COLORADO
Department of Health Care Policy & Financing

FY 2017–2018 Validation of Performance Measures for Access Behavioral Care—Northeast

January 2018

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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Acknowledgments and Copyrights

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 described in §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.

For fiscal year (FY) 2017–2018, 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, 2016 through June 30, 2017. 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: Nov 17, 2017.

Access Behavioral Care—Northeast Information

Basic information about **Access Behavioral Care—Northeast** (**ABC-NE**) appears in Table 1, including the office location(s) involved in the validation of performance measures audit that covered the FY 2017–2018 measurement period.

Table 1—Access Behavioral Care—Northeast Information

BHO Name:	Access Behavioral Care—Northeast
BHO Location:	11100 E. Bethany Drive, Aurora, CO 80014
BHO On-Site Visit Location:	11100 E. Bethany Drive, Aurora, CO 80014
BHO Contact:	Michelle Tomsche
Contact Telephone Number:	720.744.5299
Contact Email Address:	Michelle.tomsche@coaccess.com
Site Visit Date:	Friday, December 8, 2017

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 who was responsible for calculating the rates. The indicators are numbered as they appear in the scope document.

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

	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 **ABC-NE**, 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 **ABC-NE** 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 **ABC-NE** during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided **ABC-NE** 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 **ABC-NE** to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and answered questions from **ABC-NE**.

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 **ABC-NE**. Some team members, including the lead auditor, participated in the on-site meetings at **ABC-NE**; 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.
Regina Cameron, MSW *Audit Specialist; Lead Auditor*	Multiple years of experience in quality improvement, project and program management/coordination, research, analysis, evaluation, data abstraction, and audits.
Jenny Starbuck, BA *Senior Project Manager; Secondary 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.
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):** **ABC-NE** 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 **ABC-NE** 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 **ABC-NE** 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 **ABC-NE**. 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 **ABC-NE** 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 **ABC-NE** 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 **ABC-NE** 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 **ABC-NE**'s systems during the on-site review for verification. This method provided the Department and **ABC-NE** 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 **ABC-NE**.

  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 **ABC-NE** 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 **ABC-NE** and the Department who were involved with any aspect of performance indicator reporting. Table 4 displays a list of **ABC-NE** interviewees:

Table 4—List of Access Behavioral Care—Northeast Interviewees

Name	Title
Lindsay Cowee	Director, Quality Management
Chris Zhu	Business Intelligence Analyst
Jeni Sargent	Director, Credentialing, Configuration and Enrollment
Michelle Tomsche	Director, Behavioral Health Operations
Catherine Morrisey	Project Manager, Quality Improvement
David Napoli	Director, Business Intelligence
Kristen Brown	Manager, Behavioral Health Operations
Amanda Howe	Business Intelligence Analyst
Kevin Lawrence	Supervisor, Claims, Appeals and Auditors
Julie McNamara	Director, System Operations and Vendor Management
Cindy Dalton	Director, Information Technology
Marty Janssen	Deputy Director
Callista Medland	Business Intelligence Analyst
List of Department Observers	
Name	**Title**
Jerry Ware	Contract Manager
Danielle Culp	Quality Health Improvement Specialist

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 **ABC-NE**, 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 **ABC-NE** were:

☒ Acceptable
☐ Not acceptable

Data Control

The organizational infrastructure of **ABC-NE** must support all necessary information systems. Each quality assurance practice and backup procedure must be sound to ensure timely and accurate processing of data, as well as provide data protection in the event of a disaster. HSAG validated the data control processes used by **ABC-NE**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, HSAG determined that the data control processes in place at **ABC-NE** were:

☒ Acceptable
☐ Not acceptable

Performance Measure Documentation

Complete and sufficient documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by **ABC-NE** and the Department. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, and computer programming code, output files, work flow diagrams, narrative descriptions of performance measure calculations, and other related documentation. Overall, HSAG determined that the documentation of performance measure data collection and calculations by **ABC-NE** and the Department was:

