COLORADO
Department of Health Care Policy & Financing

FY 2016–2017 Validation of Performance Measures for Access Behavioral Care—Denver

April 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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Validation Overview

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs), 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 and PIHPs 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, a PIHP, 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) 2016–2017, 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, 2015, through June 30, 2016. 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.

[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: Mar 20, 2017.

Access Behavioral Care—Denver Information

Information about **Access Behavioral Care—Denver** (**ABC-D**) appears in Table 1.

Table 1—Access Behavioral Care—Denver Information

BHO Name:	Access Behavioral Care—Denver
BHO Location:	11100 E. Bethany Drive, Aurora, CO 80014
BHO Site Visit Location:	11100 E. Bethany Drive, Aurora, CO 80014
BHO Contact:	Michelle Tomsche, Operations Director, Behavioral Health Services, Colorado Access
Contact Telephone Number:	720.744.5299
Contact Email Address:	Michelle.tomsche@coaccess.com
Site Visit Date:	February 17, 2017

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.

Table 2 lists 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—Denver

Indicator		Calculated by:
3a	*Hospital Readmissions Within 7, 30, and 90 Days Post-discharge (non-state and all facilities)*	BHO
3b	*Hospital Readmissions Within 180 Days (all facilities)*	BHO
5	*Adherence to Antipsychotics for Individuals With Schizophrenia**	Department
7	*Overall Penetration Rates*	Department
7	*Penetration Rates by Age Group*	Department
7	*Penetration Rates by Medicaid Eligibility Category*	Department
11a	*Follow-up Appointments After Emergency Department Visits for a Mental Health Condition**	Department
11b	*Follow-up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence**	Department

Indicator		Calculated by:
12	*Mental Health Engagement*	BHO
13	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	BHO
14a	*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners*	BHO
14b	*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*	BHO

*For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

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, the indicator definitions (Appendix A) and the indicator specifications. 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 2015–2016 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 3 describes each team member's role and expertise.

Table 3—Validation Team

Name and Role	Skills and Expertise
Mariyah Badani, JD, MBA, CHCA *Director, Audits/State & Corporate Services*	Management of audit department, multiple years of auditing experience, certified HEDIS compliance auditor; data integration, systems review, and analysis experience.
Timea Jonas, CHCA *Audit Specialist; Lead Auditor*	Multiple years of auditing experience, certified HEDIS compliance auditor; claims processing, data review and analysis, and healthcare fraud analysis experience.
Regina Cameron, MSW *Audit Specialist; Secondary Auditor*	Multiple years of experience in quality improvement, project and program management/coordination, research, analysis, evaluation, data abstraction, and audits.
Tammy GianFrancisco *HEDIS Manager*	Coordinator for the audit department, liaison between the audit team and clients, manages deliverables and timelines, and coordinates source code review activities.

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 2016–2017* 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 claims/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-D** and Department staff members involved with any aspect of performance indicator reporting. Table 4 displays a list of **ABC-D** key interviewees:

Table 4—List of Access Behavioral Care—Denver Participants

Name	Title
Jeni Sargent	Director, Configuration and Enrollment—COA
Cindy Dalton	IT Operation—COA
Callista Medland	Business Intelligence Analyst—COA
Sarah Henderson	Encounter Data Manager—COA
Catherine Morrisey	QI Project Manager—COA
Lindsay Cowee	Director, Quality Management—COA
Jeff George	Director of IT—COA
Kevin Lawrence	Claims Appeal Auditing, Adjustment Supervisor—COA
Julie McNamara	Director, System Operation/Vendor Management—COA
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-D** 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-D**, 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-D** 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-D** and the Department. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, and 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-D** and the Department was:

☒ Acceptable
☐ Not acceptable

Validation Results

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

Strengths

As in prior years, **ABC-D** continued to be one of Colorado Access' (COA's) lines of business. All administrative functions related to performance measure validation processes were performed by COA. Staff members with extensive experience and knowledge of processes related to behavioral health measures and their reporting requirements continued to be a great asset. **ABC-D** and the Department continued to have monthly meetings to address any data-related issues and discuss solutions collaboratively. The BHO also had monthly internal meetings to discuss incentive measure performance for the Community Mental Health Service Program (CMHSP). Since the prior year, paper claims submission declined, leaving less room for human error. **ABC-D** had developed an excellent readiness process to receive eligibility files in an 834 file format, which will be implemented when the Department rolls out the new system. In addition, to further ensure accuracy, and as part of its vendor oversight, **ABC-D** continued to validate claims data previously audited by TriZetto.

Areas for Improvement

ABC-D should continue to communicate with the Department and other BHOs to ensure that all BHOs have the same understanding regarding reporting requirements.

HSAG suggested that the BHO consider adding additional fields when generating its data file. For instance, adding the actual date of the follow-up service would provide helpful information to assist in the quality check process.

During the primary source verification process, HSAG raised a concern regarding the way numerator cases were identified for Indicator #13. **ABC-D**'s data file showed that at least one member should have been counted as numerator positive for both the initiation and engagement rates. **ABC-D** staff members were responsive, investigated the issue, and resubmitted the revised rate prior to generation of this report. **ABC-D** should implement additional verification to further ensure data accuracy for measure reporting.

Eligibility Data System Findings

HSAG identified no concerns with how **ABC-D** received and processed enrollment data. COA continued to obtain monthly eligibility full and daily change/update files from the Department via secure file transfer protocol (FTP) site in a flat file format. Eligibility information was loaded into a data scrubber where several business rules were applied to ensure that only accurate enrollment information

was loaded into QNXT, the BHO's transactional system. QNXT transformed eligibility information from flat file to 834 file format. 834 files were provided to the BHO's affiliated community mental health centers (CMHCs). Providers continued to have the ability to log into the BHO's system and obtain eligibility information for members. Each member received a unique identification number. For measure production, enrollment information was reconciled with the monthly full file. In case of any discrepancy, the BHO was able to perform real-time eligibility verification via the Department's portal.

Claims/Encounter Data System Findings

HSAG identified no issues or concerns with how **ABC-D** received, processed, or reported claims and encounter data.

No major changes were noted as to how **ABC-D** received, processed, validated, and transferred claims/encounter data. QNXT, operated by TriZetto, remained the claims processing system. As in prior years, providers continued to submit claims electronically or on paper. Electronic claims were submitted to COA in a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 837 format. These files were loaded into QNXT via TriZetto's FTP site. Paper claims were scanned and posted on TriZetto's FTP site where, prior to being loaded in QNXT, they were converted into the 837 format using optical character recognition (OCR) software. The affiliated CMHC submitted encounter data via FTP. These files were loaded into QNXT. Nightly, TriZetto audited 2.5 percent of auto-adjudicated and 5 percent of manually adjudicated claims. To further ensure data accuracy, **ABC-D** audited 7 percent of claims previously verified by TriZetto. **ABC-D** performed audits on 100 percent of facility claims exceeding the $10,000 threshold and professional claims exceeding the $5,000 threshold. In addition to the claims/encounter data, **ABC-D** received pharmacy and inpatient data from the Department via FTP and loaded all data into the data warehouse.

The BHO submitted 837 and flat files to the Department via FTP site monthly. An adequate validation process was in place to ensure data accuracy.

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

The BHO had sufficient oversight of its processing vendor, TriZetto. Monthly meetings were in place to address any data issues and collaboratively discuss solutions.

