult discharges; Adult 7 day readmit/All Hospital Adult discharges; Adult 30 day readmit/All Hospital Adult Discharges; Adult 90 day readmit/All Hospital Adult discharges; Older Adult 7 day readmit/Non-state Older Adult discharges; Older Adult 30 day readmit/Non-state Older Adult discharges; Older Adult 90 day readmit/Non-state Older Adult discharges; Older Adult 7 day readmit/All Hospital Older Adult discharges; Older Adult 30 day readmit/All Hospital Older Adult Discharges; Older Adult 90 day readmit/All Hospital Older Adult discharges; All ages 7 day readmits/All ages All hospital discharges; All 30 day readmits/All ages all hospital discharges; All 90 day readmits/All ages hospital discharges; All 7 day readmits/Non-state hospital discharges; All 30 day readmits/Non-state hospital discharges; All 90 day discharges/Non-state hospital discharges

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 4),** race **(refer to Table 4),** and service category **(refer to Table 5 for HEDIS specs and additional place of service (POS) and service codes.)**

- 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.
- 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: Number of FTE Enrollees

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 4

Medicaid Eligibility and Race/Ethnicity Categories

Medicaid Eligibility Category is determine by the member's most recent Medicaid eligibility span during the fiscal year

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
030	ADULTS WITHOUT DEPEND CHILDREN
031	BUYIN: WORKING ADULT DISABLED
032	BUYIN: CHILDREN W/ DISABILITIES

Medicaid Race Category is determined by the member's most recent Medicaid eligibility span during the fiscal year.

Race Code	Description
1	SPANISH AMERICAN
2	OTHER – WHITE
3	BLACK
4	AMERICAN INDIAN
5	ASIAN
6	OTHER
7	UNKNOWN
8	NATV HAWAIIAN OTH PACIFIC ISL

TABLE 5

Penetration Rates by Service Category

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

- *Any service*
- *Inpatient*
- *Intensive outpatient or partial hospitalization*
- *Outpatient or ED*

Calculations

Counts

- 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. 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.

Age	• Members should be reported in the respective age category as of the last date of the fiscal year
Denominator	1. Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are pulled from the DSS. The data are pulled after the end of the prior fiscal year thus allowing for retroactive enrollment to be captured. 2. The enrollment spans are converted to a number of days enrolled by taking the enrollment end date minus the enrollment begin date plus one. The days are then summed and divided by 365 (366 in leap years). This creates a member year or FTE calculation. 3. Each client's age group, race, and eligibility type are determined using the most recent data stored in MMIS client demographic and eligibility records.
Numerator	1. Encounter data submitted by the BHOs are analyzed in the Colorado Medicaid decision support system (DSS). 2. The encounters are grouped by Medicaid managed care mental health provider (BHO) number, and the number of unique client IDs are summed to obtain the number of clients served. 3. For unique client IDs by age, race, and eligibility type the client's demographic information is pulled and then joined to the encounter information, by Medicaid client ID, so that each BHO encounter is associated with an age group, race code and eligibility type
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. 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.
Inpatient	• Include inpatient care at either a hospital or treatment facility with a covered mental health diagnosis as the principal diagnosis: • **295.00-298.99** • **300.00-301.99** • **307.00-309.99** • **311.00-314.99** One of the following criteria should be used to identify inpatient services. • An Inpatient Facility code in conjunction with a covered mental health diagnosis. o***r*** • DRGs (Table MPT-B) 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, H0017
RTC codes : H2013, 0191, 0192, 0193, H0018, H0019, S5135

Table MPT-B Codes to Identify Inpatient Services

MS—DRG
876, 880-887

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; 90791, 90792, 90832, 90834, 90837	*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, 99201-99205, 99211-99219, 99241-99245, 99304-99310, 99315-99318, 99324-99328, 99334-99337, 99341-99350, 99366-99368, 99441-99443	*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, 96101-96103, 96105, 96110, 96111, 96116, 96118-20, 96125, 90832, 90834, 90837, 90839	G0155, G0176, G0177, G0409, H0002, H0004, H0023, H0025, H0031,H0032 H0034, H0036, H0037, H0039, H0040, H0044, H1011, H2000, H2010, H2011, H2013-H2020, H2027, H2033, M0064, S9484, S9485, T1005, T1016, T1017, H0033, H0038, H0043, H0046, H2012, H2021, H2022, H2023, H2024, H2025, H2026, H2030, H2031, H2032, S5150, S5151, 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, 90791, 90792, 90785, 90846	*WITH*	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 23, 33, 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 2013 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 diagnosis 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 diagnosis 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 diagnosis during the specific fiscal year, July 1 through June 30.
Numerators: Total number of discharges with an outpatient service (**see Table 7)** 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 codes in **Table 7** 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.