☒ Acceptable
☐ Not acceptable

Validation Results

HSAG evaluated **ABC-NE**'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 identified no concerns with how **ABC-NE** received and processed enrollment data. Prior to March 1, 2017, **ABC-NE** received both monthly eligibility full files and daily change files from the Department through a secure file transfer protocol (FTP) site in a flat file format. On March 1, 2017, **ABC-NE** began receiving 834 monthly eligibility full files and daily change files from DXC Technology (DXC). **ABC-NE** experienced no challenges with the transition to the new DXC system for receiving eligibility data. Both the 834 and flat files were mapped into tables and loaded into Oracle, the BHO's database management system. Oracle validated the files and checked for changes, additions, and terminations prior to loading the files into QNXT™, the BHO's transactional system. QNXT processed the files and loaded them back into Oracle and the enterprise data warehouse (EDW).

Eligibility files were submitted to **ABC-NE** providers and affiliated Community Mental Health Centers (CMHCs) daily. Providers continued to have the ability to log into the Colorado Access portal or the Department portal to obtain eligibility information for members.

Each member received a unique identification (ID) number. **ABC-NE** did experience limited instances in which members were issued more than one Medicaid ID number; these included members who had changed their names and a few foster care members. In these instances, **ABC-NE** linked both ID numbers and kept the assigned QNXT number within the system. In addition, the Medicaid ID numbers were linked to the corresponding enrollment periods.

Claims/Encounter Data System Findings

HSAG identified no issues or concerns with how **ABC-NE** received, processed, or reported claims and encounter data. Claims and encounters were received and processed in the same way; data were received in an 837 file through a secure FTP site or clearinghouse. The files were loaded into QNXT via a Cognizant FTP site that performed checks using BizTalk, a Microsoft software, to identify accurate formatting and complete data. A 999 response file was generated in addition to a 277 acceptance or rejection report. Paper claims were sorted, batched, scanned, and uploaded to Cognizant's FTP site within three days, which converted them into an 837 format using optical character recognition (OCR) software before loading them into QNXT. CMHCs submitted encounter data through a secure FTP site. The files were loaded into QNXT through Cognizant.

Nightly, Cognizant staff members audited 2.5 percent of auto-adjudicated claims and 5 percent of manually adjudicated claims. As an additional quality check, **ABC-NE** conducted audits daily on 7 percent of claims previously verified by Cognizant. **ABC-NE** and Cognizant performed audits on

100 percent of facility claims exceeding a $10,000 threshold and professional claims exceeding a $5,000 threshold.

State hospital data were received from the Department quarterly via a secure email in an Excel format.

ABC-NE submitted 837 and flat files to the Department through a secure FTP site monthly. On March 1, 2017, the Department began a new process for BHOs to submit encounters to the Department interchange using DXC. **ABC-NE** experienced several challenges with this transition, including formatting discrepancies and incorrect data fields, and have yet to submit encounters successfully using this method. **ABC-NE** continue to test the new data submission process. The BHOs and the Department conducted monthly meetings to address this ongoing issue. **ABC-NE** also engaged in weekly calls with other BHOs to work through these challenges.

Data Integration

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

Claims and encounters were extracted from QNXT and loaded into EDW for rate calculation. **ABC-NE** generated a query in EDW to generate both denominator and numerator compliant members for each indicator. Once the data was queried it was extracted into an Oracle system in which tables were created. The state hospital data was loaded into Oracle and a query was run to load the state hospital data with the data contained in the Oracle tables in the EDW.

The business intelligence department generated the indicator rates and submitted them to the quality department. The quality department conducted PSV on 5–10 members per indicator to ensure accuracy before the data were submitted to the Department.

Performance Indicator Specific Findings

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.

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 12 below display the review findings and key recommendations for **ABC-NE** for each validated performance measure. For more detailed information, please see Appendix D.

Table 6—Key Review Findings for Access Behavioral Care—Northeast
Indicator 1: *Mental Health Engagement* (all members excluding foster care)

Findings
ABC-NE calculated this rate. The programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **ABC-NE** during the on-site visit. HSAG performed PSV on-site and identified no discrepancies.
Key Recommendations
• Data monitoring for rate calculation is crucial. **ABC-NE** should continue its monitoring process to ensure accuracy for the next measurement year. • HSAG recommends the Department modify the wording convention in the scope document for this indicator to specify that the measure applies to "New Episodes of Care" rather than "New Members."