COA managed data flow and calculated performance indicator rates. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measure Scope Document*. Claims and encounters were extracted from QNXT and loaded into an operational data store (ODS) database for rate calculation. Query language was applied to the data in ODS to identify each indicator's denominator and numerator cases. Several verification processes were in place to ensure data accuracy for measure reporting.

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

ABC-D worked with the Department and other BHOs to ensure that each BHO had the same understanding of the "New Member" definition.

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 5.

Table 5—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 6 through Table 20 below display the review findings and key recommendations for **ABC-D** for each validated performance measure. For more detailed information, please see Appendix D.

Table 6—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 3a: *Hospital Readmissions Within 7, 30, and 90 Days Post-discharge*

Findings
ABC-D calculated this rate. Programming code used for calculation of this rate was reviewed by HSAG. No concerns were identified. The result of the source code review was provided to the BHO prior to the on-site visit. HSAG performed primary source verification on-site and identified no discrepancies.
Key Recommendations
• Data monitoring for rate calculation is crucial. **ABC-D** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 7—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 3b: *Hospital Readmissions Within 180 Days (all facilities)*

Findings
ABC-D calculated this rate. Programming code used for calculation of this rate was reviewed by HSAG. No concerns were identified. The result of the source code review was provided to the BHO prior to the on-site visit. HSAG performed primary source verification on-site and identified no discrepancies.
Key Recommendations
• Data monitoring for rate calculation is crucial. **ABC-D** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 8—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 5: *Adherence to Antipsychotics for Individuals With Schizophrenia

Findings
This rate was calculated by the Department based on encounter data received from **ABC-D**. Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC-D**, it was determined that all processes used to collect data met standards. Prior to the site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns.
Key Recommendations
• **ABC-D** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHC and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

* For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

Table 9—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 7: *Overall Penetration Rates*

Findings
This rate was calculated by the Department based on encounter data received from **ABC-D**. Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC-D**, it was determined that all processes used to collect data 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 identified no issues or concerns.
Key Recommendations
• **ABC-D** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHC and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

Table 10—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 7: *Penetration Rates by Age Group*

Findings
This rate was calculated by the Department based on encounter data received from **ABC-D**. Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC-D**, it was determined that all processes used to collect data 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 identified no issues or concerns.
Key Recommendations
• **ABC-D** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHC and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

Table 11—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 7: *Penetration Rates by Medicaid Eligibility Category*

Findings
This rate was calculated by the Department based on encounter data received from **ABC-D**. Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC-D**, it was determined that all processes used to collect data 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 identified no issues or concerns.
Key Recommendations
• **ABC-D** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHC and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

Table 12—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 11a: *Follow-up Appointments After Emergency Department Visits for a Mental Health Condition***

Findings
This rate was calculated by the Department based on encounter data received from **ABC-D.** Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC-D**, it was determined that all processes used to collect data met standards. Prior to the site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns.
Key Recommendations
• **ABC-D** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHC and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

* For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

Table 13—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 11b: *Follow-up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence

Findings
This rate was calculated by the Department based on encounter data received from **ABC-D**. Encounter data were submitted to the Department in a flat file format. Based on HSAG's interviews with key staff members from the Department and **ABC-D**, it was determined that all processes used to collect data met standards. Prior to the site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns.
Key Recommendations
• **ABC-D** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHC and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

* For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

Table 14—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 12: *Mental Health Engagement*
(Measurement Period: July 1, 2014, Through June 30, 2015)

Findings
ABC-D calculated this rate. Programming code used for calculation of this rate was reviewed by HSAG. No concerns were identified. The result of the source code review was provided to the BHO prior to the on-site visit. HSAG performed primary source verification on-site and identified no discrepancies.
Key Recommendations
• Data monitoring for rate calculation is crucial. **ABC-D** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 15—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 12: *Mental Health Engagement*
(Measurement Period: July 1, 2015, Through June 30, 2016)

Findings
ABC-D calculated this rate. Programming code used for calculation of this rate was reviewed by HSAG. No concerns were identified. The result of the source code review was provided to the BHO prior to the on-site visit. HSAG performed primary source verification on-site and identified no discrepancies.
Key Recommendations
• Data monitoring for rate calculation is crucial. **ABC-D** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 16—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 13: *Initiation and Engagement of Alcohol and Other Drug Dependence*
(Measurement Period: July 1, 2014, Through June 30, 2015)

Findings
ABC-D calculated this rate. HSAG reviewed the programming code used for calculation of this performance indicator and identified no concerns. The source code review result was provided to the BHO. HSAG performed primary source verification on-site. No discrepancies were identified, and it was determined that **ABC-D** is fully capable of reporting this measure.
Key Recommendations
• For the next measurement year, **ABC-D** should continue its data monitoring process to ensure accuracy and completeness.

Table 17—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 13: *Initiation and Engagement of Alcohol and Other Drug Dependence*
(Measurement Period: July 1, 2015, Through June 30, 2016)

Findings
ABC-D calculated this rate. HSAG reviewed the programming code used for calculation of this performance indicator and identified no concerns. The source code review result was provided to the BHO. During on-site primary source verification, the auditors noted that at least one member was reported to be numerator positive for only the initiation indicator; however, evidence showed that this member should have been reported as numerator positive for the engagement indicator as well. **ABC-D** researched the issue and submitted the new, recalculated rate for this measure. It was determined that **ABC-D** is fully capable of reporting this measure.
Key Recommendations
• For the next measurement year, **ABC-D** should continue its data monitoring process to ensure accuracy and completeness.

Table 18—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 14a: *Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for Mental Health Condition—All Practitioners*
(Measurement Period: July 1, 2014, Through June 30, 2015)

Findings
ABC-D calculated this rate. HSAG reviewed the programming code used for calculation of this performance indicator and identified no concerns. The source code review result was provided to the BHO. HSAG performed primary source verification on-site. No discrepancies were identified, and it was determined that **ABC-D** is fully capable of reporting this measure.
Key Recommendations
• For the next measurement year, **ABC-D** should continue its data monitoring process to ensure accuracy and completeness.

Table 19—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 14a: *Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for Mental Health Condition—All Practitioners*
(Measurement Period: July 1, 2015, Through June 30, 2016)

Findings
ABC-D calculated this rate. HSAG reviewed the programming code used for calculation of this performance indicator and identified no concerns. The source code review result was provided to the BHO. HSAG performed primary source verification on-site. No discrepancies were identified, and it was determined that **ABC-D** is fully capable of reporting this measure.
Key Recommendations
• For the next measurement year, **ABC-D** should continue its data monitoring process to ensure accuracy and completeness.

Table 20—Key Review Findings for Access Behavioral Care—Denver
Performance Indicator 14b: *Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for Mental Health Condition—Licensed Practitioners*
(Measurement Period: July 1, 2015, Through June 30, 2016)

Findings
ABC-D calculated this rate. HSAG reviewed the programming code used for calculation of this performance indicator and identified no concerns. The source code review result was provided to the BHO. HSAG performed primary source verification on-site. No discrepancies were identified, and it was determined that **ABC-D** is fully capable of reporting this measure.
Key Recommendations
• For the next measurement year, **ABC-D** should continue its data monitoring process to ensure accuracy and completeness.

Table 21 lists the validation result for each performance measure indicator for **ABC-D**.

