FY 2016–2017 Validation of Performance Measures for Colorado Health Partnerships, LLC

April 2017

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

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Acknowledgments and Copyrights

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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.

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Colorado Health Partnerships, LLC Information

Information about **Colorado Health Partnerships, LLC** (**CHP**) appears in Table 1.

Table 1—Colorado Health Partnerships, LLC Information

BHO Name:	Colorado Health Partnerships, LLC
BHO Location:	609 Main Street, Alamosa, CO 81101
BHO Site Visit Location:	9925 Federal Drive, Suite 100, Colorado Springs, CO 80921
BHO Contact:	Arnold Salazar, Executive Director
Contact Telephone Number:	719.587.5109
Contact Email Address:	arnolds@CHNPartners.com
Site Visit Date:	February 15, 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 Colorado Health Partnerships, LLC

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

Table 4—List of Colorado Health Partnerships, LLC Participants

Name	Title
Wayne Watkins	Director, Information Technology
Erica Arnold-Miller	Vice President, Quality Management
Curt Curnow	Manager, Health Care Policy & Financing (HCPF)
Scott Jones	Director of Reporting
Andrea Scott	Business Systems Analyst II
Sharon Forney	Eligibility Specialist (on the phone)
Bill Mackie	Programmer/Analyst
Dan Codden	Manager of Corporation Claims
List of Department Observers	
Name	**Title**
Jerry Ware	Quality and Compliance Specialist

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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 **CHP** 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 **CHP**, 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 **CHP** 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 **CHP** 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 **CHP** and the Department was:

☒ Acceptable
☐ Not acceptable

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Validation Results

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

Strengths

Although **CHP** experienced a significant increase in population size, as a result of the Medicaid expansion, the BHO's average number of monthly and annual claims processed had increased. Via the report card, **CHP** continued monitoring the contracted community mental health centers (CMHCs) specific to encounters. The report card included stratifications by provider modifiers and pivot tables for in-depth exploration of data-related issues. The report card was also used to reconcile with the CMHCs on their submissions every month.

Quarterly mini-audits were conducted by **CHP** to confirm that members were meeting all requirements to be included in each measure. For each mini-audit, eight to 10 cases per measure were selected.

CHP had developed an excellent readiness process to receive eligibility files in an 834 file format, which will be implemented when the Department rolls out its new system. **CHP** continued to have monthly teleconferences with HCPF Medicaid Management Information System (MMIS) and Rates staff to address any outstanding issues and to discuss any future changes or upgrades scheduled. As in prior years, several administrative functions were delegated to **CHP**'s LLC partner, Beacon Health Options.

Areas for Improvement

CHP should ensure the scope document is reviewed in its entirety and continue to communicate with the Department and other BHOs to ensure that all BHOs have the same understanding regarding reporting requirements. During primary source verification, HSAG noted that paid and nonpaid claims were possibly used to calculate Indicator #12. After further clarification, the BHO was instructed to recalculate its rate for Indicator #12. The **CHP** staff members were responsive, investigated the issue, and resubmitted the revised rate prior to generation of this report.

For the next measurement year, **CHP** should add additional columns to the Member Level Detail file to capture all dates relevant to each measure. This would provide a more complete picture of all eligible services.

Eligibility Data System Findings

HSAG had no concerns with how **CHP** received and processed data with respect to eligibility. The BHO maintained the same process for obtaining and processing eligibility information as used in the prior

year. Both daily change/update and monthly eligibility files were received from the Department in the form of a flat file via secure file transfer protocol (FTP) site.

Manual validation was performed to ensure that only accurate enrollment information was loaded into the Connection Administrative System (CAS), the BHO's data warehouse, via CareConnect. **CHP** continued to distribute enrollment data to the appropriate CMHCs via FileConnect. Providers, staff members, and CMHCs continue to have the ability to use real-time eligibility verification via the Department's portal.

Each member received and maintained a unique member identification number. However, if a member was given a new/different Medicaid identification number by the State, then Beacon's internal ID was modified and synced to the member's history.

Claims/Encounter Data System Findings

HSAG identified no issues or concerns with how **CHP** received, processed, or reported claims and encounter data. No major system or process changes were noted for the current reporting year. All claims/encounter data were housed and processed in CAS. Providers submitted claims electronically or on paper. Electronic claims submitted by providers were downloaded daily using an automated process. Paper claims were scanned using optical character recognition (OCR) technology. All claims were received in a Health Insurance Portability and Accountability Act of 1996 (HIPPA)-compliant 837 format. Affiliated CMHCs submitted encounter data via FileConnect. The BHO continued to use the data report card to monitor the CMHCs' performance. Robust quality checks were in place, which included performing audits on 100 percent of claims exceeding the $5,000 threshold. Nightly, 3 percent of manually processed claims were audited for quality and payment accuracy.

