COLORADO

Department of Health Care Policy & Financing

FY 2022–2023 Validation of Performance Measures for Health Colorado, Inc. Region 4

March 2023

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 Overview

In accordance with 42 CFR §438.330(c), states must require that managed care organizations (MCOs) and 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 the state Medicaid agencies are required to perform per the Medicaid managed care regulations as described in the Code of Federal Regulations (CFR) §438.358(b)(2). The EQR technical report must include information on the validation of the MCOs' and RAEs' performance measures (as required by the state) or the MCOs' and 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, October 2019*,[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). Health Services Advisory Group, Inc. (HSAG), the EQRO for the Colorado Department of Health Care Policy & Financing (the Department), conducted the validation activities during fiscal year (FY) 2022–2023.

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, 2021, through June 30, 2022. All measures were calculated by the Department using data submitted by the RAEs. 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. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 30, 2022.

Virtual On-Site Visit Information

Basic information about the virtual on-site visit for **Health Colorado, Inc.** (**HCI**) appears in Table 1, including the contact information for the virtual on-site visit.

Table 1—Virtual On-Site Visit Information

Organization Name:	Colorado Department of Healthcare Policy & Financing
Contact Name:	Jerry Ware
Contact Telephone Number:	303.866.2335
Contact Email Address:	Jerry.Ware@state.co.us
Virtual On-Site Visit Date:	January 23, 2023

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 Health Colorado, Inc.

	Indicator	Calculated by:
1	*Engagement in Outpatient Substance Use Disorder (SUD) Treatment*	Department
2	*Follow-Up Appointment Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*	Department
3	*Follow-Up Appointment Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder*	Department
4	*Follow-Up 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 on-site phase.

Approximately two weeks prior to the virtual on-site visit, HSAG provided the Department with an agenda describing all virtual on-site 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 on-site 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. Some team members, including the lead auditor, participated in the virtual on-site meetings at the Department; 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
Elisabeth Hunt, MHA, CPCS, CHCA *Executive Director; Lead Auditor*	Multiple years of experience in conducting audits, including readiness reviews; medical and pharmacy claims systems reviews; and data validation, analyses, and reporting.
Matthew Kelly, MBA *Project Manager; Secondary Auditor*	Multiple years of systems analysis, quality improvement, data review and analysis, and healthcare industry experience.
Cynthia Zendejas, MHA *Project Coordinator*	Coordinator for the audit department; supports deliverables and timelines, and coordinates source code review activities.
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 on-site 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 On-Site Activities

HSAG conducted a virtual on-site visit 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 on-site visit 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 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 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 on-site 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 on-site 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 on-site visit and the review of the ISCAT. In addition, the documentation requirements for any post-virtual on-site visit 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 on-site visit.

Table 4—List of Virtual On-Site Visit Attendees From the Department

Name	Title
James Bloom	Program Manager, Pharmacy and Behavioral Health Data
Jerry Ware	Program Management I/Quality Section
Helen Desta	Quality Section Manager
Emily Kelley	Quality & Health Improvement Specialist
Christopher Larson	Statistical Analyst
Lisa Henningson	Business Analyst, CO InterChange System
Oswaldo Bernal-Flores	Behavioral Health Data Analyst
Jake Melicher	Behavioral Health Data Analyst

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

While the Department presented appropriate data integration processes, which included readily identifying data completion and accuracy concerns within **HCI**'s submitted encounters, this element is denoted as *Not acceptable* due to the ongoing issues with **HCI**'s administrative encounters data.

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 **HCI** received and processed enrollment data.

HCI 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, **HCI** 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 **HCI** 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, he or she kept the same identification (ID) number. If the same member re-enrolled within 60 days of disenrollment, he or she was also attributed to the same PCMP. If a member was not previously enrolled with another RAE, his or her 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, he or she 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 he or she moved. 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

All encounters were submitted to the Department through Interchange and as a flat file through a secure FTP site on a quarterly basis. Encounters were received and processed the same way and claims were paid weekly. Institutional and professional claims were both submitted through flat files but were paid differently by **HCI**. 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. There were certain checks done by the Department to ensure that encounters were being submitted correctly. Checks included ensuring the 837 files met the Health Insurance Portability and Accountability Act (HIPAA) compliance rules and that there were no errors in the data being submitted. There were also checks to ensure the files followed rules based on CMS and State policies. In addition to these checks, the size of the file was checked, as well as row counts, totals of dollars, and totals of clients. The types of errors typically observed were formatting errors and missing data from providers. If issues were identified, the Department communicated these errors to **HCI**. If the submission was a complete rejection, which included critical errors such as missing required fields or incorrect payment amounts, **HCI** 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, **HCI** would wait until the next quarter's submission to make the corrections.