Table 21—Summary of Results

Performance Indicator		Validation Result
3a	*Hospital Readmissions Within 7, 30, and 90 Days Post-discharge (non-state and all facilities)*	**Report**
3b	*Hospital Readmissions Within 180 Days (all facilities)*	**Report**
5	*Adherence to Antipsychotics for Individuals With Schizophrenia**	**Report**
7	*Overall Penetration Rates*	**Report**
7	*Penetration Rates by Age Category*	**Report**
7	*Penetration Rates by Medicaid Eligibility Category*	**Report**
11a	*Follow-up Appointments After Emergency Department Visits for a Mental Health Condition**	**Report**
11b	*Follow-up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence**	**Report**
12	*Mental Health Engagement (2014–2015)*	**Report**
12	*Mental Health Engagement (2015–2016)*	**Report**

Performance Indicator		Validation Result
13	*Initiation and Engagement of Alcohol and Other Drug Dependence (2014–2015)*	**Report**
13	*Initiation and Engagement of Alcohol and Other Drug Dependence (2015–2016)*	**Report**
14a	*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners (2014–2015)*	**Report**
14a	*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners (2015–2016)*	**Report**
14b	*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only (2015–2016)*	**Report**

* For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

Appendix A. BHO Performance Measure Definitions

Indicators

Indicator		Calculated by:
3a	*Hospital Readmissions Within 7, 30, and 90 Days Post-discharge (non-state and all facilities)*	BHOs
3b	*Hospital Readmissions Within 180 Days (all facilities)*	BHOs
5	*Adherence to Antipsychotics for Individuals With Schizophrenia**	Department
7	*Overall Penetration Rates*	Department
7	*Penetration Rates by Age Group*	Department
7	*Penetration Rates by Medicaid Eligibility Category*	Department
11a	*Follow-up Appointments After Emergency Department Visits for a Mental Health Condition**	Department
11b	*Follow-up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence**	Department
12	*Mental Health Engagement*	BHOs
13	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*	BHOs
14a	*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners*	BHOs
14b	*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*	BHOs

*For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

The Department collaborated with the BHOs to create a scope document that serves as the specifications for the performance measures being validated. Following is the *FY 2016 BHO-HCPF Annual Performance Measures Scope Document, Created: April 27, 2016, Last Revised: September 15, 2016.* Please note that the complete scope document is not listed in this appendix. The table of contents 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.

BHO-HCPF Annual Performance Measures Scope Document

Fiscal Year 2016 (FY16)

This document includes the details for calculations of the BHO-HCPF Annual Performance Measures for the five Colorado Behavioral Health Organizations (BHOs) according to the Behavioral Health Services Program Contract. Some of the 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.

Created: April 27, 2016 *Last Revised: September 15th, 2016*

Table of Contents

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 Alternative Care Facilities (ACF) defined as an assisted living residence licensed by the State to provide alternative care services and protective oversight to Medicaid clients.

Age Category: Unless otherwise specified, aged categories are 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, Part 1. 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.

Covered Mental Health Diagnoses Codes			
ICD-9			
295.00-298.99	300.00-301.99	307.10-309.99	311-314.99
ICD-10			
F20.0-F20.3, F20.5, F20.81, F20.89, F20.9, F21-F24, F25.0, F25.1, F25.8, F25.9, F28, F29			
F30.10-F30.13, F30.2-F30.4, F30.8-F31.0, F31.10-F31.13, F31.2, F31.30-F31.32, F31.4, F31.5, F31.60-F31.64, F31.70-F31.78, F31.81, F31.89, F31.9, F32.0-F32.5, F32.8, F32.81, F32.89, F32.9-F33.3, F33.40-F33.42, F33.8-F34.1, F34.8, F34.81, F34.89, F34.9, F39			
F40.00-F40.02, F40.10, F40.11, F40.210, F40.218, F40.220, F40.228, F40.230-F40.233, F40.240-F40.243, F40.248, F40.290, F40.291, F40.298, F40.8-F41.1, F41.3, F41.8, F41.9, F42, F42.2-F42.4, F42.8, F42.9, F43.0, F43.10-F43.12, F43.20-F43.25, F43.29, F43.8-F44.2, F44.4-F44.7, F44.81, F44.89, F44.9- F45.1, F45.20-F45.22, F45.29, F45.41, F45.42, F45.8, F45.9, F48.1, F48.9			
F50.00-F50.02, F50.2, F50.8, F50.81, F50.89, F50.9, F51.01-F51.03, F51.09, F51.11, F51.12, F51.19, F51.3-F51.5, F51.8, F51.9			
F60.0-F60.7, F60.81, F60.89, F60.9, F63.0-F63.3, F63.81, F63.89, F63.9, F68.10-F68.13, F68.8, F69			
F90.0-F90.2, F90.8-F91.3, F91.8, F91.9, F93.0, F93.8-F94.2, F94.8-F95.2, F95.8, F95.9, F98.0, F98.1, F98.21, F98.29, F98.3-F98.5, F98.8, F98.9, F99			
R45.1, R45.2, R45.5-R45.7, R45.81, R45.82			

Covered Substance Use Disorder Diagnosis: Starting January 1, 2014, the BHO Colorado Medicaid Community Mental Health Services Program contract specifies that certain substance use disorder diagnoses be covered. These diagnoses can be found below or in the Medicaid BHO Contract in Exhibit D Part 2. For purposes of the performance measures calculations, the following diagnosis codes are acceptable.

Substance Use Disorder Covered Diagnoses
ICD-9
291.0, 291.1, 291.3, 291.5, 291.81, 291.82, 291.89
292.0, 292.11, 292.12, 292.81, 292.83-292.85, 292.89, 292.9, 292.90
303.0, 303.00-303.03, 303.9, 303.90-303.93
304.0, 304.00-304.03, 304.1, 304.10-304.13, 304.2, 304.20-304.23, 304.3, 304.30-304.33, 304.5, 304.50-304.53, 304.6, 304.60-304.63, 304.7, 304.70-304.73, 304.8, 304.80-304.83
305.0, 305.00-305.03, 305.1, 305.10, 305.2, 305.20-305.23, 305.3, 305.30-305.33, 305.4, 305.40-305.43, 305.5, 305.50-305.53, 305.6, 305.60-305.63, 305.9, 305.90-305.93
ICD-10
F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180-F10.182, F10.188, F10.19-F10.21, F10.220, F10.221, F10.229-F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.280-F10.282, F10.288, F10.29, F10.920, F10.921, F10.929, F10.94, F10.950, F10.951, F10.959, F10.96, F10.980-F10.982, F10.988, F10.99
F11.10, F11.120-F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19-F11.21, F11.220-F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.90, F11.920-F11.922, F11.929, F11.93, F11.94, F11.950, F11.951, F11.959, F11.981, F11.982, F11.988, F11.99
F12.10, F12.120-F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19-F12.21, F12.220-F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.90, F12.920-F12.922, F12.929, F12.950, F12.951, F12.959, F12.980, F12.988, F12.99
F13.10, F13.120, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180-F13.182, F13.188, F13.19-F13.21, F13.220, F13.221, F13.229, F13.230-F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.280-F13.282, F13.288, F13.29, F13.90, F13.920, F13.921, F13.929, F13.930-F13.932, F13.939, F13.94, F13.950, F13.951, F13.959, F13.96, F13.980-F13.982, F13.988, F13.99
F14.10, F14.120-F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180-F14.182, F14.188, F14.19-F14.21, F14.220-F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280-F14.282, F14.288, F14.29, F14.90, F14.920-F14.922, F14.929, F14.94, F14.950, F14.951, F14.959, F14.980-F14.982, F14.988, F14.99
F15.10, F15.120-F15.122, F15.129, F15.14, F15.159, F15.180-F15.182, F15.188, F15.19-F15.21, F15.220-F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280-F15.282, F15.288, F15.29, F15.90, F15.920-F15.922, F15.929, F15.93, F15.94, F15.950, F15.951, F15.959, F15.980-F15.982, F15.988, F15.99
F16.10, F16.120-F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19-F16.21, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.90, F16.920, F16.921, F16.929, F16.94, F16.950, F16.951, F16.959, F16.980, F16.983, F16.988, F16.99
F17.200, F17.201, F17.203, F17.208-F17.211, F17.213, F17.218- F17.221, F17.223, F17.228, F17.229, F17.290, F17.291, F17.293, F17.298, F17.299
F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.180, F18.188, F18.19-F18.21, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.280, F18.288, F18.29, F18.90, F18.920, F18.921, F18.929, F18.94, F18.950, F18.951, F18.959, F18.980, F18.988, F18.99
F19.10, F19.120-F19.122, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.180-F19.182, F19.188, F19.19-F19.21, F19.220-F19.222, F19.229-F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.280-F19.282, F19.288, F19.29, F19.90, F19.920-F19.922, F19.929, F19.930-F19.932, F19.939, F19.94, F19.950, F19.951, F19.959, F19.96, F19.980-F19.982, F19.988, F19.99

