COLORADO

Department of Health Care Policy & Financing

FY 2024–2025 Validation of Performance Measures for Northeast Health Partners Region 2

May 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

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Validation of Performance Measures

Executive Summary

Overall, the Colorado Department of Health Care Policy & Financing (the Department) demonstrated that it had adequate policies and procedures in place when calculating the five incentive performance measures with the data provided by Northeast Health Partners (NHP). Health Services Advisory Group, Inc. (HSAG) identified no concerns with how the Department received, processed, or reported the enrollment, claims, and encounter data from NHP. Additionally, HSAG identified no concerns with how the Department integrated NHP's data and calculated the performance measure indicators. All five indicators received a validation result of "R," which indicates a Reportable designation. For additional information about the specific audit findings, please refer to Appendix B through Appendix D.

Validation Overview

In accordance with 42 CFR §438.330(c), states must require that Regional Accountable Entities (RAEs) 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 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)(1-2). The EQR technical report must include information on the validation of the RAEs' performance measures (as required by the state) or the RAEs' 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 Department and determine the extent to which the reported rates follow the state specifications and reporting requirements. According to the Centers for Medicare & Medicaid Services (CMS) *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023,[1] the mandatory PMV activity may be performed by the state Medicaid agency, an agent that is not a RAE, or an external quality review organization (EQRO). HSAG, the EQRO for the Department, conducted the validation activities during fiscal year (FY) 2024–2025.

The Department contracted with seven RAEs 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 for which the RAEs provided data to the Department for the measurement period of July 1, 2023, through June 30, 2024. All measures were calculated by the Department using data submitted by the RAEs. The measure data came from multiple sources, including claims/encounter and enrollment/eligibility data.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Mar 3, 2025.

Virtual Review Information

Basic information about the virtual review for NHP appears in Table 1, including the contact information for the virtual review.

Table 1—Virtual Review Information

Organization Name:	Colorado Department of Health Care Policy & Financing
Contact Name:	James Bloom, Program Manager, Pharmacy and Behavioral Health Data
Contact Telephone Number:	303.866.3480
Contact Email Address:	James.bloom@state.co.us
Virtual Review Date:	January 27, 2025

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 RAEs. The measures were calculated annually.

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 Northeast Health Partners

	Indicator	Calculated by:
1	*Initiation and Engagement of Substance Use Disorder (SUD) Treatment*	Department
2	*Follow-Up after Hospitalization for Mental Illness*	Department
3	*Follow-Up after Emergency Department Visit for Substance Use*	Department
4	*Follow-Up Visit after a Positive Depression Screen*	Department
5	*Behavioral Health Screening or Assessment for Children in the Foster Care System*	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, HSAG obtained a list of the performance measures that were selected by the Department for validation.

HSAG prepared a document request letter that outlined 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 the Department during the pre-virtual review phase.

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

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 the Department. Table 3 lists the validation team members and their roles, skills, and expertise.

Table 3—Validation Team

Name and Role	Skills and Expertise
Emily Redman, MA, CHCA *Lead Auditor; Associate Director, Data Science & Advanced Analytics (DSAA)*	Multiple years of auditing experience related to performance measurement, quality improvement, data review and analysis, data integration and validation, and care management, as well as healthcare industry experience.
Fidel Sanchez, BA, CPhT *Secondary Auditor; Auditor I*	Multiple years of experience in pharmacy claim auditing, data review, and reporting.
Sarah Lemley *Source Code Reviewer*	Multiple years of audit-related experience; statistics, analysis, and source code/programming language knowledge.

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):** 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-virtual review assessment of information systems.
- **Source code (programming language) for performance measures:** The Department calculated the performance indicators using source code and was 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. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). If the Department did not use source code to generate the performance measures, it was 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.

Virtual Review Activities

HSAG conducted a virtual review with the Department. 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 virtual review activities are described as follows:

- **Opening session:** The opening session included introductions of the validation team and key staff members from 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 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 measures.