The BHO submitted 837 and flat files to the Department and received an error file for each within a few days of submission.

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

The BHO used the same processes as last year to manage data flow and calculate performance indicator rates. All cases were identified based on the description provided in the *BHO-HCPF Annual Performance Measures Scope* document. Several verification processes were in place to ensure data completeness and data accuracy.

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

CHP performed verification on data used for rate calculation to ensure that the correct intake information was captured to accurately calculate rates for indicators under the scope of the audit. **CHP** continued to work with the Department and the other BHOs to clarify the definition of "New Members" in the scope document for Indicator #4.

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 **CHP** for each validated performance measure. For more detailed information, please see Appendix D.

Table 6—Key Review Findings for Colorado Health Partnerships, LLC
Performance Indicator 3a: *Hospital Readmissions Within 7, 30, and 90 Days Post-discharge*

Findings
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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. **CHP** should continue its monitoring process to ensure accuracy for the next measurement period.

Table 7—Key Review Findings for Colorado Health Partnerships, LLC
Performance Indicator 3b: *Hospital Readmissions Within 180 Days (all facilities)*

Findings
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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. **CHP** should continue its monitoring process to ensure accuracy for the next measurement period.

Table 8—Key Review Findings for Colorado Health Partnerships, LLC
Performance Indicator 5: *Adherence to Antipsychotics for Individuals With Schizophrenia**

Findings
This rate was calculated by the Department based on encounter data received from **CHP**. 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 **CHP**, 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
• **CHP** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHCs 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 Colorado Health Partnerships, LLC
Performance Indicator 7: *Overall Penetration Rates*

Findings
This rate was calculated by the Department based on encounter data received from **CHP**. 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 **CHP**, 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
• **CHP** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHCs and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

Table 10—Key Review Findings for Colorado Health Partnerships, LLC
Performance Indicator 7: *Penetration Rates by Age Group*

Findings
This rate was calculated by the Department based on encounter data received from **CHP**. 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 **CHP**, 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
• **CHP** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHCs and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

Table 11—Key Review Findings for Colorado Health Partnerships, LLC
Performance Indicator 7: *Penetration Rates by Medicaid Eligibility Category*

Findings
This rate was calculated by the Department based on encounter data received from **CHP**. 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 **CHP**, 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
• **CHP** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHCs and providers to ensure that only accurate and complete data are submitted to the Department for measure calculation.

Table 12—Key Review Findings for Colorado Health Partnerships, LLC
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 **CHP**. 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 **CHP**, 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
• **CHP** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHCs 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 Colorado Health Partnerships, LLC
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 **CHP**. 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 **CHP**, 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
• **CHP** should continue to inspect accuracy and completeness of the encounter/claims data received from the CMHCs 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.

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Table 14—Key Review Findings for Colorado Health Partnerships, LLC
Performance Indicator 12: *Mental Health Engagement*
(Measurement Period: July 1, 2014, Through June 30, 2015)

Findings
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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; however, after further clarification regarding the use of paid versus nonpaid claims for this indicator, the BHO recalculated its rate and submitted it to HSAG for review. The newly calculated rate was reviewed and approved. No further issues were identified.
Key Recommendations
• Data monitoring for rate calculation is crucial. **CHP** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 15—Key Review Findings for Colorado Health Partnerships, LLC
Performance Indicator 12: *Mental Health Engagement*
(Measurement Period: July 1, 2015, Through June 30, 2016)

Findings
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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; however, after further clarification regarding the use of paid versus nonpaid claims for this indicator, the BHO recalculated its rate and submitted it to HSAG for review. The newly calculated rate was reviewed and approved. No further issues were identified.
Key Recommendations
• Data monitoring for rate calculation is crucial. **CHP** should continue its monitoring process to ensure accuracy for the next measurement year.

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

Findings
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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. **CHP** should continue its monitoring process to ensure accuracy for the next measurement year.

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

Findings
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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. **CHP** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 18—Key Review Findings for Colorado Health Partnerships, LLC
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
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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. **CHP** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 19—Key Review Findings for Colorado Health Partnerships, LLC
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
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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. **CHP** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 20—Key Review Findings for Colorado Health Partnerships, LLC
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
CHP calculated this rate. HSAG reviewed the programming code used for calculation of this rate and identified no concerns. 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. **CHP** should continue its monitoring process to ensure accuracy for the next measurement year.

