COLORADO

Department of Health Care Policy & Financing

FY 2018–2019 Validation of Performance Measures for Colorado Health Partnerships, LLC

January 2019

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

HSAG HEALTH SERVICES ADVISORY GROUP

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Validation Overview

In accordance with 42 CFR §438.330(c), states must require that managed care organizations (MCOs) and behavioral health organizations (BHOs) submit performance measurement data as part of their quality assessment and performance improvement programs. The validation of performance measures is one of the mandatory external quality review (EQR) activities that the state Medicaid agencies are required to perform per the Medicaid managed care regulations as described in the Code of Federal Regulations (CFR) §438.358(b)(2). The EQR technical report must include information on the validation of the MCOs' and BHOs' performance measures (as required by the state) or the MCOs' and BHOs' performance measures calculated by the state during the preceding 12 months.

The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures reported by the BHOs and determine the extent to which the reported rates follow the state specifications and reporting requirements. According to CMS' *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] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not a BHO, or an external quality review organization (EQRO). Health Services Advisory Group, Inc. (HSAG), the EQRO for the Colorado Department of Health Care Policy and Financing (the Department), conducted the validation activities during fiscal year (FY) 2018–2019.

The Department contracted with five BHOs to provide mental health services to Medicaid-eligible recipients enrolled in Health First Colorado (Colorado's Medicaid Program). The Department identified a set of incentive performance measures for validation that the BHOs were required to report for the measurement period of July 1, 2017, through June 30, 2018. Two of these measures were calculated by the Department using data submitted by the BHOs; five measures were calculated by the BHOs. The measures came from multiple 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: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 30, 2018.

Colorado Health Partnerships, LLC Information

Basic information about **Colorado Health Partnerships, LLC** (**CHP**) appears in Table 1, including the office location(s) involved in the validation of performance measures audit that covered the FY 2018–2019 measurement period.

Table 1—Colorado Health Partnerships, LLC Information

BHO Name:	Colorado Health Partnerships, LLC
BHO Location:	609 Main Street, Alamosa, CO 81101
BHO On-Site Visit Location:	9925 Federal Drive, Suite 100, Colorado Springs, CO 80921
BHO Contact:	Wayne Watkins
Contact Telephone Number:	719.538.1457
Contact Email Address:	wayne.watkins@beaconhealthoptions.com
Site Visit Date:	Wednesday, November 28, 2018

Performance Measures for Validation

HSAG validated rates for a set of performance measures that were selected by the Department for validation. 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 the entity that 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:
1	*Mental Health Engagement* (all members excluding foster care)	BHO
2	*Mental Health Engagement* (only foster care)	BHO
3	*Engagement of AOD Treatment*	BHO
4	*Follow-up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition*	BHO
5	*Follow-up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition*	BHO
6	*Emergency Department Utilization for Mental Health Condition*	Department
7	*Emergency Department Utilization for Substance Use Condition*	Department

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV Protocol. To complete the validation activities for **CHP**, HSAG obtained a list of the performance measures that were selected by the Department for validation.

HSAG prepared a document request letter that was submitted to **CHP** outlining the steps in the PMV process. The document request letter included a request for the source code for each performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), additional supporting documentation necessary to complete the audit, a timeline for completion, and instructions for submission. When requested, HSAG addressed ISCAT-related questions directly from **CHP** during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided **CHP** with an agenda describing all on-site activities and indicating the type of staff members needed for each session. HSAG also conducted a pre-on-site conference call with **CHP** to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and answered questions from **CHP**.

Validation Team

The HSAG PMV team was composed of a lead auditor and several validation team members. HSAG assembled the team based on the skills required for the validation and requirements of **CHP**. Some team members, including the lead auditor, participated in the on-site meetings at **CHP**; others conducted their work at HSAG's offices. Table 3 lists the validation team members and their roles, skills, and expertise.

Table 3—Validation Team

Name and Role	Skills and Expertise
Mariyah Badani, JD, MBA, CHCA *Director, Audits/State & Corporate Services*	Director of audit department; multiple years of auditing experience; certified HEDIS compliance auditor; data integration, systems review, and analysis experience.
Jenny Starbuck, BA *Senior Project Manager; Lead Auditor*	Multiple years of experience in performance measure reviews and audits, including readiness reviews; medical and pharmacy claims systems reviews; measure development; and data validation, analyses, and reporting.
Jackie DeGrow, MA *Audit Specialist; Secondary Auditor*	Multiple years of experience in healthcare compliance and quality improvement, including auditing, performance measures, and fraud prevention.
Warren Harris *Source Code Reviewer*	Multiple years of audit-related experience; statistics, analysis, and source code/programming language knowledge.
Tammy GianFrancisco *HEDIS Manager*	Coordinator for the audit department, liaison between the audit team and clients, management of deliverables and timelines, and coordination of source code review activities.