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 7

Description

The percentage of discharges for members 6-20 years of age and 21 and older who were hospitalized for treatment of a covered mental health diagnosis 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 gap in enrollment except for State hospital stays (age 22-64) which allow gaps at 1 day prior to admission through 1 day after discharge.
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 readmission or direct transfer to an acute facility follows the discharge for any covered mental health diagnosis 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 diagnosis, 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 diagnosis 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 non-acute care.
Exclusion	Because 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.

Codes to Identify Non-acute 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, 90839	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, 90791, 90792, 90832, 90834, 90837	***WITH***	03, 04, 05, 07, 11, 12, 13, 14, 15, 16, 20, 22, 33, 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 covered any diagnosis code.
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 2013 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 8.

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

- 21 years of age or older on first day of the measurement period (July 1-June 30)
- 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 8**) in the first 9 months of the measurement period (SFY) for diagnoses in any position (refer to **Table 8**).
- The type of service identified does not lock the patient into a treatment track for the numerator

Numerator: Total number of members in the denominator that meet at least one of the following track criteria (using **Table 8**) with the same billing provider during the measurement period (SFY).

- 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

TABLE 8

Codes to Identify BHO Outpatient Services

Service Domain and/or Category	CPT/HCPCS Procedure Code		POS
Assessment	90791, 90792, 90801, 90802, H0031	**WITH**	**Exclude POS 21, 51 and 23**
Treatment/Recovery (Psychotherapy, Svc planning, Vocational, Peer support)	90804-19, 90821-90824, 90826-90829 90846-7, 90849, 90853, 90857, H0032, H0004, H0036-40, H2014-8, H2023–7, H2030-2, 90832, 90834, 90837		
Case Management	T1016-7		
Med Management	90862, 96372, 99441-3, H0033-4, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510		

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, 296.80, 296.89

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 10 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 9** during the measurement period, excluding those services provided by rendering provider type codes identified in **Table 9**.

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 9

Preventive or Ambulatory Medical Visits Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services (HEDIS 2013)

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	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014	S0620, S0621		
General medical examination			V20.2,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
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 diagnosis 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) per HEDIS age group.

Numerator: All discharges from a hospital episode for treatment of a covered mental health diagnosis per HEDIS age group
Non-State Hospitals: All discharges from a non-State hospital episode for treatment of a covered mental health diagnosis 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 diagnosis 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 diagnosis, 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 diagnosis 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 diagnosis 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 per HEDIS age group. 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 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 45x.

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

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

Benchmark: Overall BHO

Indicator 19: MHSIP, YSS & YSS-F Satisfaction Surveys

Description: The Colorado Division of Behavioral Health conducts annual adult, adolescent and youth surveys to assess satisfaction with mental health services at each of the Colorado community mental health centers. The surveys address six topics of interest: Access, Appropriateness and Quality, Outcomes, Participation in Treatment, Doctor Contact outside of the Emergency Room, and Satisfaction (MHSIP only) or Cultural Sensitivity (YSS and YSS-F only). For each question in every topic other than Doctor Contact Outside of the Emergency Room, survey respondents rate their satisfaction on a scale from 1 – Most Satisfied to 5 – Least Satisfied. Survey respondents answer the Doctor Contact Outside of the Emergency Room question with yes, no, or do not remember. Refer to the current state fiscal year MHSIP, YSS and YSS-F technical reports for complete methodology. This report can be found on the State of Colorado Division of Behavioral Health website.

Denominator: Number of MHSIP (adults), YSS (adolescents) or YSS-F (youth) surveys with valid domains for each domain topic. Surveys have valid domains if at least two thirds of survey questions in that domain have been answered. For domains with a small number of questions, often all questions must be answered to meet this criterion. For example, the 2011 survey included only two questions related to Participation. In this case, both questions had to be answered for a survey to be included in the measure.

Numerator:

- For all topics other than Doctor Contact Outside of the Emergency Room, the numerator is the number of surveys with valid domains that have a positive rating of the topic. A positive rating is defined as an average of 2.49 or less across all questions in the domain.

- For the question regarding Doctor Contact Outside of the Emergency Room, the numerator is the number of survey respondents that answered yes.

Data is also presented regarding the total number of surveys returned at the mental health center and BHO levels. Finally, raw data of responses to each question and statewide means for each question are also included.