HCI also submitted a flat file through a secure FTP site quarterly 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 because **HCI** had continued challenges with submission of the 837 files to the Department due to field value rejections. During the reporting year, **HCI**'s organization that processed its claims, Beacon, made significant changes to its process in the fall of 2021, including switching from an in-house solution to an enterprise software solution, that resulted in rejected submission for all four quarters as well as the annual submission. **HCI**'s files were rejected for multiple reasons including transposition of data columns related to data for the SUD measures, incorrect units and cost information, missing data, and additional data that Beacon submitted in error. Additionally, there were significant decreases in the Community Mental Health Clinic (CMHC) utilization by up to 17 percent. Because of these issues, the Department issued a corrective action plan (CAP) in January 2023. 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 issues or concerns with how the Department integrated **HCI**'s data and calculated measures.

The Department 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 *Regional Accountable Entity Behavioral Health Incentive Specification Document SFY 2021–2022*. **HCI** submitted the flat files, which the Department used 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. All files were submitted to the Department quarterly. Quarterly checks of the flat file and FFS data were completed separately, then another check was completed after the data were combined to ensure accuracy. The Department indicated that it will implement a process to share quarterly updates of indicator calculations with **HCI** to provide **HCI** with an opportunity to compare the data to **HCI**'s expected rates. Additionally, an annual check was performed by the Department in December 2022. The annual check provided a more in-depth review of the data being submitted by **HCI**.

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

Report (R)	Indicator was compliant with the Department's specifications and the rate can be reported.
Do Not Report (DNR)	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 "DNR" 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 **HCI** for each validated performance measure. For more detailed information, please see Appendix D.

Table 6—Key Review Findings for Health Colorado, Inc.
Indicator 1: *Engagement in Outpatient Substance Use Disorder (SUD) Treatment*

Findings
The Department calculated this rate based on claims and encounter data received from **HCI**. 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. During the reporting year, **HCI**'s organization that processed its claims, Beacon, made significant changes to its internal systems in the fall of 2021, including switching from an in-house solution to an enterprise software solution, that resulted in incorrect submission for all four quarters as well as the annual submission. The annual submission was denied, and the quarterly data were accepted based on Beacon's assessment that supplemental files would correct the issues. Ultimately, the quarterly data were found to be non-credible, which resulted in a full resubmission. Additionally, the Department issued a CAP that included the following: • Correction and resubmission of quarterly data files for FY 2021–2022 due by January 30, 2023—this is the file used for metric calculation and includes all claim versions. • Corrected annual rates setting file for FY 2021–2022 due by February 20, 2023. Prior to the virtual on-site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns, and the results were provided to the Department. HSAG performed PSV during the virtual on-site and identified no discrepancies.
Key Recommendations
HSAG recommends that the Department continue to work with **HCI** to gain a better understanding of the changes in process that occurred with **HCI**'s vendor, Beacon, and continue to monitor its future data submissions. Additionally, HSAG recommends additional reviews by the Department of **HCI**'s data on a monthly basis to ensure that the data quality and completeness issues have been resolved.

Table 7—Key Review Findings for Health Colorado, Inc.
Indicator 2: ***Follow-Up Appointment Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition***