Technical Methods of Data Collection and Analysis

The CMS PMV Protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how it was analyzed by HSAG:

- **Information Systems Capabilities Assessment Tool (ISCAT):** **CHP** and the Department completed and submitted an ISCAT of the required measures for HSAG's review. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures:** Both the Department and **CHP** calculated the performance indicators using source code and were required to submit the source code used to generate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by the Department. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). If **CHP** or the Department did not use source code to generate the performance measures, they were required to submit documentation describing the steps taken for the calculation of each of the required performance measures.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow up.

On-Site Activities

HSAG conducted on-site visits with the Department and **CHP**. HSAG collected information using several methods including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening session:** The opening session included introductions of the validation team and key staff members from both **CHP** and the Department involved in the PMV activities. The review purpose, required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and supportive documentation:** This session was designed to be interactive with key staff members from both **CHP** and the Department so the validation team could obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims system and processes:** The evaluation included a review of the information systems, with a focus on the processing of claims and encounters, enrollment and disenrollment data, and provider data. HSAG conducted interviews with key staff members familiar with the processing, monitoring, reporting, and calculating of the performance

measures. Key staff members included executive leadership, enrollment specialists, business analysts, and data analytics staff members familiar with the processing, monitoring, and generating of the performance measure.

- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, an analysis of how all data sources were combined, and a review of how the analytic file was produced for the reporting of the selected performance indicators. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary Source Verification (PSV):** HSAG used PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. The Department and **CHP** provided a listing of the data reported from which HSAG selected sample records.

  HSAG selected a random sample from the submitted data and reviewed the date in the Department and **CHP**'s systems during the on-site review for verification. This method provided the Department and **CHP** an opportunity to explain their processes as needed for any unique, case-specific nuances that may have impacted final measure reporting. There were specific instances in which a sample case was acceptable based on on-site clarification and follow-up documentation provided by the Department and **CHP**.

  Using this method, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the Department and **CHP** have system documentation that supports the inclusion of the appropriate records for measure reporting.

  This method did not rely on a specific number of cases reviewed to determine compliance; rather, it was used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and, as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may have resulted in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference:** The closing conference included a summation of preliminary findings based on the on-site visit and the review of the ISCAT. In addition, the documentation requirements for any post-on-site visit activities were reviewed.

HSAG conducted several interviews with key staff members from **CHP** and the Department who were involved with any aspect of performance indicator reporting. Table 4 and Table 5 display **CHP** interviewees and Department staff members who attended the on-site visit.

Table 4—List of Colorado Health Partnerships, LLC Interviewees

Name	Title
Dario Russo	Structured Query Language Developer
Andrea Scott	Structured Query Language Developer
Eric Arnold-Miller	Vice President, Quality Management
Bill Mackie	Programmer/Analyst II
Wayne Watkins	Director, Information Technology
Lucas Surnear	Business Systems Analyst II
Karen Swanker	Technical Manager, Corporate Claims
Kimberly Kern	Supervisor, Corporate Claims

Table 5—List of On-Site Visit Attendees From the Department

Name	Title
Jerry Ware	Contract Manager

Data Integration, Data Control, and Performance Measure Documentation

Several aspects involved in the calculation of performance indicator data 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 measure data. The steps used to combine various data sources (including claim/encounter, eligibility, and other administrative data) must be carefully controlled and validated. HSAG validated the data integration process used by the Department and **CHP**, which 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 **CHP** 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

Validation Results

HSAG evaluated **CHP**'s data systems for the processing of each data type used for reporting the performance indicator data. General findings are indicated below.

Eligibility/Enrollment Data System Findings

HSAG had no concerns with how **CHP** received and processed eligibility data; however, HSAG identified an area for process improvement.

CHP received daily 834 change files and monthly full eligibility files from the Department's secure file transfer protocol (FTP) site. The files were downloaded through an automated process daily from the Department's vendor, DXC. The daily change files contained reinstatements, terminations, adds, and updated member demographic information. The monthly files contained all member eligibility information for the month the file was received. Upon receipt of the enrollment files, **CHP**'s eligibility team ran logic to identify any errors that may have been present. If errors were found, an error report was generated, and **CHP** staff members worked with the Department and DXC to find a resolution.