- **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 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 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's systems during the virtual review for verification. This method provided the Department an opportunity to explain its 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 virtual review clarification and follow-up documentation provided by the Department.

  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 had 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 virtual review and the review of the ISCAT. In addition, the documentation requirements for any post-virtual review activities were reviewed.

HSAG conducted several interviews with key staff members from the Department who were involved with any aspect of performance indicator reporting. Table 4 displays the Department staff members who attended the virtual review.

Table 4—List of Virtual Review Attendees From the Department

Name	Title
James Bloom	Program Manager, Pharmacy and Behavioral Health Data
Christopher Larson	Statistical Analyst
Doug Davis	Behavioral Health Unit Supervisor
Lisa Henningson	Managed Care Business Analyst
Oswaldo Bernal-Flores	Behavioral Health Lead Rates & Reconciliation Analyst
Emily Kelley	Quality Improvement Specialist
Jerry Ware	External Quality Review Organization Quality 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, 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 were:

☒ Acceptable
☐ Not acceptable

Data Control

The organizational infrastructure 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, 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 the Department 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 the Department. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, and computer programming code; output files; workflow 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 the Department was:

☒ Acceptable
☐ Not acceptable

Validation Results

HSAG evaluated the Department'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 the Department received and processed enrollment data for members enrolled with NHP.

The Department walked through the systems and processes related to eligibility and enrollment for NHP. NHP received daily 834 eligibility change files and monthly 834 full eligibility files from the Department's secure file transfer protocol (FTP) site. The daily files contained enrollment and eligibility reinstatements, adds, terminations, and changes. Each monthly file contained all members enrolled for the month in which it was received. Eligibility was determined in the Department's Interchange system, using policy rules as defined by the program and policy staff members at the Department. Each file was automatically downloaded and scrubbed to determine if the record was a duplicate, new entry, or had any errors. If an error was present, NHP reached out to the State enrollment team at the Department to obtain a resolution, and a manual update would be made in the Department's system until a new 834 file was received. An example of an error included member eligibility changing from one month to the next (e.g., a member is eligible in one month, then shows ineligible for the same month in a future file, etc.). Errors were corrected as the new eligibility files were loaded, since they overwrote the previous information. The Department maintained a change record of eligibility updates. In addition to these checks within the Interchange system, the Department's vendor, International Business Machines (IBM), ran a weekly attribution batch file within its Business Intelligence and Data Management System (BIDM) to determine the best primary care medical provider (PCMP) for each member's needs.

Members were assigned to NHP based on the provider rendering the service. Since members were assigned this way, the attribution process closed the span before the member would start seeing a new provider in another RAE region. If a member disenrolled and then re-enrolled, they kept the same identification (ID) number. If the same member re-enrolled within 60 days of disenrollment, they were also attributed to the same PCMP. If a member was not previously enrolled with another RAE, their enrollment started the day the Medicaid eligibility information was received from the Colorado Benefits Management System (CBMS). This could occur at any time during the month. If a member moved outside of the region, they would not be attributed to the PCMP where the member had historical utilization and would instead be reattributed to the PCMP within the new region where they moved. If a member was assigned to a specific RAE region, but they preferred a specific PCMP and required a behavioral health provider in a different RAE region, the enrollment reason code 02, BH RAE override was applied. This code ensured that the system would not move the member to a different RAE based on their location. Deceased members were disenrolled on the date of death, which could be retroactively updated. Additionally, incarcerated members were disenrolled on the date of incarceration, which could also be retroactively updated.

Claims/Encounter Data System Findings

HSAG identified no concerns with how the Department received, processed, or reported encounter data from NHP.