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.

Hospitalization: Revenue codes for hospitalization are 100-219 or 0100-0219

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: 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 3: Hospital readmissions

Indicator 3a: Hospital Readmissions, 7, 30 and 90 Days

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). Age for this indicator is determined at first hospital discharge. Two indicators are submitted:

- ***Non-State Hospital:*** 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.
- ***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.

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, July 1 through June 30
- ***All Hospitals:*** Total number of member discharges from all hospitals during the specified fiscal year, July 1 through June 30

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: *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, is 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, are provided by the HCPF.

Calculation of Measure: BHOs, 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: Weighted average of all BHOs.

Indicator 3b: Hospital Readmissions, 180 days

Description: Proportion of BHO member admitted from a hospital episode for treatment of a covered mental health diagnosis with a previous discharge for another hospital episode for treatment of a covered mental health diagnosis in the past 180 days by age group and overall (recidivism rates). Age for this indicator is determined at last hospital admission. One indicator is submitted: (note: non-state hospital is not calculated for 1b)

- ***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.

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

- ***All Hospitals:*** Total number of member admissions from all hospitals during the specified fiscal year, July 1 through June 30

Numerator: Number of BHO member admissions with a discharge within 180 days prior to the admission.

- ***All Hospitals:*** Total number of Member discharges from all hospitals, during the specified fiscal year, July 1 through June 30, with a discharge within 180 days prior to the admission.

Data Source: *Denominator:* Number of member admissions, 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 admissions from the State hospital system, ages 21 through 64 years, is 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, are provided by the HCPF.

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

Ratios: Child 180 day readmit/All Hospital; Adolescent 180 day readmit/All Hospital; Adult 180 day readmit/All Hospital; Older Adult 180 day readmit/All Hospital

Benchmark: Weighted average of all BHOs.

Indicator 5: Adherence to antipsychotics for individuals with schizophrenia

Description: The percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Definitions:
IPSD*:* Index prescription start date; the earliest prescription dispensing date for any antipsychotic medication between January 1 and September 30 of the measurement year

Treatment Period*:* The period of time beginning on the IPSD through the last day of the measurement year

PDC*:* Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.

Oral Medication dispensing event*:* One prescription of an amount lasting 30 days or less.

- To calculate dispensing events for prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events
- Multiple prescriptions for different medications dispensed on the same day are counted as separate dispending events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days' supply. Use the Drug ID to determine if the prescriptions are the same or different.

Long-acting injections dispending event: Injections count as one dispensing event.

- Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.

Calculating number of days covered for oral medications*:*

- If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days' supply.
- If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator
- If multiple prescriptions for the same oral medication are dispensed on different days, sum the days' supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days' supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap).
- Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different

Calculating number of days covered for long-acting injections*:*

- Calculate number of days covered (for the numerator) for long-acting injections using the days-supply specified for the medication in Table SAA-A.
- For multiple J codes or NDCs for the same or different medications on the same day, use the medication with the longest days' supply.
- For multiple J codes or NDCs for the same or different medications on different days with overlapping days' supply, count each day within the treatment period only once toward the numerator.

Denominator: The eligible population

Note: members with a diagnosis of dementia are excluded from the measure

Numerator: The number of members who achieved a PDC of at least 80% for their antipsychotic medications (Table SAA-A) during the measurement year.

Data Source: HCPF quarterly pharmacy file; BHO encounter data

Calculation of Measure: HCPF

Benchmark: HEDIS

Codes to Identify Dementia
ICD-9
290.0, 290.10-290.13, 290.20, 290.21, 290.3, 290.40-290.43, 290.8, 290.9, 291.2, 292.82, 294.0, 294.10, 294.11, 294.20, 294.21, 331.0, 331.82
ICD-10
F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, F10.27, F10.97, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.83

Indicator 7: Penetration rates

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 the table below),** race **(refer to the table below),** and service category **(refer to the table below 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.

Notes: 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: 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

Medicaid Eligibility	
Medicaid Eligibility Category is determined 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	MAGI PARENTS/CARETAKERS

005	MAGI CHILDREN
006	FOSTER CARE
007	MAGI PREGNANT
008	BC CHILDREN
020	BCCP-WOMEN BREAST&CERVICAL CAN
030	MAGI ADULTS
031	BUYIN: WORKING ADULT DISABLED
032	BUYIN: CHILDREN W/ DISABILITIES

Race / Ethnicity Categories

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

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*
- *Substance Use Disorder*

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.
Substance Use Disorder	Client receiving SUD treatment will be counted in the overall BHO Penetration rate. In addition, Clients receiving SUD treatment will be shown separately in the breakout by service category. • Include all encounters with an approved SUD diagnosis • **291.XX, 292.XX, 303.XX, 304.XX, 305.XX** Also include encounters with covered SUD procedure code • **H0001, H0004, H0005, H0006, H0020, H0038** • **S3005, S9445, T1007, T1019, T1023**
Inpatient	Includes 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) Includes 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	0191, 0192, 0193, H0018, H0019,

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).		
H0035, H2001, H2012, S9480		0905, 0907, 0912, 0913, 0906
CPT		**POS**
90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90840, 90847, 90849, 90853, 90870, 90875, 90876	**WITH**	52
Visits identified by the following CPT/POS codes must be with a mental health practitioner.		
99221-99223, 99231-99233, 99234-99236, 99238, 99239, 99251-99255, 99201-99205, 99211-99215, 99217-99219, 99242-99245, 99304-99310, 99315-99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 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).		
90832, 90834, 90837, 90839, 90887, 96101-96103, 96116, 96118-20,	G0176, G0177, H0002, H0004, H0023, H0025, H0031- H0034, H0036- H0040, H0043, H0044, H0045, H1011, H2000, H2011, H2012, H2014-H2018, H2021-H2026, H2027, H2030-H2032, H2033, M0064, S5150, S5151, S9453, S9454, S9485, T1005, T1016, T1017	0513, 0900-0904, 0911, 0914-0919, 0762, 0769, 045x

CPT		**POS**
90791, 90792, 90785, 90846, 90847, 90849, 90853, 90870, 90875, 90876	**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.	
96372, 97535, 97537, 98966-98968, 99201-99205, 99211-99215, 99217-99220, 99224-99226, 99241-99245, 99281-99285, 99341-99345, 99347-99350,	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 is closely based upon HEDIS specifications.