Data Source (s): OBH administered surveys; OBH will send to the Department (HCPF) for calculation the items that were answered “yes” for Medicaid (MHSIP Question #54; YSS Question #30; YSS-F Question #30).

Calculation of Measure: HCPF for the BHOs

Benchmark: Overall BHOs

Documentation Work Sheets

BHO Name:	Access Behavioral Care
On-Site Visit Date:	January 17, 2014
Reviewer:	David Mabb, Timea Jonas, and Derrick Mendel

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 17, 2014
Reviewer:	David Mabb, Timea Jonas, and Derrick Mendel

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.	☒	☐	☐	
◆ 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 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.	☒	☐	☐	
◆ 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 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, 2012, through June 30, 2013 (FY 2012–2013).

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	78	1	1.28%	78	1	1.28%
	30 Days	78	7	8.97%	78	7	8.97%
	90 Days	78	13	16.67%	78	13	16.67%
Adolescent 13–17 Years of Age	7 Days	120	3	2.50%	128	3	2.34%
	30 Days	120	5	4.17%	128	5	3.91%
	90 Days	120	9	7.50%	128	10	7.81%
Adult 18–64 Years of Age	7 Days	273	5	1.83%	326	11	3.37%
	30 Days	273	23	8.42%	326	39	11.96%
	90 Days	273	42	15.38%	326	63	19.33%
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	480	9	1.88%	541	15	2.77%
	30 Days	480	35	7.29%	541	51	9.43%
	90 Days	480	64	13.33%	541	86	15.90%

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	52,515	3,144	5.99%
Adolescents between 13 and 17 years of age	12,600	1,975	15.68%
Adults between 18 and 64 years of age	39,970	7,769	19.44%
Adults 65 years of age or older	8,152	510	6.26%
Overall	113,237	13,398	11.83%

* 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	113,237	328	0.29%
Intensive Outpatient or Partial Hospitalization	113,237	39	0.03%
Ambulatory Care (Outpatient/ER)	113,237	12,854	11.35%

* 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	22,396	2,355	10.52%
AFDC/CWP Children	53,034	3,283	6.19%
AND/AB-SSI	11,462	3,976	34.69%
BC Children	10,309	753	7.30%
BC Women	768	79	10.28%
BCCP-Women Breast & Cervical Cancer	102	16	15.69%
Buy-In: Working Adults with Disabilities	126	45	35.74%
Foster Care	2,218	1,044	47.08%
OAP-A	8,050	499	6.20%
OAP-B-SSI	2,013	479	23.80%

Table D-4—Penetration Rates by Medicaid Eligibility Category *for* Access Behavioral Care			
	Enrollment*	Members Served	Rate
Modified Adjusted Gross Income	2,746	800	29.13%
Buy-In: Children with Disabilities	13	2	15.03%

* 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	170	61	35.88%	179	63	35.20%
	30 Days	170	102	60.00%	179	105	58.66%
21+ Years of Age	7 Days	165	72	43.64%	177	79	44.63%
	30 Days	165	97	58.79%	177	105	59.32%
Combined Ages	7 Days	335	133	39.70%	356	142	39.89%
	30 Days	335	199	59.40%	356	210	58.99%

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**
2,039	**1,849**	**90.68%**

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 Care Visits)**	**% Mental Health Members with Physical Health Care Visit**
9,068	**7,831**	**86.36%**

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	**52,515**	**78**	**1.49**	**52,515**	**78**	**1.49**
Adolescent 13–17 Years of Age	**12,600**	**120**	**9.52**	**12.600**	**128**	**10.16**
Adult 18–64 Years of Age	**39,970**	**273**	**6.83**	**39,970**	**273**	**6.83**
Adult 65 Years of Age and Older	**8,152**	**9**	**1.10**	**8,152**	**9**	**1.10**
All Ages	**113,237**	**480**	**4.24**	**113,237**	**541**	**4.78**

* 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	78	714	9.15	78	714	9.15
Adolescent 13–17 Years of Age	120	861	7.18	128	933	7.29
Adult 18–64 Years of Age	273	2,654	9.72	326	6,164	18.91
Adult 65 Years of Age and Older	9	180	20.00	9	180	20.00
All Ages	480	4,409	9.19	541	7,991	14.77

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	52,515	193	3.68
Adolescent 13–17 Years of Age	12,600	306	24.29
Adult 18–64 Years of Age	39,970	920	23.02
Adult 65 Years of Age and Older	8152	6	0.74
All Ages	113,237	1,425	12.58

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

Survey Results

Domain Scores

Based on the Mental Health Statistics Improvement Program (MHSIP), Youth Services Survey for Families (YSS-F), and Youth Services Survey (YSS) survey data, the scores reflect the percentage of agreement by adults surveyed in each of five domains. In previous years, these surveys were mailed to consumers receiving services in a given time period. For FY 2013–2014, the surveys were made available to consumers coming into community mental health centers for appointments during the three-week period of October 24, 2013, to November 15, 2013. MHSIP, YSS-F, and YSS 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.