All encounters were submitted to the Department through Interchange and as a flat file through a secure FTP site on a quarterly basis. Institutional and professional claims were both submitted through flat files but were paid differently by NHP. Institutional claims were paid based on the overall claim, not based on the different lines in the claim. Professional claims were paid based on procedural code on each claim line. There were certain checks done by the Department to ensure that encounters were being submitted correctly. In addition to these checks, the size of the file was checked, as well as row counts and totals of dollars. The types of errors typically observed were formatting errors and missing data from providers. If issues were identified, the Department communicated these errors to NHP. If the submission was a complete rejection, which included critical errors such as missing required fields or incorrect payment amounts, NHP would then resubmit its updated file within a few business days and did not wait until next quarter's submission to make any corrections. If the submission was a rejection, which included minor errors such as a missing diagnostic code or missing provider ID, NHP would wait until the next quarter's submission to make the corrections.

NHP submitted the flat file to the Department in addition to the 837 file that was submitted by the middle of the month for the previous quarter. The flat file was used for performance measure calculations because the RAEs had continued challenges with submission of the 837 files to the Department due to field value rejections. The Department indicated that most rejections occurred because of provider enrollment issues and out-of-date information from the RAEs. If the file was rejected, the Department communicated the rejection to NHP, and NHP resubmitted the file within a week. The Department also used data from fee-for-service (FFS) encounters for measure calculation. The Department demonstrated alignment with the performance measure specifications in its determination of appropriate provider billing type data based on the FFS files, since FFS codes could be billed by non-behavioral health providers to which the performance measures did not apply.

Data Integration

HSAG identified no concerns with how the Department handled data integration, data preproduction, and measure calculation.

The Department contracted with IBM to both manage its data warehouse and perform measure calculations for Indicators 1–3 as its certified HEDIS measure calculation vendor. IBM had adequate validation and reconciliation processes in place at each data transfer point to ensure data completeness and data accuracy of the data warehouse. Regular joint meetings occurred for oversight of IBM data warehouse team processes, along with comprehensive reporting that was provided to the Department for data monitoring. IBM's software platform for HEDIS measure calculation, CareAnalyzer, was verified by the auditor to be certified for measurement year (MY) 2023 reporting of the HEDIS measures in

scope of the audit. The Department demonstrated sufficient monitoring of vendor performance and included evaluation of vendor performance in its oversight processes.

The Department's internal programmers used Structured Query Language (SQL) for calculation of Indicators 4 and 5. All cases included in each measure were identified based on the *Regional Accountable Entity Behavioral Health Incentive Specification Document SFY 2023–2024*. The Department used NHP's flat files of encounter data to determine the denominator for each indicator. The exclusions were calculated separately for the flat file and the FFS encounters, then combined with the flat files to calculate the rates. Quarterly checks of the encounter flat file and FFS data were completed separately, then another check was completed after the data were combined to ensure accuracy. Peer review checks on SQL queries are used to ensure accurate programming of the measure inclusion and exclusion criteria. The Department indicated that it provided quarterly updates of indicator calculations to provide NHP with an opportunity to compare the data to NHP's expected rates. Additionally, an annual check was performed by the Department in December to provide a more in-depth review of the data being submitted by NHP.

HSAG conducted PSV for four to five members for each of the measures in scope of the audit. Enrollment, administrative, and practitioner data in the source systems were reviewed for each member to confirm compliance with measure specifications and alignment with the output file provided to HSAG. All members reviewed were found to be compliant with the measure specification requirements.

Performance Indicator Specific Findings

Based on all validation activities, HSAG determined results for each performance indicator. The CMS PMV Protocol identifies two possible validation finding designations for performance indicators, which are defined in Table 5.

Table 5—Designation Categories for Performance Indicators

Reportable (R)	Indicator was compliant with the Department's reporting requirements and the technical specifications, and the rate can be reported.
Not Reportable (NR)	This designation is assigned to indicators for which (1) the RAE rate was materially biased or (2) the RAE 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 10 display the review findings and key recommendations for NHP for each validated performance measure. For more detailed information, please see Appendix D.