Once the files were clear of errors, they were processed and loaded into the Connection Administrative System (CAS), **CHP**'s eligibility and transaction system. A file load program within CAS processed the files and performed validation to ensure only complete enrollment information was received before it was loaded into the data warehouse. Files were stored in tables in the data warehouse. **CHP**'s eligibility production team validated the data and contacted DXC or the Department if there was discrepancy. **CHP** experienced no issues receiving eligibility data during the measurement period. **CHP** used each member's state Medicaid identification (ID) number to uniquely identify its members. It experienced no issues with duplicate IDs but confirmed that it performed secondary checks using the member's first name, last name, date of birth, and social security number to confirm the ID. **CHP** also confirmed that if a member was given a new/different Medicaid ID number by the State, then **CHP**'s internal ID number was modified and synced to the member's history.

CHP continued to distribute enrollment data to the appropriate Community Mental Health Centers (CMHCs) via FileConnect, a front-end system that connected to CAS. SQL code generated a flat file from the data warehouse, and the flat file was sent weekly to the CHMCs. CMHCs also verified eligibility in real time using the Department's portal. **CHP** had quality checks in place to validate eligibility data received from the Department; however, it did not have a process in place to validate eligibility data sent to the CMHCs. Therefore, HSAG recommends that, in the future, organizations implement a formal validation process for all outgoing files sent to downstream entities to ensure complete and accurate data transfers.

Claims/Encounter Data System Findings

HSAG identified no issues or concerns with how **CHP** processed or reported claims and encounter data.

All claims and encounter data were housed and processed in CAS. Professional and institutional claims received electronically were downloaded daily using an automated process through a clearinghouse, ProviderConnect. Providers submitted claims to ProviderConnect or sent them electronically to the BHO through FileConnect within 90 days of service. Once loaded into ProviderConnect, claims that did not auto-adjudicate were assigned to **CHP** staff members to finalize and authorize.

Paper claims that were received via mail were processed by **CHP**'s vendor, Fidelity National Information Systems (FIS). FIS stamped all claims with the time and date of receipt, verified claims for completeness, and scanned the claims using optical character recognition (OCR) technology to create the 837 file. Once the 837 file was created, Edifecs, a third-party vendor, sent the file to **CHP** where it was automatically loaded into CAS. If the paper claim could not be converted automatically via OCR, the claim was manually entered into the 837 file. Electronic images of paper claims were kept for 10 years, and the original paper copies were shredded after 60 days. FIS processed claims within three to four days of receipt.

Affiliated CMHCs submitted encounter data monthly in a flat file through FileConnect. A notification was sent to **CHP** staff members upon receipt of the file, and a programmer moved the flat file into a local SQL server where the file would be scrubbed for errors. If any errors were found, an error report would be generated and sent to the CMHCs via FileConnect for reconciliation. **CHP** received the flat files on the tenth day of each month.

State hospital data were received from the Department quarterly via a secure email in an Excel format. Manual validation was conducted on this file to remove any duplicate records. Once validated, the file was loaded into a table on the local service and sent to the data warehouse.

CHP submitted standard 837i and 837p files and flat files to the Department through a secure FTP site monthly. **CHP** experienced challenges with submission of the 837 files to the Department due to field value rejections. Therefore, **CHP** sent both 837 and flat files to ensure the Department received all necessary information.

Data Integration

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

CHP generated data from its corporate data warehouse. All denominator and numerator compliant members were exported into an Excel spreadsheet and included member ID, dates of service, member name, and date of birth. **CHP** staff members reviewed the data to ensure counts matched the member-

level detail data, reasonability of lengths of stays, and that inpatient stays matched the total number of discharge counts. A quality manager reviewed the data before submission to the Department to check for reasonability. **CHP** submitted data to the Department through a secure FTP site and notified the Department of the submission.

During PSV for Indicators 4 and 5, it was discovered that **CHP** included covered and non-covered mental health diagnoses in the calculations of the measures. Although **CHP** calculated these measures differently than the other BHOs in the State, the impact of including these non-covered diagnoses in **CHP**'s rates was small (i.e., 2–3 percent of the numerator-positive cases were based on non-covered diagnoses). Therefore, the Department determined that the rates did not need to be recalculated for **CHP**. HSAG recommends that, in the future, the Department clarify in the specification document if reporting should only include follow-up visits for covered mental health diagnoses or if non-covered diagnoses should also be included.