Table 21 lists the validation result for each performance measure indicator for **CHP**.

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**

	Performance Indicator	Validation Result
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**
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
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*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.

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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*

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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

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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.

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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.

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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

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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

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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

<table>
<tr><th colspan="2">Description</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><th colspan="2">Eligible Population</th></tr>
<tr><td>Ages</td><td>Three age categories are identified, ages 6-20, 21-64, and 65+</td></tr>
<tr><td>Continuous Enrollment</td><td>Date of discharge through 30 days after discharge.</td></tr>
<tr><td>Allowable Gap</td><td>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.</td></tr>
<tr><td>Event / Diagnosis</td><td>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.</td></tr>
<tr><td>Mental health readmission or direct transfer</td><td>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.</td></tr>
<tr><td>Exclusion</td><td>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.</td></tr>
</table>

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.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Data Integration and Control Findings

Documentation Work Sheets

BHO Name:	Colorado Health Partnerships, LLC
On-Site Visit Date:	February 15, 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:	Colorado Health Partnerships, LLC
On-Site Visit Date:	February 15, 2017
Reviewer:	Timea Jonas, CHCA

Denominator Elements for Colorado Health Partnerships, LLC				
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 Colorado Health Partnerships, LLC				
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.	☐	☐	☒	
• 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 primary source verification, HSAG noted that paid and unpaid claims were used to calculate Indicator #12; however, **CHP** staff members were responsive, investigated the issue, and resubmitted the revised rate prior to generation of this report. **CHP** should ensure that the scope document is reviewed in its entirety and continue to communicate with the Department, and other BHOs to ensure that all BHOs have the same understanding regarding reporting requirements.

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 Colorado Health Partnerships, LLC

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	107	3	2.80%	108	3	2.78%
	30 Days	107	8	7.48%	108	8	7.41%
	90 Days	107	9	8.41%	108	9	8.33%
Adolescent 13–17 Years of Age	7 Days	613	15	2.45%	637	15	2.35%
	30 Days	613	48	7.83%	637	49	7.69%
	90 Days	613	81	13.21%	637	85	13.34%
Adult 18–64 Years of Age	7 Days	1,847	59	3.19%	1,877	59	3.14%
	30 Days	1,847	196	10.61%	1,877	196	10.44%
	90 Days	1,847	321	17.38%	1,877	322	17.16%
Adult 65 Years of Age and Older	7 Days	17	2	11.76%	17	2	11.76%
	30 Days	17	2	11.76%	17	2	11.76%
	90 Days	17	4	23.53%	17	4	23.53%
All Ages	7 Days	2,584	79	3.06%	2,639	79	2.99%
	30 Days	2,584	254	9.83%	2,639	255	9.66%
	90 Days	2,584	415	16.06%	2,639	420	15.92%

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

Table D-2—*Hospital Readmissions Within 180 Days* for Colorado Health Partnerships, LLC

Population	Time Frame	All Hospitals		
		Denominator (Discharges)	Numerator (Readmissions)	Rate
Child 0–12 Years of Age	180 Days	106	13	12.26%
Adolescent 13–17 Years of Age	180 Days	642	115	17.91%
Adult 18–64 Years of Age	180 Days	1,875	426	22.72%
Adult 65 Years of Age and Older	180 Days	16	4	25.00%
All Ages	180 Days	2,639	558	21.14%

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

Table D-3—*Adherence to Antipsychotics for Individuals With Schizophrenia for Colorado Health Partnerships, LLC**

Population	Denominator	Numerator	Rate
Overall	918	552	60.13%

*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 Colorado Health Partnerships, LLC

Population	Enrollment*	Members Served	Rate
Overall	**444,855**	**66,085**	**14.86%**

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

Table D-5—*Penetration Rates by Age Category* for Colorado Health Partnerships, LLC

Population	Enrollment*	Members Served	Rate
Children 12 Years of Age and Younger	**132,215**	**9,466**	**7.16%**
Adolescents Between 13 and 17 Years of Age	**43,398**	**7,449**	**17.16%**
Adults Between 18 and 64 Years of Age	**253,974**	**47,321**	**18.63%**
Adults 65 Years of Age or Older	**15,268**	**1,849**	**12.11%**
Overall	**444,855**	**66,085**	**14.86%**

* Expressed as FTE, rounded to the nearest integer.