Findings
The Department calculated this rate based on claims and encounter data received from **HCI**. 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. During the reporting year, **HCI**'s organization that processed its claims, Beacon, made significant changes to its internal systems in the fall of 2021, including switching from an in-house solution to an enterprise software solution, that resulted in incorrect submission for all four quarters as well as the annual submission. The annual submission was denied, and the quarterly data were accepted based on Beacon's assessment that supplemental files would correct the issues. Ultimately, the quarterly data were found to be non-credible, which resulted in a full resubmission. Additionally, the Department issued a CAP that included the following: • Correction and resubmission of quarterly data files for FY 2021–2022 due by January 30, 2023—this is the file used for metric calculation and includes all claim versions. • Corrected annual rates setting file for FY 2021–2022 due by February 20, 2023. Prior to the virtual on-site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns, and the results were provided to the Department. HSAG performed PSV during the virtual on-site and identified no discrepancies.
Key Recommendations
HSAG recommends that the Department continue to work with **HCI** to gain a better understanding of the changes in process that occurred with **HCI**'s vendor, Beacon, and continue to monitor its future data submissions. Additionally, HSAG recommends additional reviews by the Department of **HCI**'s data on a monthly basis to ensure that the data quality and completeness issues have been resolved.

Table 8—Key Review Findings for Health Colorado, Inc.

Indicator 3: ***Follow-Up Appointment Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder***

Findings
The Department calculated this rate based on claims and encounter data received from **HCI**. 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. During the reporting year, **HCI**'s organization that processed its claims, Beacon, made significant changes to its internal systems in the fall of 2021, including switching from an in-house solution to an enterprise software solution, that resulted in incorrect submission for all four quarters as well as the annual submission. The annual submission was denied, and the quarterly data were accepted based on Beacon's assessment that supplemental files would correct the issues. Ultimately, the quarterly data were found to be non-credible, which resulted in a full resubmission. Additionally, the Department issued a CAP that included the following: • Correction and resubmission of quarterly data files for FY 2021–2022 due by January 30, 2023—this is the file used for metric calculation and includes all claim versions. • Corrected annual rates setting file for FY 2021–2022 due by February 20, 2023. Prior to the virtual on-site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns, and the results were provided to the Department. HSAG performed PSV during the virtual on-site and identified no discrepancies.
Key Recommendations
HSAG recommends that the Department continue to work with **HCI** to gain a better understanding of the changes in process that occurred with **HCI**'s vendor, Beacon, and continue to monitor its future data submissions. Additionally, HSAG recommends additional reviews by the Department of **HCI**'s data on a monthly basis to ensure that the data quality and completeness issues have been resolved.

Table 9—Key Review Findings for Health Colorado, Inc.
Indicator 4: *Follow-Up After a Positive Depression Screen*

Findings
The Department calculated this rate based on claims and encounter data received from **HCI**. 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. During the reporting year, **HCI**'s organization that processed its claims, Beacon, made significant changes to its internal systems in the fall of 2021, including switching from an in-house solution to an enterprise software solution, that resulted in incorrect submission for all four quarters as well as the annual submission. The annual submission was denied, and the quarterly data were accepted based on Beacon's assessment that supplemental files would correct the issues. Ultimately, the quarterly data were found to be non-credible, which resulted in a full resubmission. Additionally, the Department issued a CAP that included the following: • Correction and resubmission of quarterly data files for FY 2021–2022 due by January 30, 2023—this is the file used for metric calculation and includes all claim versions. • Corrected annual rates setting file for FY 2021–2022 due by February 20, 2023. Prior to the virtual on-site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns, and the results were provided to the Department. HSAG performed PSV during the virtual on-site and identified no discrepancies.
Key Recommendations
HSAG recommends that the Department continue to work with **HCI** to gain a better understanding of the changes in process that occurred with **HCI**'s vendor, Beacon, and continue to monitor its future data submissions. Additionally, HSAG recommends additional reviews by the Department of **HCI**'s data on a monthly basis to ensure that the data quality and completeness issues have been resolved.

Table 10—Key Review Findings for Health Colorado, Inc.
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 **HCI**. 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. During the reporting year, **HCI**'s organization that processed its claims, Beacon, made significant changes to its internal systems in the fall of 2021, including switching from an in-house solution to an enterprise software solution, that resulted in incorrect submission for all four quarters as well as the annual submission. The annual submission was denied, and the quarterly data were accepted based on Beacon's assessment that supplemental files would correct the issues. Ultimately, the quarterly data were found to be non-credible, which resulted in a full resubmission. Additionally, the Department issued a CAP that included the following: • Correction and resubmission of quarterly data files for FY 2021–2022 due by January 30, 2023—this is the file used for metric calculation and includes all claim versions. • Corrected annual rates setting file for FY 2021–2022 due by February 20, 2023. Prior to the virtual on-site visit, HSAG reviewed the programming code used by the Department for rate calculation and identified no issues or concerns, and the results were provided to the Department. HSAG performed PSV during the virtual on-site and identified no discrepancies.
Key Recommendations
HSAG recommends that the Department continue to work with **HCI** to gain a better understanding of the changes in process that occurred with **HCI**'s vendor, Beacon, and continue to monitor its future data submissions. Additionally, HSAG recommends additional reviews by the Department of **HCI**'s data on a monthly basis to ensure that the data quality and completeness issues have been resolved.