Table 7—Key Review Findings for Access Behavioral Care—Northeast
Indicator 2: *Mental Health Engagement* (only foster care)

Findings
ABC-NE calculated this rate. The programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **ABC-NE** during the on-site visit. HSAG performed PSV on-site and identified no discrepancies.
Key Recommendations
• Data monitoring for rate calculation is crucial. **ABC-NE** should continue its monitoring process to ensure accuracy for the next measurement year. • HSAG recommends the Department modify the wording convention in the scope document for this indicator to specify that the measure applies to "New Episodes of Care" rather than "New Members."

Table 8—Key Review Findings for Access Behavioral Care—Northeast
Indicator 3: *Engagement of AOD Treatment*

Findings
ABC-NE calculated this rate. The programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **ABC-NE** during the on-site visit. HSAG performed PSV on-site and identified no discrepancies.
Key Recommendations
• HSAG recommends **ABC-NE** work closely with the Department to ensure it has a clear understanding of the scope document and the data elements required for submission. • HSAG recommends the Department replace the ICD9PCS with ICD-10 codes within the scope document for this indicator.

Table 9—Key Review Findings for Access Behavioral Care—Northeast
Indicator 4: *Follow-up Appointment Within 7 Days*
After a Hospital Discharge for a Mental Health Condition

Findings
ABC-NE calculated this rate. The programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **ABC-NE** during the on-site visit. HSAG performed PSV and identified no discrepancies.
Key Recommendations
• **ABC-NE** should continue to inspect the 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 Access Behavioral Care—Northeast
Indicator 5: *Follow-up Appointment Within 30 Days*
After a Hospital Discharge for a Mental Health Condition

Findings
ABC-NE calculated this rate. The programming code used for calculation of this rate was reviewed and approved by HSAG. The result of the source code review was provided to **ABC-NE** during the on-site visit. HSAG performed PSV and identified no discrepancies.
Key Recommendations
• **ABC-NE** should continue to inspect the 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 Access Behavioral Care—Northeast
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 **ABC-NE**. Encounter data was 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 **ABC-NE**, it was determined that all processes used to collect data met standards. Prior to the site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns.
Key Recommendations
• **ABC-NE** should continue to inspect the 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. • HSAG recommends the Department modify the wording convention in the scope document for this indicator to include member months for the purposes of calculating the denominator.

Table 12—Key Review Findings for Access Behavioral Care—Northeast
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 **ABC-NE**. Encounter data was 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 **ABC-NE**, it was determined that all processes used to collect data met standards. Following the site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns.
Key Recommendations
• **ABC-NE** should continue to inspect the 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. • HSAG recommends the Department modify the wording convention in the scope document for this indicator to include member months for the purposes of calculating the denominator.

Table 13 lists the validation result for each performance measure indicator for **ABC-NE**.

Table 13—Summary of Results

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

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 *FY 2018 BHO-HCPF Incentive Performance Measures Scope Document, Created: January 31, 2017, Last Revised: October 2017.* 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.

HSAG HEALTH SERVICES ADVISORY GROUP

BHO-HCPF Incentive Performance Measures Scope Document

Fiscal Year 2018 (FY18)

This document includes the details for calculations of the BHO-HCPF 2016-2017 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: November 2017*

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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, 2016 to May 14, 2017

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: 50.19% - 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, 2016 to May 14, 2017

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 with 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: 62.66% - 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, 2016 to May 14, 2017

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: 38.01%

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 22 (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: 52.53%

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 22 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 22 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 22 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
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 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.