Mental Health Statistics Improvement Program (MHSIP)

Table E-1 displays the domain name, corresponding definition, and percentage of Medicaid adults ages 18 years and older surveyed who agreed with the indicated domain definition.

Table E-1—MHSIP Domain Definitions and Scores *for* Access Behavioral Care

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. I was able to get all the services I thought I needed. I was able to see a psychiatrist when I wanted to.	**74.46%**
Consumer Perception of Appropriateness/Quality	Staff here believe 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. I was given information about my rights. Staff encouraged me to take responsibility for how I live my life. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone lines, etc.).	**83.52%**

Table E-1—MHSIP Domain Definitions and Scores *for* Access Behavioral Care		
Domain	**MHSIP Items in Each Domain**	**Percentage of Adults Who Agreed**
Consumer Perception of Participation in Service/Treatment Planning	I, not staff, decided my treatment goals. I felt comfortable asking questions about my treatment and medication.	**71.43%**
Consumer Perception of Outcomes	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. My housing situation has improved.	**59.66%**
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.	**82.68%**

Youth Services Survey for Families (YSS-F)

Table E-2 displays the domain name, corresponding definition, and percentage of parents/guardians surveyed on behalf of Medicaid children ages 0 to 14 years who agreed with the indicated domain definition.

Table E-2—YSS-F Domain Definitions and Scores *for* Access Behavioral Care		
Domain	**YSS-F Items in Each Domain**	**Percentage of Parents Who Agreed**
Consumer Perception of Access	The location of services was convenient. Services were available at times that were convenient for me.	**75.00%**
Consumer Perception of Participation in Service/Treatment Planning	I helped to choose my services. I helped to choose my treatment goals. I participated in my own treatment.	**93.48%**
Consumer Perception of Cultural Sensitivity	Staff treated me with respect. Staff respected my family's religious/spiritual beliefs. Staff spoke with me in a way that I understood. Staff was sensitive to my cultural/ethnic background.	**93.48%**
Consumer Perception of the Appropriateness/Quality of Services	Overall, I am satisfied with the services I received. The people helping me stuck with me no matter what. I felt I had someone to talk to when I was troubled. I received services that were right for me. I got the help I wanted. I got as much help as I needed.	**91.67%**

Table E-2—YSS-F Domain Definitions and Scores *for* Access Behavioral Care		
Domain	**YSS-F Items in Each Domain**	**Percentage of Parents Who Agreed**
Consumer Perception of Outcomes	I am better at handling daily life. I get along better with family members. I get along better with friends and other people. I am doing better in school and/or work. I am better able to cope when things go wrong. I am satisfied with my family life right now.	**65.22%**

Youth Services Survey (YSS)

Table E-3 displays the domain name, corresponding definition, and percentage of Medicaid adolescents ages 15 to 17 years surveyed who agreed with the indicated domain definition.

Table E-3—YSS Domain Definitions and Scores *for* Access Behavioral Care		
Domain	**YSS Items in Each Domain**	**Percentage of Patients Who Agreed**
Consumer Perception of Access	The location of services was convenient. Services were available at times that were convenient for me.	**100.00%**
Consumer Perception of Participation in Service/Treatment Planning	I helped to choose my services. I helped to choose my treatment goals. I participated in my own treatment.	**85.71%**
Consumer Perception of Cultural Sensitivity	Staff treated me with respect. Staff respected my family's religious/spiritual beliefs. Staff spoke with me in a way that I understood. Staff was sensitive to my cultural/ethnic background.	**100.00%**
Consumer Perception of the Appropriateness/Quality of Services	Overall, I am satisfied with the services I received. The people helping me stuck with me no matter what. I felt I had someone to talk to when I was troubled. I received services that were right for me. I got the help I wanted. I got as much help as I needed.	**100.00%**
Consumer Perception of Outcomes	I am better at handling daily life. I get along better with family members. I get along better with friends and other people. I am doing better in school and/or work. I am better able to cope when things go wrong. I am satisfied with my family life right now.	**42.86%**