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

Table 11—Summary of Results

#	Indicator	Validation Result
1	*Engagement in Outpatient Substance Use Disorder (SUD) Treatment*	**DNR**
2	*Follow-Up Appointment Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*	**DNR**
3	*Follow-Up Appointment Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder*	**DNR**
4	*Follow-Up After a Positive Depression Screen*	**DNR**
5	*Behavioral Health Screening or Assessment for Children in the Foster Care System*	**DNR**

Appendix A. RAE Performance Measure Definitions

Indicators

#	Indicator	Calculated by:
1	*Engagement in Outpatient Substance Use Disorder (SUD) Treatment*	Department
2	*Follow-Up Appointment Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*	Department
3	*Follow-Up Appointment Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder*	Department
4	*Follow-Up 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 2021–2022*, Version 2.1, dated July 30, 2021. 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 2021-2022

This document includes the details for calculations of the Regional Accountable Entity Behavioral Health Incentive Measures for the seven Regional Accountable Entities. All measures are calculated using paid claims/encounters data.

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Indicator 1: Engagement in Outpatient Substance Use Disorder (SUD) Treatment

Measure Description

The percentage of members who had two or more outpatient services for a primary diagnosis of SUD on or within 30 days of their first episode of substance use disorder treatment.

Measurement Period

Triggering event: July 1, 2021 to June 1, 2022

Full measurement period: July 1, 2021 to June 30, 2022

Denominator

Members will be included in the denominator if they are enrolled in the ACC and received an intake service for a primary covered SUD diagnosis (see Appendix A). For an outpatient visit, or intensive outpatient visit use the first date of service to determine the intake date. For an episode of detoxification use the last date of the first detox episode to determine the intake date.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC	1		and	During evaluation period
Initiated treatment for a primary Covered SUD diagnosis (see Appendix A)	1	**Codes to Identify Detoxification**		During the evaluation period
		H0010 H0011	or	
		Codes to Identify Outpatient or Intensive Outpatient Visit		
		HCPCS		
		G0176, G0177, H0001, H0002, H0004, H0005, H0007, H0015, H0020, H0022, H0031, H0033, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012	or	

		CPT		
		99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99242, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90847, 90849, 90853, 90875, 90876		

Population Exclusions

Members are excluded if there is previous substance use treatment history in the past 60 days.

Numerator

Members in the denominator who have had at least two or more outpatient visits or intensive outpatient encounters with any primary SUD diagnosis (see Appendix A) on or within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day.

Notes:

1. Do not count events that include inpatient detoxification or detoxification codes (see table below) when identifying engagement of SUD treatment.
2. Billing provider type is only used on FFS data for the calculation of this metric.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members included in the denominator	1		and	During evaluation period
Two or more outpatient visits with a PCMP	1	90791, 90832, 90834, 90837, 90846, 90847	or	Within 30 days after initiation encounter

<table>
<tr>
<td rowspan="5">Two or more outpatient visits or intensive outpatient encounters with a primary covered SUD diagnosis (see Appendix A).</td>
<td rowspan="5">1</td>
<td colspan="4">Codes to Identify Outpatient or Intensive Outpatient Visit</td>
<td rowspan="5">Within 30 days after initiation encounter</td>
</tr>
<tr>
<td>HCPC</td>
<td rowspan="3">with</td>
<td>Billing Provider Type</td>
<td rowspan="3">or</td>
</tr>
<tr>
<td>G0176, G0177, H0001, H0002, H0004, H0005, H0006, H0007, H0015, H0020, H0022, H0031, H0032, H0033, HH0034, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, H0032, S9480, S9485, T1006, T1012</td>
<td>63, 64, 37, 35, 38, 25</td>
</tr>
<tr>
<td>CPT</td>
<td>Billing Provider Type</td>
</tr>
<tr>
<td>99202-99205, 99211-99215, 99217-99220, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832-90834, 90836-90840, 90847, 90849,</td>
<td>With</td>
<td>63, 64, 37, 35, 38, 25</td>
<td>or</td>
</tr>
</table>