Table 6—Key Review Findings for Northeast Health Partners
Indicator 1: *Initiation and Engagement of Substance Use Disorder (SUD) Treatment*

Findings
The Department calculated this rate based on claims and encounter data received from NHP, as well as fee-for-service encounter data. NHP encounter data were submitted to the Department in an 837-file format and a flat file format. The Department relied upon the flat file for its rate calculation. Prior to the virtual review, HSAG ensured the programming code used by the Department's vendor, CareAnalyzer, for rate calculation was certified by NCQA. HSAG performed PSV during the virtual review and identified no discrepancies.
Key Recommendations
HSAG has no recommendations for this indicator.

Table 7—Key Review Findings for Northeast Health Partners
Indicator 2: *Follow-Up after Hospitalization for Mental Illness*

Findings
The Department calculated this rate based on claims and encounter data received from NHP, as well as fee-for-service encounter data. NHP encounter data were submitted to the Department in an 837-file format and a flat file format. The Department relied upon the flat file for its rate calculation. Prior to the virtual review, HSAG ensured the programming code used by the Department's vendor CareAnalyzer for rate calculation was certified by NCQA. HSAG performed PSV during the virtual review and identified no discrepancies.
Key Recommendations
HSAG has no recommendations for this indicator.

Table 8—Key Review Findings for Northeast Health Partners
Indicator 3: *Follow-Up after Emergency Department Visit for Substance Use*

Findings
The Department calculated this rate based on claims and encounter data received from NHP, as well as fee-for-service encounter data. NHP encounter data were submitted to the Department in an 837-file format and a flat file format. The Department relied upon the flat file for its rate calculation. Prior to the virtual review, HSAG ensured the programming code used by the Department's vendor CareAnalyzer for rate calculation was certified by NCQA. HSAG performed PSV during the virtual review and identified no discrepancies.
Key Recommendations
HSAG has no recommendations for this indicator.

Table 9—Key Review Findings for Northeast Health Partners
Indicator 4: *Follow-Up Visit after a Positive Depression Screen*

Findings
The Department calculated this rate based on claims and encounter data received from NHP, as well as fee-for-service encounter data. NHP encounter data were submitted to the Department in an 837-file format and a flat file format. The Department relied upon the flat file for its rate calculation. Prior to the virtual review, HSAG reviewed the programming code used by the Department for rate calculation and identified minor issues that were corrected by the Department, and HSAG verified that the code was corrected in line with measure specifications. HSAG performed PSV during the virtual review and identified no discrepancies.
Key Recommendations
HSAG recommends that the Department consider testing of analytic output when updates are made to programming code for this indicator in order to prevent any misalignment with the measure specifications.

Table 10—Key Review Findings for Northeast Health Partners
Indicator 5: *Behavioral Health Screening or Assessment for Children in the Foster Care System*

Findings
The Department calculated this rate based on claims and encounter data received from NHP, as well as fee-for-service encounter data. NHP encounter data were submitted to the Department in an 837-file format and a flat file format. The Department relied upon the flat file for its rate calculation. Prior to the virtual review, HSAG reviewed the programming code used by the Department for rate calculation and identified minor issues that were corrected by the Department, and HSAG verified that the code was corrected in line with measure specifications. HSAG performed PSV during the virtual review and identified no discrepancies.
Key Recommendations
HSAG recommends that the Department consider testing of analytic output when updates are made to programming code for this indicator in order to prevent any misalignment with the measure specifications.

Table 11 lists the validation result for each performance measure indicator for NHP.

Table 11—Summary of Results

#	Indicator	Validation Result
1	*Initiation and Engagement of Substance Use Disorder (SUD) Treatment*	**R**
2	*Follow-Up after Hospitalization for Mental Illness*	**R**
3	*Follow-Up after Emergency Department Visit for Substance Use*	**R**
4	*Follow-Up Visit after a Positive Depression Screen*	**R**
5	*Behavioral Health Screening or Assessment for Children in the Foster Care System*	**R**

Appendix A. RAE Performance Measure Definitions

Indicators

#	Indicator	Calculated by:
1	*Initiation and Engagement of Substance Use Disorder (SUD) Treatment*	Department
2	*Follow-Up after Hospitalization for Mental Illness*	Department
3	*Follow-Up after Emergency Department Visit for Substance Use*	Department
4	*Follow-Up Visit after a Positive Depression Screen*	Department
5	*Behavioral Health Screening or Assessment for Children in the Foster Care System*	Department

The Department collaborated with the RAEs to create a scope document that serves as the specifications for the performance measures being validated. Following is the *Regional Accountable Entity Behavioral Health Incentive Specification Document SFY 2023–2024*, Version 4, dated August 12, 2024. 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.