Performance Indicator Specific Findings

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

Table 6—Designation Categories for Performance Indicators

Report (R)	Indicator was compliant with the Department's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to indicators for which (1) the BHO rate was materially biased or (2) the BHO was not required to report.

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

Table 7 through Table 13 display the review findings for **CHP** for each validated performance measure. For more detailed information, please see Appendix D.

Table 7—Key Review Findings for Colorado Health Partnerships, LLC
Indicator 1: *Mental Health Engagement* (all members excluding foster care)

Findings
CHP calculated this rate. Programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **CHP** prior to the on-site visit. HSAG performed PSV on-site and identified no discrepancies.

Table 8—Key Review Findings for Colorado Health Partnerships, LLC
Indicator 2: *Mental Health Engagement* (only foster care)

Findings
CHP calculated this rate. Programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **CHP** prior to the on-site visit. HSAG performed PSV on-site and identified no discrepancies.

Table 9—Key Review Findings for Colorado Health Partnerships, LLC
Indicator 3: *Engagement of AOD Treatment*

Findings
CHP calculated this rate. Programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **CHP** prior to the on-site visit. HSAG performed PSV on-site and identified no discrepancies.

Table 10—Key Review Findings for Colorado Health Partnerships, LLC
Indicator 4: *Follow-up Appointment Within 7 Days*
After a Hospital Discharge for a Mental Health Condition

Findings
CHP calculated this rate. Programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **CHP** during the on-site visit. HSAG performed PSV on-site and identified that **CHP** included covered and non-covered mental health diagnoses in the calculations of the measures. Although **CHP** calculated these measures differently than Access Behavioral Care—Denver, Access Behavioral Care—Northeast, and Behavioral Healthcare, Inc., the impact of including these non-covered diagnoses in **CHP**'s rates was small (i.e., 2–3 percent of the numerator-positive cases were based on non-covered diagnoses). Therefore, the Department determined that the rates did not need to be recalculated for **CHP**. HSAG recommends that, in the future, the Department clarify in the specification document if reporting should only include follow-up visits for covered mental health diagnoses or if non-covered diagnoses should also be included.

Table 11—Key Review Findings for Colorado Health Partnerships, LLC
Indicator 5: *Follow-up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition*

Findings
CHP calculated this rate. Programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **CHP** during the on-site visit. HSAG performed PSV on-site and identified that **CHP** included covered and non-covered mental health diagnoses in the calculations of the measures. Although **CHP** calculated these measures differently than Access Behavioral Care—Denver, Access Behavioral Care—Northeast, and Behavioral Healthcare, Inc., the impact of including these non-covered diagnoses in **CHP**'s rates was small (i.e., 2–3 percent of the numerator-positive cases were based on non-covered diagnoses). Therefore, the Department determined that the rates did not need to be recalculated for **CHP**. HSAG recommends that, in the future, the Department clarify in the specification document if reporting should only include follow-up visits for covered mental health diagnoses or if non-covered diagnoses should also be included.

Table 12—Key Review Findings for Colorado Health Partnerships, LLC
Indicator 6: *Emergency Department Utilization for Mental Health Condition*

Findings
This rate was calculated by the Department based on claims and encounter data received from **CHP.** Encounter data were submitted to the Department in an 837 file format and 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. During the on-site visit, it was noted that the Department did not save a copy of the data that were submitted prior to the on-site. The data were re-run and HSAG validated the new data.

Table 13—Key Review Findings for Colorado Health Partnerships, LLC
Indicator 7: *Emergency Department Utilization for Substance Use Condition*

Findings
This rate was calculated by the Department based on claims and encounter data received from **CHP**. Encounter data were submitted to the Department in an 837 file format and 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. During the on-site visit, it was noted that the Department did not save a copy of the data that were submitted prior to the on-site. The data were re-run and HSAG validated the new data.

Table 14 lists the validation result for each performance measure indicator for **CHP**.