<table>
<tr><td></td><td></td><td>90853, 90875, 90876</td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="4"></td><td rowspan="4"></td><td colspan="4">UB Revenue Codes</td><td rowspan="4">Within 30 days after initiation encounter</td></tr>
<tr><td colspan="4">The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes. Visits identified by the following Revenue codes must be used in conjunction with any primary covered Substance Use diagnosis code (see Appendix A).</td></tr>
<tr><td>Revenue Code</td><td rowspan="2">with</td><td>Billing Provider Type</td><td rowspan="2">or</td></tr>
<tr><td>0529, 0900, 0914, 0915, 1000, 1002</td><td>01
02</td></tr>
<tr><td></td><td></td><td colspan="4">UB Revenue Code 0900 with the following</td><td rowspan="3">Within 30 days after initiation encounter</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></tr>
<tr><td></td><td></td><td>G0176, G0177, H0001, H0002, H0004, H0005, H0007, H0015, H0020, H0022, H0031, H0033, H0034, H0035, H0036, H0037, H0038, H0039, H0040, H2000, H2001, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012, 99202-99205,</td><td>32, 45</td></tr>
</table>

		99211-99215, 99217-99220, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 90875, 90876				

Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC on the date of intake through 30 days after the intake date, with no gaps.

Data Source

RAE claims/encounter systems

FFS Claims

Calculation of Measure

This measure will be calculated by the Department.

Indicator 2: Follow-up appointment within 7 days of an Inpatient Hospital discharge for a mental health condition

Measure Description

The percentage of member discharges from an inpatient hospital episode for treatment of a primary covered mental health diagnosis to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a mental health provider on or within 7 days of discharge.

Measurement Period

Triggering event: July 1, 2021 to June 24, 2022

Full measurement period: July 1, 2021 to June 30, 2022

Denominator

Members will be included in the denominator if they are enrolled in the ACC and received a discharge from an inpatient hospital episode for treatment of a primary covered mental health diagnosis (See Appendix A) to the community or a non-24-hour treatment facility.

Notes:

1. The Department will not exclude state hospital stays not paid under Medicaid due to lack of data.
2. Billing provider type is only used on FFS data for the calculation of this metric.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC	1		and	During evaluation period
Member discharge from an inpatient hospital episode for a primary covered mental health diagnosis (see Appendix A).	1	**UB Revenue Code** 100-219 or 0100-0219		

Population Exclusions

Members with a non-acute care discharge will be excluded from the denominator based on the chart below.

Codes to Identify Non-Acute Care					
Condition Description	**Billing Provider Type**	**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			655		
Intermediate care facility					54
Residential substance abuse treatment facility			1002		55
Psychiatric residential treatment center		H0017-H0019	1001		56
Psychiatric residential treatment center (when services are paid for by Fee For Service)	30		0911		
Residential Child Care Facility (when services are paid for by Fee For Service)	52	90791, 90792, 90785, 90832, 90834, 90837, 90846, 90847, 90853, 96101, 96102, 90833, 90836, 90839, 90840, 90863			11, 14
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)

The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a primary diagnosis of mental health- within the 7-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.

- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 7-day follow-up period, regardless of primary diagnosis for the admission.

These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Numerator

Members in the denominator who were seen on an outpatient basis (this excludes case management) with a mental health provider on or within 7 days of discharge.