Regional Accountable Entity

Behavioral Health Incentive Specification Document

SFY 2023-2024

COLORADO
Department of Health Care Policy & Financing

Version 4: 08.12.2024

This document includes the details for calculations of Behavioral Health Incentive Program Indicator Measures for the seven Regional Accountable ***Entities.***

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Indicator 1: Initiation and Engagement of Substance Use Disorder (SUD) Treatment

[CMS Core Measure IET-AD; Measure Steward = NCQA]

Measure Description

Percentage of new substance use disorder (SUD) episodes that results in treatment initiation and engagement. Two rates are reported:

- Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
- Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Measurement Period

July 1, 2023 - June 30, 2024

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Calculation of Measure

This measure will be calculated by the Department.

Indicator 2: Follow-up after Hospitalization for Mental Illness

[CMS Core Measure FUH-AD; Measure Steward = NCQA]

Measure Description

Percentage of member discharges for beneficiaries age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

- Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge
- Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge

Measurement Period

July 1, 2023 - June 30, 2024

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Calculation of Measure

This measure will be calculated by the Department.

Measure Reporting Details

This measure will be calculated using both the Adult and Child Core Set Specifications.

Indicator 3: Follow-up after Emergency Department Visit for Substance Use

[CMS Core Measure FUA-AD; Measure Steward = NCQA]

Measure Description

Percentage of emergency department (ED) visits for beneficiaries age 13 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

- Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).
- Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).

Measurement Period

July 1, 2023 - June 30, 2024

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Calculation of Measure

This measure will be calculated by the Department.

Measure Reporting Details

This measure will be calculated using both the Adult and Child Core Set Specifications.

Indicator 4: Follow-up Visit after a Positive Depression Screen

[Measure Steward = HCPF]

Measure Description

Percentage of members over the age of 11 who received a follow-up visit on or within 30 days of screening positive for depression.

This measure has two parts; Part 1), which must be met prior to moving on to (Part 2). The overall measure description is: Percentage of members engaged in mental health service on or within 30 days of screening positive for depression.

Part 1

The member must have a depression screening AND the depression screening rate must increase by 10% Gap closure between RAE performance and the Department Goal, as identified by the number of members with an outpatient visit in the evaluation period who received a depression screening: (any of the following codes)

- G8431 – Screening for Depression Documented as Positive, AND Follow-Up Plan Documented
- G8432 – Screening for Depression not Documented, Reason not Given
- G8510 – Screening for Depression Documented as Negative, Follow-Up Plan not Required
- G8511 – Screening for Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given

Part 2

All members identified in Part 1 with a positive depression screening who also received one of the following services on the same day or within 30 days: See table under "Numerator".

Measurement Period

Triggering event: July 1, 2023 to June 1, 2024 (Part 1)

Full measurement period: July 1, 2023 to June 30, 2024 (Part 2)

Denominator

All members with a positive depression screening as identified by procedure code G8431 and G8511.

Notes:

1. Billing provider type is only used on FFS data for the calculation of this metric.
2. Exclusions from the Denominator:
    a. Exclude members under 12 years old
    b. Exclude G9717 Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder
    c. Exclude G8433 (Screening for Depression not Completed, Documented Reason)

Numerator

All members with a positive depression screen who also received one of the following services the same day or within 30 days:

<table>
<tr><th>Condition Description</th><th># Event</th><th colspan="4">Detailed Criteria</th><th>Criteria Connector</th><th>Timeframe</th></tr>
<tr><td>Members included in the denominator</td><td>1</td><td colspan="4"></td><td>and</td><td>During evaluation period</td></tr>
<tr><td>Outpatient visit with a PCMP</td><td>1</td><td colspan="4">90791, 90832, 90834, 90837, 90846, 90847</td><td>or</td><td>Within 30 days of the positive depression screen</td></tr>
<tr><td rowspan="3">At least one of the following services</td><td rowspan="3">1</td><td colspan="4">Codes to identify follow-up Assessment in any setting (Behavioral Health or Primary Care)</td><td rowspan="3">Or</td><td rowspan="3">Within 30 days of the Positive Depression Screen</td></tr>
<tr><td>CPT</td><td rowspan="2">with</td><td>Billing Provider Type</td></tr>
<tr><td>90791, 90792, 90832, 90834, 90837, 90846, 90847</td><td>35, 37, 38, 41, 25, 26, 05, 39</td></tr>
</table>

<table>
<tr>
<td></td>
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<table>
<tr><th colspan="3">Codes to identify follow-up Assessment in a Behavioral Health Setting using a Behavioral Health Screen or Evaluation and Management Codes, including Emergency Department E&M Codes and Consultation E&M Codes</th></tr>
<tr><th>CPT/HCPC</th><th></th><th>Billing Provider Type</th></tr>
<tr><td>H0002, H2011, H0031, 90833, 90836, 90838, 99202-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 99281-99285, 99241-99245,</td><td>With</td><td>37, 35, 38, 25</td></tr>
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<td>Or</td>
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<tr><td></td><td></td><td>99251-
99255</td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td colspan="5">UB Revenue Code 0529 or 0900 with the following</td></tr>
<tr><td></td><td></td><td>CPT/HCPC</td><td rowspan="2">with</td><td>Billing Provider Type</td><td rowspan="2">or</td><td rowspan="2">Within 30 days of the Positive Depression Screen</td></tr>
<tr><td></td><td></td><td>H0002, H2011, H0031, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 99202-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-</td><td>32, 45</td></tr>
</table>

		99443, 99281-99285, 99241-99245, 99251-99255				

Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC on the date of the positive depression screen for 30 days, with no gaps.

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data, as appropriate.

Calculation of Measure

This measure will be calculated by the Department once, annually.

Indicator 5: Behavioral Health Screening or Assessment for Children in the Foster Care system

[Measure Steward = HCPF]

Measure Description

Percentage of foster care children who received a behavioral screening or assessment on or within 30 days of ACC enrollment.

Measurement Period

Triggering event: July 1, 2023 to June 1, 2024

Full Measurement Period: July 1, 2023 to June 30, 2024

Denominator

Total number of members who became Medicaid eligible on or after July 1, 2023 based on aid code and are assigned to a RAE. Members must be continuously enrolled for 30 days from the date of ACC enrollment.

Notes:

1. Billing provider type is only used on FFS data for the calculation of this metric.
2. If a member moves from one aid category to another, they will not be added to the denominator a second time. Only members new to foster care will count in the denominator.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members who became Medicaid eligible based on aid code, are enrolled in a RAE for 30 days from the date of ACC enrollment	1	Aid Codes used to identify members 10, 11, 12, 13, 19, 20, 23, 70	and	During the evaluation period

Population Exclusions

Exclude members with aid code 30 from denominator.

Condition Description	Billing Provider Type	HCPCS	UB Revenue	UB Type of Bill	POS
Psychiatric residential treatment center (when services are paid for by Fee For Service)	30		0911		
Qualified Residential Treatment Programs (when services are paid for by Fee For Service)	52, 68	90791, 90792, 90785, 90832, 90834, 90837, 90846, 90847, 90853, 96101, 96102, 90833, 90836, 90839, 90840, 90863, H0019			11, 14, 56

Numerator

Total number of members from the denominator who received one of the following services on or within 30 days of ACC enrollment:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members included in the denominator	1		and	During evaluation period
Outpatient visit with a PCMP	1	90791, 90832, 90834, 90837, 90846, 90847	or	Within 30 days from the date of RAE enrollment
At least one of the following services	1	Codes to identify follow-up Assessment in a Behavioral Health Setting using a Behavioral Health Screen or Evaluation		Within 30 days from the date of RAE enrollment