Indicator 11a: Follow-up appointments after emergency department visits for a mental health condition

Description: The percentage of discharges for members 6 years of age or older from an emergency department for treatment of a covered behavioral health and were seen for an outpatient visit, intensive outpatient encounter, or partial hospitalization within 7 or 30 days of the ED visit. This measure consists of two indicators:

1) The percentage of emergency department visits for a mental health diagnosis for which a member received a follow-up appointment within 7 days;
2) The percentage of emergency department visits for a mental health diagnosis for which a member received a follow-up appointment within 30 days;

Definitions:
Intake Period: July 1 2015 through June 30 2016

Age: Members must be 6 years and older as of the date of the ED visit

Continuous Enrollment: Members must be continuously enrolled from the date of the ED visit through 30 days after the ED visit with no gaps.

ED Visits: ED visits that don't result in an inpatient admission within 24 hours of the day of the ED visit. ED visit codes include CPT 99281-99285 and revenue code 045x.

Denominator: The total number of members, ages 6 and older, who had an emergency department visit with a primary diagnosis of a covered mental health diagnosis (see "Definitions" on page 2) at the ED visit.

Notes:

- The denominator for this measure is based on ED visits, not members. If a member has more than one ED visit all visits are included in the denominator
- However, if a member has more than one ED visit in a 30-day period only the last ED visit will be included in the denominator

Numerator: Total number of ED visits with an outpatient visit, intensive outpatient encounter of partial hospitalization within 7 and 30 days of the ED visit. The follow-up visit can occur on the same day as the ED visit. See table below for follow-up visit codes.

Exclusions: ED visits followed by admission or direct transfer to an acute or non-acute inpatient facility within 30 days after the ED visit regardless of the primary diagnosis for the admission.

Data Source: BHO encounter claim file

Calculation of Measure: HCPF

Benchmark: HEDIS and all BHOs

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, 28x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB Revenue or type of bill codes for billing (e.g. ICF, SNF)				

Codes to Identify Visits			
CPT		**HCPCS**	
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.			
98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350		G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011-2012, H2022, H2014- H2018, M0064, S9480, S9485	
CPT		**POS**	
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.			
90791, 90792, 90832, 90834, 90837, 90839, 90847, 90849, 90853, 90870, 90875, 90876	**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 any covered diagnosis code.			
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983			

Indicator 11b: Follow-up appointments after emergency department visits for alcohol and other drug dependence (AOD)

Description: The percentage of discharges for members 13 years of age or older from an emergency department for treatment of alcohol and other drug dependence and were seen for an outpatient visit, intensive outpatient encounter, or partial hospitalization within 7 or 30 days of the ED visit. This measure consists of two indicators:

1) The percentage of emergency department visits for AOD for which a member received a follow-up appointment within 7 days;
2) The percentage of emergency department visits for AOD for which a member received a follow-up appointment within 30 days;

Definitions:
Intake Period: July 1 2015 through June 30 2016

Age: Members must be 13 years and older as of the date of the ED visit

Continuous Enrollment: Members must be continuously enrolled from the date of the ED visit through 30 days after the ED visit with no gaps.

ED Visits: ED visits that don't result in an inpatient admission within 24 hours of the day of the ED visit. ED visit codes include CPT 99281-99285 and revenue code 045x.

Denominator: The total number of members, ages 13 and older, who had an emergency department visit with a primary diagnosis of AOD (see table below) at the ED visit.

Notes:

- The denominator for this measure is based on ED visits, not members. If a member has more than one ED visit all visits are included in the denominator
- However, if a member has more than one ED visit in a 30-day period only the last ED visit will be included in the denominator

Numerator: Total number of ED visits with an outpatient visit, intensive outpatient encounter of partial hospitalization within 7 and 30 days of the ED visit. The follow-up visit can occur on the same day as the ED visit. See table below for follow-up visit codes.

Exclusions: ED visits followed by admission or direct transfer to an acute or non-acute inpatient facility within 30 days after the ED visit regardless of the primary diagnosis for the admission.

Data Source: BHO encounter claim file

Calculation of Measure: HCPF

Benchmark: HEDIS and all BHOs

Codes to Identify Non-Acute Care			
HCPCS	**UB Revenue**	**UB Type of Bill**	**POS**
	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
	019x	21x, 22x	31, 32
		18x, 28x	
	0118, 0128, 0138, 0148, 0158		
	0655		
			54
	1002		55
H0017-H0019	1001		56
			61
Other non-acute care facilities that do not use the UB Revenue or type of bill codes for billing (e.g. ICF, SNF)			

Codes to Identify Visits		
CPT	**HCPCS**	
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.		
98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350	G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011-2012, H2022, H2014- H2018, M0064, S9480, S9485	
CPT	**POS**	
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90791, 90792, 90832, 90834, 90837, 90839, 90847, 90849, 90853, 90870, 90875, 90876	**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 any covered diagnosis code.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

Codes to Identify AOD	
ICD-9 Diagnosis of AOD	291.00, 291.10, 291.20, 291.30, 291.40, 291.50, 291.81, 291.82, 291.89, 291.90, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.30, 535.31, 571.1
ICD-10 Diagnosis of AOD	F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180-10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280-10.282, F10.288, F10.29, F10.920, F10.921, F10.929, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980-10.982, F10.988, F10.99, F11.10, F11.120, F11.129, F11.20, F11.220-10.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.90, F12.10, F12.20, F12.220-12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.90, F13.10, F13.120, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280-13.282, F13.288, F13.29, F13.90, F14.10, F14.120, F14.20, F14.220-14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280-14.282, F14.288, F14.29, F14.90, F15.10, F15.120, F15.20, F15.220-15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280-15.282, F15.288,

	F15.29, F15.90, F16.10, F16.120, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.90, F18.10, F18.120, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F19.10, F19.120, F19.20, F19.220-19.222, F19.229-19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280-19.282, F19.288, F19.29, F19.90, F55.0-55.4, F55.8, K29.20, K29.21, K70.10

Indicator 12: Mental health engagement

Description: The percentage of new members diagnosed with a covered mental health diagnosis (see "definitions", page 2) who were engaged by the behavioral health organization, as defined below:

- New members who received at least four engagement services within 45 days of the initial visit or episode. The initial visit may be counted as the first engagement service.

Definitions:
Intake Period: July 1, 2015 to May 16, 2016

Intake Date: Used to capture new episodes the intake date is the earliest visit during the intake period with one of the selected covered diagnosis, identified by the following codes:

- CPT – 90791, 90792
- HCPCS – H0031

Negative Diagnosis History: A period of 90 days (3 months) before the intake date when the member had no claims/encounters with a covered mental health diagnosis (see "definitions", page 2).

Denominator:
Step 1: Identify all members with an intake date

Step 2: Exclude members with a negative diagnosis history

Step 3: Calculate continuous enrollment. Members must be continuously enrolled for 90 days (3 months) before the intake date through 45 days after the intake date, with no gaps.

Numerator: Four or more engagements (see table below for engagement codes) within 45 days after the intake date. The initial visit on the date of intake may count as one engagement service. Services can occur on the same day.