Notes:

1. Billing provider type is only used on FFS data for the calculation of this metric.

Condition Description	# Event	Detailed Criteria			Criteria Connector	Timeframe
Member included in the denominator	1	and				Within 7 days of the discharge
Outpatient visit with a PCMP	1	90791, 90832, 90834, 90837, 90846, 90847			or	Within 7 days of the discharge
Mental health (outpatient) follow-up visit with a mental health provider	1	**Codes to Identify Mental Health Visits**			or	Within 7 days of the discharge
		HCPCS	with	**Billing Provider Type**		
		G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011,		37, 35, 38, 28		

		H2012, H2014-H2018, H2022, M0064, S9480, S9485				
		CPT	with	**Billing Provider Type**	or	
		98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350		37, 35, 38, 28		
		CPT	with	**Billing Provider Type**	or	
		90791, 90792, 90832, 90834, 90837, 90839, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255		37, 35, 38, 28		
		UB Revenue Codes				Within 7 days of the discharge
		The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes. Visits identified by the following Revenue codes must be used in conjunction with any primary covered Mental Health diagnosis code (see Appendix A).				
		Revenue Code	**with**	**Billing Provider Type**	or	
		0900, 0914, 0915, 0529		01		

		UB Revenue Code 0900 with the following				
		CPT/HCPC		**Billing Provider Type**		
		G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2014-H2018, H2022, M0064, S9480, S9485, 98960-98962, 99201-99205, 99211-99215, 99217-99220, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832, 90834, 90837, 90839, 90847, 90849, 90853, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	with	32, 45	or	Within 7 days of the discharge

* 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.

Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC from date of discharge for 7 days, with no gaps.

Data Source

RAE claims/encounter systems

FFS Claims

Calculation of Measure

This measure will be calculated by the Department.

Indicator 3: Follow-up Appointment within 7 days of an Emergency Department (ED) visit for a Substance Use Disorder

Measure Description

The percentage of member discharges from an emergency department episode for treatment of a covered substance use disorder (SUD) to the community or a non-24-hour treatment facility who were seen on an outpatient basis by a behavioral health provider on or within 7 days of discharge.

Measurement Period

Triggering event: July 1, 2021 to June 24, 2022

Full measurement period: July 1, 2021 to June 30, 2022

Denominator

Members will be included in the denominator if they are enrolled in the ACC and received a discharge from an emergency department episode for treatment of a primary covered substance use disorder diagnosis (see Appendix A) to the community or a non-24-hour treatment facility.

Notes:

1. The Department will not exclude state hospital stays not paid under Medicaid due to lack of data.
2. Billing provider type is only used on FFS data for the calculation of this metric.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC	1		and	During evaluation period
Member discharge from an emergency department episode for a primary substance use disorder diagnosis (see Appendix A).	1	**UB Revenue Code**		
		45x or 045x	or	
		CPT		
		99281-99285	or	

Population Exclusions

Members with a non-acute care discharge will be excluded from the measure.

Codes to Identify Non-Acute Care					
Condition Description	**Billing Provider Type**	**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			655		
Intermediate care facility					54
Residential substance abuse treatment facility			1000		55
Psychiatric residential treatment center		H0017-H0019	1001		56
Psychiatric residential treatment center (when services are paid for by Fee For Service)	30		0911		
Residential Child Care Facility (when services are paid for by Fee For Service)	52	90791, 90792, 90785, 90832, 90834, 90837, 90846, 90847, 90853, 96101, 96102, 90833, 90836, 90839, 90840, 90863			11, 14
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)

The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a primary diagnosis of substance use disorder (SUD) within the 7-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.

- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 7-day follow-up period, regardless of primary diagnosis for the admission.

These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Numerator

Members in the denominator who were seen on an outpatient basis (this excludes case management) with a behavioral health provider on or within 7 days of discharge.

<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>Member included in the denominator</td><td>1</td><td colspan="4"></td><td>and</td><td>Within 7 days of the discharge</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 7 days of the discharge</td></tr>
<tr><td rowspan="3">Substance Use Disorder (outpatient) follow-up visit with a behavioral health provider</td><td rowspan="3">1</td><td colspan="4">Codes to Identify Detoxification</td><td rowspan="3">or</td><td rowspan="3"></td></tr>
<tr><td colspan="2">HCPCS</td><td rowspan="2">with</td><td>Billing Provider Type</td></tr>
<tr><td colspan="2">H2036
H0010
H0011</td><td>63, 64, 37, 35, 38, 25</td></tr>
</table>