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and Management Codes, including Emergency Department E&M Codes and Consultation E&M Codes
<table>
<tr><th>CPT/HCPC</th><td rowspan="2">with</td><th>Billing Provider Type</th></tr>
<tr><td>H0002, H2011, H0031, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 99202-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 99281-99285, 99241-99245, 99251-99255</td><td>37, 35, 38, 25,</td></tr>
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		90834, 90836, 90837, 90838, 90846, 90847, 99202-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 99281-99285, 99241-99245, 99251-99255			Within 30 days from the date of RAE enrollment

Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC for 30 days from the time enrollment began.

Data Source

All RAE claims, Encounter systems, FFS Claims, and Pharmacy data.

Calculation of Measure

This measure will be calculated by the Department once, annually.

Appendix B. Data Integration and Control Findings

Documentation Worksheets

Virtual Review Date:	January 27, 2025
Reviewer:	Emily Redman, MA LPCC-S, CHCA

Data Integration and Control Element	*Met*	*Not Met*	*N/A*	Comments
Accuracy of data transfers to assigned performance measure data repository.				
• The Department accurately and completely processes 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 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 RAE 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 production activity logs and staff review of report runs, is adequate.	☒	☐	☐	
• Prescribed data cutoff dates are followed.	☒	☐	☐	
• The Department retains 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 processes and documentation comply with standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

Appendix C. Denominator and Numerator Validation Findings

Reviewer Worksheets

Virtual Review Date:	January 27, 2025
Reviewer:	Emily Redman, MA LPCC-S, CHCA

Denominator Elements for Northeast Health Partners				
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.	☐	☒	☐	Initial source code review findings indicated that the Department missed some updates to the programming code when performing the coding and peer review for Indicators 4 and 5. The Department was able to make corrections to the code and HSAG validated the updated code, and the Department provided updated measure rates.
• The Department has correctly calculated member months and years, if applicable to the performance measure.	☐	☐	☒	Member months were not applicable to the performance measures in scope of the activity.
• The Department has 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.	☒	☐	☐	

Denominator Elements for Northeast Health Partners				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
• Systems or methods used to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	Population estimates were not required for the performance measures in scope of the activity.

Numerator Elements for Northeast Health Partners				
Audit Element	***Met***	***Not Met***	***N/A***	**Comments**
• The Department has 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 has 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.	☐	☐	☒	The Department did not use any nonstandard codes in measure calculation.
• 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 2024–2025 is July 1, 2023, through June 30, 2024.

Indicator 1: *Initiation and Engagement of Substance Use Disorder (SUD) Treatment*

Table D-1—*Initiation and Engagement of Substance Use Disorder (SUD) Treatment* for Northeast Health Partners

Population	Denominator	Numerator	Rate
All Ages	3,252	1,022	31.42%

Indicator 2: *Follow-Up after Hospitalization for Mental Illness*

Table D-2—*Follow-Up after Hospitalization for Mental Illness* for Northeast Health Partners

Population	Denominator	Numerator	Rate
All Ages	110	28	25.45%

Indicator 3: *Follow-Up after Emergency Department Visit for Substance Use*

Table D-3—*Follow-Up after Emergency Department Visit for Substance Use* for Northeast Health Partners

Population	Denominator	Numerator	Rate
All Ages	866	192	22.17%

Indicator 4: *Follow-Up Visit after a Positive Depression Screen*

Table D-4—*Follow-Up Visit after a Positive Depression Screen* for Northeast Health Partners

Population	Denominator	Numerator	Rate
All Ages	682	519	76.10%

Indicator 5: *Behavioral Health Screening or Assessment for Children in the Foster Care System*

Table D-5—*Behavioral Health Screening or Assessment for Children in the Foster Care System* for Northeast Health Partners

Population	Denominator	Numerator	Rate
All Ages	191	30	15.71%