The intent of this measure is to ensure members receive ongoing engagement within the first 45 days of an initial visit. Therefore, engagement services for monthly supported housing (H0044) may only count as one service during the 45-day period, however, the "per day" supported housing (H0043) can be counted multiple times within the 45-day period.

Examples:

- A member receiving two monthly supported housing services (H0044) in the 45-day period should count as one service.
- A member receiving two supported housing services (H0043) in the 45-day period may count as two services.

Data Source: BHO claims/encounter systems

Calculation of Measure: BHOs – this indicator will be used as a performance incentive measure for FY16; therefore, BHOs will calculate the measure for FY15 *and* for FY16 to ensure that the FY15 baseline is calculated in line with this scope document.

Ratios: Reporting is the percentage of members who received four or more services within the 45 days from the intake period. Rates are reported by age category.

Benchmark: Weighted average of all BHOs

Numerator Codes to Identify Engagement Services	
CPT	**HCPCS**
90791, 90792, 90832-90834, 90836-90840, 90846, 90847, 90849, 90853, 90875, 90876, 90887, 96101-96103, 96116, 96118-96120, 96372, 97535, 97537, 99201-99205, 99211, 99212-99215, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99441-99443	G0176, G0177, H0001, H0002, H0004-H0006, H0020, H0031-H0034, H0036-H0040, H0043, H0044, H2000, H2001, H2011, H2012, H2014-H2018, H2021-H2027, H2030-H2033, M0064, S5150, S5151, S9445, S9453, S9454, S9480, S9485, T1016, T1017

Indicator 13: Initiation and engagement of alcohol and other drug dependence treatment

Description: The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

a) Initiation of AOD Treatment. The percentage of members who initiate treatment through an outpatient visit or intensive outpatient encounter within 14 days of the diagnosis.
b) Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Definitions:
Intake Period: July 1, 2015 to May 16, 2016

Intake Date: Used to capture new episodes, the intake date is the earliest date of service during the intake period for one of the following:

- An outpatient visit or intensive outpatient visit with a diagnosis of AOD *(use date of service to determine the intake date)*
- A detoxification visit *(see below for intake date)*

Detoxification Notes: An episode of detoxification is determined by consecutive days of detox codes from the same provider. For a detoxification visit, use the last date of the detox episode to determine the intake date.

General Notes: For members with more than one episode of AOD, use the first episode.

Negative Diagnosis History: A period of 60 days (2 months) before the intake date when the member had no claims/encounters with a diagnosis of AOD dependence. For detoxification count 60 days back from the first date of the detox episode.

Denominator:
Step 1: Identify all members with an intake date

Step 2: Exclude members with a negative diagnosis history

Step 3: Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the intake date through 44 days after the intake date, with no gaps.

Notes: The denominator is the same for both indicators.

Numerator:
a) Initiation of AOD Treatment: Initiation of AOD treatment through an outpatient visit or intensive outpatient encounter within 14 days of diagnosis.

- If the initial service was an outpatient, intensive outpatient, or detoxification visit the member must have an outpatient visit or intensive outpatient encounter with a diagnosis of AOD, within 14 days of the intake date (inclusive).

Notes: Do not count events that include inpatient detoxification or detoxification codes (see table below) when identifying initiation of treatment.

b) Engagement of AOD Treatment: Initiation of AOD treatment and two or more outpatient visits or intensive outpatient encounters with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day.

Notes: Do not count events that include inpatient detoxification or detoxification codes (see table below) when identifying engagement of AOD treatment. The denominator is the same for both indicators. Members must first meet the requirements of 6a) and then also meet the requirements of 6b) to be included in the numerator for 6b).

Data Source: BHO claims/encounter systems

Calculation of Measure: BHOs – this indicator will be used as a performance incentive measure for FY16; therefore, BHOs will calculate the measure for FY15 *and* for FY16 to ensure that the FY15 baseline is calculated in line with this scope document.

Ratios: Report two age groups (13-17 years & 18+ years), and a total rate (13+ years)

Benchmark: HEDIS and all BHOs

*Note: The specification presented here for the Initiation & Engagement of AOD Treatment performance indicator is closely based upon HEDIS specifications.

Codes to Identify an Outpatient or Intensive Outpatient Visit				
HCPCS				**ICD9PCS**
G0176, G0177, H0001, H0002, H0004, H0005, H0007, H0015, H0020, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, M0064, S9480, S9485, T1006, T1012			**WITH**	Diagnosis of AOD (see below)
CPT				**ICD9PCS**
99202-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350			**WITH**	Diagnosis of AOD (see below)
UBREV				**ICD9PCS**
0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0919, 0944, 0945, 0982, 0983			**WITH**	Diagnosis of AOD (see below)
CPT		**POS**		**ICD9PCS**
90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 90875, 90876	**WITH**	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72	**AND**	Diagnosis of AOD (see below)
CPT		**POS**		**ICD9PCS**
99221-99223, 99231-99233, 99238, 99239, 99251-99255	**WITH**	52, 53	**AND**	Diagnosis of AOD (see below)
Codes to Identify Detoxification				
HCPCS				
S3005, T1007, T1019, T1023				
Codes to Identify AOD				
ICD-9 Diagnosis of AOD	291.00, 291.10, 291.20, 291.30, 291.40, 291.50, 291.81, 291.82, 291.89, 291.90, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.30, 535.31, 571.1				
ICD-10 Diagnosis of AOD	F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180-10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280-10.282, F10.288, F10.29, F10.920, F10.921, F10.929, F10.94, F10.950, F10.951, F10.959, F10.96, F10.97, F10.980-10.982, F10.988, F10.99, F11.10, F11.120, F11.129, F11.20, F11.220-10.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F11.90, F12.10, F12.20, F12.220-12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F12.90, F13.10, F13.120, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280-13.282, F13.288, F13.29, F13.90, F14.10, F14.120, F14.20, F14.220-14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280-14.282, F14.288, F14.29, F14.90, F15.10, F15.120, F15.20, F15.220-15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280-15.282, F15.288, F15.29, F15.90, F16.10, F16.120, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F16.90, F18.10, F18.120, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F18.90, F19.10, F19.120, F19.20, F19.220-19.222, F19.229-19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280-19.282, F19.288, F19.29, F19.90, F55.0-55.4, F55.8, K29.20, K29.21, K70.10				
AOD Procedure	94.61, 94.63, 94.64, 94.66, 94.67, 94.69				

Indicator 14a: Follow-up appointments within 7 and 30 days after hospital discharge for a mental health condition – all practitioners

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) ***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.

Denominator: 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.

Numerator: Total number of discharges with an outpatient service (see table below) 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 below 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.

Data Source: Denominator: Number of Member discharges, from non-State hospitals, ages 6-20 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: BHOs – this indicator will be used as a performance incentive measure for FY16; therefore, BHOs will calculate the measure for FY15 *and* for FY16 to ensure that the FY15 baseline is calculated in line with this scope document.