		Codes to Identify Behavioral Health Visits				
		HCPC	with	**Billing Provider Type**	or	Within 7 days of the discharge
		G0176, G0177, H0001, H0002, H0004, H0005, H0006, H0007, H0015, H0020, H0022, H0031, H0032 H0033, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012		63, 64, 37, 35, 38, 25		
		CPT	with	**Billing Provider Type**	or	Within 7 days of the discharge
		99202-99205, 99211-99215, 99217-99220, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 90875, 90876		63, 64, 37, 35, 38, 25		

<table>
<tr><td rowspan="4"></td><td rowspan="4"></td><td colspan="5">UB Revenue Codes</td><td rowspan="4">Within 7 days of the discharge</td></tr>
<tr><td colspan="5">The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes. Visits identified by the following Revenue codes must be used in conjunction with any primary covered Substance Use diagnosis code (see Appendix A).</td></tr>
<tr><td>Revenue Code</td><td rowspan="2">with</td><td>Billing Provider Type</td><td rowspan="2">or</td></tr>
<tr><td>0529, 0900, 0914, 0915, 1000, 1002</td><td>01</td></tr>
<tr><td colspan="5">UB Revenue Code 0900 with the following</td><td rowspan="2">Within 7 days of the discharge</td></tr>
<tr><td>CPT/HCPC</td><td rowspan="2">with</td><td>Billing Provider Type</td><td rowspan="2">or</td></tr>
<tr><td>S3005, T1007, T1019, T1023, G0176, G0177, H0001, H0002, H0004, H0005, H0007, H0015, H0020, H0022, H0031, H0033, H0034, H0035, H0036, H0037, H0039, H0040, H2000, H2001, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2035, H2036, S9480, S9485, T1006, T1012 99202-99205, 99211-99215, 99217-99220, 99221-99223, 99231-99233,</td><td>32, 45</td></tr>
</table>

		99238, 99239, 99251-99255, 99242-99245, 99341-99345, 99347-99350, 90791, 90792, 90832-90834, 90836-90840, 90847, 90849, 90853, 90875, 90876				

Continuous Enrollment Criteria

Members must be continuously enrolled in the ACC from date of discharge for 7 days, with no gaps.

Data Source

RAE claims/encounter systems

FFS Claims

Calculation of Measure

This measure will be calculated by the Department.

Indicator 4: Follow-up after a Positive Depression Screen

Measure Description

Percentage of members 12 and older engaged in mental health service on or within 30 days of screening positive for depression within a Primary Care Setting (Primary Care Visit as defined by the RAE ACC Well Visit KPI Specification and Value Set).

> *In order to qualify for payment, depression screening rates must increase by a 10% Gap closure between RAE performance and the Department Goal, as identified by the number of members with an outpatient primary care visit in the evaluation period who received a depression screening (G8431, G8510)

Measurement Period

Triggering event: July 1, 2021 to June 1, 2022

Full measurement period: July 1, 2021 to June 30, 2022

Denominator

All members with a positive depression screening as identified by procedure code G8431in a primary care setting.

Notes:

1. Billing provider type is only used on FFS data for the calculation of this metric.

Exclusions from the Denominator:

1. **Exclude members under 2 years old**

Numerator

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

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 of the positive depression screen

<table>
<tr>
<td rowspan="5">At least one of the following services</td>
<td rowspan="5">1</td>
<td colspan="4">Codes to identify follow-up Assessment in any setting (Behavioral Health or Primary Care)</td>
<td rowspan="5">Within 30 days of the Positive Depression Screen</td>
</tr>
<tr>
<td>CPT</td>
<td rowspan="3">with</td>
<td>Billing Provider Type</td>
<td rowspan="3">Or</td>
</tr>
<tr>
<td>90791, 90792, 90832, 90834, 90837, 90846, 90847</td>
<td>35, 37, 38, 41, 25, 26, 05, 39</td>
</tr>
<tr>
<td colspan="4">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</td>
</tr>
<tr>
<td>CPT/HCPC</td>
<td rowspan="2">With</td>
<td>Billing Provider Type</td>
<td rowspan="2">Or</td>
</tr>
<tr>
<td>H0002, 90833, 90836, 90838, 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316, 99318, 99324-</td>
<td>37, 35, 38, 25</td>
</tr>
</table>

<table>
<tr><td rowspan="3"></td><td></td><td>99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 99281-99285, 99241-99245, 99251-99255</td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2"></td><td colspan="5">UB Revenue Code 0529 or 0900 with the following</td></tr>
<tr><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>H0002, H2011, H0031, 90833, 90836, 90838, 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-99310, 99315, 99316,</td><td>32, 45</td></tr>
</table>

		99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 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

RAE claims/encounter systems

FFS Claims

MCO Encounters as appropriate

Calculation of Measure

This measure will be calculated by the Department.