Table D-6—*Penetration Rates by Medicaid Eligibility Category* for Colorado Health Partnerships, LLC

Population	Enrollment*	Members Served	Rate
AND/AB-SSI	**26,874**	**9,178**	**34.15%**
BC Children	**6,623**	**294**	**4.44%**
BCCP—Women Breast & Cervical Cancer	**33**	**4**	**11.99%**
Buy-In: Working Adults With Disabilities	**1,718**	**450**	**26.19%**
Foster Care	**7,050**	**2,082**	**29.53%**
OAP-A	**14,140**	**1,696**	**11.99%**
OAP-B-SSI	**4,335**	**1,154**	**26.62%**

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Population	Enrollment*	Members Served	Rate
MAGI Adults	**153,840**	**25,348**	**16.48%**
Buy-In: Children With Disabilities	**332**	**44**	**13.24%**
MAGI Parents/Caretakers	**58,074**	**9,524**	**16.40%**
MAGI Children	**166,656**	**14,939**	**8.96%**
MAGI Pregnant	**5,179**	**1,031**	**19.91%**

* 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 Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
7 Day	**3,728**	**1,263**	**33.88%**
30 Day	**3,728**	**1,632**	**43.78%**

*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 Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
7 Day	**5,868**	**731**	**12.46%**
30 Day	**5,868**	**1,153**	**19.65%**

*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 Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
Child 0–12 Years of Age	2,796	1,411	50.46%
Adolescent 13–17 Years of Age	1,788	892	49.89%
Adult 18–64 Years of Age	7,678	3,073	40.02%
Adult 65 Years of Age and Older	124	41	33.06%
All Ages	12,386	5,417	43.73%

Table D-10—*Mental Health Engagement* (Measurement Period: July 1, 2015, Through June 30, 2016) for Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
Child 0–12 Years of Age	2,932	1,503	51.26%
Adolescent 13–17 Years of Age	1,803	874	48.47%
Adult 18–64 Years of Age	8,084	3,112	38.50%
Adult 65 Years of Age and Older	127	36	28.35%
All Ages	12,946	5,525	42.68%

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 Colorado Health Partnerships, LLC

Population	Initiation of AOD Treatment			Engagement of AOD Treatment		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
13–17 Years of Age	270	150	55.56%	270	108	40.00%
18+ Years of Age	3,752	1,581	42.14%	3,752	1,226	32.68%
Combined Ages	4,022	1,731	43.04%	4,022	1,334	33.17%

Table D-12—*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (Measurement Period: July 1, 2015, Through June 30, 2016) for Colorado Health Partnerships, LLC

Population	Initiation of AOD Treatment			Engagement of AOD Treatment		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
13–17 Years of Age	318	159	50.00%	318	99	31.13%
18+ Years of Age	5,383	2,201	40.89%	5,383	1,634	30.35%
Combined Ages	5,701	2,360	41.40%	5,701	1,733	30.40%

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 Colorado Health Partnerships, LLC

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	585	312	53.33%	602	322	53.49%
	30 Days	585	426	72.82%	602	439	72.92%
21–64 Years of Age	7 Days	1,144	472	41.26%	1,181	480	40.64%
	30 Days	1,144	721	63.02%	1,181	743	62.91%
65+ Years of Age	7 Days	12	2	16.67%	12	2	16.67%
	30 Days	12	3	25.00%	12	3	25.00%
Combined Ages	7 Days	1,741	786	45.15%	1,795	804	44.79%
	30 Days	1,741	1,150	66.05%	1,795	1,185	66.02%

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 Colorado Health Partnerships, LLC

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	729	383	52.54%	749	391	52.20%
	30 Days	729	520	71.33%	749	536	71.56%
21–64 Years of Age	7 Days	1,360	556	40.88%	1,389	561	40.39%
	30 Days	1,360	816	60.00%	1,389	828	59.61%
65+ Years of Age	7 Days	13	3	23.08%	13	3	23.08%
	30 Days	13	5	38.46%	13	5	38.46%
Combined Ages	7 Days	2,102	942	44.81%	2,151	955	44.40%
	30 Days	2,102	1,341	63.80%	2,151	1,369	63.64%

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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 Colorado Health Partnerships, LLC

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	729	163	22.36%	749	165	22.03%
	30 Days	729	347	47.60%	749	356	47.53%
21–64 Years of Age	7 Days	1,360	274	20.15%	1,389	276	19.87%
	30 Days	1,360	548	40.29%	1,389	556	40.03%
65+ Years of Age	7 Days	13	2	15.38%	13	2	15.38%
	30 Days	13	4	30.77%	13	4	30.77%
Combined Ages	7 Days	2,102	439	20.88%	2,151	443	20.6%
	30 Days	2,102	899	42.77%	2,151	916	42.58%