Benchmark: HEDIS and all BHOS

Description	
The percentage of discharges for members 6-20 years of age, 21-64, and 65+ 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 for each age group 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	Three age categories are identified, ages 6-20, 21-64, and 65+
Continuous Enrollment	Date of discharge through 30 days after discharge.
Allowable Gap	No gap in enrollment except for State hospital stays (ages 22-64) which allow gaps at 1 day prior to admission through 1 day after discharge.
Event / Diagnosis	Discharged 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. Use only facility claims to identify discharges and diagnoses for denominator events (including readmissions or direct transfers). Do not include professional claims. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between July 1 and June 30 of the fiscal year.
Mental health readmission or direct transfer	If readmission or direct transfer to an acute care 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 covered mental health diagnosis, it is probably for a related condition. In some cases, data associated with member transfers from inpatient care to less acute 24-hour care that are initiated by the Department of Youth Corrections, the Department of Human Services, or similar organizations are not available to the BHO. In these cases, an affected member may be included in the denominator, even though the transfer prevents a follow-up visit from occurring. Thus, the lack of available data reflecting these transfers will result in a lower percentage of completed follow-up visits for the BHO. 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 *non-acute 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, 28x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute 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.
Numerator: 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.
Numerator: 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.	
98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350	G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2014-H2018, H2022, M0064, S9480, S9485

CPT		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.		
90791, 90792, 90832, 90834, 90837, 90839, 90847, 90849, 90853, 90870, 90875, 90876	**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 any covered diagnosis code.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

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

Indicator 14b: Follow-up appointments within 7 and 30 days after hospital discharge for a mental health condition-licensed practitioners only

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) ***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.

Denominator: 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.

Numerator: Total number of discharges with an outpatient service (see table below) within 7 and 30 days (the 30 days includes the 7-day number also). The outpatient service must be provided by a mental health practitioner with credentials specified in the table below, *"Mental Health Practitioner Specifications for Provisions of Follow-Up Services"*. 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 below 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.

Data Source: Denominator: Number of Member discharges, from non-State hospitals, ages 6-20 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

Benchmark: HEDIS and all BHOS

Description	
The percentage of discharges for members 6-20 years of age, 21-64, and 65+ 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 for each age group 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	Three age categories are identified, ages 6-20, 21-64, and 65+
Continuous Enrollment	Date of discharge through 30 days after discharge.
Allowable Gap	No gap in enrollment except for State hospital stays (ages 22-64) which allow gaps at 1 day prior to admission through 1 day after discharge.
Event / Diagnosis	Discharged 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. Use only facility claims to identify discharges and diagnoses for denominator events (including readmissions or direct transfers). Do not include professional claims. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge on or between July1 and June 30 of the fiscal year.
Mental health readmission or direct transfer	If readmission or direct transfer to an acute care 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 covered mental health diagnosis, it is probably for a related condition. In some cases, data associated with member transfers from inpatient care to less acute 24-hour care that are initiated by the Department of Youth Corrections, the Department of Human Services, or similar organizations are not available to the BHO. In these cases, an affected member may be included in the denominator, even though the transfer prevents a follow-up visit from occurring. Thus, the lack of available data reflecting these transfers will result in a lower percentage of completed follow-up visits for the BHO. 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 *non-acute 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, 28x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute 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.
Numerator: 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.
Numerator: 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.			
98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350		G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2014-H2018, H2022, M0064, S9480, S9485	
CPT		**POS**	
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.			
90791, 90792, 90832, 90834, 90837, 90839, 90847, 90849, 90853, 90870, 90875, 90876	**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 any covered diagnosis code.
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

Mental Health Practitioner Specifications for Provision of Follow-up Services
Licensure / Degree:
Psychiatrist BRDCRT/CHD-ADOL Psychiatrist APN W/Prescript Authority MD/DO Board Certified MD/DO Specialist (e.g. Child psychiatrist) Physician's Assistant (PA) Advanced Clinical Nurse (APN) /Clinical Nurse Specialist WITH prescriptive authority MD Non-Psychiatrist Registered Nurse (including Nurse Practitioners) Doctor of Osteopathy (Psych Board Cert or Psych Residency) Advanced Practice Nurse Practitioner; Advanced Practice Registered Nurse Practitioner Certified Nurse Practitioner Clinical Nurse Specialist Registered Nurse Psychologist / PhD Psychologist / PsyD Licensed Clinical Social Worker Licensed Professional Counselor Licensed Marriage and Family Counselor Licensed Alcohol Drug Counselor

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

Appendix B. Data Integration and Control Findings

Documentation Work Sheets

BHO Name:	Access Behavioral Care—Denver
On-Site Visit Date:	February 17, 2017
Reviewer:	Timea Jonas, CHCA

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

Reviewer Work Sheets

BHO Name:	Access Behavioral Care—Denver
On-Site Visit Date:	February 17, 2017
Reviewer:	Timea Jonas, CHCA

Denominator Elements for Access Behavioral Care—Denver				
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.	☐	☐	☒	Populations were not estimated.

Numerator Elements for Access Behavioral Care—Denver				
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.	☐	☐	☒	**ABC-D** used only standard codes.
• 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).	☒	☐	☐	During the primary source verification process, there was a concern regarding the way numerator cases were identified for Indicator #13. **ABC-D**'s data file showed that at least one member should have been counted as numerator positive for both initiation and engagement rates. **ABC-D** staff members were responsive, investigated the issue, and resubmitted the revised rate prior to generation of this report. **ABC-D** should implement additional verification to further ensure data accuracy for measure reporting.

Appendix D. Performance Measure Results Tables

Encounter Data

The measurement period for performance measures validated in FY 2016–2017 is July 1, 2015, through June 30, 2016. This appendix also includes additional rate tables for indicators 12, 13, and 14a for the measurement period of July 1, 2014, through June 30, 2015.

Indicator 3a—*Hospital Readmissions Within 7, 30, and 90 Days Post-discharge*

Table D-1—*Hospital Readmissions Within 7, 30, and 90 Days Post-discharge* for Access Behavioral Care—Denver

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	87	5	5.75%	87	5	5.75%
	30 Days	87	10	11.49%	87	10	11.49%
	90 Days	87	15	17.24%	87	15	17.24%
Adolescent 13–17 Years of Age	7 Days	148	3	2.03%	148	3	2.03%
	30 Days	148	7	4.73%	148	7	4.73%
	90 Days	148	15	10.14%	148	15	10.14%
Adult 18–64 Years of Age	7 Days	1,188	40	3.37%	1,247	40	3.21%
	30 Days	1,188	122	10.27%	1,247	122	9.78%
	90 Days	1,188	201	16.92%	1,247	201	16.12%
Adult 65 Years of Age and Older	7 Days	13	0	0.00%	13	0	0.00%
	30 Days	13	0	0.00%	13	0	0.00%
	90 Days	13	1	7.69%	13	1	7.69%
All Ages	7 Days	1,436	48	3.34%	1,495	48	3.21%
	30 Days	1,436	139	9.68%	1,495	139	9.30%
	90 Days	1,436	232	16.16%	1,495	232	15.52%

Indicator 3b—*Hospital Readmissions Within 180 Days (all facilities)*

Table D-2—*Hospital Readmissions Within 180 Days* for Access Behavioral Care—Denver

Population	Time Frame	All Hospitals		
		Denominator (Discharges)	Numerator (Readmissions)	Rate
Child 0–12 Years of Age	180 Days	88	20	22.73%
Adolescent 13–17 Years of Age	180 Days	149	27	18.12%
Adult 18–64 Years of Age	180 Days	1,280	311	24.30%
Adult 65 Years of Age and Older	180 Days	13	2	15.38%
All Ages	180 Days	1,530	360	23.53%

Indicator 5—*Adherence to Antipsychotics for Individuals With Schizophrenia*

Table D-3—*Adherence to Antipsychotics for Individuals With Schizophrenia** **for Access Behavioral Care—Denver**

Population	Denominator	Numerator	Rate
Overall	599	285	47.58%

*For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

Indicator 7—*Penetration Rates*

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

Table D-4—*Overall Penetration Rates* for Access Behavioral Care—Denver

Population	Enrollment*	Members Served	Rate
Overall	200,094	29,485	14.74%

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

Table D-5—*Penetration Rates by Age Category* for Access Behavioral Care—Denver

Population	Enrollment*	Members Served	Rate
Children 12 Years of Age and Younger	60,891	3,795	6.23%
Adolescents Between 13 and 17 Years of Age	19,391	2,850	14.70%
Adults Between 18 and 64 Years of Age	111,197	22,021	19.80%
Adults 65 Years of Age or Older	8,615	819	9.51%
Overall	200,094	29,485	14.74%

* Expressed as FTE, rounded to the nearest integer.