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

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, 2021 to June 1, 2022

Full Measurement Period: July 1, 2021 to June 30, 2022

Denominator

Total number of members who became Medicaid eligible on or after July 1, 2021 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	and	During the evaluation period

Population Exclusions

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		
Residential Child Care Facility (when services are paid for by Fee For Service)	52	90791, 90792, 90785, 90832, 90834, 90837, 90846, 90847, 90853, 96101, 96102, 90833, 90836, 90839, 90840, 90863			11, 14

Exclude members with aid code 70 from denominator.

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 and Management Codes, including Emergency Department E&M Codes and Consultation E&M Codes		Within 30 days from the date of RAE enrollment

<table>
<tr><td></td><td></td><td>CPT/HCPC
H0002, H0031, H2011, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 99201-99205, 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>with</td><td>Billing Provider Type
37, 35, 38, 25,</td><td></td></tr>
<tr><td></td><td></td><td colspan="3">UB Revenue Code 0529 or 0900 with the following
CPT/HCPC
H0002, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 99201-99205, 99211-99215, 99217-99226, 99231-99236, 99238, 99239, 99304-
with
Billing Provider Type
32, 45</td><td>Within 30 days from the date of RAE enrollment</td></tr>
</table>

		99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99366, 99367, 99368, 99441-99443, 99281-99285, 99241-99245, 99251-99255			

Continuous Enrollment Criteria

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

Data Source

RAE claims/encounter systems

FFS Claims

Calculation of Measure

This measure will be calculated by the Department.

Appendix B. Data Integration and Control Findings

Documentation Worksheets

Virtual On-Site Visit Date:	January 23, 2023
Reviewer:	Elisabeth Hunt and Matthew Kelly

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.	☐	☒	☐	While the Department demonstrated appropriate procedures, considering the significant data concerns related to **HCI**'s encounters, this element is considered not met by **HCI**.
• 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 On-Site Visit Date:	January 23, 2023
Reviewer:	Elisabeth Hunt and Matthew Kelly

Denominator Elements for Health Colorado, Inc.				
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.	☐	☒	☐	Significant data missing from CMHCs, resulting in an unknown degree of bias due to incomplete data.
• 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 has correctly calculated member months and years, if applicable to the performance measure.	☒	☐	☐	
• 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.	☒	☐	☐	
• Systems or methods used to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	The Department does not estimate populations.

Numerator Elements for Health Colorado, Inc.				
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 does not use any nonstandard codes.
• Parameters required by the specifications of the performance measure are adhered to (e.g., the measured event occurred during the time period specified or defined in the performance measure).	☒	☐	☐	

Appendix D. Performance Measure Results Tables

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 2022–2023 is July 1, 2021, through June 30, 2022.

Indicator 1: *Engagement in Outpatient Substance Use Disorder (SUD) Treatment*

Table D-1—*Engagement in Outpatient Substance Use Disorder (SUD) Treatment* for Health Colorado, Inc.

Population	Denominator	Numerator	Rate
All Ages	2,549	1,355	53.16%

Indicator 2: *Follow-Up Appointment Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition*

Table D-2—*Follow-Up Appointment Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition* for Health Colorado, Inc.

Population	Denominator	Numerator	Rate
All Ages	735	340	46.26%

Indicator 3: *Follow-Up Appointment Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder*

Table D-3—*Follow-Up Appointment Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder* for Health Colorado, Inc.

Population	Denominator	Numerator	Rate
All Ages	2,521	727	28.84%

Indicator 4: *Follow-Up After a Positive Depression Screen*

Table D-4—*Follow-Up After a Positive Depression Screen* for Health Colorado, Inc.

Population	Denominator	Numerator	Rate
All Ages	3,226	1,318	40.86%

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 Health Colorado, Inc.

Population	Denominator	Numerator	Rate
All Ages	242	36	14.88%