Table 14—Summary of Results

#	Indicator	Validation Result
1	*Mental Health Engagement* (all members excluding foster care)	**R**
2	*Mental Health Engagement* (only foster care)	**R**
3	*Engagement of AOD Treatment*	**R**
4	*Follow-up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition*	**R**
5	*Follow-up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition*	**R**
6	*Emergency Department Utilization for Mental Health Condition*	**R**
7	*Emergency Department Utilization for Substance Use Condition*	**R**

Appendix A. BHO Performance Measure Definitions

Indicators

#	Indicator	Calculated by:
1	*Mental Health Engagement* (all members excluding foster care)	BHO
2	*Mental Health Engagement* (only foster care)	BHO
3	*Engagement of AOD Treatment*	BHO
4	*Follow-up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition*	BHO
5	*Follow-up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition*	BHO
6	*Emergency Department Utilization for Mental Health Condition*	Department
7	*Emergency Department Utilization for Substance Use Condition*	Department

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 *Fiscal Year 2018 BHO-HCPF Incentive Performance Measures Scope Document, Created: January 31, 2017, Last Revised: June 5, 2018.* Please note that the complete scope document is not listed in this appendix. The table of contents and corresponding page numbers have been modified for use in this report; however, the verbiage for the measures validated under the scope of the review is reproduced in its entirety.

BHO-HCPF Incentive Performance Measures Scope Document

Fiscal Year 2018 (FY18)

This document includes the details for calculations of the BHO-HCPF 2017-2018 Incentive Measures for the five Colorado Behavioral Health Organizations (BHOs) according to the Community Behavioral Health Services Program. All measures are calculated using paid claims/encounters data.

Created: January 31, 2017 *Last Revised: June 5, 2018*

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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.

Diagnosis: All performance measures based on diagnosis are calculated using **primary** diagnosis only; all secondary and subsequent diagnoses are not considered.

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-2, 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-10	
Start Value	End Value
F20.0	F42.3
F42.8	F48.1
F48.9	F51.03
F51.09	F51.12
F51.19	F51.9
F60.0	F63.9
F68.10	F69
F90.0	F99
R45.1	R45.2
R45.5	R45.82

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

Substance Use Disorder Covered Diagnoses	
ICD-10	
Start Value	End Value
F10.10	F10.26
F10.28	F10.96
F10.98	F13.26
F13.28	F13.96

F13.98	F18.159
F18.18	F18.259
F18.28	F18.959
F18.980	F19.16
F19.18	F19.26
F19.28	F19.99

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

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

HEDIS: Healthcare Effectiveness Data and Information Set

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

Hospital Discharge: A discharge from a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis that does not result in a re-hospitalization within 24 hrs. (transfer). There can be multiple discharges during the specified fiscal year period. The discharge must result in a paid claim for the hospital episode, except where the discharge is from a State Hospital for ages 21-64. Adult members on the list of discharges from the State hospital who are not eligible at the time of hospital admission should be included in the measure if eligibility is discontinued 1 day before the admission date. Adult members on the list of discharges from the State hospital who are eligible at the time of hospital admission, but who lose eligibility during the hospital stay should also remain on the hospital discharge list.

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

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

Member Months: Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.

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

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

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

Indicator 1: Mental health engagement (all members excluding foster care)

Description: The percentage of new members (excluding foster care) 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, 2017 to May 14, 2018

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
- MMIS MH ICD-10 Ranges (*refer to definition*)

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 who are not in foster care

- Foster care aid codes to exclude: FF, 10, 11, 12, 13, 19, 20, 23, 70

Step 2: Exclude members without 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: BHO

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: 48.48% - calculated by adding 10% to the highest performer. *This benchmark is based on total population*

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, H0032-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 2: Mental health engagement (ONLY foster care)

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

- New members in foster care 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, 2017 to May 14, 2018

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
- MMIS MH ICD-10 Ranges (*refer to definition*)

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 in foster care using an aid code below with an intake date

- Aid codes to identify members in foster care: FF, 10, 11, 12, 13, 19, 20, 23, 70

Step 2: Exclude members without 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. Continuous eligibility should not be "restricted" to an aid category during enrollment.

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: BHO

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: 62.36% - calculated by adding 10% to the highest performer. *This benchmark is based on total population*

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, H0032-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 3: 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 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, 2017 to May 14, 2018

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)*
- MMIS SUD ICD-10 Ranges (*refer to definition*)

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

Data Source: BHO claims/encounter systems

Calculation of Measure: BHO (utilization data on BHO services)

Benchmark: 33.55%

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 definition)
CPT				**ICD9PCS**
99202-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350			**WITH**	Diagnosis of AOD (see definition)
UBREV				**ICD9PCS**
0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0919, 0944, 0945, 0982, 0983			**WITH**	Diagnosis of AOD (see definition)
CPT		**POS**		**ICD9PCS**
90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 90875, 90876	**WITH**	02,03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72	**AND**	Diagnosis of AOD (see definition)
CPT		**POS**		**ICD9PCS**
99221-99223, 99231-99233, 99238, 99239, 99251-99255	**WITH**	52, 53	**AND**	Diagnosis of AOD (see definition)
Codes to Identify Detoxification				
HCPCS				
S3005, T1007, T1019, T1023				
AOD Procedure	94.61, 94.63, 94.64, 94.66, 94.67, 94.69			

Indicator 4: Follow-up appointments within 7 days after hospital discharge for a mental health condition

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 days (follow-up rates). 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 23

Denominator: The population based on discharges from any inpatient facility during the specified fiscal year July 1 through June 23 (can have multiple discharges for the same individual).