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: 72.61%

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
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, 2016 to June 30, 2017

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

Benchmark: 12.86%

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, 2016 to June 30, 2017

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

Benchmark: 18.77%

Appendix B. Data Integration and Control Findings

Documentation Work Sheets

BHO Name:	Access Behavioral Care—Northeast
On-Site Visit Date:	December 8, 2017
Reviewer:	Regina Cameron, Jenny Starbuck

Data Integration and Control Element	*Met*	*Not Met*	*N/A*	Comments
Accuracy of data transfers to assigned performance measure data repository.				
• The Department and the BHO accurately and completely process transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	☒	☐	☐	
• Samples of data from the repository are complete and accurate.	☒	☐	☐	
Accuracy of file consolidations, extracts, and derivations.				
• The Department's and the BHO's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	☒	☐	☐	
• Actual results of file consolidations or extracts are consistent with results expected from documented algorithms or specifications.	☒	☐	☐	
• Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	☒	☐	☐	
• Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	N/A	Comments
If the Department and the BHO use a performance measure data repository, the structure and format facilitate any required programming necessary to calculate and report required performance measures.				
• The repository's design, program flow charts, and source codes enable analyses and reports.	☒	☐	☐	
• Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	
Assurance of effective management of report production and reporting software.				
• Documentation governing the production process, including Department and BHO production activity logs and staff review of report runs, is adequate.	☒	☐	☐	
• Prescribed data cutoff dates are followed.	☒	☐	☐	
• The Department and the BHO retain copies of files or databases used for performance measure reporting in the event that results need to be reproduced.	☒	☐	☐	
• The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	☒	☐	☐	
• The Department's and the BHO's processes and documentation comply with standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Appendix C. Denominator and Numerator Validation Findings

Reviewer Work Sheets

BHO Name:	Access Behavioral Care—Northeast
On-Site Visit Date:	December 8, 2017
Reviewer:	Regina Cameron, Jenny Starbuck

Denominator Elements for Access Behavioral Care—Northeast				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
• For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	☒	☐	☐	
• Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	☒	☐	☐	
• The Department and the BHO have correctly calculated member months and years, if applicable to the performance measure.	☒	☐	☐	
• The Department and the BHO have properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	☒	☐	☐	
• Parameters required by the specifications of each performance measure are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	☒	☐	☐	
• Exclusion criteria included in the performance measure specifications have been followed.	☒	☐	☐	
• Systems or methods used by the Department and the BHO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	Population estimates were not required.

Numerator Elements for Access Behavioral Care—Northeast				
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 utilized.
• 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).	☒	☐	☐	

Appendix D. Performance Measure Results Tables

Encounter Data

The measurement period for performance measures validated in FY 2017–2018 is July 1, 2016, through June 30, 2017.

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

Table D-1—*Mental Health Engagement* (all members excluding foster care)
(Measurement Period: July 1, 2016, through June 30, 2017)
for Access Behavioral Care—Northeast

Population	Denominator	Numerator	Rate
All Ages	4,281	1,962	45.8%

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

Table D-2—*Mental Health Engagement* (only foster care)
(Measurement Period: July 1, 2016, through June 30, 2017)
for Access Behavioral Care—Northeast

Population	Denominator	Numerator	Rate
All Ages	222	131	59.0%

Indicator 3—*Engagement of AOD Treatment*

Table D-3—*Engagement of AOD Treatment*
(Measurement Period: July 1, 2016, through June 30, 2017)
for Access Behavioral Care—Northeast

Population	Initiation of AOD Treatment			Engagement of AOD Treatment		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
All Ages	2,787	1,238	44.4%	2,787	625	22.4%

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*
(Measurement Period: July 1, 2016, through June 30, 2017)
for Access Behavioral Care—Northeast

Population	Denominator	Numerator	Rate
All Ages	1,297	524	40.4%

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*
(Measurement Period: July 1, 2016, through June 30, 2017)
for Access Behavioral Care—Northeast

Population	Denominator	Numerator	Rate
All Ages	1,148	642	55.9%

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

Table D-6—*Emergency Department Utilization for Mental Health Condition*
(Measurement Period: July 1, 2016, through June 30, 2017)
for Access Behavioral Care—Northeast

Population	Denominator	Numerator	Rate
All Ages	163,296	2,638	16.2

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

Table D-7—*Emergency Department Utilization for Substance Use Condition*
(Measurement Period: July 1, 2016, through June 30, 2017)
for Access Behavioral Care—Northeast

Population	Denominator	Numerator	Rate
All Ages	163,296	3,550	21.7