Table D-6—*Penetration Rates by Medicaid Eligibility Category* for Access Behavioral Care—Denver

Population	Enrollment*	Members Served	Rate
AND/AB-SSI	11,493	4,561	39.68%
BC Children	3,129	76	2.43%
BCCP—Women Breast & Cervical Cancer	12	2	16.03%
Buy-In: Working Adults With Disabilities	597	215	35.99%
Foster Care	2,585	894	34.59%
OAP-A	8,083	738	9.13%
OAP-B-SSI	2,213	721	32.59%

Population	Enrollment*	Members Served	Rate
MAGI Adults	71,911	12,813	17.82%
Buy-In: Children With Disabilities	70	12	17.23%
MAGI Parents/Caretakers	21,328	3,181	14.91%
MAGI Children	76,728	5,771	7.52%
MAGI Pregnant	1,945	370	19.02%

* Expressed as FTE, rounded to the nearest integer.

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

Indicator 11a—*Follow-up Appointments After Emergency Department Visits for a Mental Health Condition*

Table D-7—*Follow-up Appointments After Emergency Department Visits for a Mental Health Condition
for Access Behavioral Care—Denver**

Population	Denominator	Numerator	Rate
7 Day	2,204	702	31.85%
30 Day	2,204	937	42.51%

*For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

Indicator 11b—*Follow-up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence*

Table D-8—*Follow-up Appointments After Emergency Department Visits for Alcohol and Other Drug Dependence
for Access Behavioral Care—Denver**

Population	Denominator	Numerator	Rate
7 Day	5,156	329	6.38%
30 Day	5,156	683	13.25%

*For the FY 2016–2017 Colorado BHO PMV activity, the measure will be validated but no penalties will be associated with this measure.

Indicator 12—*Mental Health Engagement*

Table D-9—*Mental Health Engagement*
(Measurement Period: July 1, 2014, Through June 30, 2015)
for Access Behavioral Care—Denver

Population	Denominator	Numerator	Rate
Child 0–12 Years of Age	852	376	44.13%
Adolescent 13–17 Years of Age	474	190	40.08%
Adult 18–64 Years of Age	2,203	738	33.50%
Adult 65 Years of Age and Older	29	10	34.48%
All Ages	3,558	1,314	36.93%

Table D-10—*Mental Health Engagement*
(Measurement Period: July 1, 2015, Through June 30, 2016)
for Access Behavioral Care—Denver

Population	Denominator	Numerator	Rate
Child 0–12 Years of Age	940	426	45.32%
Adolescent 13–17 Years of Age	545	247	45.32%
Adult 18–64 Years of Age	2,466	732	29.68%
Adult 65 Years of Age and Older	36	10	27.78%
All Ages	3,987	1,415	35.49%

Indicator 13—*Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment*

Table D-11—*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
(Measurement Period: July 1, 2014, Through June 30, 2015)
for Access Behavioral Care—Denver

Population	Initiation of AOD Treatment			Engagement of AOD Treatment		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
13–17 Years of Age	110	58	52.73%	110	38	34.55%
18+ Years of Age	3,338	610	18.27%	3,338	425	12.73%
Combined Ages	3,448	668	19.37%	3,448	463	13.43%

Table D-12—*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
(Measurement Period: July 1, 2015, Through June 30, 2016)
for Access Behavioral Care—Denver

Population	Initiation of AOD Treatment			Engagement of AOD Treatment		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
13–17 Years of Age	147	70	47.62%	147	56	38.10%
18+ Years of Age	4,132	1,428	34.56%	4,132	1,161	28.10%
Combined Ages	4,279	1,498	35.01%	4,279	1,217	28.44%

Indicator 14a—*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners*

Table D-13—*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners*
(Measurement Period: July 1, 2014, Through June 30, 2015)
for Access Behavioral Care—Denver

Population	Time Frame	Non-State Hospitals			All Hospitals		
		Denominator (Discharges)	Numerator (Found Within Date Criteria)	Rate	Denominator (Discharges)	Numerator (Found Within Date Criteria)	Rate
6–20 Years of Age	7 Days	256	136	53.13%	269	139	51.67%
	30 Days	256	181	70.7%	269	185	68.77%
21–64 Years of Age	7 Days	763	328	42.99%	790	343	43.42%
	30 Days	763	454	59.50%	790	475	60.13%
65+ Years of Age	7 Days	22	7	31.82%	22	7	31.82%
	30 Days	22	9	40.91%	22	9	40.91%
Combined Ages	7 Days	1,041	471	45.24%	1,081	489	45.24%
	30 Days	1,041	644	61.86%	1,081	669	61.89%

Table D-14—*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—All Practitioners*
(Measurement Period: July 1, 2015, Through June 30, 2016)
for Access Behavioral Care—Denver

Population	Time Frame	Non-State Hospitals			All Hospitals		
		Denominator (Discharges)	Numerator (Found Within Date Criteria)	Rate	Denominator (Discharges)	Numerator (Found Within Date Criteria)	Rate
6–20 Years of Age	7 Days	244	125	51.23%	251	125	49.80%
	30 Days	244	165	67.62%	251	168	66.93%
21–64 Years of Age	7 Days	851	308	36.19%	885	325	36.72%
	30 Days	851	453	53.23%	885	480	54.24%
65+ Years of Age	7 Days	12	4	33.33%	12	4	33.33%
	30 Days	12	6	50.00%	12	6	50.00%
Combined Ages	7 Days	1,107	437	39.48%	1,148	454	39.55%
	30 Days	1,107	624	56.37%	1,148	654	56.97%

Indicator 14b—*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*

Table D-15—*Follow-up Appointments Within 7 and 30 Days After Hospital Discharge for a Mental Health Condition—Licensed Practitioners Only*
(Measurement Period: July 1, 2015, Through June 30, 2016)
for Access Behavioral Care—Denver

Population	Time Frame	Non-State Hospitals			All Hospitals		
		Denominator (Discharges)	Numerator (Found Within Date Criteria)	Rate	Denominator (Discharges)	Numerator (Found Within Date Criteria)	Rate
6–20 Years of Age	7 Days	244	114	46.72%	251	114	45.42%
	30 Days	244	153	62.70%	251	155	61.75%
21–64 Years of Age	7 Days	851	267	31.37%	885	278	31.41%
	30 Days	851	409	48.06%	885	429	48.47%
65+ Years of Age	7 Days	12	3	25.00%	12	3	25.00%
	30 Days	12	4	33.33%	12	4	33.33%
Combined Ages	7 Days	1,107	384	34.69%	1,148	395	34.41%
	30 Days	1,107	566	51.13%	1,148	588	51.22%