Numerator: Total number of discharges from any inpatient facility with an outpatient service within 7 days. 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.

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: 51.34%

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. 1. 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 7 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 July 1 and June 23 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 23 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 7-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 23 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 7-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 53
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: 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**	02,03, 04, 05, 07, 11, 12, 13, 14, 15, 16, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	**WITH**	52, 53

UB Revenue
The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.
0513, 0900-0905, 0907, 0911-0917, 0919
Visits identified by the following Revenue codes must be with a mental health practitioner or in conjunction with any covered diagnosis code.
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

Indicator 5: Follow-up appointments within 30 days after hospital discharge for a mental health condition

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 30 days (follow-up rates). ***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 May 31.

Denominator: The population based on discharges from any inpatient facility during the specified fiscal year July 1 through May 31 (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.

Numerator: Total number of discharges from any inpatient facility with an outpatient service within 30 days. 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.

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: 72.94%

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	
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 May 31 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 May 31 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 May 31 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, 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 53
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.

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**	02,03, 04, 05, 07, 11, 12, 13, 14, 15, 16, 20, 22, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	**WITH**	52, 53

UB Revenue
The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.
0513, 0900-0905, 0907, 0911-0917, 0919
Visits identified by the following Revenue codes must be with a mental health practitioner or in conjunction with any covered diagnosis code.
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

Indicator 6: Emergency Department Utilization for mental health condition

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

Definitions:
Intake Period: July 1, 2017 to June 30, 2018

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

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

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

Data Source: Denominator: HCPF; Numerator: BHO encounter claim file

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

Benchmark: 7.2

Indicator 7: Emergency Department Utilization for substance use disorder condition

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

Definitions:

Intake Period: July 1, 2017 to June 30, 2018

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

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

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

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

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

Benchmark: 19.71

Appendix B. Data Integration and Control Findings

Documentation Work Sheets

BHO Name:	Colorado Health Partnerships, LLC
On-Site Visit Date:	November 28, 2018
Reviewer:	Jenny Starbuck and Jackie DeGrow

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:	November 28, 2018
Reviewer:	Jenny Starbuck and Jackie DeGrow

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.	☒	☐	☐	

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.	☐	☐	☒	Nonstandard codes were not used by the BHO to determine numerator events.
• 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).	☒	☐	☐	

Performance Measure Results Tables

Included below are the final, approved measure results for the measures included in the scope of HSAG's audit. The measurement period for performance measures validated in FY 2018–2019 is July 1, 2017, through June 30, 2018.

Indicator 1—*Mental Health Engagement* (all members excluding foster care)

Table D-1—*Mental Health Engagement* (all members excluding foster care) for Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
All Ages	13,131	6,749	51.40%

Indicator 2—*Mental Health Engagement* (only foster care)

Table D-2—*Mental Health Engagement* (only foster care) for Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
All Ages	571	355	62.20%

Indicator 3—*Engagement of AOD Treatment*

Table D-3—*Engagement of AOD Treatment* for Colorado Health Partnerships, LLC

Population	Initiation of AOD Treatment			Engagement of AOD Treatment		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
All Ages	7,114	3,225	45.30%	7,114	2,272	31.90%

Indicator 4—*Follow-up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition*

Table D-4—*Follow-up Appointment Within 7 Days After a Hospital Discharge for a Mental Health Condition* for Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
All Ages	3,653	2,014	55.10%

Indicator 5—*Follow-up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition*

Table D-5—*Follow-up Appointment Within 30 Days After a Hospital Discharge for a Mental Health Condition* for Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
All Ages	3,166	2,229	70.40%

Indicator 6—*Emergency Department Utilization for Mental Health Condition*

Table D-6—*Emergency Department Utilization for Mental Health Condition* for Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
All Ages	457,360	4,720	10.32%

Indicator 7—*Emergency Department Utilization for Substance Use Condition*

Table D-7—*Emergency Department Utilization for Substance Use Condition* for Colorado Health Partnerships, LLC

Population	Denominator	Numerator	Rate
All Ages	457,360	9,346	20.43%